UTS UNIVERSITY OF TECHNOLOGY SYDNEY

Mistreatment of women during maternal health service utilisation: the case of Western Ethiopia

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A thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

Under the supervision of **Professor Kathleen Baird**, **Dr Vanessa Scarf** and **Dr Annabel Sheehy**

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Certificate of Original Authorship

I, Habtamu Kasaye, declare that this thesis is submitted in fulfilment of the requirements for the award of PhD Degree in Midwifery in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Publications included in this thesis

Four chapters of the findings of this thesis have been published and one is submitted for publication in peer-reviewed journals. I take complete responsibility for the accuracy of the findings presented in both these publications and this thesis. All authors have granted permission for the inclusion of these publications/submitted papers to be included in this PhD thesis.

THESIS FORMAT

This is a thesis by compilation, consisting of nine chapters including published peer review papers, a result section and a discussion. Chapters two comprises of a general literature review and systematic review paper that was published in BMC Pregnancy and Childbirth Journal. Chapters 4, 5 and 6 include peer reviewed and published papers, while Chapter 7 is a chapter that contains submitted paper to the publication and their details are listed below:

Incorporated in Chapter 2

1. Kasaye, H., Sheehy, A., Scarf, V., & Baird, K. (2023). 'The roles of multi-component interventions in reducing mistreatment of women and enhancing respectful maternity care: a systematic review'. *BMC Pregnancy and Childbirth*, vol 23(1), 305. https://doi.org/10.1186/s12884-023-05640-3.

Incorporated as Chapter 4

2. Kasaye, H., Scarf, V., Sheehy, A. & Baird, K. The mistreatment of women during maternity care and its association with the maternal continuum of care in health facilities. *BMC Pregnancy Childbirth* 24, 129 (2024). https://doi.org/10.1186/s12884-024-06310-8

Incorporated as Chapter 5

3. Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024a). Health care providers' perspectives on the mistreatment towards women during maternity care: Do perceptions of the working environment and empathy level matter? Women Birth, 37(3), 101601. https://doi.org/10.1016/j.wombi.2024.101601.

Incorporated as Chapter 6

4. Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024b). Women's narratives of experiences, drivers and consequences of mistreatment during maternity care in western Ethiopia. PloS one, 19(12), e0313217. https://doi.org/10.1371/journal.pone.0313217.

Incorporated as Chapter 7

5. Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. How under-resourcing, lack of recognition and gender-based oppression drive mistreatment of women in maternity care in Ethiopia: a qualitative study (Under review at the Journal of Global Health Action)

List of acronyms and abbreviations

AIC	Akaike information criterion
AJOL	African Journals Online
AOR	Adjusted Odds Ratio
BEmONC	Basic Emergency Obstetric and Newborn Care
BIC	Bayesian information criterion
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CI	Confidence Intervals
CINAHL	Cumulated Index to Nursing and Allied Health Literature
CPD	Continuous Professional Development
CRC	Compassionate and Respectful Care
DA	Disrespect and abuse
GRADE	Grading of Recommendations, Assessment, Development, and Evaluations
HCPs	Healthcare Providers
HSTP	Health Sector Transformation Plan
ICC	Intraclass Correlation Coefficient
ICM	International Confederation of Midwives
LMICs	Low- and Middle-Income Countries
MMR	Maternal mortality ratio
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
PROSPERO	International Prospective Register of Systematic Reviews
QoC	Quality of Care Framework
RCTs	Randomized Controlled Trials
RMC	Respectful Maternity Care
SDGs	Sustainable Development Goals'
SEM	Socioecological Model
SSA	Sub-Saharan Africa
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization

Abstract

Background: Ensuring quality maternity care is crucial to reducing global maternal and neonatal mortality. Reports have surfaced regarding the mistreatment of women during maternity care in Ethiopia. Yet, the precise effects on the continuum of maternity care, as well as the underlying structural factors and resulting consequences, remain ambiguous. Therefore, this thesis explores the extent, types, and drivers of mistreatment of childbearing women in East Wollega Zone, Western Ethiopia in 2022. It also assesses its consequences on maternity care uptake and identifies the best available interventions to reduce mistreatment and enhance respectful maternity care.

Methods: A nested convergent mixed-methods design was conducted to investigate the mistreatment of women. Initial face-to-face interviewer-administered surveys involved 760 women, accompanied by a self-administered survey with 148 healthcare providers using validated tools were conducted. Subsequently, thirty-seven in-depth interviews were undertaken with selected women and professionals to delve extensively into experiences of mistreatment and explore perceptions regarding the factors driving it and its consequences. Quantitative findings were analysed using mixed effects and standard binary logistic regression models, while qualitative data from interviews underwent thematic and framework analysis. An integrated narrative approach was employed to combine results from both analyses.

Results: Five research articles were produced in this thesis, four of which have been published and one is under review, exploring various forms of mistreatment, their drivers, consequences, and possible interventions. Two broader categories of mistreatment of women were identified in this study: interpersonal abuse (37.4%) and

mistreatment during the process of care (ranging from 6.2% to 51%). The findings of the healthcare professionals survey indicated that 93.24% observed instances of mistreatment towards women by their peers, and 75.7% admitted to personally mistreating women.

Women who experienced mistreatment demonstrated a significantly reduced likelihood of completing a continuum of care pathway. Qualitative findings aligned with the survey results and resulted in the development of three themes, including (1) experience of mistreatment, (2) perceived drivers and (3) the consequences of mistreatment, each having sub-themes aligned with the general violence against women in the community and the lack of quality of care in the health facility. The mistreatment of women was also found to be driven by a combination of personal factors, patterns and interactions between staff and women, facility conditions, limitations of the health system, and the context of society particularly gender-based oppressions.

Conclusion: This mixed-method study found pervasive mistreatment of women, which acts as a barrier to maternal healthcare service utilisation in East Wollega Zone, western Ethiopia. Identified drivers include provider prejudices, negative perceptions of the working environment, health provider burnout, non-adherence to care standards, defensive responses to fear of blame for poor outcomes, reduced staff empathy, and inadequate leadership accountability and staffing levels, along with issues related to community unrest and violence against women in the society. Future interventions aimed at preventing or eliminating mistreatment should focus on micro- to macro-level drivers, with community members also engaging by demanding respectful care and practising self-reflection to help realise women's equality in society.

CHAPTER 1: INTRODUCTION

1.1. Chapter preface

This thesis is a mixed-methods study of the mistreatment of women within maternity care in Western Ethiopia, incorporating the viewpoints of both women and healthcare providers. This first chapter provides an overview of maternal and child health within the context of the United Nations' Sustainable Development Goals (United Nations, 2015b), introduces the significance of respectful maternity care practices and the consequences of their absence. Included in the chapter is an examination of women's mistreatment in Ethiopia and across the globe, including a succinct summary of the gaps in current knowledge and research that assisted in refining the research question and rationalised the need for this current study. Orienting the reader to the context of the study and the structure of this thesis, the chapter concludes by providing a description of the broader circumstances of this Ethiopian study, in conjunction with outlining the structure of the thesis.

1.2. Introduction

Evidence demonstrates that experiences of poor maternal healthcare exist within a global context, highlighting the critical need for the implementation of diverse strategies that improve the experiences and outcomes of women throughout the childbirth continuum. One indication of inadequate maternal healthcare is the occurrence of high maternal mortality rates. In 2020 alone, 287,000 women died worldwide from childbearing-related causes (World Health Organization, 2023). Sub-Saharan Africa and Central/ Southern Asia jointly contributed 87% of these global

maternal deaths, with 70% and 17% respectively (World Health Organization, 2023). High maternal mortality in low-income countries compared to more affluent nations underscores the impact of the existing gross inequities (Crear-Perry et al., 2021; World Health Organization, 2023). Reducing this disproportionately high maternal mortality ratio is one of the 17 transformative areas of the Sustainable Development Goals' (SDG) because women's mortality hinders the development towards a sustainable global future(United Nations, 2015b). Notwithstanding the positive trend of decreasing global mortality (a 2.1% global mortality reduction was observed between the years 2000 and 2017) (World Health Organization, 2019), with a current maternal mortality ratio of 223 per 100,000 live births, there is still work required to reach the global target of 70 maternal deaths per 100,000 live births by 2030 (United Nations, 2015b).

To put this target figure in perspective, recent Australian Government data revealed the Australian maternal mortality ratio to be 6 per 100,000 live births (Health et al., 2021). The setting of this study, Ethiopia, contributes significantly to global maternal mortality, accounting for 4.7% of all global maternal deaths, with the 2020 maternal mortality ratio being 267 deaths per 100,000 live births (World Health Organization, 2023). Correlated to the high maternal mortality in Ethiopia is the limited access women have to healthcare during pregnancy and birth, with only half of all births occurring in health facilities (Ethiopian Public Health Institute, 2021).

Ensuring that women have access to essential health services throughout the continuum of maternity care, spanning from preconception to the postnatal period, has proven to be effective in decreasing maternal and newborn morbidity and mortality. This includes providing services that are both safe and acceptable to women (Kikuchi et al., 2015; Souza et al., 2013). Despite the recognition of the importance of access to such care, global attention to maternal and newborn deaths appears to have

diminished as a result of the shift of focus and resources to the global COVID-19 pandemic, international political instability, and the existing challenges of inequality in the quality of care and life worldwide (Souza et al., 2024). This problem is exacerbated in Low-and Middle-Income Countries (LMIC), where health facilities often lack adequate resources and staffing with trained HCPs to provide safe woman-centred care (Montagu et al., 2017). Ethiopia is no exception to this; the lower quality of care and potential for adverse health outcomes for women are further exacerbated by the high occurrence of mistreatment of women, similar to other SSA countries (Bohren et al., 2014; Freedman et al., 2014a; Kassa et al., 2020).

1.3. Background

Benefits of accessing maternity care

Pregnancy, childbirth and the early parenting period are unique, remarkable events in a woman's life. However, without positive support, they could lead to significant health and social impacts (Bohren et al., 2015; Deave et al., 2008). Positive experiences of childbearing and mothering depend on women having access to educated and trained healthcare providers (HCPs) throughout the childbearing continuum. Safe care delivered by educated providers is critical to reducing maternal mortality and providing the increased support needed for women with vulnerabilities, such as domestic violence, physical, psychological and parenting complexities (Bhutta et al., 2014; Downe et al., 2018a; Kikuchi et al., 2015; Shakibazadeh et al., 2018; Wigert et al., 2020). Midwives and other HCPs have a pivotal role in mitigating the risks to vulnerable women and babies. The International Confederation of Midwives (ICM) defines a midwife as:

> "*a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery*" (p.1.) (International Confederation of Midwives, 2017).

Contemporary international predictive modelling has shown the substantial potential of the midwifery role as a profession to prevent maternal deaths, stillbirths, and neonatal deaths (Nove et al., 2021; Sandall et al., 2024). Despite the known the contribution of the midwives, a significant challenge hindering progress is the international shortage of midwives, which currently amounts to 900,000 midwives globally (Bar-Zeev et al., 2021). Achieving meaningful reductions in adverse outcomes and deaths associated with pregnancy, birth, and mothering will require more than just increasing the number of maternity care providers. It necessitates that the care provided be safe and respectful (Denny, 2018; Kruk et al., 2018a; Miller et al., 2016; Rosen et al., 2015; Souza et al., 2013). The World Health Organization (WHO) has emphasised that the provision of respectful maternity care should be a routine component of quality maternity care characterised by safe, supportive and respectful interactions between women and HCPs (World Health Organization, 2018a).

The development of respectful maternity care

Various interventions were implemented to address the disproportionately high maternal and child mortality rates in low-and middle-income countries, including improving healthcare access, exempting service fees, increasing the number of health

facilities, and promoting skilled birth attendance (SBA) and human resource development. These strategies were central during the Millennium Development Goals (MDGs) era and continued into the early stages of the SDGs. These interventions successfully transitioned traditional home births, often attended by unskilled birth attendants, to healthcare facilities. However, this shift posed challenges for resource-limited health systems related to increasing patient flow leading to quality issues (Souza et al., 2024).

Recognition of quality care issues marked a turning point emphasising the importance of respectful maternity care beyond striving for access to care (Miltenburg et al., 2023). With the growing recognition that progress in healthcare delivery requires its provision to be rooted in the principles of the Universal Declaration of Human Rights (UDHR) (United Nations, 1948), the concept of Respectful Maternity Care (RMC) has gradually evolved. Initiatives for improving women's health, addressing the elimination of violence against women and humanising childbirth collectively serve as foundational elements in developing the concept of RMC (Mahler, 1987; Umenai et al., 2001; United Nations, 1993).

In 2010, Bowser and Hill conducted the initial international exploration of disrespect and abuse during facility-based childbirth (Bowser et al., 2010). This work led to establishing the White Ribbon Alliance and developing the Respectful Maternity Care Charter (White Ribbon Alliance, 2011). In 2014, the WHO issued a statement emphasising the right of *all women* to receive the highest achievable standard of healthcare throughout the maternity continuum of care while condemning instances of disrespect and abuse during facility-based childbirth (World Health Organization, 2014). The principles of Respectful Maternity Care further evolved with the WHO formally incorporating Respectful Maternity Care as a key component of a positive

childbirth experience in the *WHO recommendations on intrapartum care for a positive childbirth experience* document (World Health Organization, 2018b). The principles of Respectful Maternity Care advanced further with the WHO formally incorporating Respectful Maternity Care as a key component of a positive childbirth experience in the *WHO recommendations on intrapartum care for positive childbirth experience* document (World Health Organization, 2018b).

Definition of respectful maternity care and mistreatment of women

Respectful Maternity Care

The concept of RMC has expanded to include the practices of non-maleficence, beneficence, and other pertinent ethical principles for the prevention and elimination of mistreatment of women during childbirth (Shakibazadeh et al., 2018). The WHO defines RMC as care that is:

"*organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth*" (p. 19) (World Health Organization, 2018b).

Mistreatment of women during maternity care

Despite growing awareness of the rationale for preventing and eliminating the mistreatment of women during childbearing, consensus on the definition and measurement approaches to the mistreatment of women has not been reached (Bohren et al., 2015; Vogel et al., 2016; World Health Organization, 2014). The many varying terms currently attributed to maternity care that is lacking respect for women, such as disrespect and abuse (Bowser et al., 2010; Lusambili et al., 2020), obstetric violence (Mihret, 2019; Vacaflor, 2016; Williams et al., 2018), maltreatment (Krampah,

2018; Moyer et al., 2014) and mistreatment (Bohren et al., 2017c), highlighting the lack of international consensus.

Bowser and Hill's landscape analysis served as an awareness creation breakthrough for the initial phases of the RMC movement (Bowser et al., 2010). They classified women's experiences of disrespect and abuse in facility-based childbirth services into seven categories. The categories included physical abuse, non-confidential care, non-consented care, discrimination based on specific attributes of the women, non-dignified care, detention in facilities and abandonment of care (Bowser et al., 2010). While their work was hugely successful in garnering momentum to fuel the initiation of the RMC movement, Bowser & Hill's (2010) typologies did not consider defining mistreatment through integrating the behaviours of HCPs, conditions of health facilities and other factors, such as staffing levels of skilled providers, lack of resources such as clean and safe birthing areas that could be interpreted as mistreatment when they are not present. Their work merely focused on conceptualising mistreatment of women as a deviation from the right to health care or a violation of women's rights, which may not reveal the social contexts of mistreatment in which such acts are normalised (Freedman et al., 2014b). These facts highlight that any interactions between women or their families and HCPs, as well as facility conditions that are locally perceived as undignified or humiliating, should be included as components of the mistreatment of women during maternity care.

To pave the way for the measurement of mistreatment of women during childbirth, the latter work by the WHO team incorporated interpersonal abusive behaviours, as well as health facility and system-level weaknesses, as components of mistreatment (Bohren et al., 2015), while Shakibazadeh et al. (2018) focused on investigating what encompasses respectful behaviours. Bohren et al. (2015) classified the mistreatment

of women during childbirth into seven typologies, these being: (1) physical abuse, (2) verbal abuse, (3) stigma and discrimination, (4) sexual abuse, (5) poor rapport between women and providers, (6) failure to meet professional standards of care, and (7) health system conditions and constraints. Further research by Bohren et al. (2018) led to the development and validation of labour observational and community survey tools that researchers can use to measure the mistreatment of women during maternity care, and this work has been adapted as a survey measurement tool in this thesis.

Subsequent systematic reviews have confirmed that methods utilised across various studies to measure mistreatment often lack reliability, generalisability, and validity (Dhakal et al., 2021; Sando et al., 2017). This does not align with the perspective that health facilities' condition and failure to deliver quality maternity care are components of mistreatment, as suggested by Bohren et al. (2018) , Vedam et al. (2019) incorporated the concept of autonomy (Vedam et al., 2017a) and respectful care (Vedam et al., 2017b), as an element of respectful care. Overall, the phenomenon of mistreatment of women remains inconsistently defined by scholars, with terms such as obstetric violence, dehumanised care, disrespect and abuse, and lack of person-centred care, among others. This variation highlights a lack of consensus on what the mistreatment entails and how it should be named. However, the central issue remains the same: the dishonouring experiences between women and healthcare professionals, which have led to significant concerns about the quality of care. These issues deserve sustained focus to ensure quality and positive experiences throughout maternity care.

1.4. Description of the problem

Despite decades of global efforts to eliminate the mistreatment of women at health facilities during maternity care, it remains a widespread problem (Babiaková et al., 2015; Jungari et al., 2021; Kassa et al., 2020; Sakala et al., 2018; Tobasía-Hege et al., 2019). A WHO-led study identified that more than a third of women from lower-income countries experienced mistreatment during childbirth (Bohren et al., 2019b). However, mistreatment of women is not exclusive to developing nations; women in high-income countries also experience it (Beck, 2018; Lukasse et al., 2015; Ravaldi et al., 2018; Vedam et al., 2019; Watson et al., 2017). A study across six European countries revealed that one in five women had experienced mistreatment in healthcare facilities (Lukasse et al., 2015). In the United States of America, one-sixth of all women have experienced mistreatment (Vedam et al., 2019), one in every ten women in Australia (Keedle et al., 2024) and two out of five women experienced mistreatment in Latin America (Tobasía-Hege et al., 2019).

Regardless of its global prevalence, the mistreatment of women during maternity care is particularly pronounced in low-income countries. For instance, a systematic review study has shown that it affects up to 44% of women in SSA (Kassa et al., 2020). Various studies conducted across different regions of Ethiopia (Asefa et al., 2015; Asefa et al., 2018; Banks et al., 2018; Bobo et al., 2019; Sheferaw et al., 2019; Siraj et al., 2019; Ukke et al., 2019; Wassihun et al., 2018) have reported women's experiences of nearly all forms of disrespect and abuse as conceptualised by Bowser and Hill (2010). Despite methodological heterogeneity making it challenging to establish a clear and consistent association among the studies (Sando et al., 2017),

Mengesha et al. (2020) underscored the dishonouring of women's rights in most primary studies.

Mistreatment of women in health facilities has a lasting impact and has been shown to result in enduring pain, emotional trauma, and dissatisfaction with maternity care (Reed et al., 2017). It increases the likelihood of adverse health outcomes and hinders efforts to of reduce maternal and newborn mortality in LMICs (Ababor et al., 2019; Bohren et al., 2014; Bowser et al., 2010; Kujawski et al., 2015; Mannava et al., 2015; Mengesha et al., 2020; Raj et al., 2017). Furthermore, according to Abbabor et al. (2019), mistreatment can act as a deterrent, discouraging women from utilising health facilities for childbirth. Common sociocultural beliefs in low-income countries reinforce the perception within communities that giving birth at home, either on their own or with a family member, provides women more dignity and reduces the risk of mistreatment than birthing in health facilities (Gebremichael et al., 2018; Kujawski et al., 2015).

1.5. Rationale for the study

Following the WHO statement on preventing and eliminating disrespect and abuse during facility-based childbirth (World Health Organization, 2014) and the acknowledgement of the impact of poor-quality care on Ethiopia's relatively high maternal mortality ratio (Central Statistical Agency, 2012), the Ethiopian Government has prioritised RMC (Ministry of Health, 2015). The Ethiopian Health Sector Transformation Plan (HSTP) has identified Compassionate and Respectful Care (CRC) as a top priority for improving equity and quality in service delivery, including RMC (Ministry of Health, 2015). In alignment with this agenda, the Ministry of Health has developed and implemented CRC and RMC training as interventions (Ministry of Health, 2017) and later, initiatives to foster a Motivated, Competent and

Compassionate health workforce (Ministry of Health, 2021b)aimed at reducing mistreatment in healthcare services.

However, to date, there has been no established legislative framework that reinforces CRC and RMC beyond the initiatives aimed at creating awareness of the HCPs. The effectiveness of the Ethiopian RMC program has only been assessed in two studies (Asefa et al., 2020d; Mihret et al., 2020). The interventions in both studies involved RMC training for HCPs, displaying wall posters, establishing essential infrastructure, offering supportive supervision and providing motivational strategies to staff. A non-randomised pre-and post-study concluded that the perpetration of mistreatment could be significantly mitigated through the practice of combining multiple RMC interventions (Asefa et al., 2020d). Asefa et al. (2020c) concluded in another study that RMC training alone was insufficient to improve the provision of RMC and that systematic strengthening of the health system is key. Further research is required because it is unclear which specific/combination of RMC intervention packages were most effective and sustainable over time.

Research is crucial because, as already stated, the mistreatment of women in Ethiopia is frequent (Kassa et al., 2019). The initial focus of previous Ethiopian work in this field has been experiences reported by women (Adinew et al., 2017; Banks et al., 2018; Bobo et al., 2019; Gebremichael et al., 2018; Mihret, 2019; Rosen et al., 2015; Sheferaw et al., 2017; Sheferaw et al., 2019; Siraj et al., 2019; Ukke et al., 2019; Wassihun et al., 2018). This body of work now requires expansion to facilitate the development of strategies to identify other factors that could drive RMC from HCPs' perspectives as well. Here, in the social context of women avoidance of a health facility birth, it is important to understand the extent to which the mistreatment of women during maternity care influences the uptake of the maternity continuum of care in local

health facilities. With the exception of a small number of studies (Asefa et al., 2018; Burrowes et al., 2017), the perceptions and experiences of key stakeholders in maternity care relationships, the influences of working environment situation, healthcare professionals' empathy levels on their respectful behaviours, the midwives and other health care providers, are all absent from current literature. (Asefa et al., 2018; Burrowes et al., 2017).

Prior to this doctoral research, there was scant evidence concerning the government intervention package proven effective in preventing the mistreatment of women in health facilities in Ethiopia. It was, therefore, critical to determine if and how the mistreatment of women can be prevented in healthcare settings. A systematic review of the literature was undertaken to identify the existence of any interventions aimed at mitigating the mistreatment of women during childbearing. Chapter 2 of the thesis presents this review, including an examination of existing research that explored the magnitude, drivers and effects of mistreatment on the uptake of maternity care across the continuum of care. Insights gained from the review guided the methods of this study within the local Ethiopian context.

1.6. Study aims and research questions

This study aimed to explore the extent and drivers of the mistreatment of women during the maternal continuum of care and how this mistreatment affected women's utilisation of maternity care in maternity health facilities of East Wollega Zone Western Ethiopia, 2022.

Research questions:

1. What proportion of women who gave birth in the last three months experienced mistreatment when receiving maternity care from a health facility?

2. What are the consequences of the mistreatment of women on maternal continuum of care?
3. What are the experiences and perspectives of HCPs' regarding the mistreatment of women during maternity care at health facilities?
4. What is the level of mistreatment of women during maternity care as self-reported by HCPs?
5. What are the underlying drivers leading to the mistreatment of women in health care facilities?

1.7. Study context and population

Overview of study setting

This study was conducted in western Ethiopia. Ethiopia is located in the north-eastern part of Africa, commonly known as the Horn of Africa. Ethiopia shares its borders with Somalia on the east, Djibouti to the northeast, Sudan and South Sudan to the west, Kenya to the south, and Eritrea to the north and northeast. It is governed by a Federal Parliamentary System and administratively divided into twelve regions and two city administrations. The regions are subdivided further into zones, zones into woredas/districts, and woredas into kebeles (lowest government administrative unit). The capital city of Ethiopia is Addis Ababa, which is also the headquarters of the African Union and is located almost in the centre of the country (House of Federation, 2021).

Ethiopia is among one of the most populous countries (currently 12th) in the world and the second most populated country in Africa, ranking just below Nigeria (United Nations, 2022b). Based on the 2007 Ethiopian Population and Housing Census, the average projected population of Ethiopia in 2024 is 109.5 million, and about 76% of

the whole population lives in rural areas (Central Statistical Agency, 2013)[a]. Ethiopia is a country of diversified peoples, with over 80 ethnic groups speaking their own languages. Sixty-two per cent (62.8%) of the total population are Christian, and 33.9% are Muslim, while the remaining population comprises traditional religious followers (Central Statistical Agency, 2013).

This study was conducted in the Oromia Regional State, East Wollega zone, located in the western part of Ethiopia (Figure 1.1.). East Wollega zone's capital city is Nekemte, and it contains one special-city woreda (Nekemte), 17 woredas, 43 towns and 287 rural kebeles. The East Wollega zone's total population was 1.8 million in 2022. East Wollega zone has two tertiary-level hospitals, both found in Nekemte town, three district hospitals and 67 health centres (Central Statistical Agency, 2013; Ministry of Health, 2015, 2019).

Although zonal-level data was not publicly available, regional data shows that the area has the third-highest total fertility rate in the country, with 5.4 births per woman and an average household size of 5.2 people. It consists of nearly 4.5% of the regional and 1.7% of the national population (Central Statistical Agency, 2013, 2022), while the number of women of reproductive age accounts for 18% of the total population, and about 56 thousand expected pregnancies annually(Central Statistical Agency, 2022). In maternal service provision, this area, like the entire Oromia region, has underperformed, with only 71% of pregnant women attending antenatal care and just 44% of births occurring in health facilities with skilled health professionals in 2020/21 (Ethiopian Public Health Institute, 2021). These low coverage in maternal health services and reports of mistreatment of women in the area were key motivations for

[a] The Ethiopian Statistical Agency/service's projection is lower than UN's estimate (2022).

conducting this study (Centeral Statistical Agency, 2017; Ethiopian Public Health Institute, 2021).

Figure 1.1: Map indicating the geographical location of East Wollega zone, Western Ethiopia

Health care delivery system in Ethiopia

The Ethiopian healthcare delivery system is structured into a three-tier system that includes primary, secondary, and tertiary levels. The Primary Health Care Unit comprises health centres and five satellite health posts. A Health Post is found at least in each kebele where small teams of health extension workers (community health workers) provide services for an average of 5000 people. Next is a Health Centre, which is staffed with an average of 20 staff providing preventive and treatment services. A primary hospital provides inpatient and ambulatory health services to an average population of 100,000. It provides blood transfusion and emergency surgical services, including surgery and caesarean sections. The secondary level is a general hospital, which serves as a centre of health care for an average of one million people and is a referral centre for primary hospitals. A referral centre for the general hospital is the tertiary level, a specialised hospital providing care for an average of five million people. The overall health system includes over 17,699 health posts, 3,777 health centres, 367 functional public hospitals, and about 210,000 health professionals, from which 20,228 were midwives (Ministry of Health, 2021a, 2021b).

Ethiopia has a health worker density estimated to be 1.0 per 1,000 population (midwives, nurses, medical doctors and health officers) (Ministry of Health, 2022), which is considerably lower than the 4.45 per 1,000 population standards proposed by the World Health Organisation (WHO) (World Health Organization, 2016a). There is an inadequate skill mix of health professionals, while there is a relatively higher number of nurses, there is a high shortage of physicians (one GP to ten thousand people) and midwives (one midwife to six thousand people) (Ministry of Health, 2022; World Health Organization, 2016a).

Maternal health care in Ethiopia

Even though Ethiopia's maternal mortality ratio (MMR), maternal deaths per 100,000 live births, reduced by a little more than half from 871 in 2000 to 412 in 2016 (Centeral Statistical Agency, 2017; Central Statistical Agency, 2000)Maternal mortality in Ethiopia remains a significant concern (World Health Organization, 2019). The Ethiopian Government has committed to reducing MMR to 279 maternal deaths per 100,000 live births by the year 2024 in the second *Health Sector Transformation Plan* (Ministry of Health, 2021b). While the Ethiopian government has yet to report the achievement of this transformation plan, the UN Interagency Maternal Mortality Ratio estimate puts Ethiopia's MMR at 267 per 100,000 livebirths in 2020, indicating good progress, though still falling far short of the global SDG target of 70 (United Nations, 2015b).

Despite the reduction in MMR, other indicators of maternal health, such as the utilisation of antenatal care, having a skilled birth attendant present for labour and birth, and uptake of postnatal care, remain low (Ministry of Health, 2021a). Although WHO recommends that all women should have antenatal, skilled birth attendance and postpartum check-ups, Ethiopia still faces significant challenges in providing universal access to these services to all women (World Health Organization, 2016d, 2018b, 2022). For instance, in 2019, only 74% of pregnant women attended at least one antenatal episode of care from skilled HCPs, and only 48% of births were attended in health facilities, while only 33.8% of women received postnatal care within the first two days after childbirth (Ethiopian Public Health Institute, 2021).

In Ethiopia, midwives, health officers, obstetric doctors, emergency surgical officers, and nurses provide maternal and newborn care. Primary and tertiary hospitals provide maternity care, which includes Basic Emergency Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Obstetric and Newborn Care (CEmONC).

The CEmONC includes advanced care when emergency surgical procedures, such as caesarean section, blood transfusion and anaesthesia, are required. Only BEmONC is provided in the health centre, as these are small community institutions. Care in the BEmONC settings includes the management of normal labour and birth and early diagnosis and referral of complicated cases during pregnancy, labour, birth and postnatal periods. Midwives mainly provide care in these centres (Ministry of Health, 2015).

1.8. Structure of the thesis

Adhering to a compilation-based structure, this thesis comprises nine chapters supported by peer review journal articles (published and submitted for publication). Due to the combination of chapters and articles, the reader may notice some repetition presented in the chapters and in the journal articles, particularly when reading the background, research questions and rationale for the study. The repetition stems from the requirement to provide clarity of ideas in the context of the chapter-based segments of the thesis.

The mistreatment of women in childbearing is a complex and serious issue. Due to the desire to explore the overarching research aim in an in-depth manner, this study comprises five distinct research questions (see Section 1.6 Study aims and research questions). Therefore, various methods were used in this study to best respond to the issues and contexts related to these five research questions. The complexity of the issue within the context of a thesis built on chapters and manuscripts has led to some formatting repetition. For example, whilst the methodology-proper of the thesis is outlined in Chapter 3, each of the thesis's sections comprising published or submitted manuscripts contain their own method sections tailored to each specific component of the research question presented in these submissions.

Chapter 1 has introduced the background of the study on respectful maternity care and the mistreatment of women during maternity care. It outlines the statement of the issue, justifies the undertaking of the study, presents the research questions, and describes the study area and settings.

Chapter 2 commences with a literature review. The review presents and examines the existing studies concerning the prevalence, drivers, and consequences of the mistreatment of women in both a global and a local Ethiopian context. It highlights gaps in the literature, thus providing the rationale for this study. Additionally, this chapter includes a published systematic review that explored the effectiveness of existing interventions in reducing the mistreatment of women during maternity care and the promotion of respectful maternity care within healthcare facilities. This is the published paper:

> Kasaye, H., Sheehy, A., Scarf, V., & Baird, K. (2023). 'The roles of multi-component interventions in reducing mistreatment of women and enhancing respectful maternity care: a systematic review'. *BMC Pregnancy and Childbirth*, vol 23(1), 305. https://doi.org/10.1186/s12884-023-05640-3.

Chapter 3 is the methodology chapter, which adopted a mixed method design to explore the complex research question. The philosophical underpinning of the study is presented, highlighting the complexity of the issue of mistreatment of women during maternity care. Following this is information about the study's design and the justification for utilising mixed methods in the study. The descriptions of study participants, sampling, recruitment, data collection procedures, quality assurance and analysis methods were also provided separately for both qualitative and quantitative methods. Ethical considerations are also positioned in Chapter 3.

Chapter 4 focuses on the first and second research questions. It provides the analysis of survey findings from the women's participant group and the proportions of reported mistreatment experienced by women. Additionally, this chapter explores the association between mistreatment and the continuum of maternity care. A manuscript was published in the "*Respectful Maternity Care Special Issue*" collection in the BMC Pregnancy and Childbirth Journal:

> Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024). The mistreatment of women during maternity care and its association with the maternal continuum of care in health facilities. BMC Pregnancy Childbirth, 24(1), 129. https://doi.org/10.1186/s12884-024-06310-8.

Chapter 5 presents an article that explores healthcare providers' perspectives on the mistreatment of women. It addresses the third, fourth and fifth research questions, investigating HCPs' perceptions of the workplace and how their empathy levels influence mistreatment towards women. Survey data gathered from diverse professionals highlighted perceptions of the extent of mistreatment of women in their care, perceptions of their working environments and their levels of empathy, and their correlates. This chapter is based on a manuscript published in the Q1 midwifery journal, *Women and Birth:*

> Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024). Health care providers' perspectives on the mistreatment towards women during maternity care: Do perceptions of the working environment and empathy level matter? Women Birth, 37(3), 101601. https://doi.org/10.1016/j.wombi.2024.101601.

Chapter 6 reports the qualitative findings of in-depth interviews conducted with the women participants. The analysis of these in-depth interviews was approached

thematically, and a hybrid method was employed that combined deductive and inductive reasoning to find meaning in the data. This chapter explores the women's personal experiences of mistreatment during their maternity care, their perceptions of the maternity services, the underlying drivers of abusive behaviours by health care providers, and the impact the mistreatment had on these women's future utilisation of health care and their future fertility desires and plans. This manuscript has been published.

> Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024b). Women's narratives of experiences, drivers and consequences of mistreatment during maternity care in western Ethiopia. *PloS one*, *19*(12), e0313217. https://doi.org/10.1371/journal.pone.0313217

Chapter 7 focuses on the HCP participant group and presents insights from healthcare providers' perspectives, including midwives, nurses, physicians, and health officers. The findings from the in-depth interviews were presented, mainly focusing on the drivers of the mistreatment of women. The manuscript is currently under review for publication in the Journal of Global Health Action:

> Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. How under-resourcing, lack of recognition and gender-based oppression drive mistreatment of women in maternity care in Ethiopia: a qualitative study (Under review).

Chapter 8 presents the integration of the survey and interview findings, thus providing a cohesive description of the results obtained from both qualitative and quantitative methods, converging the findings from both participant groups and research questions that were provided using the narrative integration approach.

Chapter 9 is the discussion chapter, where the overall findings of the thesis are synthesised and compared with pre-existing literature. The extent of mistreatment from

both women's and healthcare providers' perspectives, the factors contributing to mistreatment, and the consequences of such mistreatment were sequentially explored. The subsections on implications, recommendations, limitations of the study, and the conclusion represent the final components of this chapter, providing a comprehensive conclusion to the overall thesis.

1.9. Summary

The pervasive and persistent global experience of mistreatment during maternity care was introduced in Chapter 1, highlighting the inequitable burden of these experiences in low-income countries such as Ethiopia, a country where health care disparities are evident. Despite a minimal evidence base, this introduction reported the existent research on the benefits of respectful maternity care, not least because of the impact of mistreatment on women's perceptions of essential health care. This Doctoral research aimed to explore questions that had not been adequately examined in the field previously, most notably the extent of mistreatment from both women and healthcare providers, its drivers, and the consequences on the experience and provision of maternity care and the requirement for effective interventions in the aim for eradicating this form of maternity care. For clarity, the term ‘health care providers’ (HCPs) refers to a multi-professional team that includes midwives, obstetricians, nurses, health officers and emergency surgical officers in the context of this thesis. When a midwife is the sole caregiver, this distinction will be consistently maintained throughout the entire thesis.

In the upcoming Chapter 2, an analysis of existing literature and an investigation of multi-component interventions, and their role in reducing mistreatment of women and promoting respectful maternity care, will be addressed.

CHAPTER 2: LITERATURE REVIEW

2.1. Chapter preface

Following the introduction, this chapter reviews the international literature on the mistreatment of women during maternity care in health facilities, including Ethiopian research. The chapter describes the aim and overview of the literature review and the magnitude of mistreatment in the global, African and Ethiopian context. An exploration of the drivers of the mistreatment of women in the health system from the perspective of healthcare providers and women will also be presented. Finally, a published systematic review that investigated existent interventions aimed at reducing the mistreatment of women during maternity care and/or enhancing the provision of culture-respectful maternity care is presented at the chapter's end.

2.2. Introduction

This literature review aims to identify and appraise the existing research on the mistreatment of women during maternity care and identify gaps in the literature. It provides a comprehensive understanding of the mistreatment of women in health facilities, and an appraisal and interpretation of the findings are presented. Identifying the specific components of health care interventions that successfully and sustainably reduce women's mistreatment was also essential, as was determining the lack of knowledge in this field of study. The systematic review synthesised the best available evidence on interventions that used multiple strategies to reduce the mistreatment of women and improve respectful maternity care in health facilities and then assessed the effectiveness

of their initiatives. This review provides valuable evidence for designing and implementing interventions to minimise mistreatment of women in health facilities.

This chapter encompasses and reviews various studies conducted across multiple countries, reporting varying prevalence rates of mistreatment during maternity care. These variations may reflect actual variations in experiences, or methodological differences, particularly in the measurement tools used to assess mistreatment (Dhakal et al., 2021). For instance, some studies employed validated survey instruments (Afulani et al., 2022; Bohren et al., 2019b; Vedam et al., 2019), while others did not (Bobo et al., 2019; Sheferaw et al., 2017; Siraj et al., 2019).

Even among studies using validated tools, variations existed in the types of mistreatments examined. For instance, Vedam et al. (2019) focused on verbal abuse, lack of autonomy, and discrimination but did not report on physical abuse, which has been a prominent concern in reports from many low-and middle-income countries including Nigeria, Ghana, Guinea, and Myanmar (Bohren et al., 2019b). This omission may be due to physical abuse being more common in low-income settings, as shown by studies from Ethiopia, Kenya, and Tanzania, and other countries (Abuya et al., 2015a; Asefa et al., 2015).

Variability in the reported prevalence of mistreatment could also arises from differences in the context and timing of data collection. Some studies used direct observation of interactions during service provision (Banks et al., 2018; Rosen et al., 2015), others conducted facility exit interviews during the postpartum period (Kruk et al., 2018c; Leite et al., 2023). Some collected data weeks to years in the community (Bohren et al., 2019b; Kruk et al., 2018c) to several years after birth (Keedle et al., 2024). These variations contribute to differences in the reported differing prevalence rates of mistreatment. For

instance, studies during the immediate postpartum period or conducted while women are still in the facilities may be influenced by courtesy bias, direct observations leading to social desirability bias, and retrospective studies by recall bias.

While most studies focus on describing poor treatment, researchers used varied terminologies to assess and describe its occurrence. These terms, such as "obstetric violence," "mistreatment," "humanised childbirth," "disrespect and abuse," "lack of person-centred care," "maltreatment," and "undignified practices during childbirth," are all commonly used (Bohren et al., 2018; Bowser et al., 2010; Moyer et al., 2014; Williams et al., 2018). This variety of terminology reflects the ongoing debate and discussion among researchers about this phenomenon.

Among these terms, "obstetric violence" has been widely used by scholars from Latin America. Its foundation is rooted in the humanised childbirth movement, which emerged in the early 1980s intending to minimise the over-medicalisation of childbirth. This concept was later legalised in several Latin American countries, including Venezuela, Argentina, Panama, Mexico, Brazil, and Uruguay, starting in the 2000s (Faheem, 2021). However, there is a counterargument opposing the use of the term ‘obstetric violence’. Critics suggest that it may be a misnomer, as it is emotionally charged and could imply that healthcare professionals are deliberately committing acts of violence against women, which is often not the case (Chervenak et al., 2024).

In contrast to the term "obstetric violence," the term "mistreatment of women" provides a broader framework for understanding poor treatment. It extends beyond childbirth to include experiences during antenatal and postnatal care. This terminology also emphasises systemic issues within healthcare facilities and systems, such as overcrowding, under-resourcing, inadequate staffing, and insufficient training, which all

contribute to mistreatment. As suggested by WHO researchers (Bohren et al., 2018), this terminology avoids placing blame on specific groups, instead focusing on the woman's experience and its applicability across various healthcare specialties. Therefore, to reflect the comprehensive nature of the issue, the term ‘mistreatment of women during maternity care’ has been used throughout this thesis and associated publications.

Overall, the timing, methodological differences, and terminological variations across studies underscore the need for caution when interpreting and comparing findings on mistreatment during the provision of maternity care. These variations also highlight the multifaceted nature of the mistreatment of women during maternity care, which can stem from personal behavioural factors, interpersonal interactions, and systemic issues within healthcare facilities. Addressing these complex issues requires multi-level interventions, as outlined in the systematic review presented in this chapter.

2.3. The magnitude of mistreatment of women during maternity care

Though global research on the mistreatment of women is limited, individual studies worldwide have reported its prevalence, albeit often using different terminologies. The following details present the reviews of the global burden of mistreatment and its estimated prevalence in African, Sub-Saharan Africa (SSA) and Ethiopian contexts.

Global burden of mistreatment of women during maternity care

Despite global efforts to reduce maternal mortality and eliminate disrespect and abuse during maternity care (Alkema et al., 2016; World Health Organization, 2014), research indicates its continuing disturbing prevalence (Bohren et al., 2015; Shakibazadeh et al., 2018), irrespective of the economic stability of nations (Lukasse et al., 2015; Sakala et

al., 2018; Vedam et al., 2019). A cohort study from six Northern European Countries, including Belgium, Denmark, Iceland, Norway, Sweden and Estonia, concluded that healthcare abuse was common for pregnant women, and it has resulted in fear of childbirth and preferred caesarean birth (Lukasse et al., 2015). Within routine antenatal care, 20.7% of women experienced some abuse during healthcare. The prevalence of abuse significantly varied between the countries, with the lowest in Belgium (13.5%) and the highest in Estonia (30.2%). Another recent study from Germany and the Netherlands highlighted the significance of the problem, with three-quarters of the study participants reported experiencing mistreatment during birth, i.e. *obstetric violence,* as they report (Reuther, 2021).

A study undertaken in the United States of America (USA) (Vedam et al., 2019) identified that one in every six mothers had experienced mistreatment during prenatal care and/or childbirth. The most common mistreatments were being shouted at, threatened or scolded, ignored, receiving no help on request and being refused care. These encounters were more common for women who gave birth in a hospital (28.1%) compared to those who birthed at home (5.1%). Vedam et al. (2019) showed that the rates of mistreatment were higher for women of colour and for those of low socio-economic status than for women who were white, even when adjusted for low socio-economic status. Sakala and colleagues (2018) reported similar findings in a Californian study that drew attention to prejudice against women due to ethnicity and race, with 11% of black women reporting unfair treatment by HCPs compared to one per cent of white women having reported receiving such treatment.

In close geographical proximity to the USA, studies have indicated there to be a wide range of mistreatment of women during maternity care in the Southern American continent. Montesinos-Segura et al. (2018) chronicled that nearly all women experienced

at least one category of mistreatment (97.4%) from 14 hospitals across nine Peruvian cities. A cross-sectional study from Pelotas City, Brazil, evaluated the experience of 4087 mothers and found that 18.3% of all women reported at least one form of disrespect and abuse (Mesenburg et al., 2018). They identified that 10% of women reported experiencing verbal abuse, 6% experienced inappropriate or undesirable procedures, 6% were denied care, and 5% experienced physical abuse (Mesenburg et al., 2018). An observational study from Mexico reported a similar extent of mistreatment, whereby 18.8% of women experienced at least one form of mistreatment, from which verbal abuse (87.1%) was the most commonly reported, followed by physical abuse (66.9%) and then discrimination (62%) (Monge et al., 2020).

Mistreatment of women during maternity care has been reported in other countries. A report from the Australian Birth Experience Study showed that approximately one in every ten women commented that they had experienced some form of mistreatment during childbirth (Keedle et al., 2024). Sharma et al. (2019) determined that all women in their study in Uttar Pradesh, India, had encountered mistreatment from health facilities. Another community-based cross-sectional survey in Varanasi, India, reported that 28.8% of women reported mistreatment verbal abuse, physical abuse and neglect or abandonment of care being most common (Bhattacharya et al., 2018). Neglect (32.2%) and verbal abuse (37.7%) were reported by Jordanian women in the Middle East (Alzyoud et al., 2018). Evidently, the mistreatment of women during pregnancy, birth and the early parenting period is a global phenomenon.

Mistreatment of women during maternity care in the African region

Studies from different parts of Africa also present the ubiquity of the mistreatment of women during maternity care (Abuya et al., 2015a; Abuya et al., 2015b; Afulani et al., 2020; Amole et al., 2019; Galle et al., 2019; Kruk et al., 2018c; Lappeman et al., 2019;

Larson et al., 2019; Sando et al., 2016; Sethi et al., 2017; Umar et al., 2019). Nigerian research found that about 66% of postnatal women discharged from health facilities reported that health workers' behaviours and health system constraints had led to their mistreatment (Umar et al., 2019). Similarly, Amole et al. (2019) reported that one in two women (55.9%) had experienced mistreatment during childbirth, mostly citing abandonment and non-confidential care.

Malawian women have also reported experiences of mistreatment, including a lack of privacy (58.2%), poor communication from healthcare providers (73.1%) and giving birth in isolation (83.2%) (Sethi et al., 2017). Research undertaken in Mozambique reported that the prevalence of mistreatment of women was 80% in district hospitals and 24% in tertiary referral hospitals (Galle et al., 2019). Poor communication from healthcare providers during maternity care was reported in South African research, describing these encounters as concealed neglect that makes women feel invisible and neglected in health facilities (Lappeman et al., 2019).

The prevalence of such encounters is likely lower because it appears that instances of mistreatment are not always disclosed in studies. Evidence suggests that women are more likely to report mistreatment once they are discharged from a health facility. In Tanzania, women reported higher rates of mistreatment when interviewed at home through follow-up services (28.2%) compared to when they were in a health facility (19.5%) (Kruk et al., 2018c). Similarly, Sando et al. (2016) reported 15% of all women reported at least one instance of mistreatment whilst in a health facility. This figure dramatically increased to 70% during follow-up interviews of the same participants (Sando et al., 2016).

Variations in reported encounters of mistreatment have been related to intervention studies. In Kenya, interventions implemented to address mistreatment (including policy development, RMC training and strengthened links between the community and the health facility) indicated that pre-intervention 20% of women participants had experienced mistreatment, whilst post-intervention 13% of participants reported mistreatment (Abuya et al., 2015a; Abuya et al., 2015b). Another study from Kenya reported that HCPs' perception of the mistreatment of women in their care elevated the percentage to 37% of participants reporting observing physical abuse during childbirth (Afulani et al., 2020).

Most of the African studies have been conducted in the sub-Saharan region and primarily focused on mistreatment during labour and childbirth. Currently, there is a scarcity of literature addressing mistreatment during the antenatal and postnatal periods for women.

Mistreatment of women during maternity care in Ethiopia

Studies conducted in Ethiopia, the setting for this study, provide evidence that mistreatment of women occurs country-wide, with abandonment and neglect the most common forms (Rosen et al., 2015). One study which collected data in multiple regions of Ethiopia via directly observing labouring women (Sheferaw et al., 2017), provided evidence that mistreatment of women occurred in one-third of participants' birthing experiences. Interviews across 38 health centres and hospitals uncovered high rates of mistreatment, with three out of four women (74%) having experienced mistreatment (Sheferaw et al., 2019). These difference rates of mistreatment are likely a result of their methods of data acquisition. Researchers' directly observing providers versus women's reported experiences impacts the results. Researcher presence during data collection can affect the healthcare provider's behaviour and may encourage more respect to be shown to participants related to well documented observer effect, the Hawthorne effect (Sedgwick et al., 2015).

The pervasive nature of mistreatment across Ethiopia has been recorded by various research studies in both urban settings (Asefa et al., 2015; Wassihun et al., 2018) and rural locales (Banks et al., 2018; Mihret, 2019; Siraj et al., 2019; Ukke et al., 2019). Reported mistreatment of women appears slightly higher in hospital settings (81.8%) compared to community health centres (75.3%) (Asefa et al., 2015). These Ethiopian studies indicate that three-quarters to nearly all women have encountered disrespectful or abusive maternity care (Asefa et al., 2015; 2019; Siraj et al., 2019; Ukke et al., 2019; Wassihun et al., 2018) and these encounters were evident in all regions indicating mistreatment from—the Northwest of Ethiopia (Banks et al, 2018), South Ethiopia (Siraj et al., 2019; Ukke et al., 2019), Eastern (Bante et al., 2020) and Western Ethiopia (Bekele et al., 2020; Bobo et al., 2019).

In contrast, only 14.5% of HCPs reported the mistreatment of women in another study in Addis Ababa, Ethiopia (Asefa et al., 2018), which may be due to the normalisation of mistreatment in health facilities. Furthermore, it appears that the likelihood of a woman being mistreated is greater in public health facilities if the staffing levels do not appropriately match the healthcare demand (Mesenburg et al., 2018; Wassihun et al., 2018). In smaller communities, the underreporting of mistreatment may stem from either its absence, owing to robust relationships between HCPs and women, or the reluctance of women to report mistreatment due to concerns about potential repercussions from familiar HCPs, which could be witnessed by the low magnitude of mistreatment in rural health centres (Banks et al., 2018). Banks et al. (2018) identified 21.1% of women from rural health centres reported experiencing at least one form of mistreatment of women.

Despite the fundamental principles of consent, protection from coercion and physical abuse that should be abided by in healthcare (World Health Organization, 2014) treatment without consent and physical abuse have also shown to be a common

experience for childbearing women (Bobo et al., 2019). The mistreatment encompasses non-dignified care, lack of consent, non-confidential care, and, in extreme cases, physical abuse directed towards women before, during, and after childbirth. These findings highlight the significance of mistreatment, as evidenced in the literature reviewed thus far. However, it is noteworthy that most studies primarily focused on HCPs' behaviours and did not consider health facility issues as potential mistreatment. This oversight neglects the possibility that health facilities themselves or the underlying factors influencing providers may contribute to mistreatment.

2.4. Factors contributing to the mistreatment of women during maternity care

The literature suggests that mistreatment of women is ubiquitous in maternity care throughout Ethiopia, with observed variations in reported rates of disrespect and abuse, as well as possible differences in prevalence across settings and categorisation of participants in the study. Studies focusing on women are more likely to reveal rates of mistreatment compared to those centred on clinicians (Bohren et al., 2015; Freedman et al., 2014b).

Women's encounters with mistreatment have been associated with their socio-demographic and economic status, such as the location of residence (Montesinos-Segura et al., 2018), low educational level (Mihret, 2019), their religion, ethnicity and/or race, with these factors affecting how HCPs treat women (Bohren et al., 2017c; Warren et al., 2017). Other circumstances, such as being a single mother (Amroussia et al., 2017), and/or pregnancy at a young age (McMahon et al., 2014) can all contribute to the mistreatment of women. Mistreatment appears to become a more significant issue when HCPs have identified skill bases or training gaps, if they perceive themselves to be

overloaded/stressed, and underpaid or if their work environment makes them perceive that their skills and professional contributions are not recognised by others (Asefa et al., 2018; Okedo-Alex et al., 2020). This implies that a critical driver of the mistreatment of women in health facilities is HCPs prejudices and preconceived judgements of the women they care for, compounded by the challenges of demanding working conditions.

Social factors such as socioeconomic status, residential location, ethnicity, single motherhood, and young age, discussed in the preceding paragraph, and it should be interpreted cautiously. While these factors may influence how women are treated, they do not directly cause mistreatment. Instead, they mediate its occurrence by shaping HCPs' attitudes and behaviours toward women seeking care. For instance, adolescent and young women have been reported to experience more mistreatment than older women (Ajayi et al., 2023; McMahon et al., 2014). In societies where sexual violence is prevalent, young women are more likely to face unwanted pregnancies, whether due to sexual abuse or forced marriages. In such cases, healthcare professionals are expected to offer support, advice, and counselling to help women manage their psychological distress. However, when HCPs exhibit judgmental attitudes and prejudices, they exacerbate the suffering of the women by mistreating them. This suggests that while social factors are underlying contributors, the critical factor driving mistreatment during maternity care is the biases and perceptions of healthcare professionals, rather than the social factors themselves.

Similarly, financial and resource limitations was reported as a driver of mistreatment. Beyond Ethiopia, women facing financial constraints, particularly the inability to afford hospital or health centre costs, have been noted to influence the likelihood of experiencing mistreatment in maternity care (Abuya et al., 2015b; McMahon et al., 2014; Warren et al., 2017). In Ethiopia, although maternity care services are free in public health

facilities, however, a woman’s social status affects the care received. Women who have low-economic status have been shown to perceive being poorly treated because of their socio-demographic and economic status (Bobo et al., 2019).

The normalisation of women's mistreatment during maternity care in Ethiopia has been documented as contributing to these encounters. As previously mentioned, due to underreporting, the actual rate of mistreatment may be higher. There is a suggestion that disrespect and abuse are so deeply ingrained in healthcare culture that women may not even recognise it as such (Asefa et al., 2015). For instance, women, in one study, were noted to seem unaware that receiving respectful care was their right. The normalisation of mistreatment occurs when healthcare providers presume it is their right to behave disrespectfully towards women (Molla et al., 2017). The normalisation and community-level socio-cultural factors, such as embedded beliefs about gender inequality and women lacking empowerment, respect and autonomy, exacerbate the phenomenon (Miltenburg et al., 2018; Okedo-Alex et al., 2020).

Mistreatment in healthcare environments is not limited to women’s characteristics alone. Other issues which related with the health system or health facilities' failures are also known to end up with occurrences of mistreatment. One of these issues is when there are limited health service providers. The likelihood of a woman being mistreated has been reported to enhance as the number of women seeking care from understaffed public health facilities (Mesenburg et al., 2018; Wassihun et al., 2018). As such, instances of mistreatment of women rise in health systems lacking specific policies aimed at promoting respectful care or providing mechanisms for women to safely lodge complaints about their treatment, which underscores the normalisation or concealment of women's mistreatment in these environments (Okedo-Alex et al., 2020; Warren et al., 2017).

Healthcare providers' low-status perceptions and lack of respect from service receivers and other health facility staff, such as managers, were also reported to increase the likelihood of professionals mistreating women (Asefa et al., 2018). This situation, where everybody disrespects each other, leads to the cultural normalisation of disrespect even towards HCPs based on their professional status, which has been suggested to be a driver for HCPs mistreating women (Asefa et al., 2018). Mistreatment behaviours are more common in health facilities with unequal power dynamics between healthcare providers. It has been suggested that junior healthcare providers who have encountered mistreatment from their superiors or from women and families will be more likely to mistreat the individuals in their care (Galle et al., 2020; Rominski et al., 2017).

Finally, another driver of mistreatment in maternity care is insufficient infrastructure in health facilities. The impact of under-resourced and overburdened health institutions leads to overcrowded facilities, poor working conditions, and substandard amenities, which prevent women from having space and privacy and prevent them from having families to support them in birth (Banks et al., 2018; Bohren et al., 2017c).

2.5. Health providers' perspective toward the mistreatment of women

Research indicates that HCPs acknowledge the presence of mistreatment of women during maternity care. Most mistreatment of women during maternity care is perceived as unintentional, with the cause being attributed to the limitations of their work environments. Health systems lacking adequate infrastructure and resources for equitable and respectful care have also been acknowledged by HCPs (Burrowes et al., 2017; D.Zomeku et al., 2020; Shimoda et al., 2020). It may be unintentional; however, mistreatment has consequences. In a study where most HCPs participants reported

having witnessed disrespectful care, the authors noted that 79.6% of HCPs believed that the absence of respectful care discourages women from seeking childbirth at health facilities (Asefa et al., 2018).

Healthcare providers acknowledge the negative impact of mistreatment of women during maternity care but struggle to prevent it. In Addis Ababa, the capital city of Ethiopia, 14.5% of HCPs self-reported them perpetrators of the mistreatment of women in their care (Asefa et al., 2018). Research undertaken in other African nations replicate these findings. Shimoda et al. (2020) identified that nearly all Tanzanian nursing participants in an East African study (96.1%) reported treating women in a disrespectful and abusive way. In another East African country, research in Kenya revealed that nearly one-third (35%) of HCPs in the study providers reported mistreating women themselves (Afulani et al., 2020). In Ghana in West Africa, two out of five HCPs admitted treating women disrespectfully and in discriminatory ways (Moyer et al., 2021).

Therefore, it seems that HCPs maintain there should be no justification for disrespectfully treating women during maternity care. However, they rationalise it by providing reasons for its occurrence. Other African research demonstrated that many HCPs mistreat women due to the fear of being held responsible for adverse outcomes for women and babies (Rominski et al., 2017). Their understanding seems to be that physical abuses are conducted when the life of a woman or baby is under threat. One study from Ghana indicated that physically abusing a woman was acceptable if the assault was undertaken when attempting to save a newborn's life (Dzomeku et al., 2020). Not all research indicates that the rationale for mistreatment is benevolent and a means to an end. A study by Galle et al. (2020) in Mozambique reported that HCPs considered to hold power over women, leading professionals to violate the rights of women being free from any sort of violence.

2.6. Consequences of Mistreatment of women

Regardless of any justification for mistreatment, respectful and dignified maternity care is a professional expectation mandated by the WHO for all healthcare providers (World Health Organization, 2018b). Mistreatment during maternity care is a profound violation of basic human rights, even when it does not cause immediate physical harm. According to Universal Declaration of Human Rights, every individual has the right to live a free from harm and ill-treatment, to receive adequate, timely, and appropriate information, to enjoy privacy and confidentiality, to be treated with dignity and equality, to be free from discrimination and to exercise self-determination (United Nations, 1948; White Ribbon Alliance, 2011). The mistreatment of women during maternity care undermines these fundamental rights and contravenes the global commitment made by United Nations member states. These commitments include the principle of "*leaving no one behind,*" and pledges to eliminate all forms of discrimination and violence against women and girls (United Nations, 2015a, 2015b).

While understanding the consequences of mistreatment is crucial for driving the urgent policy and practice changes needed, it should ultimately be recognised as a significant violation of women's bodily autonomy and rights. Mistreatment is unacceptable under any circumstances, whether it results in immediate consequences or is normalised by society. There is no justification for abusing or disrespecting women. With this understanding, the following section will discuss the consequences and impacts of mistreatment.

Among various impacts of mistreatment of women evidenced in previous studies, the reduced reputation women have for health facilities and health professionals could be mentioned. Women have reported low levels of satisfaction with their care if they experienced disrespect, humiliation, being abandoned when needing help, or physical

abuse. Contrastingly, satisfaction levels were higher for those who did not experience mistreatment during maternity care (Mocumbi et al., 2019).

Dissatisfaction related to mistreatment is more than a perception or memory of their childbearing care. It has real-life consequences. For example, mistreatment of women has been reported to elevate a woman's chance of experiencing postpartum depression (Silveira et al., 2019), and leading to the discontinuation of breastfeeding (Leite et al., 2023). In one Southern Ethiopian study, a different consequence was revealed, abusive care of women by HCPs (which resulted from poor conditions in health facilities) leads to the underutilisation of maternity services (Roro et al., 2014). A qualitative study identified that women who faced mistreatment during antenatal care avoided giving birth at health facilities (Molla et al., 2017). Avoidance of using health facilities may result from women's lack of confidence in health facilities or due to their fear of being mistreated or receiving disrespectful care again (Kujawski et al., 2015).

Whilst the impact of mistreatment and women's future utilisation of maternity care has been suggested by researchers and qualitative participants, the extent to which mistreatment leads to discontinuation of service utilisation and the consequences of poor uptake of services on women and the broader community remained unexplored prior to this study.

Prior to addressing the utilisation of services for future healthcare needs, it was important to determine existing research which described and assessed the effectiveness of programs or initiatives that aimed to reduce the mistreatment of women and/or enhance respectful maternity care during women's maternity care in health facilities. The following section, a published systematic review, illuminated the existent programs and strategies.

2.7. Effectiveness systematic review

Preamble:

Sections 2.3 to 2.6 discussed the magnitude and driving factors of mistreatment from both women's and healthcare providers' perspectives and its consequences. These sections outlined the current situation and underscored the scale and significance of the issues. While understanding these problems is crucial, it is even more important to explore and identify strategies to minimise or, ideally, eliminate instances of mistreatment. Therefore, this section presents the best available interventions identified in previous studies.

This section presents a systematic review conducted to identify the best available evidence on the effectiveness of RMC interventions in promoting RMC practices and preventing the mistreatment of women. Based on studies involving over 16,000 women globally, multi-component interventions target multiple levels, including individual, interpersonal, health facility, health system, and the broader community and society. The detailed findings of this review are presented in the following subsection and have been published in the 23rd Volume of BMC Pregnancy and Childbirth Journal in May 2023:

> Kasaye, H., Sheehy, A., Scarf, V., & Baird, K. (2023). 'The roles of multi-component interventions in reducing mistreatment of women and enhancing respectful maternity care: a systematic review'. *BMC Pregnancy and Childbirth*, 23(1), 305. https://doi.org/10.1186/s12884-023-05640-3.

Abstract

Background: Despite recognition of the adverse impacts of the mistreatment of women during pregnancy, labour and birth, there remains limited evidence on interventions that could reduce mistreatment and build a culture of respectful maternity care (RMC) in health facilities. The sustainability of effective individual interventions and their adaptability to various global contexts remain uncertain. In this systematic review, we aimed to synthesise the best available evidence that has been shown to be effective in reducing the mistreatment of women and/or enhancing RMC during women's maternity care in health facilities.

Methods: We searched the online databases PubMed, CINAHL, EBSCO Nursing/Academic Edition, Embase, African Journals Online (AJOL), Scopus, Web of Science, and grey literature using predetermined search strategies. We included cluster randomised controlled trials (RCTs) and pre-and-post observational studies and appraised them using JBI critical appraisal checklists. The findings were synthesised narratively without conducting a meta-analysis. The certainty of evidence was assessed using GRADE criteria.

Results: From the 1493 identified records, 11 studies from six sub-Sahara African countries and one study from India were included: three cluster RCTs and nine pre- and post-studies. We identified diverse interventions implemented via various approaches including individual health care providers, health systems, and policy amendments. Moderate certainty evidence from two cluster RCTs and four pre- and post-studies suggests that multi-component interventions can reduce the odds of mistreatment that women may experience in health facilities, with odds of reduction ranging from 18 to 66 per cent. Similarly, women's perceptions of maternity care as respectful increased in

moderate certainty evidence from two cluster RCTs and five pre- and post-studies with reported increases ranging from 5 per cent to 50 per cent.

Conclusions: Multi-component interventions that address attitudes and behaviours of health care providers, motivate staff, engage the local community, and alleviate health facility and system constraints have been found to effectively reduce mistreatment of women and/or increase respectful maternity care. Such interventions which go beyond a single focus like staff training appear to be more likely to bring about change. Therefore, future interventions should consider diverse approaches that incorporate these components to improve maternal care.

Keywords: mistreatment of women, respectful maternity care, multi-component interventions

Introduction

Pregnancy, childbirth, and the early parenting period are remarkable events in a woman's life, with women encountering a range of experiences such as joyful, positive transitions through to periods of trauma and vulnerability (Cowan et al., 1992; Deave et al., 2008). To enhance positive outcomes, health systems and health care providers (HCPs) must ensure high-quality, equitable, evidence-based, and respectful maternity care (RMC) for all women (Miller et al., 2016). The absence or deficiency of RMC manifesting as the mistreatment of women diminishes the quality and efficacy of maternity care across all cultures (Bohren et al., 2015). Mistreatment is perceived when the provision of maternity care is perceived by women to be disrespectful, abusive, neglectful, or undignified (Bohren et al., 2015; Bowser et al., 2010). The prevalence of women experiencing at least one form of mistreatment ranges from one in 17.3 per cent in the United States of America to 44 per cent in sub-Saharan African (SSA) (Bohren et al., 2019b; Kassa et al., 2020; Lukasse et al., 2015; Tobasía-Hege et al., 2019; Vedam et al., 2019). Despite the contextual variation between settings and across countries, it is important to note that mistreatment is any humiliating encounter that women experience in a health facility (Bohren et al., 2015; Bowser et al., 2010). It is important to note that perceived mistreatment can have long-lasting negative impacts on a woman’s dignity and self-esteem and negatively impact mothering and decisions for future childbearing (Bohren et al., 2018; Maya et al., 2018; Silveira et al., 2019)

Mounting evidence demonstrates varied adverse impact of the mistreatment of women and its deterrence of women's utilisation of maternal health care. Experiences of mistreatment result in dissatisfaction of received care and lower confidence in maternity care and curtail subsequent health-seeking behaviours (Kujawski et al., 2015; Mengesha

et al., 2020; Mocumbi et al., 2019; Raj et al., 2017). In particular, perceptions of distrust of health care facilities by women in low- and middle-income countries have been shown to override socio-cultural beliefs about the importance of accessing maternity care (Ababor et al., 2019). Even though the impact of mistreatment is known, there is limited specificity of information for developing ameliorative strategies to build a culture of RMC in maternity services and prevent cultures of mistreatment and clinical encounters within which women are disrespected, abused, neglected, and/or degraded.

Organisations such as the White Ribbon Alliance and the World Health Organization (WHO) highlight the urgent requirement for all women to have access to maternity care that is safe and respectful (White Ribbon Alliance, 2011; World Health Organization, 2014, 2018a), however, there is a lack of practical and sustainable interventions which enhance respectful care and reduce mistreatment of women. Studies from low-income countries suggest that training interventions aimed at transforming attitudes, values and behaviours of health care providers can bring about some positive effects in maternity care(Abuya et al., 2015a; Kujawski et al., 2017). Similarly, the mobilisation of communities to demand RMC, as well as dispute resolution strategies for women who have experienced mistreatment can result in changes which may minimise abusive care (Abuya et al., 2015a; Kujawski et al., 2017). In a systematic review comprising of five African studies, Downe et al. (2018b) concluded that policy interventions could generate changes to minimise the mistreatment of women during maternity care. However, it is uncertain from this review as to the degree of effectiveness of specific components of the interventions, and their sustainability and adaptability to varying global contexts, especially communities with resource limitations (2018b). A recent mixed-method review which focused on educational interventions for health care providers was shown to understanding of RMC by staff, yet Dhakal et al. (2022) concluded that it was not evident

whether the included interventions impacted women's perceptions of actual mistreatment.

Reducing mistreatment is complicated and requires strategies that focus beyond health care providers' attitudes, behaviours and actions (Vogel et al., 2016). At the institutional and policy level, the resource constraints and staffing deficits of health facilities and health systems significantly worsen the experiences of women and families (Bohren et al., 2015; Freedman et al., 2014b). Research examining the phenomenon of mistreatment of women from various viewpoints is therefore required. Identifying specific components of RMC interventions that successfully and sustainably reduce women's mistreatment is necessary. This systematic review aimed to synthesise the best available evidence on such interventions which utilise differing approaches to address the issue of mistreatment. The effectiveness of these interventions in reducing the mistreatment of women and/or enhancing respectful

maternity care in health facilities was also examined.

Methods

A systematic review was performed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis-2020 (PRISMA-2020) guideline (Page et al., 2021), as shown in supporting file S1 Table, and also followed the systematic review protocol registered in the International Prospective Register of Systematic Reviews (PROSPERO) with registration number— **CRD42021287049**.

Eligibility criteria

As described below, the studies were selected according to the PICOS (participants/population, intervention, comparisons, outcomes, and study designs).

Population

The study population was women receiving maternity care from health facilities and maternal health care providers. Although respectful care and mistreatment-free services are equally important for other health care recipients from health facilities, our focus in this review is on services provided to women during maternity care. Studies that evaluated outcomes reported by women who received maternal health care from health facilities or health care providers were included.

Interventions

Studies that evaluated the effectiveness of RMC interventions at any level including the community, health facility, and individual health care providers in reducing mistreatment of women and/or enhancing respectful maternity care were included. The interventions were included in the review based on the outcome that they intended to evaluate. Hence, interventions which targeted various levels and components to change health care providers' attitudes and behaviours, health facilities and system failures, and change how women react to the abusive and disrespectful care were included. We excluded interventions that did not primarily focus on reducing mistreatment of women and/or enhancing respectful care, but instead aimed exclusively at achieving unrelated outcomes such as increasing service utilisation or decreasing specific interventions of childbearing.

Comparator

The effectiveness of the RMC interventions was compared with the standard usual routine care which existed prior to the implementation of the RMC interventions.

Outcomes

The primary outcome sought in this systematic review was whether the level of mistreatment that women experienced could be reduced secondary to the implementation of the interventions. Mistreatment was defined as explicit experiences in childbirth, such as verbal, sexual, and physical abuse, neglect, stigma and discrimination, poor communication, and/or other forms of mistreatment related to health care providers or health care facilities, as described in Bohren et al.'s (2015) and Bowser and Hill's (2010) global reviews. Articles which evaluated the occurrence of any of these disrespectful and abusive care were included. Hence, studies which included evaluations of the intervention, either as observations of the levels of women's mistreatment between the two groups or those that included the self-reported experiences of women themselves, were also included. Overall mistreatment of women could be measured as occurrences in any form or the proportion of occurrences of each component, such as physical abuse, verbal abuse (also known as non-dignified care, non-consented care, nonconfidential care, discrimination, neglect, or abandonment of care), and detention in health facilities. It could also extend to poor rapport/communication between women and health care providers.

Another outcome of interest was respectful maternity care, as reported by women or observed by the investigators. Respectful maternity care is a woman-centred maternity care that is organised for, and provided to, all women by upholding their privacy, confidentiality, and dignity, protecting women from harm and mistreatment through the

provision of continuous support and enabling active decision making by women throughout their pregnancy, childbirth and during postnatal care (World Health Organization, 2018b). Respectful maternity care improvement is measured as changes in the domains of respectful maternity care which include being free from harm and mistreatment, the protection of dignity, privacy and confidentiality, informed consent, and respect for their preferences among others as suggested by Shakibazadeh et al. (2018)

Types of studies

Cluster RCTs and pre-and-post interventional studies with and without control groups were included in the review.

Database selection and search strategy

The search was conducted from 10 November 2021 through December 13, 2021, to retrieve both published and unpublished studies. An initial search of PubMed and CINAHL databases was performed based on the eligibility criteria mentioned under eligibility criteria. After analysing the text and terminology used in potential studies identified from PubMed and CINAHL databases, a second search was undertaken using all identified keywords and index terms performed in EBSCO Nursing/Academic Edition, Ovid Embase, African Journals Online (AJOL), Scopus, Web of Science, and Google Scholar.

Manual searches of the reference lists of all identified papers and previous systematic review papers were performed to identify studies cited within the selected papers. Searches for unpublished studies in ProQuest's dissertation and thesis database, grey literature from search engines such as Google, WHO Global Health Library websites, White Ribbon Alliance, and the International Confederation of Midwives were also

performed. The keywords used in the initial search included *'mistreatment'*, '*respectful maternity care'*, *'maternity care'*, and *'interventions'*. The details of the database search strategies are provided in the supporting file S2 Table.

Data management and study selection

The results from all database searches were exported to Endnote version X9 (The EndNote Team, 2013) for storage and management. The results were labelled in Endnote as either originating from the database or manually searched. Bibliographies captured in Endnote were then exported to the Covidence Systematic Review software (Veritas Health Innovation, Melbourne, Australia; available at www.covidence.org) for the screening and identification of relevant studies, and duplicates were removed.

The remaining titles and abstracts were assessed for relevance to the eligibility criteria independently by HK and VS. Following title and abstract screening, papers deemed relevant to the review were then reviewed in full-text form. Further review by KB and AS resolved any discrepancies within the initial review process.

Data collection and analysis

Assessment of methodological quality

Papers selected for retrieval were assessed independently by HK and AS to ensure methodological quality using standardised critical appraisal instruments from the JBI System for the Unified Management, Assessment, and Review of Information (JBI SUMARI; JBI, Adelaide, Australia) for quasi-experimental (for pre-and-post non-randomised interventional studies) and RCTs (Tufanaru et al., 2020). Differences in opinion between the two reviewers were resolved through discussion, and a consensus

was reached with the involvement of KB and VS. No studies were excluded based on the results of the critical appraisal.

Data collection and synthesis

Data were extracted from the included studies using a checklist developed for this purpose by HK and VS, and agreement reached by consensus by re-examination of the queried studies by AS and KB. Data were only used when there was consensus from all the authors. The extracted data included study authors, year of publication, study country and setting, study participants, sample sizes, recruitment methods, study design, interventions, reported outcomes, measurement means, and effect measures as detailed in Table 2.1.

Although statistical pooling via a meta-analysis of the effects of the interventions was our preferred and planned method of synthesis per protocol, a meta-analysis of effect estimates could not be achieved due to extreme clinical and methodological heterogeneity between the included studies. The interventions in the included studies were highly varied in terms of mode of action: including various educational/training packages for health care providers, diverse community-level interventions, and policy- and health facility-level quality improvement strategies. The characteristics of the included studies are summarised in a table utilising the PICO format. This enabled the comparison of studies, including settings, population of interest, interventions being implemented, and outcomes evaluated. The outcomes of the studies were analysed for their effectiveness and then synthesised as a descriptive narrative, utilising the format of texts as recommended when there is synthesis of findings without meta-analysis (Campbell et al., 2020). The effect measures from each study were extracted and interpreted as reported by primary authors as relative or absolute risk measures—

including adjusted odds ratios and relative risks for dichotomous data while mean difference between groups in studies measured outcome as continuous variables.

Assessing certainty in the findings

The Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach for systematic reviews was used to rate the certainty of the evidence for mistreatment of women, sub-categories of mistreatment of women (physical abuse, verbal abuse, non-confidential care, non-consented care, and violation of privacy), and respectful maternity care. The final grading of the certainty of the evidence was agreed by consensus of all reviewers after initially graded independently by HK and VS. A summary of the findings is presented.

Results

Search results and study selections

In the initial systematic search, 1493 studies were retrieved using electronic databases and other methods. After removing duplicates, 1265 studies were screened by examining their titles and abstracts, of which 28 were retrieved for full-text assessment. Sixteen of these studies were excluded due to incorrect or unreported outcomes (n = 9), incorrect design (n = 6), lack of comparison and incorrect population (n =1), as depicted in Figure 2.1.

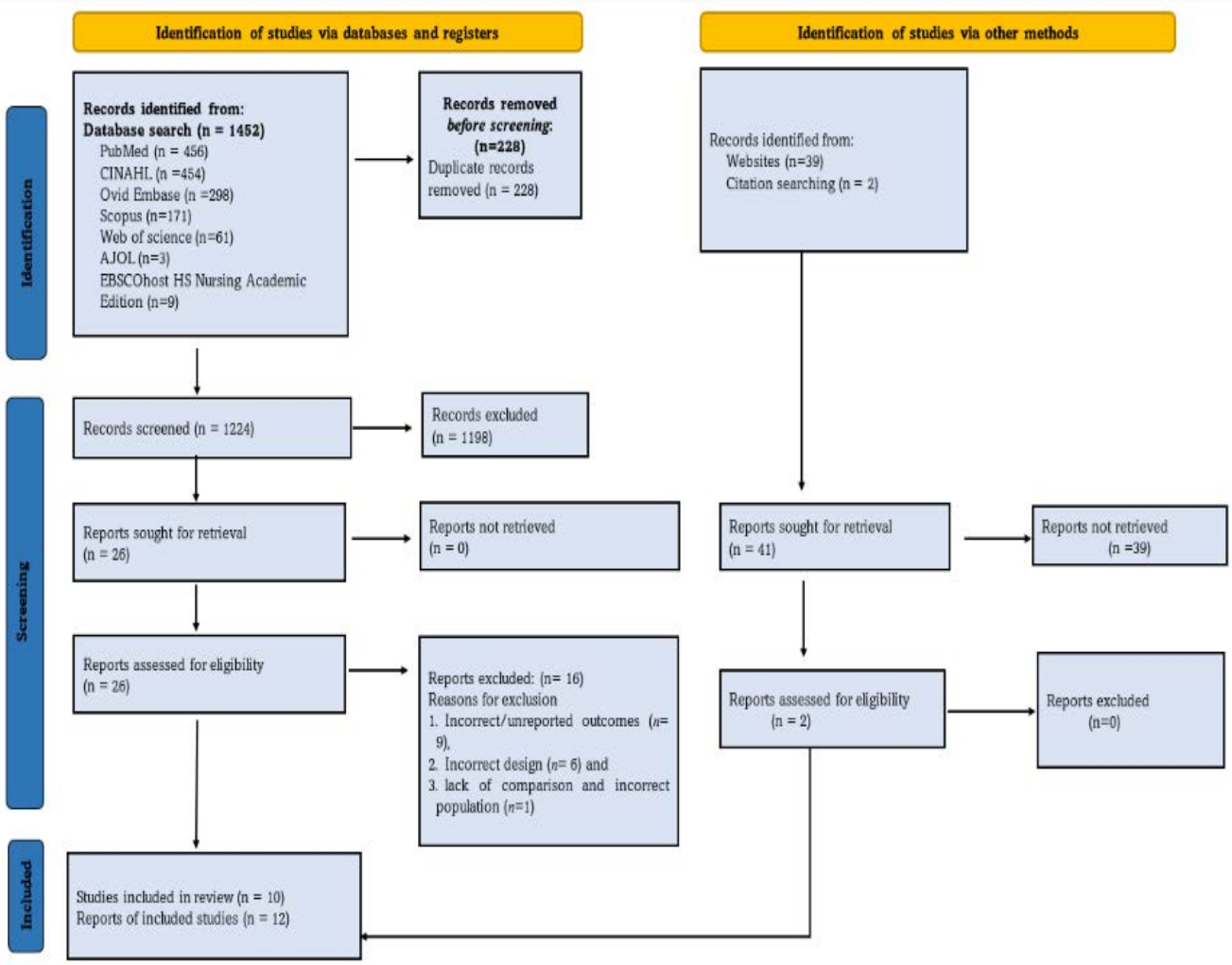

Figure 2.1: *Study selection PRISMA flow diagram*

Characteristics of included studies

Owing to the wide range of methodological inadequacies of the studies, all selected reports were included in the analysis for pragmatic reasons, which were relevant to the aim of the review and comprised the highest available methodological rigor of all assessed studies. Three of the 12 included studies were RCTs (Brown et al., 2007; Kujawski et al., 2017; Montagu et al., 2020), and the remaining nine were pre-and-post/ quasi experimental studies (Abuya et al., 2015a; Afulani et al., 2019; Asefa et al., 2020c; Asefa et al., 2020d; Mihret et al., 2020; Oosthuizen et al., 2020; Ratcliffe et al., 2016a;

Ratcliffe et al., 2016b; Umbeli et al., 2014). Out of the 12 studies included, it is worth noting that regardless of no criteria used to exclude studies based on their geographical region, eleven studies were conducted in sub-Saharan Africa (specifically, in Ethiopia, Tanzania, South Africa, Ghana, Kenya, and Sudan) and one study was conducted in India.

A total of 16834 women and 64 health care providers participated in the studies, and the numbers in the intervention and comparison groups (control or pre-intervention) ranged from 219 to 4469 participants (mean 945, median1035) with an age of 15 years of age and above. In addition to identifying the effects of interventions during birth, Mihret et al. (2020) also assessed the effects of interventions on disrespect and abuse during antenatal care. Exit interviews following childbirth or antenatal care and community follow-up surveys were the main approaches for data collection. Asefa et al. (2020c) identified the effects of interventions from health care providers' perspectives. The overall characteristics of the included studies are presented in Table 2.1.

Table 2.1 *Characteristics of included studies*

Lead author (citation) Country	Characteristics
Abuya et al (2015). Kenya	◊ **Design**: multicenter pre-and post-study without a control group ◊ **Participants**: Women aged 15 to 45 years were surveyed for their experiences within 24-48 hours of birth at discharge ◊ **Sample**: **1,369** (641 women at baseline and 728 women at endline) ◊ **Intervention**: Multi-component intervention implemented at facility, community, and policy levels in the *Hashima* project from June 2011 – Feb 2014. o **Community level** - Community workshops- civic education for the community on the right to sexual and reproductive health, sensitisation meetings with the community members to demand respectful care. - Counselling community members who experienced disrespect and abuse by the counsellors in the facility. o **Facility level** - Providing training for health care providers (HCPs) that aimed at enhancing the protection of clients' and providers' rights through improving quality of care. - Caring for carers- counselling services for HCPs to assist them cope with high workload, critical incidents, and trauma. - Monitoring D&A- through facilitating incident reporting mechanisms. - Mentorship- in-service role-modelling the champion provider behaviour as routine continuous professional education - Maternity open day- trust-building session prepared in health facility through explaining procedures in the maternity ward for the invited members of the local communities. o **Policy level** - Continuous policy dialogue with government, civil society, and professional knowledge networks ◊ **Outcome**: women reported and observed experiences of disrespect and abuse. ◊ **Measurement:** measured as dichotomous variable, percentage of women responding to six questions asking whether they were disrespected or humiliated at least for one form of categories of D&A. ◊ **Evaluation of effect:** multivariate logistic generalised linear mixed models (GLMM) were used for both observational and exit interview data and reported as both adjusted and crude odds ratios (OR). • **Observation**: lack of privacy and physical aggression were reduced from baseline while non-consented care and sharing bed were increased from the baseline level. • **Survey with women**: overall D&A was reduced from baseline level 129(20.1%) to 13.2% (– adjusted OR: 0.55 (0.40 – 0.75). • Physical abuse, verbal abuse, violation of confidentiality and detention were also significantly declined from their baseline levels. Reliability and validity of the survey tool were not shown.
Afulani et al. (2019) Ghana	◊ **Design**: Pre- and post-intervention study without control groups was conducted in five high volume childbirth health facilities (one hospital and 4 health centres) ◊ **Participants**: women aged 15-49 years who give birth in preceding 8 weeks in study health facilities were approached at discharge from facilities. ◊ **Sample**: 215 women at baseline (March-April 2017) and 318 at endline (November 2017). ◊ **Intervention**: Two days *integrated simulation-based training* was provided for 43 health care providers including midwives, medical doctors, anaesthetists, and nurses in two rounds. The content of the training includes: - Five simulation scenarios - Skills capturing session in identified seven areas of focus. ◊ **Outcome:** RMC as reported by women ◊ **Measurement**: RMC measured as a continuous variable of score of person-cantered maternity care scale (PCMC) structured into 4-point Likert scale from 24 items and then converted to 100. ◊ **Evaluation of the effect:** RMC, average PCMC increased by 43% from 50 (baseline score) to 72 (endline score); it was also reported as increased in linear regression coefficient (18 points than the baseline score, (β = 17.6; 95% CI = 15.6-19.6)

Lead author (citation) Country	Characteristics
	• Dignity and respect, communication and autonomy and supportive care were subclass indictors showed increment. ◊ *Used a tool validated in Kenya and India with high content, construct, and criterion validity with a good reliability.*
Asefa, Morgan, Gebremedhin, et al., (2020). Ethiopia	◊**Design**: Pre- and post-study without a control group conducted between December 2017 and September 2018 in three Hospitals in Southern Ethiopia. ◊**Participants**: women who gave birth in study facilities took part in the study at discharge. ◊**Sample**: 388 women were surveyed- 190 before intervention and 198 after intervention. ◊**Intervention**: Respectful Maternity care training- the contents and intensity of the interventions implemented include: o **Facility level** - Respectful maternity care training for health care providers- three-day workshops for 64 HCPs in two rounds. - Five wall posters: four in English and one in Amharic posted in labour ward to be used as on job aids incorporating universal rights of childbearing women developed by White Ribbon Alliances and infographics prepared by WHO. - Supportive supervisions: two round quality improvement post-training supportive supervisions were conducted through developing action plans for the standard-based identified gaps. ◊**Comparator**: usual care before the implementation of the intervention ◊**Outcome**: women's experiences of mistreatments ◊**Measurement**: measured as number of mistreatment categories women experienced using 25 items originating from six categories of mistreatment. ◊**Evaluation of the effect**: the effect of the intervention was evaluated using a multilevel mixed-effects Poisson regression model. • Adjusted exponentiated regression coefficient =0.82, 95% CI 0.74 to 0.91
Asefa, Morgan, Bohren, & Kermode, et al. (2020) Ethiopia	◊**Design:** Pre- and post-intervention study without a control group conducted between April and May 2018. ◊**Participants:** health care providers who provide Labor and childbirth and received intervention participated in the survey. ◊**Sample:** 64 HCPs responded to pre-intervention survey and all of them participated in post intervention survey. - **Intervention: - Facility level as described above in Asefa et al.** - Three days training delivered as presentations, role play, demonstrations, case studies, individual readings, videos, and a hospital visit. - Contents of training- overview of maternal health in Ethiopia, human rights, and law in the context of reproductive health, RMC rights and standards, professional ethics, and continuous quality improvement. ◊ **Outcome**: HCPs perceptions of RMC ◊ **Measurement**: perceptions of RMC was measured using eight domains and classified it as positive and negative perceptions. ◊ **Evaluation of the effect:** an exact McNemar's test was performed to analyse pre-post differences in participants' perceptions of RMC. - Proportion of perceiving RMC domains positively was 21.9% before the training, and 35.9% after the training (p = 0.08)
Brown et al. (2007) South Africa	◊ **Design:** a pilot cluster RCT study conducted at 10 hospitals (five randomly allocated to receive educational intervention to promote childbirth companion) ◊ **Participants:** Postnatal women who received labour and birth care in study hospitals. ◊ **Sample:** 2090 survey before intervention (October 1998) and 2058 exit interviews carried out after intervention (December 1999) ◊ **Intervention**: Childbirth companion promotion- a multidimensional educational intervention delivered as interactive workshop for HCPs, banners and posters at labour ward, brochures and video program promoting birth companion. ◊ **Comparator**- the five control hospitals received an unrelated evidence-based intervention to promote the external cephalic version (ECV). ◊ **Outcome:** birth companion and indicators of mistreatment (described as inhuman care in study- being shouted at, being slapped, or struck, being left alone) ◊ **Measurement:** self-reported by women whether they were allowed a companion, and experiencing inhumane care mentioned. ◊ **Evaluation of the effect:** Used non-parametric test (Mann Whitney U test) and did not report the effect size, only reported it as there were no significant effect
Kujawski et al. (2017) Tanzania	◊**Design**: cluster RCTs. ◊**Participants**: women aged 15 and above and gave birth in study facilities were participated in exit interview. ◊**Sample**: 3068 women were included (Baseline**:** 1388 (744 from control hospital and 644 from intervention hospital) and (**Endline:** 1680 (769 from control hospital and 1001 from an intervention hospital)

Lead author (citation) Country	Characteristics
	◊**Intervention**: *Staha* intervention comprising two components was implemented over two years in Korogwe District, Tanzania and compared with Muheza District as: o **Community level** - **Client service charter-** community and health facility stakeholders adapted client service charter. The charter was issued to the communities and posted in health facilities found within the intervention district. o **Facility level:** - **Quality improvement program-** following the adaptation of the client service charter for six-month, quality improvement activities that activated charter content were performed to address disrespectful and abusive care. ◊**Comparator-** compared to women gave birth in health facilities without any intervention (usual care) and to the practices existing before interventions. ◊**Outcome**: women's self-reported experiences of any form of D&A. ◊**Measurement**: labelled as experienced D&A if women reported at least one of 14 questions during labour and birth based on the Bowser and Hills' categories. ◊**Evaluation of effect:** adjusted logistic regression difference in difference model between baseline and endline on a total of 2983 eligible survey results. • 66% reduced odds of a woman experiencing D&A (adjusted OR: 0.34, 95% CI: 0.21–0.58, p< 0.0001). • The biggest reductions were for physical abuse (aOR: 0.22, 95% CI: 0.05–0.97, p= 0.045) and neglect (aOR: 0.36, 95% CI: 0.19–0.71, p= 0.003). ◊*The validity and reliability of the survey tool was not reported.*
Mihret et al. (2020) Ethiopia	◊ **Design:** Pre-and-post single centre without a control group interventional study from November 2018 to May 2019. ◊ **Participants:** women who received antenatal care and gave childbirth in study hospital were surveyed for their experiences before and after intervention ◊ **Sample: 738 (**369 at baseline and 369 at endline/after intervention). ◊ **Intervention:** RMC and monitoring and evaluation training for HCPs and managers, setting up waiting room, availing resources for ensuring privacy (curtains), essential, drugs written guideline and protocol, recognising best performing staff and continuous supportive supervision by quality improvement team. ◊ **Comparator-** pre-intervention services ◊ **Outcome:** proportion of disrespect and abuse among pregnant women who received ANC and labour and birth in health facility. ◊ **Measurement:** The D&A was identified as any form of abusive care using 24 Yes/No questions based on Bohser and Hill's categories of D&A. ◊ **Evaluation of the effect:** significance of the intervention was checked using independent t- test, reported as significant. ◊ Overall D&A before intervention was 71.8 and 15.9% after intervention.
Montagu et al. (2020) India	◊ **Design:** cluster RCT was conducted at three primary health centres and six community health centres of Unnao and Kanpur Districts of Uttar Pradesh state in India. ◊ **Participants:** women aged 18-49 and gave childbirth within last seven days in participating health facilities ◊ **Sample:** 570 (285 at each group) women at baseline from September 2016 to March 2017 and 600 (300 at each group) women at endline from May to December 2018 participated in surveys. ◊ **Intervention:** establishing quality improvement team and participation in Improvement Collaborative workshops to work towards the improvement of person-centred maternity care through a plan-do-study-act (PDSA). ◊ ***Comparators:*** usual care at non-interventional control health facilities. ◊ **Outcome:** Person-centred maternity care (PCMC) that includes RMC domains (dignity and respect; communication and autonomy; and supportive care.). ◊ **Measurement:** measured using 23 validated survey items scaled to 100-point scale, highest score indicating better PCMC/RMC care. ◊ **Evaluation of the effect:** from baseline to endline, the adjusted mean PCMC score of the intervention group increased 22.9 points (95%CI: 20.9, 25.0). ◊ **After the intervention-** PCMC mean score for intervention group was 97.13 with SD of (2.91) and in a control group mean score 63.42 with SD of (11.44)
Oosthuizen et al. (2020) South Africa	◊ **Design:** Pre- and post-pilot interventional study in Tshwane health district in 10 midwife-led obstetric units (MOUs) of South Africa. Five MOUs purposively selected to be part of the intervention while the remaining five were treated as a control group. ◊ **Participants:** women who had given child in MOUs and returned for postnatal care from 3 days to six weeks. ◊ **Sample:** 653 women at baseline from February to April 2016 and 679 at endline survey from October 2016 to March 2017.

Lead author (citation) Country	Characteristics
	◊ **Intervention:** CLEVER package- that includes awareness creation of women's experiences for strengthening health system with MOUs' participants, intensive behavioural change activities for 3-months and six-month support ◊ **Comparators:** usual care before intervention and care in control groups ◊ **Outcome:** RMC and satisfaction ◊ **Measurement:** validated survey tools were used to measure RMC by a question that asked to rate how women feel they were respected and the other rate their level of satisfaction. ◊ **Evaluation of the effect:** the percentage of RMC changed from 38.1% at baseline to 74.5% endline, and satisfaction from 47% to 73.6%. o RMC (aOR= 4.33) and satisfaction (aOR=4.04) raised four times at endline as compared to baseline in the interventional groups (P-values <0.0001) RMC (aOR= 1.14) and satisfaction (aOR=1.20) raised at endline as intervention compared to control groups (P-values <0.0001) ◊ As compared to the control groups, endline RMC was 71.6% for controls and 74.5% for interventional groups, while endline satisfaction was 71.1 for control groups and 73.6% for interventional groups.
Ratcliffe et al. (2016) Tanzania	◊ **Design:** Pre- and post-intervention study between January 2013 and December 2014 at large, urban regional referral hospital in Dar es Salaam, Tanzania. ◊ **Participants:** women who gave birth at the facility during four to six weeks post-delivery in the woman's home. ◊ **Sample:** 70 women at baseline and 149 women after intervention. ◊ **Interventions:** two discrete interventions were implemented: o **Health facility level** - Open Birth Days (OBD), a birth preparedness and antenatal care education program for women while they are in third trimester pregnancy - Workshop with HCPs on respectful maternity care aimed at examining practice with respect to professional code of conduct, clients' preferences and discussion on barriers that prevent provision of RMC. ◊ **Comparator:** service existing in the facility before the implementation of the intervention ◊ **Outcome:** women's experiences of respectful care and satisfaction with care. ◊ **Measurement:** RMC measured as the perception of the women rating how health care providers were respectful (five Likert scale question) ◊ **Evaluation of the effect:** measured as the change in percentage of the RMC perception and very satisfied. - Perception of respectful care: 22.8 % of women rated the respect shown to them by providers as "excellent" compared to none at baseline. - Satisfaction: 75.8 % of women reported being very satisfied with their birth experience compared to only 12.9 % at baseline.
Ratcliffe et al. (2016) Tanzania	◊ **Design through intervention-** as described above in Ratcliffe et al. ◊ **Outcome:** experiences of disrespect and abuse as reported by women ◊ **Measurement:** D&A was measured using on the items developed based on the Bowser and Hills' categories of D&A ◊ **Evaluation of outcome:** evaluated as percentage difference between occurrences of individual categories of D&A and any form of abusive care as dichotomous variable: ◊ **Any form of D&A:** 70% at baseline and 18% at endline
Umbeli et al. (2014) Sudan	◊ **Design:** Pre- and post-intervention study was conducted in Omdurman maternity hospital, Sudan. ◊ **Participants:** women who gave childbirth in study facility were surveyed. ◊ **Sample:** a total of 4469 women were surveyed (2000 before and 2469 after) training. ◊ **Intervention:** training HCPs on communication skills, support during childbirth, providing information and empathy. ◊ **Comparators:** usual care before intervention ◊ **Outcome: respectful care and satisfaction level** ◊ **Measurement:** RMC measured as a women's perceptions of friendly and respectful care. ◊ **Evaluation of the effect:** difference between women's opinion about health care providers' behaviour in labour ward. o The proportion of HCPs who were supportive, friendly, and respectful was 1793 (89.7%) before training and 2338 (94.7%) after training. ◊ Proportion of women received information on onset of labour from 76.8% to 96.8%, requested investigations from 54.9% to 94.5%, condition of the fetus from 15.3% to 92.1%, progress of labour from 9.9% to 89.9%, expected duration of labour from 8.9% to 95.0%, examination and procedure to be done from 7.5% to 57.9% from baseline level to the endline.

The methodological quality of included studies

A JBI critical appraisal checklist was used to assess the methodological quality of each study. Summaries of these assessments are presented in Tables 2.2 and 2.3. All quasi-experimental studies scored positive ('Yes') for more than half of the appraisal domains, ranging from five to seven of nine quality domains. In four out of nine quasi-experimental studies (Abuya et al., 2015a; Afulani et al., 2019; Mihret et al., 2020; Oosthuizen et al., 2020), the participants in the comparison groups were not similar. In contrast, all studies identified causes (interventions) and effects (mistreatment and/or respectful maternity care). Only Oosthuizen et al. (2020) included a parallel control group before and after the intervention. The remaining quasi-experimental studies used the survey findings conducted before the interventions were implemented as comparison groups.

Multiple outcome measurements before and after the intervention were also identified when analysing the suitability of the included studies. If multiple surveys were conducted before and after the intervention, the authors would have ascertained whether the observed changes occurred naturally in the absence of the interventions or were due to the intervention they implemented. Because interventions were given at the cluster level (health facility level or community level) to different study participants before and after the implementation of interventions, participant follow-up was not achievable in all studies, except for the (Asefa et al., 2020c) study in which data were collected from the same participants before and after the intervention. All quasi-experimental studies which measured both before and after the intervention utilised the same measurement tools; however, the reliability and validity of the tools used to measure the outcome were not reported in three of the nine studies (Asefa et

al., 2020c; Ratcliffe et al., 2016a; Umbeli et al., 2014). Although all studies performed analyses aimed to investigate specific effects of the interventions, the influences of other confounding factors were not controlled for in the statistical analyses of six of the nine quasi-experimental studies (Asefa et al., 2020c; Mihret et al., 2020; Oosthuizen et al., 2020; Ratcliffe et al., 2016a; Ratcliffe et al., 2016b; Umbeli et al., 2014).

Table 2.2: *Critical appraisal results for the quasi-experimental studies included in the review.*

Studies	Critical appraisal questions									Score
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	
Abuya et al. (2015)	Y	N	Y	N	N	NA	Y	Y	Y	6
Afulani et al. (2019)	Y	N	Y	N	N	NA	Y	Y	Y	6
Asefa et al.	Y	Y	Y	N	N	Y	Y	N	N	5
Asefa et al. (2020d)	Y	Y	Y	N	N	NA	Y	Y	Y	7
Mihret et al. (2020)	Y	N	Y	N	N	NA	Y	Y	N	5
Oosthuizen et al. (2020)	Y	N	Y	Y	N	NA	Y	Y	Y	7
Ratcliffe et al. (2016a)	Y	Y	Y	N	N	NA	Y	N	N	5
Ratcliffe et al.(2016b)	Y	Y	Y	N	N	NA	Y	Y	N	6
Umbeli et al. (2014)	Y	Y	Y	N	N	NA	Y	UC	N	5
Total % of positive scores	100	55	100	11	0	11	100	66	55	

JBI critical appraisal checklist for quasi-experimental studies (Y= Yes, N=No, UC=Unclear N/A=Not Applicable)
Q1= Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?
Q2=Were the participants included in any comparisons similar?
Q3= Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?
Q4= Was there a control group?
Q5= Were there multiple measurements of the outcome both pre and post the intervention/exposure?
Q6= Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed?
Q7= Were the outcomes of participants included in any comparisons measured in the same way?
Q8= Were outcomes measured in a reliable way?
Q9=Was appropriate statistical analysis used?

All three cluster RCT studies randomly assigned the intervention to the clusters, as shown in Table 2.3. As the interventions in these studies were held at the cluster level, it is less likely to expect concealment of the intervention assignment to the groups, and all of them were scored as not concealed (Brown et al., 2007; Kujawski et al., 2017; Montagu et al., 2020). Even though the groups were recruited by matching

samples, significant socio-demographic variation between the survey respondents existed before and after the interventions in each group of all three studies.

Information regarding blinding in the studies was considered inadequate. Therefore, biases in both the performance of the intervention and detection of the outcome by the personnel (health care providers) and outcome assessors (data collectors in this instance) have the potential to be present. Only Kujawski et al. (2017) described and acknowledged the possibility of information contamination among women before recruiting them to participate in the study (initial awareness regarding the presence of intervention at a specific health facility). Prior information regarding the presence of intervention may have influenced self-selection to the interventional facility. In the remaining two cluster RCTs (Brown et al., 2007; Montagu et al., 2020), there was no clear information regarding the level of bias introduced by knowledge of the intervention by participants (women) and outcome assessors. As the recruitment of women was performed after the intervention was implemented in all three studies, concealment of the participant groups to the personnel who delivered the intervention was not possible. Both the control and intervention groups were treated identically in Kujawski et al.'s (2017) and Montagu et al.'s (2020) trials, while additional unrelated interventions occurred in the control groups in Brown et al.'s (2007) trial. While participants in all these studies were analysed in the groups in which they were initially randomised and the outcomes were measured similarly in both groups, the tools used to measure the outcome were not replicable, and no appropriate statistical analysis was conducted in one cluster trial (Brown et al., 2007).

Table 2.3: Critical appraisal results for the quasi-experimental studies included in the review

Studies	Appraisal questions													Score
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	
Kujawski et al. ( )	Y	N	N	Y	N	UC	Y	NA	Y	Y	Y	Y	Y	9
Montagu et al. ( )	Y	N	N	UC	N	UC	Y	NA	Y	Y	Y	Y	Y	8
Brown et al. (2007)	Y	N	N	UC	N	UC	N	NA	Y	Y	UC	N	N	4
Total % of positive scores	100	0	0	0	0	0	66	0	100	100	66	66	66	

JBI critical appraisal checklist for randomised controlled trials (Y= Yes, N=No, UC=Unclear N/A=Not Applicable)

Q1=Was true randomisation used for assignment of participants to treatment groups?
Q2=Was allocation to treatment groups concealed?
Q3=Were treatment groups similar at the baseline?
Q4=Were participants blind to treatment assignment?
Q5=Were those delivering treatment blind to treatment assignment?
Q6=Were outcomes assessors blind to treatment assignment?
Q7=Were treatments groups treated identically other than the intervention of interest?
Q8=Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed?
Q9=Were participants analysed in the groups to which they were randomised?
Q10=Were outcomes measured in the same way for treatment groups?
Q11=Were outcomes measured in a reliable way?
Q12=Was appropriate statistical analysis used?
Q13=Was the trial design appropriate, and any deviations from the standard RCT design (individual randomisation, parallel groups) accounted for in the conduct and analysis of the trial?

Interventions

Interventions varied between studies, ranging from health care provider RMC training to community engagement strategies for reducing mistreatment and policy amendments. This section describes the types of interventions by classifying them as multi-component, training-based, quality improvement, and companion of birth.

Multi-component interventions

Three pre- and post-studies (Abuya et al., 2015a; Ratcliffe et al., 2016a; Ratcliffe et al., 2016b) and one cluster RCT (Kujawski et al., 2017) study evaluated multi-component interventions targeting health care providers and/or women and community members. Abuya et al.'s (2015a) before and after study in Kenya evaluated the interventions designed to lower the rate of disrespectful and abusive behaviours

under the Hashima project at the policy, community, health facility (13 facilities), and individual levels. They evaluated the effects of the interventions by surveying 1,369 women at discharge from the facility (641 women before and 728 women after intervention). In this study, RMC training was provided to healthcare providers and policymakers to enhance their understanding of the existence of disrespect and abusive care. Workshops on women's reproductive rights were also examined. The workshops were led by community members to enhance the relationships between community agencies and health facilities. Through technical meetings, the researchers also conducted continued policy dialogues with government representatives, professional associations, and civil society.

Similar to the results reported by Abuya et al.'s (2015a) study, Kujawski et al.'s. (2017) cluster RCTs evaluated a two-stage intervention at the community and health facility levels. They designed a client service charter to create standards for mutual respect enacted by community and health-facility providers. The content of these community-level charters was then adapted by health facilities and incorporated into quality improvement activities. These quality improvement activities include ensuring privacy during admission and examinations, transparency of processes and care, trust-building mechanisms, and anonymous exit surveys to measure women's satisfaction. The effectiveness of the quality improvement activities developed from the client service charter was evaluated by surveys involving 1680 women (769 women in the control group and 1001 women in the intervention group) compared to the baseline surveys of 1388 women (744 women in the control group and 644 women in the intervention group) in the control and intervention groups.

In a pre- and post-study (70 women at baseline and 149 women after intervention) conducted in Tanzania (Ratcliffe et al., 2016a; Ratcliffe et al., 2016b), the authors

evaluated two facility-based interventions which aimed to mitigate the mistreatment of women and enhance the delivery of RMC. The intervention included an antenatal care education program for women in the third trimester of pregnancy, drawing attention to the low information level among women as identified in a survey performed before designing the intervention (Sando et al., 2016). They also implemented workshops with healthcare providers after examining the barriers and enablers of RMC. The evaluation assessed whether the workshops impacted women's experiences of disrespect and abuse by examining whether the survey results varied between the populations sampled before and after the interventions were introduced.

Training based intervention at facility levels

The common method of implementing change toward RMC at the health facility level is health care provider training/simulation and using pre- and post-intervention data for evaluation purposes. Three studies in Ethiopia (Asefa et al., 2020c; Asefa et al., 2020d; Mihret et al., 2020) evaluated the effects of health care provider RMC training, followed by infrastructure improvements such as resource availability, visual prompts (posters), recognition of providers who adhere to RMC, and post-training health care provider supportive supervisions.

Other health care providers' training focusing on RMC incorporates information about creating awareness about women's experiences (Oosthuizen et al., 2020), ways of treating women with dignity and respect, communication, respecting women's autonomy, birth choices and preferences, and encouraging birth companions (Afulani et al., 2019; Umbeli et al., 2014). Further health facility interventions in the included studies were a quality improvement workshop aimed at improving health providers' ability to deliver RMC through a plan-do-study-act cycle (Montagu et al., 2020).

Birth Companion

Another means of augmenting RMC included the presence of a birth companion for labouring women. A cluster RCT study from South Africa (Brown et al., 2007) evaluated the benefits of promotive strategies toward the availability of birth companions. They encouraged the uptake of birth companions by providing educational intervention to promote childbirth companions in interventional hospitals compared to usual care in control hospitals (Brown et al., 2007).

Effectiveness of interventions

The effect measures of the outcomes of the studies are described in the summary of findings table (Table 4). We synthesised the effectiveness of interventions by grouping studies in the outcomes the programs' focused on achieving and the categories of interventions implemented. We reviewed the reduction of mistreatment during maternity care and a change in respectful maternity care, women's satisfaction, health care provider perceptions of RMC, and the employment of birth companions for women during labour.

and birth. Changes in these outcomes are presented in the following sub-sections.

Mistreatment of women in health facilities

Moderate certainty evidence emerged from two cluster RCTs (Brown et al., 2007; Kujawski et al., 2017) and four pre- and post-studies (Abuya et al., 2015a; Asefa et al., 2020d; Mihret et al., 2020; Ratcliffe et al., 2016b) assessed the effects of multi-component interventions in diminishing mistreatment of women as reported by women in health facilities.

Kujawski et al. (2017) projected implementing client service charters at the community and health facility level was associated with reduced odds of a woman experiencing mistreatment of women by two-thirds (aOR = 0.34, 95% CI: 0.21–0.58, 2983 participants) as compared to control groups. Other pre-post interventional studies (Abuya et al., 2015a; Ratcliffe et al., 2016b) also reported the possibility of reducing the odds of mistreatment of women through multi-component interventions. Abuya et al. (2015a) revealed that multi-component interventions were associated with a reduction in the odds of women experiencing humiliation and disrespect by 42 per cent (aOR = 0.58, 95% CI: 0.43-0.79, absolute risk reduction=7%, 1369 participants). Ratcliffe et al. (2016b) also revealed the benefits of implementing interventions on health care providers and women. They reported that the prevalence of disrespect and abuse experienced by women was reduced from 70 per cent at baseline to 18 per cent after intervention (absolute risk reduction= 52%, 219 participants).

Other pre- and post-intervention studies have also shown a declining trend in women experiencing mistreatment in maternity care after the implementation of interventions (Asefa et al., 2020d; Mihret et al., 2020). Asefa et al. (2020d) reported the number of mistreatment categories that women experienced was declined by 18 per cent after implementation of RMC promotive interventions through training and supportive supervision (adjusted exponent of β=0.82, 95% CI: 0.74-0.91, 388 participants). Mihret et al. (2020) study, implementing health care provider training, concluded that the prevalence of any mistreatment that women experienced was reduced from 71.8 per cent in the pre-intervention group to 15.9 per cent in the post-intervention group (absolute risk reduction = 56%, 738 participants).

One cluster RCT (Brown et al., 2007), with significant methodological weaknesses, evaluated the effects of an intervention to promote the importance of a birth companion

being present. Consistent with methodologically flawed research, their findings were insignificant. While the authors did not perform appropriate statistical analysis to estimate an intervention's effect size, physical abuse was reported to be reduced from 2 per cent to 1 per cent in the intervention arm. In comparison, it increased from 3 per cent to 4 per cent in the control group. Although the difference was not statistically significant, the risks associated with other types of mistreatments, such as verbal abuse and abandonment of care, increased in both arms of the RCT, as opposed to physical abuse. Verbal abuse (being shouted at) and abandonment (being left alone) increased from 14 per cent and 12 per cent before intervention levels to 15 per cent and 16 per cent after intervention in interventional groups (4148 participants).

Respectful maternity care

Moderate certainty evidence from two cluster RCTs (Kujawski et al., 2017; Montagu et al., 2020) and four pre- and post-interventional studies (Afulani et al., 2019; Asefa et al., 2020c; Oosthuizen et al., 2020; Ratcliffe et al., 2016a; Umbeli et al., 2014) suggests an enhancement of respectful maternity care secondary to various interventions in the community, health system, and facility levels (overall 13119 study participants). Following the implementation of health care provider team-based quality improvement activities through plan-do-act-study cycles, Montagu et al. (2020) reported an improvement in RMC scores (expressed as person-centred maternity care) by 22.9 points (95% CI: 20.9-25.0) in intervention groups compared to control group (1170 samples). Furthermore, Kujawski et al. (2017) identified that implementation of community and health facility-based interventions was associated with increased respectful care from health care providers to women during their stay at the birth facility (RR: 3.44, 95% CI: 2.45–4.84, p-values < 0.0001, 2983 participants).

Similarly, a pre- and post-study by Afulani et al. (2019) reported a relative increment of mean RMC (person-centred maternity care) score by 43 per cent from 50 per cent at baseline to 72 per cent after intervention implementation. While controlling for potential confounders, the RMC score after the intervention was 18 times higher than the baseline score (β =17.6; 95% CI: 15.6-19.6, 538 participants). Such increments were also observed in individual subscales for dignity and respect, communication and autonomy, and supportive care, with risk differences of 15, 87, and 55 per cent, respectively.

Based on a pre- and post-study, Oosthuizenez et al. (2020) reported positive childbirth experiences (RMC) increased from 38.1 per cent at baseline to 74.5 per cent during follow-up in intervention groups (aOR = 4.33, p-value < 0.0001, 1332 participants). Umbeli et al. (2014) evaluated the effects of training health care providers on communication skills to improve specific aspects of RMC. The proportion of women reporting perceived supportive, friendly, and respectful care from health care providers increased by 5 per cent (89.7% before training to 94.7 per cent after training, 4469 participants). Another pre- and post-study evaluated the effects of educating women on birth preparedness and complication readiness and training health care providers to mitigate mistreatment of women reported an increment of perceived respectful care to 22.8per cent compared to none at baseline (219 participants) (Ratcliffe et al., 2016a).

Asefa et al. Asefa et al. (2020c) assessed the positive outcomes of training health care providers on respectful maternity care. They concluded that training alone could only result in a minimum resolution of the mistreatment of women (i.e., lack of RMC). Nevertheless, they did report the proportion of health care providers who positively

perceived RMC domains increased from 21.9 per cent before the training to 35.9 per cent after the training (*p*-value = 0.08, 64 participants).

Maternal satisfaction

Three pre- and post-studies(Oosthuizen et al., 2020; Ratcliffe et al., 2016a; Umbeli et al., 2014) and one cluster RCT (Kujawski et al., 2017) evaluated whether interventions increased women's satisfaction with maternity care. These studies reported improved satisfaction after implementing interventions to address mistreatment during maternity care, however, there were limitations in the measurement of women's satisfaction. One of these studies, conducted by Ratcliffe et al. (2016a), reported a significant increase in maternal satisfaction from 12.9 per cent before the intervention to 75.8per cent after training health care providers, suggesting that effective interventions can lead to improved satisfaction despite the limitations in measurement (219 participants). Umbeli et al. (2014) and Oosthuizen et al. (2020) also suggested an improvement in maternal satisfaction by 5.9 per cent (89.8% at baseline to 95.7% after the intervention, 4469 participants) and 26.6 per cent (47.0% at baseline to 73.6% post-intervention, 1332 sample), respectively. However, Kujawski et al.'s (2017) cluster RCT showed little or no difference (aOR = 0.98, CI:0.91-1.06, *p*-value = 0.67, 2983 participants) between the intervention and control groups related to the proportion of women reporting being satisfied with the care provided.

Table 2.4: *Summary of findings table*

Multi-component RMC intervention compared to usual care for reduction of mistreatment of women and/or enhancing RMC

Population: Healthy women during maternal health care utilisations
Setting: Maternity care units (antenatal, labour and postnatal wards) in Ethiopia, Sudan, Kenya, Tanzania, South Africa, Ghana & India
Intervention: Multi-component RMC intervention
Comparison: usual care
Data sources: all data sources were from women self-report in primary studies— some effect measures were calculated based on summary findings by reviewers if not given in primary articles.

Outcomes		**Anticipated absolute effects** Single effect size was not pooled, and narrative synthesis of each studies effect measures were given	№ of participants (studies)	Certainty of the evidence (GRADE)
Any form of mistreatment of women	The effect measure from one cluster RCT (Kujawski et al., 2017) — aOR=0.34, 95% CI: (0.21-0.58) (3.2% in intervention groups vs 15.76% in control groups). Observation studies: four pre-and-post studies showed reduction in any forms of mistreatment; aOR=0.58, 95% CI: (0.43, 0.79) (20% before vs 13.2% after intervention) (Abuya et al., 2015a), 18% risk reduction— aIRR=0.82(95% CI 0.74, 0.91) (Asefa et al., 2020d). Other two pre-post studies showed absolute risk reduction from crude OR of 0.07(95% CI 0.05 - 0.1) (71.8% vs 15.9%) (Mihret et al., 2020) and OR= 0.08, 95% CI: 0.043 - 0.17) (18% after intervention vs 70% before intervention) (Ratcliffe et al., 2016b).	8680 (5 studies—1 RCT (Kujawski et al., 2017) and 4 pre-and-post observational studies (Abuya et al., 2015a; Asefa et al., 2020d; Mihret et al., 2020; Ratcliffe et al., 2016b))	⊕⊕⊕◯ Moderate[a,b]	

Physical abuse	Effect measures from two cluster RCTs: (Kujawski et al., 2017) — (OR: 0.22, 95% CI: 0.05–0.97) (1.8% control vs 0.3% intervention), while the other cluster RCT did not report summary statics but identified it as significant (Brown et al., 2007). Pre-and-post studies also showed reduction of physical abuse— (OR 0.5; 95 % CI: 0.3–0.9) (4.2% before vs 2.1% after intervention) (Abuya et al., 2015a), absolute risk reduction from 16.7% before to 8. 9% after intervention (Asefa et al., 2020d), 61% at baseline to 15.4% at the postintervention (Mihret et al., 2020) and from 52% to 1% (Ratcliffe et al., 2016b)	7830 (6 studies— 2 cluster RCTs (Brown et al., 2007; Kujawski et al., 2017) and 4 pre-and-post observational studies (Abuya et al., 2015a; Asefa et al., 2020d; Mihret et al., 2020) (Ratcliffe et al., 2016b))	⊕⊕◯◯ Low[a]
Verbal abuse	Verbal abuses were decreased with effect measures from pre-and-post studies— (OR 0.6; 95 % CI: 0.4-0.8) (18.0% before vs 11.3% after intervention) (Abuya et al., 2015a), decreased from 78% to 24.4% (Mihret et al., 2020), 54% to 5% (Ratcliffe et al., 2016b). Even though not significant, non-dignified care was also decreased in one cluster RCT (Kujawski et al., 2017) 2.2% vs 11.2% (aOR=0.58, 95%CI: 0.3-1.1) and in another pre-and-post study by (Asefa et al., 2020d)— from 8.6% to 5.8%.	5772 (5 studies— 4 pre-and-post observational studies (Abuya et al., 2015a; Mihret et al., 2020; Ratcliffe et al., 2016b) (Asefa et al., 2020d) & 1 cluster RCT (Kujawski et al., 2017))	⊕⊕⊕◯ Moderate[a]
Non-confidential care	Effect measures for decrement of non-confidential care— (OR 0.5; 95 % CI: 0.2–0.9) (3.9% before vs 1.8% after intervention) (Abuya et al., 2015a), 69% reduced risk, RR= 0.31, 95% CI: (0.26—0.37) (79.5% vs 24.7%) (Mihret et al., 2020) and 98% reduced risk, RR= 0.02 95% CI: (0.01—0.10) (54% vs 1%) (Ratcliffe et al., 2016b)	2326 (3 pre-and-post observational studies (Abuya et al., 2015a; Mihret et al., 2020; Ratcliffe et al., 2016b))	⊕⊕◯◯ Low[c]

Non-consented care	Effect measures —18% absolute risk reduction (83.3% vs 65.3%, RR= 0.78, 595% CI: (0.70—0.90) (Asefa et al., 2020d). Similarly, Mihret et al. (Mihret et al., 2020) showed 52.9% risk reduction (69.9% vs 17.1%, RR=0.24, 95% CI: (0.19 - 0.31) while (Ratcliffe et al., 2016b) showed 4% risk reduction from 5% to 1%. Unlike these three studies, Abuya's (Abuya et al., 2015a) pre-and-post study highlighted increment of the risk after intervention by 20% (61% vs 81%; aOR=3.4, 95%CI: 2.5–4.7).	2545 (4 pre-and-post observational studies (Abuya et al., 2015a; Asefa et al., 2020d; Mihret et al., 2020; Ratcliffe et al., 2016b))	⊕⊕◯◯ Low[c]
Privacy violated	From pre-and-post study- effect measures showed decrement of privacy violation—52.5% reduction (79.7% to 27.1%; RR= 0.34, 95%CI: (0.28—0.41) (Mihret et al., 2020) and (Ratcliffe et al., 2016b)—50.4% reduction (53.1% vs 2.7%; RR=0.05, 95%CI: (0.02 - 0.13). Although not significant additional two pre-and-post study also showed reduction in privacy violation—from 7.4% to 5.7%; aOR= 0.69, 95% CI: (0.44 – 1.08) (Abuya et al., 2015a) and from 81.8% to 77.4 %, RR = 0.95, 95%CI: (0.85 — 1.05)(Asefa et al., 2020c).	2708 (4 pre-and-post observational studies (Abuya et al., 2015a; Asefa et al., 2020c; Mihret et al., 2020; Ratcliffe et al., 2016b).)	⊕⊕◯◯ Low[c]
Respectful maternity care	Two cluster RCTs showed an increment of RMC:—person-centred maternity care score raised by 22.9 points (95%CI: 20.9—25.0) (Montagu et al., 2020) and — aRR 3.44 (2.45 - 4.84) (Kujawski et al., 2017). Similarly, four pre-and-post studies also showed improvement of RMC related to intervention—18 points increment in RMC: (β = 17.6, 95% CI: (15.6—19.6), a relative increase of 43% from 50 to 72 (Afulani et al., 2019); increased by 36.4% (38.1% to 74.5%) (Oosthuizen et al., 2020); respectful care increased from none at baseline to 22.8% at the time of evaluation (Ratcliffe et al., 2016a) and 5% increment in RMC (89.7% vs 94.7%) (Umbeli et al., 2014).	13119 (6 studies— 2 cluster RCTs (Kujawski et al., 2017; Montagu et al., 2020) and 4 pre-and-post observational studies (Afulani et al., 2019; Oosthuizen et al., 2020; Ratcliffe et al., 2016a; Umbeli et al., 2014))	⊕⊕⊕◯ Moderate[a]

aOR: adjusted odds ratios; **CI**: confidence interval; **IRR:** incidence risk ratio; **RMC**: respectful maternity care; **RCT**: randomised controlled trial

High certainty: we are very confident that the true effect lies close to that of the estimate of the effect.
Moderate certainty: we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low certainty: our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very low certainty: we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Explanations

a. The cluster RCT was assessed as having a serious risk of bias due to lack of allocation concealment, blinding, and variation in patient characteristics and patient-reported outcomes. All observational studies were also assessed as having a serious risk of bias because of lack of allocation concealment, blinding, randomisation, patient-reported outcome, failure to adequately control for potential confounders in two studies, and lack of repeated measurement both before and after the intervention.
b. The inconsistency between the studies could be due to the observed variations in the implemented intervention and outcome measurements.
c. The findings were based only on observational studies that had a serious risk of bias because of lack of allocation concealment, blinding, randomisation, patient-reported outcome, failure to adequately control for potential confounders in two studies, and lack of repeated measurement both before and after the intervention in all studies. Additionally, the data were based on patient/women/ reports.

Discussion

This systematic review illustrates how community-, policy-, health system-, and health facility-level interventions can influence women's perceived experiences of mistreatment and/or respectful care during their maternal care encounters in health facilities. All papers included in the review implemented and evaluated various interventions which extended from quality improvement activities in health facilities to the community- and policy-inclusive strategic activities. Even though their effect sizes varied from study to study, most of the wide-ranging interventions were reported to have had made a positive effect in reducing the mistreatment of women and/or enhancing respectful maternity care in health facilities.

Downe et al. (2018b) published a systematic review that explored the roles of RMC policies in changing the intrapartum experiences of women, suggesting that such interventions could reduce non-respectful behaviours and practices in maternity care. In addition, Dhakal et al. (2022) explored low-level evidence highlighting educational interventions and their effectiveness in promoting respectful maternity care. As such, this review builds on this evidence, focusing on multi-component interventions during the continuum of maternity care rather than focusing on specific components of interventions, thus highlighting the complexity of the phenomenon of mistreatment.

Given the complex nature of mistreatment of women, the reviewed studies suggest that interventions targeting all system approaches (health facilities, communities, health systems, and policies) are required to be executed in order to bring about sustained and transformational change for women. This could be achieved by improving interpersonal relationships between HCPs and women, addressing health facility and health system constraints such as shortage of skilled staff inadequate

medical supplies, and implementing policies that empower community engagement in health care decisions. Even though such interventions echo the complexity of the issue and are therefore heterogeneous, and it is difficult to quantitatively ascertain their cumulative effects, the clinical significance of such interventions are indispensable in addressing the complex drivers of the mistreatment of women. The importance of initiating a multi-factorial response to the phenomenon of mistreatment and the varied characteristics of maternity care settings across the globe has been established in the *Bangkok Charter for health promotion* and *WHO intrapartum recommendations* (2006; World Health Organization, 2018b).

Our review identified that the overall experience of mistreatment of women was reduced by at least half when related to multi-component interventions in pre-post and cluster RCT studies (Abuya et al., 2015a; Kujawski et al., 2017; Ratcliffe et al., 2016b). Individual interventions enable a shift in knowledge and attitudes that allow behavioural change and mutual respect between HCPs and clients. Changing individual HCPs' and clients' behaviours cannot be sustained without improving both health facilities and the overall health system by enacting decisive policy actions by engaging with communities and users of the service. Designing and implementing impactful strategies aimed at reducing mistreatment and enhancing RMC for women must address the unique and hierarchical levels of health facilities, including cultural and institutional change. Including higher-level interventions would not only sustain positive interaction between health care providers and women but would also address the higher-level drivers of mistreatment of women beyond individual behaviours. Although the benefits of interventions that engage communities in health care interventions were well established and frequently advocated in previous studies (Dodd et al., 2019; O'Mara-Eves et al., 2015; Tembo et al., 2021), only four of the

studies reviewed engaged community members in the development of their interventions. This may reflect the challenges women and families face when receiving disrespectful maternity care and the obstacles they face as a result of diminished agency when advocating for the delivery of RMC in an inhospitable health setting. However, engaging communities in future interventions still remains necessary to achieve a sustainable reduction in the mistreatment of women and to reduce the normalisation of women's mistreatment during maternity care.

Multi-component interventions implemented at various levels within an organisation did not clearly inform which set of interventions successfully addressed the intended goal for quality and respectful care. Specific interventions that either targeted enhancing health care providers' awareness of respectful care or quality improvement activities were seen to reduce the mistreatment of women (Asefa et al., 2020d; Mihret et al., 2020). Staff attitude and value transformation training were also found to reduce mistreatment of women; however, the overall success in minimising abusive care appeared to be more significant when the interventions were directed at changing the health facility's circumstances by providing the facility and staff with essential supplies, drugs, and equipment. Recognising health care providers' efforts to provide respectful care is also crucial. Although an impossibility for many health settings, this could be realised through motivational strategies and counselling services for health providers, the provision of greater staffing and equipment resources, supporting them in managing high workloads, critical incidents, and trauma, as identified in Mihret et al. (2020) and Abuya et al. (2015a). Recognising the daily struggles of health care providers in health facilities, including coping with resource limitations, underpayment, and high patient load, can enhance their sense of value and respect in their role.

The presence of a birth companion has been shown to be crucial in addressing inequalities, improving emotional support, and maternal and newborn health outcomes (Bohren et al., 2017b). It is also highlighted as a critical component of respectful maternity care by the World Health Organization (World Health Organization, 2016c). This review's findings further support the significance of having a birth companion; while there is no consistency of effect in reducing all forms of mistreatment of women, Brown et al. (2007) showed a reduction in physical abuse when a birth companion was present. The authors indicated that the implementation of birth companions was more challenging than expected, especially in health care systems with limited resources and frequent turnover of staff (Brown et al., 2007). To better advocate and implement interventions to routinely incorporate birth companionship, it is essential to address all factors that may hinder the positive outcome of having a birth companion (Kabakian-Khasholian et al., 2017). This includes a health facility-level commitment to enacting the policy and facilitating the physical space required for a birth companion to be present without compromising a woman's privacy.

Mistreatment and RMC are not necessarily two direct sides of the same coin. Reducing or eliminating women's mistreatment does not necessarily mean that respectful maternity care is present within a facility. Any effort to improve the quality of care should uphold the safety and dignity of women by situating respectful maternity care at the core of its service (World Health Organization, 2018a). Accordingly, research which focused on quality improvement activities were included in the review. Quality improvement activities based on local health facilities' attempts to manage the number of women accessing the service and strategies to avoid or manage the busyness of the facility were included. Such interventions enable health facilities to assess adaptable changes through continuous plan-do-study-acts (PDSA) (Montagu

et al., 2020). Likewise, scenario-based integrated simulation training for health care providers was highlighted as an intervention that enhanced woman-centred maternity care through the change of behaviours in practice (Afulani et al., 2019). Such training can allow health care providers to learn, practice, and reflect on stressful situations and minimise spontaneous reactions which can be abusive to women. If such interventions also include efforts to change infrastructure limitations and motivational strategies for HCPs, they could bring about sustainable changes in respectful maternity care.

The importance of good rapport between a health care provider and a woman is vital in building mutual respect and understanding (Madula et al., 2018; Ruben, 2016). However, most of the studies included in this review overlooked the importance of this factor. Only Umbeli et al. (2014) explored this concept, revealing that improved communication skills with HCPs can increase women's respectful care in a supportive and friendly manner. However, equal attention should be given to reducing and eliminating all forms of mistreatment, enhancing communication, and achieving respectful care is difficult to realise in a facility where mistreatment is normalised.

It must be noted that this review has some limitations that we have considered. First, it includes studies that differed in study design and methods and studies that measured both the mistreatment of women and respectful maternity care. This reflects the complexity of the phenomenon across each health care setting, but in this review contributed to the heterogeneity of the studies and prevented pooling of intervention effect sizes in the meta-analysis. The lack of a meta-analysis does not limit the quality of this review. We performed the synthesis without meta-analysis by categorising intervention effects based on the types of studies, interventions implemented, and quality of the studies, as recommended by Campbell et al. (2020). Second, we only

included studies and papers written in English. Therefore, there is a possibility that we may have missed some important reviews written in other languages; however, we believe the study selection bias due to this inclusion criteria are minimal, as most major high-quality peer-reviewed journals are published in English, reflecting the research community's desire to reach a wide audience (Morrison et al., 2012).

Conclusions

Interventions aimed at reducing women's mistreatment and enhancing respectful maternity care should simultaneously incorporate multiple and varied approaches in order to positively affect women's clinical experiences during childbearing. Low to moderate certainty evidence suggests that multi-component interventions were effective in reducing the mistreatment of women and/or enhancing respectful maternity care in health facilities. Interventions that motivate health care providers through various recognition strategies were found to be more successful in bringing change than interventions that only focused on training at an individual level. Future interventions should consider incorporating individuals, health facilities, health systems, policy-level drivers, and community/consumer engagement in the mistreatment of women and the determinants of respectful care.

2.8. Summary

In this chapter, previous studies conducted regarding the mistreatment of women during maternity care were reviewed through a comprehensive literature review and the effectiveness systematic review. Overall, the reviewed literature demonstrates the pervasive nature of the problem, underscoring the need to investigate its extent,

consequences, and potential solutions from various perspectives. The next chapter will outline the methodology of the thesis.

CHAPTER 3: METHODOLOGY

3.1. Chapter preface

Following on from the introduction chapter and the embedded systematic review, this chapter reports the methodology employed in this study. The chapter commences with a description of the philosophical standpoint adopted to investigate the complex phenomenon of mistreatment of women during maternity care. Following this, the researcher's philosophical views that guide the understanding of the mistreatment of women as a complex phenomenon arising from interactions within complex systems will be provided. The chapter then delves into how the constructs of mistreatment were defined and examined, including a justification for the choice of study design via an explanation of how mistreatment is best explored via the chosen study design. Details about the methods of the study are presented, including the study participants, data collection tools, procedures for ensuring data quality, and the methods used in the data analysis. Ethical considerations of the research are also included in this chapter.

3.2. Philosophical approach

Ontology: **The nature of mistreatment of women during maternity care**

Ontology refers to the philosophical study of the nature of being, existence, or reality and how it influences the categorisation and understanding of concepts within a phenomenon (Simons, 2015). In this study, the mistreatment of women is perceived as a complex phenomenon, a "being" that arises from intricate interactions within a healthcare system. The concept of mistreatment encompasses the interpersonal dynamics between a woman and her healthcare providers. The experience of

mistreatment reflects the conditions of the healthcare system in which a woman receives care.

This phenomenon, mistreatment of women, mirrors broader issues of violence against women in the community, employment and domestic settings, all of which are shaped by the context of the society the woman lives in and the societal valuation of women's worth. Healthcare settings employ citizens of the culture that they reside in. Therefore, the condition of health facilities, systems, and the professionalism exhibited by healthcare providers all coexist within the societal context of these overarching issues of violence.

Epistemology: How to examine concepts and constructs?

In the context of research, epistemology refers to the philosophical framework and assumptions about the nature and scope of knowledge and how it can be obtained or constructed (Stroll et al., 2023). Owing to the mistreatment of women being a pervasive phenomenon occurring in many domains related to various complex systems through which care is provided, the concept of mistreatment requires broad paradigms when examining its nature and effects within a specific social context. In such an interconnected scenario, a pragmatic approach enables an emphasis on assessing and addressing real-world problems and making a meaningful impact on the lives of individuals or communities (Kelly et al., 2020).

Thus, a pragmatist approach was used in this study to investigate the nature of mistreatment of women during maternity care in health facilities and the drivers of mistreatment in the varied health settings in Ethiopia. Once the concept of mistreatment was acknowledged in this study to exist not in isolation but within a social context that normalised violence against women, this study chose to adapt and

integrate the Ecological Framework of violence against women and the WHO's Quality of Care Framework (QoC) (Heise, 1998; Tuncalp et al., 2015).

The ecological framework of violence against women is a conceptual model that examines the multiple levels of influence contributing to such violence. The Socioecological Framework enables the examination of violence against women, such as sexual, physical, psychological, financial, verbal and emotional, among other forms of violence, through interrelated overlapping concepts ranking from personal history to the macrosystem factors (Heise, 1998). These forms of violence parallel the domain of mistreatment toward women in health facilities when they occur as interpersonal abuses, including physical, verbal, and discriminatory acts against women (Bohren et al., 2015).

The remaining forms of mistreatment, such as violation of privacy, confidentiality, abandonment, neglect, and violation of autonomy, are related to the poor quality of care experienced by women through the process of care, and it parallels the building blocks of the WHO Quality of Care Framework. The ecological framework of violence against women provides a broader societal perspective on factors influencing violence. Both frameworks, however, underscore the importance of understanding and addressing issues within a wider context, sharing a commonality in their comprehensive and multi-level approach to understanding and improving specific aspects of women's health in childbearing (Heise, 1998; Jewkes et al., 2015; Tuncalp et al., 2015).

The ecological framework conceptualises violence against women as a multifaceted phenomenon originating different influences on individuals or communities that occur within a social and cultural context. A woman's personal circumstances, conditions in

the immediate geographical or physical context where violence occurs, for example, her community, neighbourhood, home dwelling or health centre, the sociocultural beliefs of women and their agency, as well as external situational factors like the country's political instability, all come together to shape a woman's experience of violence (Heise, 1998). The WHO Quality of Care Framework, when applied to women's health, underscores the need for holistic, woman-centred, and evidence-based care throughout the whole continuum of maternal and reproductive health. It emphasises the importance of addressing not only clinical effectiveness but also the experiences, preferences, and safety of women in healthcare services (Tuncalp et al., 2015).

As referred to earlier in the thesis, the WHO typology of mistreatment (Bohren et al., 2015) conceptualises mistreatment of women as including both overt and covert aspects of mistreatment in childbearing. Overt mistreatment is considered outright intentional abuse against women (physical, verbal, sexual and discrimination and parallels broader violence against women in society. Covert mistreatment occurs when healthcare standards are not maintained, often relating to the limitations of resources (staffing, equipment, supplies) and facility policies and best-available evidence are not adhered to within the scope of the available resources (Tuncalp et al., 2015). Mistreatment, whether overt or covert, becomes obscured when normalised within a society (Jewkes et al., 2015). Complex interactions between societal, health system, health facility, and individual encounters influence women's childbearing experiences and encounters of mistreatment. Significantly, mistreatment of women affects how women use and seek maternity care from health facilities, which then adversely impacts the health outcomes of women and babies. Understanding these complexities is vital for adapting effective, sustainable, and acceptable interventions to prevent the

mistreatment of women during maternity care and enhance women's health service utilisation.

In this study, mistreatment of women during maternity care refers to any deviation from the professional standard of care, be that the service conditions, the treatments women experience, and the subjective personal experiences and perceptions of women. Due to the invisibilities of violence in the Ethiopian context (a context observed in most societies across the globe), women and healthcare providers may or may not deem any deviations from safe, quality maternity care to be an abusive violation of women's rights. The core concept of mistreatment in this study integrates seamlessly into the Socioecological Framework of Violence Against Women and the WHO's Quality of Care Framework (QoC), both of which have been integrated (Figure 3.1) into the philosophical underpinning of the study.

Due to their shared principles of addressing multi-level determinants of health experiences and outcomes, the frameworks helped to hone the research questions and integrate the research findings. The individual, interpersonal, community, institutional and structural factors that coalesce to form a woman's experience of childbearing amidst the mandates of person-centred, safe, and equitable care of the WHO (incompatible with much of the evidence presented in the literature and systematic reviews) are apt concepts to help formulate research in the complex phenomenon of mistreatment of women during healthcare in pregnancy, labour and birth, and the postnatal period (see Figure 3.1 for a visual representation of these concepts applied in the context of this study on mistreatment).

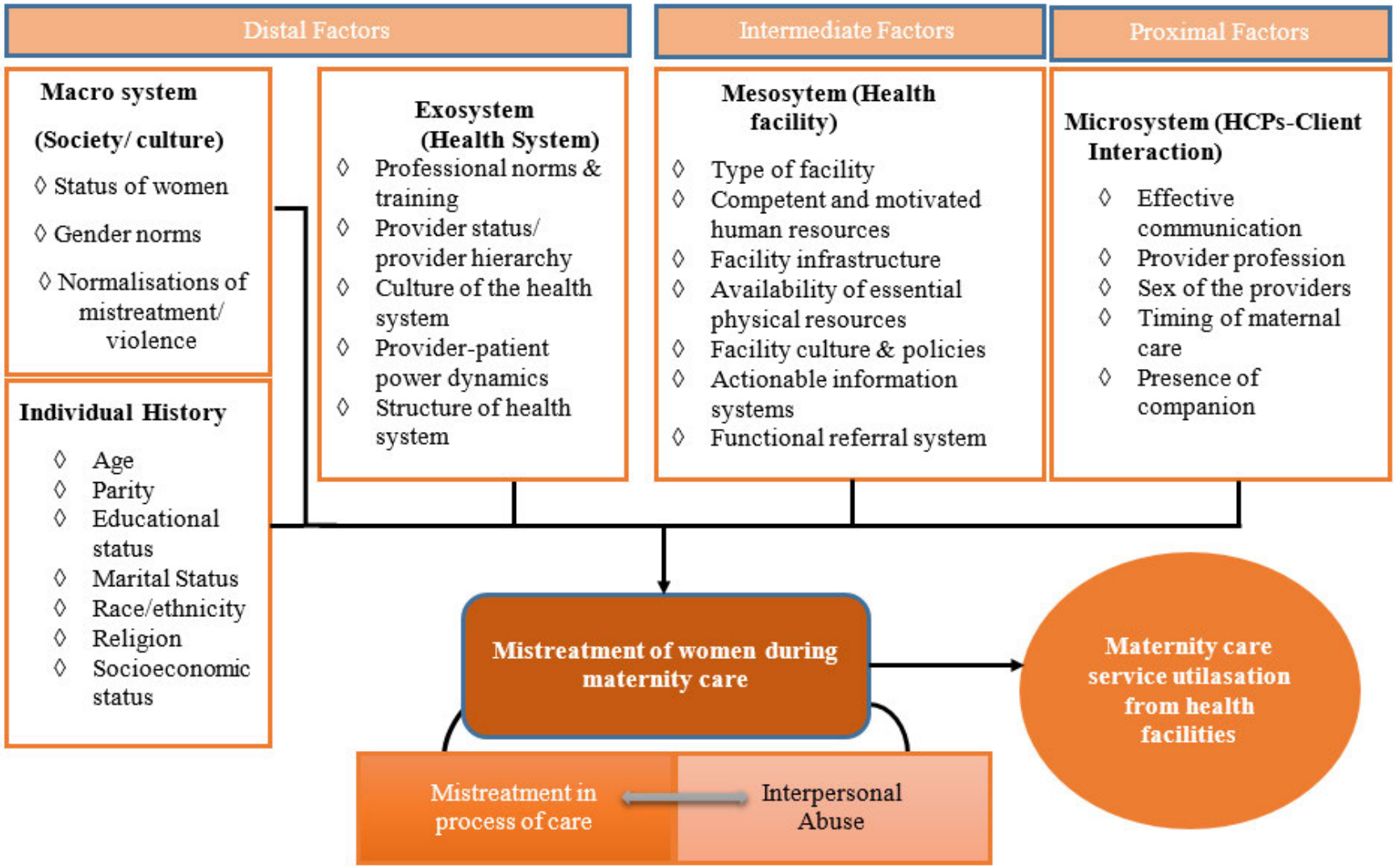

Figure 3.1: Conceptual framework for mistreatment of women during maternity care

3.3. Study Design

A nested convergent mixed-methods design (Figure 3.2.) was used to identify the level and drivers of mistreatment of women during maternity care and thereby identify the consequences of mistreatment on the maternal continuum of care at health facilities.

A mixed-methods study has philosophical assumptions that guide collecting, analysing, and mixing quantitative and qualitative approaches. As a method of inquiry, it focuses on collecting, analysing, and integrating quantitative and qualitative data (Creswell et al., 2017). A mixed-method study design is preferred for this project because it can measure women's mistreatment during maternity care and realise the drivers through both quantitative and qualitative approaches, which was also identified to be a preferred study design (Savage et al., 2017). It enables both designs' strengths while filling the gaps observed either qualitatively or quantitatively.

Therefore, the mistreatment of women was determined through a survey of women and HCPs who received at least one component of the continuum of maternity care during pregnancy, birth, or postnatal period. The magnitude of mistreatment determined through the survey is used as an exposure variable to identify the influences that such care has on the continuum of care. A proportion of survey participants from both women and HCPs groups were interviewed to deeply understand the perceived drivers of mistreatment and how this affects service utilisation.

The upcoming section provides an overview of the methods employed in the quantitative and qualitative segments. Detailed methods for each chapter can be found in their respective sections (chapters four to six).

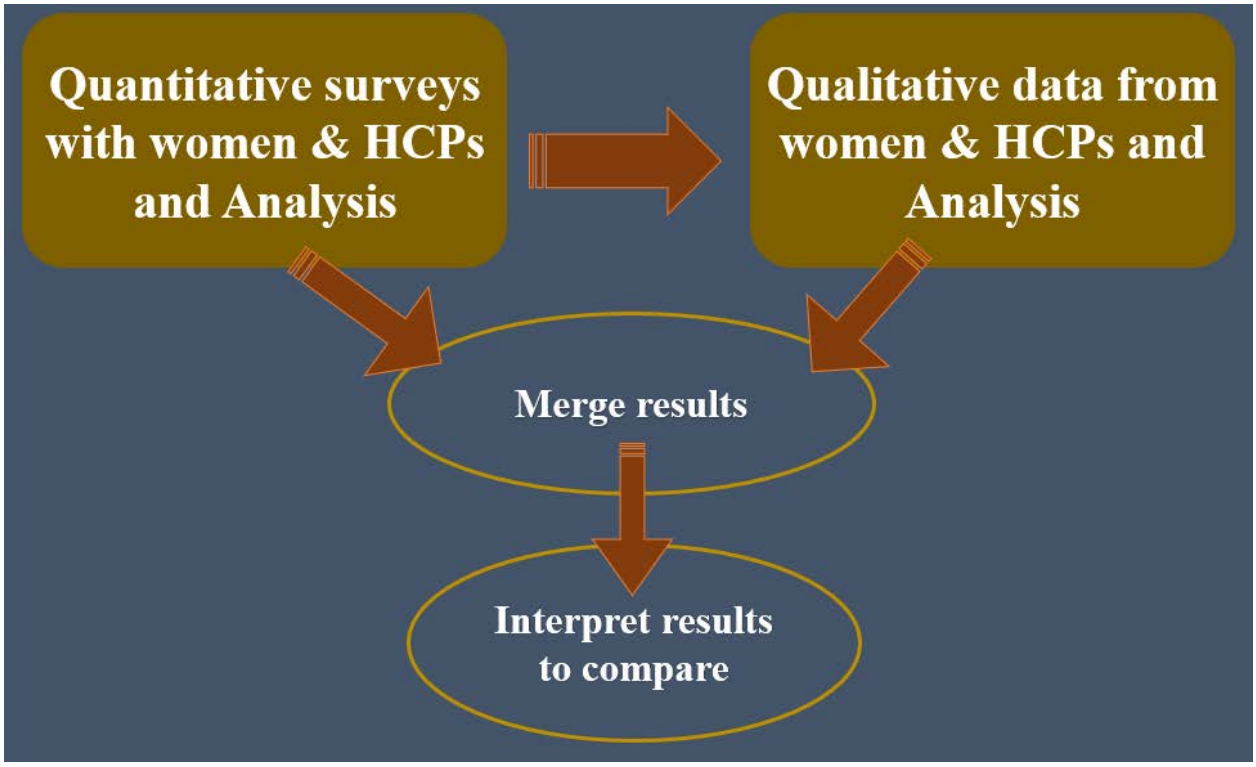

Figure 3.2: *Convergent mixed methods study design used to identify mistreatment of women during maternity care in Western Ethiopia, 2022*

3.4. Quantitative surveys

Study Participants

Two participant groups were invited to take part in surveys: women who have experienced childbirth in health facilities and maternal healthcare providers employed in selected health facilities. The inclusion of these two distinct groups is pertinent due to their direct involvement in the realm of childbirth experiences. Acquiring data from diverse perspectives has significantly contributed to the comprehension of the intricate phenomenon of mistreatment of women within healthcare facilities.

Women: The survey included women who met the following criteria:

- ◊ Received at least one component of maternity care services (such as antenatal care, labour and birth, or postnatal care) at the health facilities.

- ◊ Gave birth within three months before the data collection period.
- ◊ Eighteen years of age or older.
- ◊ Willing and able to participate, residing in the catchment area, and provided consent.

Healthcare providers: The healthcare providers (HCPs) included in the study comprised of midwives, nurses, medical doctors, health officers, and emergency surgical officers. These professional groups were selected based on their involvement in providing care during the antenatal, intrapartum, and postpartum periods within the health facilities.

Exclusion criteria

Women were excluded from taking part in the study if they had a personal relationship with any individual employed at a healthcare facility that had been selected as a recruitment site. Additionally, to adhere to ethical principles in health research and prevent re-traumatization, exclusion criteria included women unable to provide consent, those who had experienced a recent stillbirth, or those at risk of psychological trauma.

Participant Recruitment

Women

Participants were purposefully selected from four woredas (districts) due to logistical challenges exacerbated by the civil conflict in Ethiopia during the data collection period. These woredas encompassed Diga, Nekemte, Guto Gidda, and Sasiga. Women were recruited from two hospitals (Nekemte Specialised Hospital and Wollega University Referral Hospital), three health centres (Nekemte Health Centre, Cheleleki Health Centre, and Gudatu Arjo Health Centre), and one health post (Darge Health

Post). Women were invited to participate in the study during their visits to the health facilities for their children's vaccination.

The Ministry of Health's report indicates that 97% of mothers typically visit health facilities for child vaccination, a figure that aligns with our sample population (Ministry of Health, 2019). Moreover, a significant portion of the region's population resides in remote rural areas, posing challenges in accessing their homes, which is often arduous and time-consuming. Additionally, the population in the study's geographical areas is widely dispersed, and inadequate road infrastructure and transportation further compound accessibility issues. As a consequence of all the factors highlighted, opting to utilise child vaccination appointments at the health facilities as a recruitment site was a practical and pragmatic approach. By employing these appointments for recruitment, we were able to effectively reach nearly all women who had given birth during the data collection period.

Recruiting women during child vaccination appointments at health facilities had its limitations. This method may have introduced selection bias, as women who did not attend the vaccination clinics were excluded from the study. Additionally, the remote geographical location of the data collection site and security challenges due to community unrest in the area influenced the decision to adopt this pragmatic recruitment approach. This limitation is acknowledged and further discussed in Chapters Four and Seven.

Another potential limitation related to participant selection was the three-month eligibility criterion. While most vaccinations are scheduled and administrated during this timeframe, some women who delayed bringing their children for vaccination may have been excluded. Although this criterion may have led to the exclusion of some

participants, it was designed to minimise recall bias among participants. As a result, the study findings may not be generalisable to the entire population in the study area.

In Ethiopia, it is usual for women to wait up to one or two hours for their child's vaccination appointment, offering a relaxed and opportune window to approach them, explain the study, and gauge their interest in participating. This strategy worked effectively, allowing us to approach many women during this waiting period to invite their participation in the survey. Before commencing the recruitment process, a legalization letter was composed and sent to each health facility by the Wollega University Institute of Health Sciences Chief Academic and Research Directorate Office. Subsequently, permission was obtained from the administrators of each health facility.

After the permissions were obtained from the facilities and the provision of information and explanations about the study (refer to Appendix 2), women who expressed willingness to participate provided their written (refer to Appendix 4) and verbal consent (for those unable to read and write, refer to Appendix 5). Subsequently, they were directed to a designated private clinic room in the same facility where trained interviewers conducted the face-to-face interviewer-administered survey. As discussed in the literature review section, the data collection site—being the same facility for some participants where they received care—may have influenced their responses due to courtesy bias.

Participants in the healthcare provider group

The recruitment sites for healthcare provider participants were their workplaces, health centres or hospitals. All maternal healthcare providers working in the health centres and hospitals across the six selected woredas were invited to participate. Information

detailing the study's objectives and procedures (refer to Appendix 3), along with consent forms (refer to Appendix 4), were provided to potential participants to ensure they were well-informed before consenting to take part in the research.

After obtaining consent from the healthcare providers, the data collection process involved distributing survey questions enclosed in unsealed envelopes. The information sheet and consent form provided the primary researcher's contact details, enabling participants to seek additional information before completing the survey. Healthcare providers who consented were instructed to fill out the survey at their convenience and return the completed survey by sealing it in the supplied envelope. To ensure the security and confidentiality of individual responses, designated coordinators employed by the researcher handled collecting the sealed survey papers.

Measurements

The surveys approached the subject of maternity care from the varied perspectives of woman and HCPs. Therefore, each participant group received a different format of survey. However, the variables used for both participant groups were the same.

Outcome variables:

Mistreatment of women— is a primary outcome variable of this study. A validated community-based survey tool developed by a WHO-led study (Bohren et al., 2018) was used to measure the level of mistreatment of women during maternity care in a survey of women. This tool was developed based on a mixed-method and iterative approach. A total of 32 items were adapted and used to measure the level of mistreatment of women based on the seven typologies identified by Bohren et al. (2015). Mistreatment of women is classified into interpersonal abuses, failure to meet professional standards of care, poor rapport between women and healthcare providers

and health system conditions and constraints. Interpersonal abuse includes any form of physical abuse, verbal abuse, or stigma and discrimination. Each of these categories of mistreatment/abuse has sub-components (Bohren et al., 2018; Leslie et al., 2022).

To capture healthcare providers' perspectives of the mistreatment of women in healthcare facilities, it was assessed through seven constructs, including disrespectful care, abuses (physical and verbal abuses), discrimination, lack of privacy, neglect, and loss of autonomy. These align with WHO's standards for maternal and newborn care (Tuncalp et al., 2015). Thirty adapted questionnaire items from the Person-Centred Maternity Care scale captured healthcare providers' perspectives (Afulani et al., 2017).

Maternity continuum of care— is a secondary outcome of interest. Karper et al. (2007) defined the continuum of care as care given to a woman throughout her lifecycle, including adolescence, preconception, pregnancy, childbirth and postnatal period. For this study, the maternal continuum of care is defined as the care given to women during pregnancy, birth, and the postnatal period. It is classified into three levels:

- ◊ **Continuum of care during pregnancy:** A woman was considered to have received continued care during her pregnancy if she has received at least four episodes of antenatal care (ANC) from health facility/facilities. This is the WHO-recommended number of minimum antenatal points of care (World Health Organization, 2002), with anything less being considered incomplete and deficient pregnancy care. Although the recent expected number of ANC contacts was increased to eight as recommended by WHO in 2016 (World

Health Organization, 2016d), at the time of data collection this recommendation was not implemented as a guideline of care in Ethiopia.

- ◊ **Continuum of care until birth:** The woman was considered to have continued care until birth if she had received at least four antenatal care episodes and a qualified health care provider attended her birth.
- ◊ **Complete continuum of maternity care:** The woman was considered as having completed all continuum of care if she received at least four episodes of antenatal care, and her birth was attended by a qualified healthcare provider and the woman and her child received postnatal care (PNC) within 24 hours of birth, 48 - 72 hours, between one week and 14 days and at six-weeks post-birth.

Other remaining variables are described in each method section of the papers (chapters four and five)

Data collection instruments and process

The survey tools were initially adapted to the local contexts of the study area in English and subsequently translated into Afan Oromo (refer to Appendix 8 & Appendix 9). This translation was conducted by academic translators proficient in both English and Afan Oromo at Wollega University. Conceptual meanings and word choices were refined through discussions involving the researchers and translators to ensure accuracy.

Two recently graduated midwives without prior employment experience in health facilities conducted face-to-face interviews with women as part of the data collection process for the survey. The online survey option was not a feasible option due to the internet access issues for the women in the area. These data collectors were male, which may have impacted the women's responses, as free communication might have

been more easily achieved if the interviewers had been female. While women in some parts of Ethiopia prefer female midwives for receiving care, this preference is not commonly observed in the current study area, where the number of male and female midwives is roughly equal. The researcher selected these male data collectors as a practical available option to ensure the feasibility of obtaining quality data by using outsiders to service provision but familiar to the area, rather than midwives who practice in health facilities where women report experiencing mistreatment.

Additionally, newly graduated midwives were chosen for two main reasons. Firstly, their selection was based on their familiarity with the context of health facilities and maternal care provision in the area. This knowledge facilitated the researcher in explaining the situation and proceeding with data collection smoothly. The second reason for their selection pertained to data quality. In the area, most data collection is typically carried out by healthcare providers within the same facilities where women receive services. Employing these providers could introduce bias, as the topic under investigation relates to issues between healthcare providers and women receiving maternity care. Therefore, employing individuals external to the situation helped maintain data quality by minimising the subjectivity of the data collector. Another issue that challenged the researcher's data collection was feasibility. With 760 participants, it would have been time-consuming and challenging for the student researcher to complete all the survey interviews. The researcher provided supervision throughout the data collection process to ensure the rigour of data acquisition.

The researcher provided training to the data collectors, focusing on the study's objectives, the data collection instruments, techniques, and methods aimed at reducing their impact on participant responses. Given the sensitivity of the research topic, the data collectors were briefed on the entire data collection procedure,

beginning with providing participant information, delivering explanations, checking participant eligibility, and ensuring the acquisition of consent before initiating data collection at the site. Data collection was and the survey was collected through a paper-based interviewer administered questionnaire. Each woman was asked individually about their sociodemographic, pregnancy and birth related characteristics, and the care received and experiences during their recent childbirth in the health facilities where they received maternity care (antenatal care to postnatal care) in a private separate room in the health facility where vaccination provided.

Data from healthcare providers were gathered via a self-administered survey. All maternal healthcare providers practicing in the selected health facilities were invited to take part. Given the sensitive nature of the research topic and the higher educational levels of these providers, the assistance of data collectors was deemed unnecessary for this phase of data collection. Paper surveys were individually distributed to the participants, each accompanied by an envelope. Participants were instructed to complete the survey, seal it in the provided envelope, and hand it to the designated coordinator at the facility. The primary researcher periodically contacted and collected the securely sealed completed surveys.

3.5. Qualitative Data

The survey population was utilised to recruit the participants for the qualitative arm of the study.

Recruitment

Following the completion of the survey, women were invited to participate in an interview. If women showed an interest in participating in an interview, their consent was sought, and their contact information (phone number) was collected. Diverse

groups of women, including those from different residential areas (urban/rural), age, and parity levels, were recruited to ensure a broad representation of the population and reduce selection bias.

Healthcare providers were also invited to take part in in-depth, digitally recorded interviews following their survey participation. To ensure a diverse representation, mixed professions within the maternity care unit and various locations within the woredas were considered for this data collection phase. Professionals from various healthcare facilities, health centres, and hospitals were included in the study. In total, 20 healthcare providers were interviewed, comprising representatives from two hospitals and six health centres.

Data collection instruments

A semi-structured interview guide was meticulously developed based on the research questions, arranged logically to extract participants' comprehensive insights regarding women's mistreatment, its underlying drivers, and its consequences, as well as the interview guides used in previous studies in developing countries by the WHO study group (Maya et al., 2018). The interview guide encompassed four key data collection domains and was utilised for both women and healthcare professionals. These domains were designed to collect information on (1) Expectations during maternity care from healthcare facilities, (2) Experiences and perceptions of mistreatment by healthcare providers during recent maternity care, (3) Perceived factors influencing the mistreatment of women, and (4) Potential consequences of women's mistreatment on service utilisation (refer Appendix 10). These points served as guiding topics during the interviews, and all participants were openly encouraged to discuss these issues until the conversation naturally reached a conclusion considered the saturation point.

Data collection procedures

Potential interview participants were identified during the quantitative data survey process. They were then informed about the purpose of the interviews and asked about their willingness to participate. They were provided with a participant information sheet and asked to complete a written consent form, and their addresses were recorded (refer to Appendix 6 and 7). Prior to participating in an interview, participants were advised by the researcher conducting the interviews that their participation was entirely voluntary. Participants were also made aware of their right to confidentiality and that they could withdraw from the interview at any time during the interview process without any negative consequences. Additionally, participants were informed that the researchers were not associated with the health care facilities, and their participation or non-participation would have no consequence on their health care utilisation or provision by healthcare providers.

Both women and healthcare providers took part in in-depth interviews conducted by the researcher (student who conducted this thesis) in Afan Oromo, which were digitally recorded. All interviews were conducted via telephone, scheduled at mutually agreed-upon times and dates between the researcher and the participants. Each interview, on average, ranged between 30 to 60 minutes. The confidentiality of the data was protected by the researcher, as the recorded interviews were anonymised and de-identified, ensuring privacy throughout the transcription and analysis process.

3.6. Data quality assurance

Data collectors and coordinators underwent training on the study's objectives, data collection methods, and ethical principles, all of which were strictly adhered to during data collection. Prior to deployment, all tools underwent a rigorous pre-testing phase

to evaluate, refine, and ensure their alignment with the local context. Data collected during the pre-test phase of the study were utilised for analysis purposes.

Interviews were conducted at times convenient and safe as agreed upon by participants over the phone and audio recorded in a private setting. Participants were assured of confidentiality, and all collected data were securely stored, and password protected in accordance with the ethics and UTS data storage policy. During face-to-face interviewer-administered surveys, strict adherence to COVID-19 prevention practices was maintained, including maintaining a 1.5-meter physical distance, wearing face masks, and using hand sanitiser. Additionally, distress protocols (refer to Appendix 1) were developed and implemented when participants or the interviewer experienced stress due to the interview scenarios. No participant required specialised care as initially planned for distressed management from nearby health facilities. The researcher handled situations requiring breaks during interviews by pausing and ensuring the participant was comfortable to proceed with the interviews.

All interviews were digitally recorded and transcribed verbatim into the local language immediately after completion. The researcher also took field notes during the interviews to capture participants' emotions and reactions, which were considered alongside the interview transcriptions. These notes served as memory prompts for significant ideas emerging during the interviews. Subsequently, the researcher transcribed the audio recording in the local language and cross-referenced the written transcript with the recording, and then translated it into English.

To protect confidentiality, all identifying information in the data was replaced with non-identifiable participant codes such as IDI-WP# for women participants and IDI-HCPs# for healthcare providers. Throughout the interview process, the interviewer/researcher

sought clarification on terminology and content to ensure an accurate interpretation of the participants' narratives, maintaining fidelity to their experiences.

3.7. Methodological rigour

Reliability/Credibility

A validated survey tool was used for quantitative data. Reliability analysis for internal consistency of survey items was assessed using Cronbach's alpha, and details were given in chapters four and five. Continued collaboration between all four researchers is being maintained to ensure rigour of the qualitative phase and integration of the study.

Validity/trustworthiness

An exploratory factor analysis was performed to assess the construct validity of the mistreatment measurement items. This analysis identified the items used to measure the mistreatment of women as multidimensional. Among these dimensions, one was interpersonal abuse, encompassing six sub-categories of physical abuse, four verbal abuse, and three discrimination-related items. These items collectively loaded onto one factor, with an Eigenvalue of 1.85. Each item demonstrated factor loadings of 0.3 and above, indicating their significance within this factor (refer to Chapter Four).

Interviews were conducted with diverse participants, encompassing women from both rural and urban settings, spanning different age groups, and encompassing both multiparous and primiparous individuals. However, due to civil unrest in certain rural areas during data collection, the intended participation from rural residents was not fully realised. Similarly, healthcare professionals from various roles—including midwives, nurses, and health officers—were included as interview participants.

Reflexivity

The primary researcher is a male midwife and lecturer at Wollega University with a decade of clinical experience and has personally observed instances of mistreatment toward women in healthcare facilities. The researcher views the mistreatment of women in healthcare settings as a significant issue impacting the quality of maternity care that women receive. Additionally, the researcher has undergone a respectful maternity care workshop organised by the Ethiopian Midwives Association and is familiar with various scenarios from different regions of the country and worldwide.

Being interviewed by a male interviewer could have influenced the participants' responses, potentially limiting their openness compared to being interviewed by a female interviewer. However, the general acceptability of male midwives in the study area, combined with the researcher's shared background with most participants, including speaking the same language and understanding the same cultural customs, helped mitigate this limitation. These shared characteristics fostered a positive rapport and facilitated smoother communication, particularly when discussing sensitive experiences of mistreatment during pregnancy and childbirth. Rapport was further strengthened as the interviewer introduced himself and built trust through shared understanding and open communication.

The researcher's background as a midwife may also have assisted in facilitating healthcare providers' acceptance. However, it is also crucial to acknowledge that personal experiences of witnessing mistreatment and undergoing respectful maternity care training could potentially influence the study outcomes and researcher bias. To mitigate potential biases, the researcher maintained a position of neutrality throughout the entire research process, ensuring impartiality in the study's design, execution, and

interpretation of findings (further reflexivity statement is given under the methods section of chapter six and the discussion chapter).

3.8. Data analysis

As a nested convergent/concurrent mixed methods study, the quantitative and qualitative data analysis were conducted separately and then integrated to heighten the understanding of the complex phenomenon of the mistreatment of women during maternity care in Ethiopia as recommended in a mixed methods design incorporating conducting concurrent studies, merging the findings and then integrating the findings from each section of the study (Creswell et al., 2017). The two data sets, quantitative and qualitative, were treated with equal weight, with neither being prioritised over the other. This allowed the research questions to be examined by multiple means, strengthening the findings. The detailed integration of findings from both the qualitative and quantitative sections is presented in Chapter 8.

Quantitative data analysis

The survey data underwent thorough checks for completeness before being entered into Epi-info version 7.1—survey data management software using a prepared data entry template. After entry, the data were exported to Stata version 17 for cleaning and subsequent analysis (Stata Corp, 2021b). For further analysis, specific packages within the R-statistical software, tailored to each quantitative analysis, were utilised (R Core Team, 2023).

A descriptive analysis encompassing sociodemographic, pregnancy, birth, and postnatal characteristics was conducted. Descriptive statistics such as median and interquartile range were employed for continuous variables that did not follow a normal distribution, while frequencies and percentages were used for categorical variables.

The results were presented using tables, figures, and textual explanations. More detailed descriptions of the analysis methods and statistical procedures can be found in their corresponding chapters, specifically in chapters four and five.

Qualitative data analysis

The interviews were transcribed verbatim into Afan Oromo and subsequently translated into English to facilitate collaboration with the three English-speaking researchers comprising the supervision team and for wider dissemination of findings in international research literature. The transcripts underwent meticulous reading while simultaneously listening to the audio recordings to ensure accuracy and initiate the process of comprehending the dataset. These transcripts were then imported into NVivo (Version 12), a qualitative data management program, for coding purposes.

Thematic analysis was employed using the Braun and Clarke data analysis framework (Braun et al., 2006, 2021). Mistreatment experiences of women and observations from healthcare providers were descriptively analysed, while the drivers and potential consequences of mistreatment were examined using an Integrated Socioecological Framework for violence against women and the WHO Quality of Care Framework, as outlined in the study design section. For a more comprehensive understanding of the qualitative methods used, a detailed description is provided in chapter six.

Data integration

The quantitative and qualitative data analyses were conducted separately and subsequently integrated to enhance the comprehension of the multifaceted issue of women's mistreatment during maternity care in the study area. Narrative connections between the quantitative and qualitative datasets were established, with any discrepancies explored and considered rather than overlooked. Given the

phenomenon's complexity under study, amalgamating these two datasets was deemed appropriate. Quantitative and qualitative datasets were accorded equal weight, without one taking precedence over the other. This approach allows for a comprehensive exploration of the research questions, thereby fortifying the findings. The ensuing chapters following this methodology chapter present the findings derived from these datasets.

3.9. Ethical considerations

Informed consent

All potential participants (women and HCPs) were provided with information regarding the study in their preferred language to enable understanding. Participants were given sufficient time to ask questions and reflect on the information provided. Written informed consent was received from each participant, and they were informed that they were free to discontinue or withdraw from the study without any negative consequences. For women who were unable to read and write, data collectors obtained verbal consent in the presence of a witness. All data collection processes were conducted with an emphasis on protecting the privacy and confidentiality of the participants.

Ethical Approval

Ethical approval was granted from the local Institutional Review Committee in Ethiopia, Wollega University, and the Human Research Ethics Committee at the University of Technology Sydney, with the approval number of *UTS HREC REF NO. ETH21-6587*.

CHAPTER 4: FINDINGS— THE MISTREATMENT OF WOMEN AND ITS ASSOCIATION WITH THE CONTINUUM OF CARE

4.1. Chapter preface

The previous chapter presented the research design and methods used in this study. This chapter will report on the findings of the women's survey and the influences of mistreatment on the continuum of care. The research question being examined in this chapter centres on the various categories of mistreatment that women experienced during maternity care in Ethiopia and the association of these categories of mistreatment with the continuum of maternity care. The following article addresses this question, published in BMC Pregnancy and Childbirth Journal:

> Kasaye, H., Scarf, V., Sheehy, A. et al. The mistreatment of women during maternity care and its association with the maternal continuum of care in health facilities. *BMC Pregnancy Childbirth* 24, 129 (2024). https://doi.org/10.1186/s12884-024-06310-8.

Abstract

Background: Mistreatment of childbearing women continues despite global attention to respectful care. In Ethiopia, although there have been reports of mistreatment of women during maternity care, the influence of this mistreatment on the continuum of maternity care remains unclear. In this paper, we report the prevalence of mistreatment of women from various dimensions, factors related to mistreatment and also its association to the continuum of maternity care in health facilities.

Methods: We conducted an institution-based cross-sectional survey among women who gave birth within three months before the data collection period in Western Ethiopia. A total of 760 women participated in a survey conducted face-to-face at five health facilities during child immunization visits. Using a validated survey tool, we assessed mistreatment in four categories and employed a mixed-effects logistic regression model to identify its predictors and its association with the continuum of maternity care, presenting results as adjusted odds ratios (AORs) with their 95% confidence intervals (CIs).

Results: Over a third of women (37.4%) experienced interpersonal abuse, 29.9% received substandard care, 50.9% had poor interactions with healthcare providers, and 6.2% faced health system constraints. The odds of mistreatment were higher among women from the lowest economic status, gave birth vaginally and those who encountered complications during pregnancy or birth, while having a companion of choice during maternity care was associated to reduced odds of mistreatment by 42% (AOR = 0.58, 95% CI: [0.42–0.81]). Women who experienced physical abuse, verbal abuse, stigma, or discrimination during maternity care had a significantly reduced likelihood of completing the continuum of care, with their odds decreased by half compared to those who did not face such interpersonal abuse (AOR = 0.49, 95% CI: [0.29–0.83]).

Conclusions: Mistreatment of women was found to be a pervasive problem that extends beyond labour and birth, it negatively affects upon maternal continuum of care. Addressing this issue requires an effort to prevent mistreatment through attitude and value transformation trainings. Such interventions should align with a system level actions, including enforcing respectful care as a competency, enhancing health centre

functionality, improving the referral system, and influencing communities to demand respectful care.

Keywords: Mistreatment of women, maternity care, health care facilities, respectful maternity care, continuum of maternity care.

4.2. Introduction

The continuum of maternal, neonatal, and childcare is widely recognised as a critical intervention to reduce maternal, neonatal, and child mortality (Kerber et al., 2007). The provision of quality care plays a pivotal role in ensuring the continuity of these essential services. A woman's humiliating interaction with her health care provider (HCP) or other staff members, as well as the state of the health infrastructure and systems, are all considered detrimental to the quality of maternity care (Bohren et al., 2014). Various terminologies have been used to describe such experiences of women, including disrespect and abuse (Bowser et al., 2010), maltreatment (Moyer et al., 2014), and obstetric violence (Williams et al., 2018), underscoring the importance of ensuring terminological clarity. To focus on woman's experience and minimise individual blame (Bohren et al., 2018), in this study, we refer to the mistreatment of women during maternal health care as defined in the methods section.

Despite the World Health Organization's (WHO) declaration affirming every woman's right to receive the highest standard of care with dignity and respect (World Health Organization, 2015a), mistreatment of childbearing women remains a pervasive global public health issue reported across all nations and cultures (World Health Organization, 2015a). In Sub-Saharan Africa (SSA), the pooled prevalence of mistreatment was reported to affect up to 44% of women (Kassa et al., 2020). Mistreatment of childbearing women is not only confined to low- and middle-income

countries; it is also reported in high-income countries with resilient health care resources. One out of every five women in Europe (Lukasse et al., 2015), one-sixth of women in the United States of America (Vedam et al., 2019), two out of every five women in Latin America (Tobasía-Hege et al., 2019), and one in every ten women in Australia (Keedle et al., 2024) have experienced mistreatment.

In Ethiopia, various forms of disrespect and abuse categories discussed by Bowser and Hill (2010) were reported from different regions (Mengesha et al., 2020). The prevalence of these mistreatment forms ranges from 14.5% when reported by healthcare providers (Asefa et al., 2018) to almost all women self-reporting (98.9%) (Ukke et al., 2019) experiencing at least one form of mistreatment. Most studies conducted in Ethiopia have focused on the mistreatment of women, as reported by women. However, these studies often conflate various categories of mistreatment without considering their dimensionality (Adinew et al., 2017; Banks et al., 2018; Bobo et al., 2019; Mihret, 2019; Rosen et al., 2015; Sheferaw et al., 2017; Sheferaw et al., 2019; Siraj et al., 2019; Ukke et al., 2019; Wassihun et al., 2018). While such aggregation of various categories of mistreatment is important for understanding the issue, addressing them separately is crucial for effective and focused interventions in the actual context.

When women experience mistreatment in health care facilities during their pregnancy or birth, it continues to have a negative impact on their lives. It can decrease women's confidence in health facilities which can lead to an increased likelihood of maternal complications due to a lack of engagement in services (Kujawski et al., 2015; Raj et al., 2017; Reed et al., 2017). Furthermore, it can be a deterrent to service utilisation, even more than sociocultural beliefs and practice (Ababor et al., 2019). Due to a history of mistreatment, it is alleged women in low-income countries regardless of

pregnancy risk factors would prefer to give birth at home with dignity, alone or with a family member, than face mistreatment in a health facility (Bohren et al., 2014; Gebremichael et al., 2018).

Such challenge becomes even more significant when these mistreatments occur in countries where maternal continuum of care dropouts are common, as is the case in Ethiopia. This is particularly pertinent in Ethiopia, where maternal care discontinuation is a pressing concern. The 2019 Ethiopian Mini Demographic and Health Survey revealed a significant gap in continuum of maternal care. While 74% of women start antenatal care, only 48% give birth in health care facilities, and merely 34% receive postnatal checks within two days of the birth (Ethiopian Public Health Institute, 2021). This signals significant problem with service discontinuation and calls for an investigation into the underlying factors.

Previous studies have identified various socio-demographic and contextual factors associated with the completion of continuum of maternity care (Adinew et al., 2017; Banks et al., 2018; Bobo et al., 2019; Mihret, 2019; Rosen et al., 2015; Sheferaw et al., 2017; Sheferaw et al., 2019; Siraj et al., 2019; Ukke et al., 2019; Wassihun et al., 2018). However, there is limited evidence linking experiences of mistreatment and its impact on the extent of continuity of care. To fully understand the link between mistreatment and continuum of care, it is essential to measure mistreatment of women using a validated tools focusing on specific concepts at a time. Therefore, the aim of this study was to determine the prevalence of mistreatment of women in various dimensions, identify the factors associated with mistreatment, and identify its association with the continuum of maternity care in health facilities.

4.3. Methods

Study setting, design and period

A cross-sectional survey-based study was conducted from February to June 2022, adhering to the STROBE reporting guideline. This paper is part of larger mixed method study conducted in western part of Ethiopia, East Wollega Zone Oromia regional state. Ethiopia is administratively divided into twelve regions and two city administrations. These regions have been further subdivided into zones, woredas or districts, and kebeles (the lowest tier of government administrative units). Based on the 2007 Ethiopian population and housing census projections, the average projected population of Ethiopia in 2022 was 105.17 million, and about 78% of the population lived in rural areas (Central Statistical Agency, 2013).

Ethiopian health service delivery is structured in a three-tier system of primary, secondary, and tertiary levels. The primary level, or primary health care (PHC) unit, comprises health posts, health centres, and a primary hospital that provides services for about 100,000 people. It provides blood transfusion and emergency surgical services, including caesarean sections. The secondary level is a general hospital, which serves as a centre of health care for an average of one million people and is a referral centre for primary hospitals. A referral centre for the general hospital is the tertiary level, a specialised hospital providing care for an average of five million people (Ministry of Health, 2015, 2021a).

East Wollega zone, where this study was conducted, is one of administrative zones of Oromia Regional State whose capital city is Nekemte and contains one special-city woreda (Nekemte), 17 woredas, 43 towns and 287 rural kebeles. The East Wollega zone's total population was 1.806 million in 2022. The number of women of

reproductive age accounts for 18% of the total population with a total fertility rate of 4.07. East Wollega zone has two tertiary hospitals, both found in Nekemte town, three district hospitals and 67 health centres (Central Statistical Agency, 2013; Ministry of Health, 2015, 2021a).

Study Participants

The study population includes women who received at least one component of the continuum of maternity care services (antenatal care, labour and birth or postnatal care) and gave birth within three months before the data collection period. Hence, study participants were women who had given birth within the past three months after accessing maternal health care services from health facilities. They were approached between six weeks and three months after giving birth to capture their experiences related to mistreatment and service utilisation throughout the continuum of care, covering the antenatal period, childbirth, and the postnatal period.

To minimise bias, women were excluded from the study if they had a personal relationship with any person employed at any of the health care facilities where recruitment occurred. Women who were unable to provide consent, had experienced a recent stillbirth, or were at risk of psychological trauma were also excluded from the study.

Sampling and recruitment

The total sample of women included in the survey was calculated using a single population proportion formula in which the proportion (prevalence) of the mistreatment of women was 67.1% (from study conducted in Northern Ethiopia by Wassihun et al. (2018)), and a 95% confidence level, with a 5% margin of error, and the cluster effect of 2, the desired sample size was 679. After adjusting the desired sample size for a

10% non-response rate, the total sample size for women participants was determined to be 755. To enhance the robustness of the findings, 760 participants which gives the power 90% were approached in the study.

For logistical and safety reasons related to the civil conflict in Ethiopia, participants were purposively selected from four woredas: Diga, Nekemte, Guto gidda and Sasiga. Two hospitals, three health centres and one health post were selected to invite women to participate in the study. The women were approached to participate when they visited the health facilities to have their child vaccinated. This opportunity for recruitment into the study was chosen as 97% of all mothers visit a health facility to have their children vaccinated (Ministry of Health, 2021a). Utilising the vaccination clinics also reduced any accessibility difficulties the researcher may have encountered due to some of the geographical locations which are widespread and difficult access especially during a time of civil unrest. All the women who came to the vaccination clinic with their newborn baby and who met the inclusion criteria were approached to participate in the study between February and June 2022.

Measurements

Outcome variables

In this study, we focused not only on mistreatment of women during childbirth but also during antenatal care and postnatal checkups and their link with continuum of care. Hence, under the aims assessing magnitude of mistreatment of women and associated factors, mistreatment of women is outcome variable and then it is the exposure variable for the model that assessed its association with continuum of care. To achieve these, various categories of mistreatments of women were measured under two broader dimensions—the overt and covert as discussed by Bohren et al.

(Bohren et al., 2015). The overt mistreatment results from outright intentional abuse against women (physical abuse, verbal abuse, stigmatisation and discrimination) that parallels with a broader violence against women framework (Heise, 1998). We categorised the mistreatment arising from such intentional abuses under the latent construct of interpersonal abuse. In other hand, the latent construct underlying covert mistreatment includes failure to maintain professional standards of care, the poor rapport between a woman and the health care provider, as well as any constraints related to health facilities and system limitations which occurs during the process of the care and are related to the broader quality of care framework (Tuncalp et al., 2015).

The maternal continuum of care encompasses the care provided to women during pregnancy, birth, and the postnatal period. Although completion of continuum of care should include all components of these three stages, for the purpose of analysing the association between mistreatment and the continuum of care, a woman was considered to have completed the continuum of care if she received four or more episodes of antenatal care, a skilled health care provider attended the birth of the baby and, she received at least two episodes of postnatal care. The first episode of postnatal care was expected to be provided within 24 hours of birth, and the next between 48- and 72-hours following birth.

Primary exposure variable

Various forms of mistreatment including interpersonal abuse, failure to maintain professional standards of care, poor rapport between a woman and the health care provider, and health system conditions and constraints were exposure variables for

the analysis conducted to assess the association between mistreatment and maternal continuum of care.

Independent variables

- ◊ Sociodemographic characteristics: woman's age, residence (urban-rural), educational status, average monthly income- measured as a factor variable (lowest, low, middle, and highest) based on the income quintile.
- ◊ Pregnancy and birth: parity, mode of birth, support from a partner or household members, complication during pregnancy or childbirth.
- ◊ The quality of antenatal care: was based on the proportions of components of care received as recommended by WHO (World Health Organization, 2016d) including: recording of blood pressure, received tetanus toxoid immunisation, iron folate, advice on complications readiness (advice on danger signs like occurrences of severe headache, convulsion, blurring of vision, vaginal bleeding, upper abdominal pain, sudden gush of fluid per vagina, decreased fetal movement, lower abdominal tenderness and foul smelling vaginal discharge), birth preparedness, nutrition counselling, blood sample for basic investigations such as blood group and Rh factor, haemoglobin, screening test for syphilis, Hepatitis B virus surface antigen test and HIV testing, urine testing and drugs for intestinal parasites. For each of these care components, a code of 1 was assigned if the women reported receiving the specific component and 0 if not. The total sum score of these ten items was then calculated to represent the quality of antenatal care received.
- ◊ Health service-related factors: type of the health facility, primary care providers, presence of companion, date, and time of birth.

Data collection instruments and process

A validated community-based survey tool developed by a WHO-led study (Bohren et al., 2018) was adapted and translated into Afaan Oromo to measure the level of mistreatment of women during maternity care. This tool was developed based on a mixed-method and iterative approach. A total of 32 items were used to measure the level of mistreatment of women based on seven typologies as identified by Bohren et al. (2015).

Two data collectors were recruited for the data collection. The data collectors did not have an employment background in health sciences; they were engaged only to assist women with low literacy levels to complete the survey. Before they were able to assist with survey data collection, training regarding the objective of the study, data collection instrument, data collection techniques and methods was provided by the researcher to minimise their influence on participant responses. Survey data was collected through a paper-based interviewer administered questionnaire. Each woman was asked individually about their sociodemographic, pregnancy and birth related characteristics, and the care received and experiences during their recent childbirth in the health facilities where they received maternity care (antenatal care to postnatal care).

Data analysis

Survey data were checked for completeness and entered Epi-info version 7.1 software for data entry based on a predesigned data entry template. The data entered to Epi-info were exported to Stata version 17 for cleaning and analysis (Stata Corp, 2021b). Descriptive analysis of sociodemographic, pregnancy, birth and postnatal characteristics were performed. These descriptive statistics were calculated and presented using tables, figures, and text: median and interquartile range for the

variables which were continuous but not normally distributed, and frequencies and percentages for categorical variables were reported.

Thirteen indicators of mistreatment were included under interpersonal abuse. Six of these indicators focused on physical abuse which included being hit, slapped, or pinched, gagged, tied to the bed, forcefully held down, denial of pain relief, and forceful abdominal/fundal pressure. On the other hand, verbal abuse included being shouted, screamed, insulted, scolded, mocked, hissed at, receiving negative comments related to the woman's status, being threatened and blamed. Discriminatory comments related to woman's educational status, age, language, or economic status, feeling discriminated against in any way and held back from asking concerns were indicators included under stigma and discrimination category. Women who experienced at least one category of physical abuse, verbal abuse or stigma and discrimination was coded as 'Yes=1', while those who did not experience were coded as 'No=0'.

A mixed-effect logistic regression model was fitted to identify factors associated to interpersonal abuse. The model was specified using the generalized linear mixed effects regression (*glmer*) function of *lme4* package (Bates et al., 2015) using R Statistical Software (R Core Team, 2023). Variables significantly associated to outcome variable at p-value less than 0.2 in multilevel bivariable analysis were taken as candidates in multi-variable analysis. To obtain the best fitted model, three models were constructed: the first model being intercept-only model with five health facilities being a random effect variable; the second model with fixed effects for individual factors related to sociodemographic, pregnancy and birth related characteristics of the women and random effect for health facilities; and the third model containing contextual variables in addition to variables included in model two as fixed effects and health facilities for random effect variable.

To model the association between mistreatment of women and completion of continuum of care, three multilevel mixed-effects models were employed using same function and package discussed above. The first model served as a null model with only an intercept, the second model included random intercepts for health facilities, and the fixed effects consisted of interpersonal abuses and experiences of poor rapport between women and healthcare providers. The final model, which is a better fitted model, incorporated additional socio-demographic, pregnancy, and childbirth-related variables to assess the independent association between mistreatment and the continuum of care. Here, the outcome variable was completion of continuum of maternity care, i.e., having at least four antenatal care check-ups, birth attended by skilled care providers and at least two postnatal check-ups within first week of birth.

Setting health facilities as a random-effect variable in all models allowed us to account for the correlation between individuals who received care from the same health facility. By this approach we were able to obtain more precise estimates of the fixed effects of predictors and effectively control for the clustering effect, as recommended by Faraway (Faraway, 2016). The Akaike information criterion (AIC) and Bayesian information criterion (BIC) was used to assess the model fit. Predictor variables having multi-collinearity (correlation) to each other were checked by variance inflation factors (VIF) and removed from the final model. Each model's effect sizes were reported as adjusted odds ratios (AOR) with their 95% confidence intervals (CI).

4.4. Results

Sociodemographic characteristics of the participants

Overall, 760 women completed the survey, and all received their maternity care from health facilities. The participants ages ranged from 18 – 39 years with a median age of 25 years and interquartile range (IQR) of 5. The majority (*n* = 735; 96.7%) were married. Three out of four women (*n*= 576; 75.79%) were of a Protestant religion and most participants (*n*= 743; 97.76%) identified themselves as Oromo in ethnicity. One in every five women were unemployed. Most of the participants resided in urban and semiurban areas (*n*= 662; 87.11%). Three hundred thirty-eight (44.47%) women were educated to college diploma or university degree level, while nearly half (*n*= 392; 51.58%) of their husbands/partners were educated to college and above level. The median average monthly income of the women's household was 3000 Ethiopian birr (ETB) with an IQR of 3000 ETB, and three-fourths of them earned less than 5000 ETB. The median travel time to the nearest health facility was reported to be five minutes by car (median 5±7.5) (Table 4.1.).

Table 4.1: *Sociodemographic characteristics of women participated in survey, East Wollega Zone, Western Ethiopia, 2022 (n = 760)*

Characteristics	Categories	Frequency	Percentage
Age (years)	18-19	37	4.87
	20-24	339	44.60
	25-29	279	36.71
	30-34	80	10.53
	35+	25	3.29
Marital status	Married	735	96.71
	Others[2]	25	3.29
Religion	Protestant	576	75.79
	Orthodox	142	18.68
	Muslim	40	5.26
	Others	6	0.80
Ethnicity	Oromo	743	97.76
	Amhara	13	1.71
	Others	4	0.53
Occupation	Government employee	171	22.50
	Housewife	165	21.71
	Private business	154	20.26
	Agriculture	83	10.92
	Unemployed	158	20.79
	Student	29	3.82
Residence	Rural	98	12.89
	Urban	662	87.11
Educational status	No formal education	35	4.61
	Primary school	159	20.92
	Secondary school	228	30.00
	College and above	338	44.47
Husband educational status	No formal education	27	3.55
	Primary school	121	15.92
	Secondary school	220	28.95
	College and above	392	51.58

[2] Others-includes single, divorced, widowed, cohabit and separated individuals.

Characteristics	Categories	Frequency	Percentage
Income (Median and IQR =3000)	Lowest (<2000 ETB)	186	24.47
	Low (2000-3000ETB)	163	21.45
	Middle (3000-5000)	228	30.00
	Highest (>5000)	183	24.08
Travel distance to the health facility by vehicle	<2.5 minutes	243	31.97
	2.5-5minutes	181	23.82
	5-10minutes	165	21.71
Median 5 and IQR=7.5	10 and above	171	22.50

Pregnancy, birth, and postpartum related characteristics of the participants

Most of the participants' pregnancies were planned (*n*= 673; 88.5%) and the majority of women were supported during their pregnancy and birth (*n*= 744; 97.9%) by the woman's partner and other relatives. Two out of every five women were primiparous (*n*= 310; 40.8%), and the typical number of previous births among women were two.

Fifty-one women (6.7%) reported having an earlier stillbirth, while 10.0% (n=76) reported experiencing complications during their last pregnancy. Of these women, 31.6% (n=24) experienced a hypertensive disorder of pregnancy, while others reported antepartum haemorrhage (13.2%), premature rupture of membranes (19.7%), and postpartum haemorrhage (6.6%) among other complications included anaemia, hyperemesis gravidarum, oligohydramnios and Rh- isoimmunisation (Table 4.2).

Figure 4.1. depicts the services women received from health facilities during their antenatal care. Most women received eight of ten routine components of care, however less than one-sixth (*n*= 110; 14.5%) were given drugs for intestinal parasite.

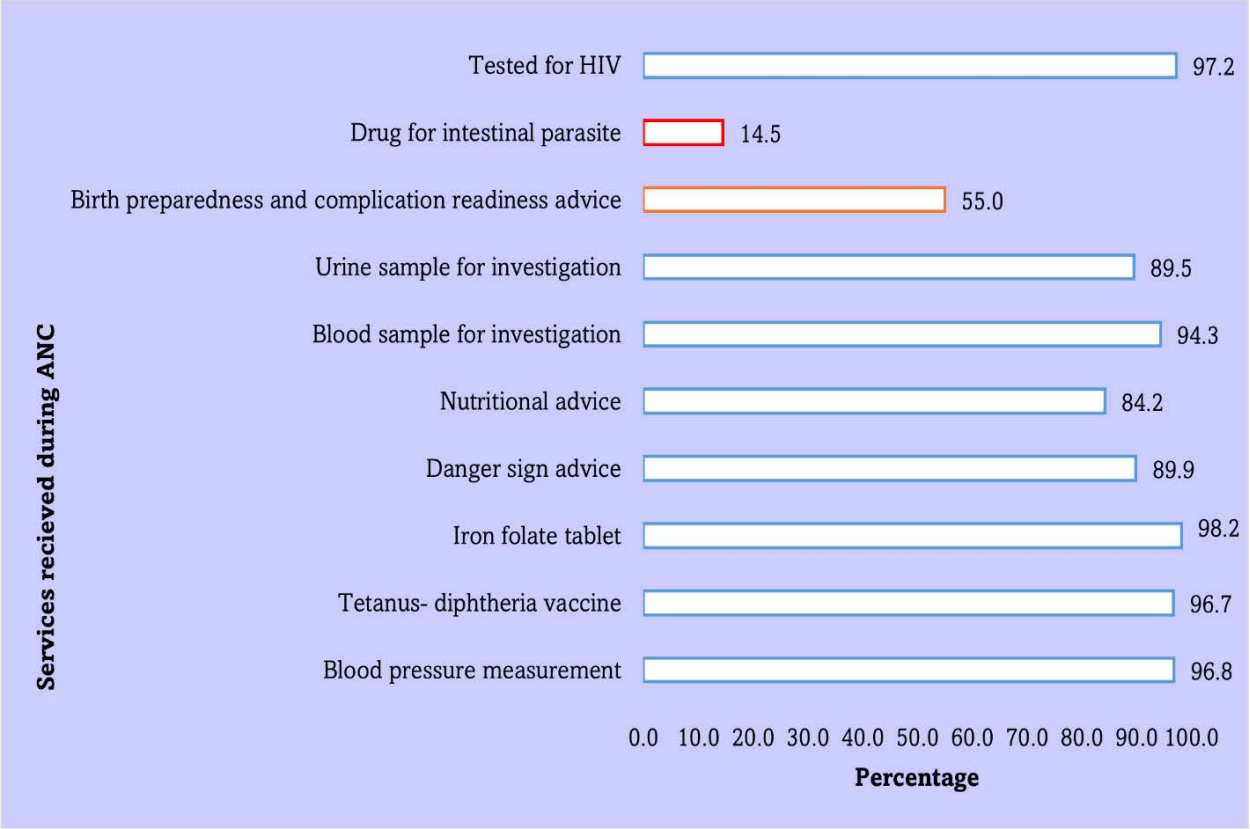

Figure 4.1: Bar chart showing the percentage of services given to women attending antenatal care from health facilities of East Wollega Zone, Western Ethiopia, 2022 (n=759)

Continuum of maternity care

Almost all women (*n*=759; 99.9%) attended at least one antenatal care visit at health facilities. Of these, 380 (50.1%) received prenatal care at public hospitals while 359 (47.3%) received it at health centres. Only two out of five women (*n*= 305; 40.1%) began to receive antenatal care during the first trimester of pregnancy as recommended by the WHO (2016) antenatal care guideline most of the women received their first antenatal care visit at 16 weeks gestation.

Among the women who received antenatal care, two-thirds (*n*= 499; 65.7%) received four or more antenatal care episodes while 97.0% of these women and 63.7% (n=484) of all women received four and above antenatal care check-ups and their birth were also attended by skilled providers. From which 136, 17.9% of all women completed continuum of care up until second post-natal check-ups within first week of birth. Only three women received all components of continuum of maternity care, including four or more antenatal care visits, skilled health provider attendance during birth, and postnatal care up to six weeks after birth.

Skilled health care providers including midwives, nurses and medical doctors assisted with 725 (95.4%) births. Most of the births (*n*= 596; 78.4%) occurred in public hospitals, while 34 (4.5%) women gave birth at home. Almost three-quarters of births (*n*= 564; 74.2%) were a spontaneous vaginal birth (see Table 4.2. and Figure 4.2.).

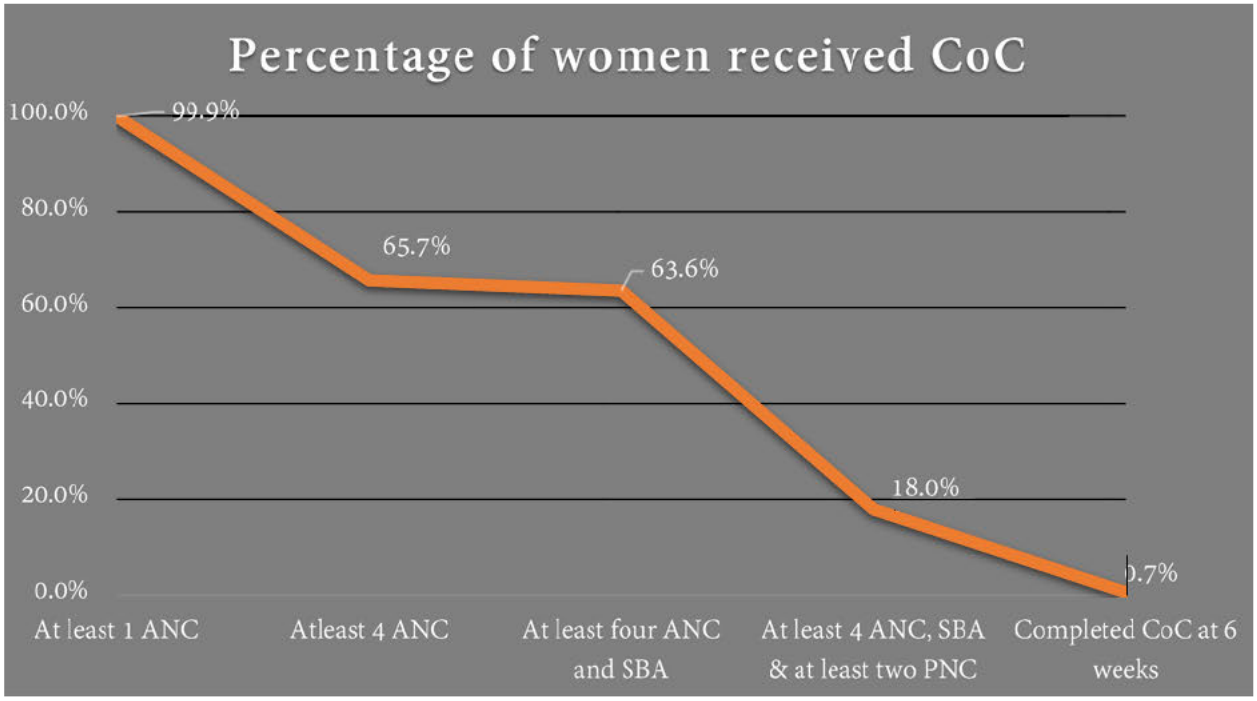

Figure 4.2: Percentage of women received continuum of maternity care from health facilities (initial ANC to six week postnatal) of East Wollega Zone, Western Ethiopia, 2022 (n=759)

Table 4.2: *Pregnancy, birth, postpartum care related characteristics of women, East Wollega Zone, Western Ethiopia, 2022 (n= 760).*

Characteristics	Categories	Frequency	Percentage
Pregnancy plan	Yes	673	88.55
Pregnancy was supported	Yes	744	97.89
Number of births (parity)	Primiparous	310	40.79
Median 2 ±2	Multiparous	409	53.82
	Grand multiparous	41	5.39
Previous history of stillbirth	Yes	51	6.71
Pregnancy complication	Yes	76	10.00
Causes of pregnancy complications (n=76)	Hypertensive disorder	24	31.58
	Antepartum haemorrhage	10	13.16
	Premature rupture of membrane	15	19.74
	Others antepartum complications[3]	22	28.95
	Postpartum haemorrhage	5	6.58
Received antenatal care	Yes	759	99.87
Health facility where antenatal care received (n=759)	Health centre	359	47.30
	Hospital	380	50.07
	Private clinic	17	2.24
	Health post	3	0.40
Gestational age at first ANC (weeks) (n=759)	First trimester	305	40.18
	Second trimester	438	57.71
Median 16 ±8	Third trimester	16	2.11
Number of antenatal cares received (n=759)	One-three	260	34.26
	Four above	499	65.74
Place (health facility) of birth	Health centre	116	15.26
	Hospital	596	78.42
	Private clinic	13	1.71
	Home	34	4.47
	On the way to health centre	1	
Skilled assistance at birth (SAB)	Yes	725	95.39
	Four + ANC and SAB	484	63.68
Mode of birth	Spontaneous vaginal birth	564	74.21
	Operative vaginal birth	92	12.11
	Caesarean section	104	13.68

[3] Anaemia, hyperemesis gravidarum, oligohydramnios, Rh- isoimmunisation …

Characteristics	Categories	Frequency	Percentage
Time of birth	Day	478	62.89
	Night	282	37.11
Day of birth	Weekday	477	62.76
	Weekend	283	37.24
Postnatal care (PNC)	PNC within 24hrs of birth	719	94.61
	PNC on the third day of birth (48-72hrs)	136	17.89
	PNC between 7-14 days of birth	27	3.55
	PNC on six weeks of birth	5	0.66

Mistreatment of women

Interpersonal abuse

This category of mistreatment occurred during direct interactions between the woman and health care providers and includes any form of physical and /or verbal abuse, or stigma or discrimination. A total of 284 (37.4%, 95% CI: [34.32–41.23]) women reported experiencing at least one form of interpersonal abuse. Most of the abuse (*n*= 248; 87.3%) occurred during woman's labour and birth, while some women also experienced mistreatment during their antenatal or postnatal care check-ups. Fourteen (4.9%) women reported experiencing mistreatment in more than two care units, including antenatal care, during birth, and postnatal care (Table 4.3).

Physical abuse was the most common form of interpersonal abuse overall, with 207 (27.2%) women reporting experiencing some form of physical abuse. The most reported types of physical abuse included denial of pain relief during procedures such as episiotomy and after caesarean section, which could also be considered emotional abuse (n=142; 18.7%) followed by forceful abdominal pressure, known as fundal pressure (n=77; 10.1%). Other types of physical abuse reported included slapping, punching, or pinching by either a finger or an object (n=70; 9.2%) among others.

One hundred fifty-eight (20.8%) women reported experiencing verbal abuse, which included being shouted and screamed at, insulted, scolded, mocked, or hissed at. Verbal abuse included negative comments, blaming, and threats. Additionally, women reported experiencing provider prejudice based on their social status. Thirty-six (4.7%) women shared that they encountered negative comments from healthcare providers, which made them feel discriminated against or inferior. These negative experiences hindered their ability to express their concerns about themselves and/or their baby.

Failure to meet professional standard of care

Two hundred twenty-seven (29.9%) received substandard care, with healthcare providers failing to obtain their consent for certain procedures or exams and frequently withholding crucial information. One hundred-ninety (25.0%) women reported that they were not asked for consent nor were they offered an explanation or rationale for the health care provider performing certain procedures such as an abdominal or vaginal examination during labour and birth. Women also reported a lack of privacy (*n*= 31; 4.1%) when in the health facility and reported being neglected or ignored (*n*= 21; 2.8%) (see Table 4.3.).

Poor rapport between women and health care providers and health systems constrains

Half of the women (*n*= 387; 50.9%) reported having an unsatisfactory interaction with health care providers. Three hundred twenty-nine (43.3%) women were not allowed to have companion of their choice present with them during antenatal care, labour, and birth or during immediate postpartum period in health facilities, leaving them feeling emotionally unsupported due to being ordered to remain still or a lack of response from healthcare providers.

Forty-seven (6.2%) women reported facing health system-related constrains regarding resources at the heath care facility, ranging from unavailability of a bed during a woman's birth or immediate postnatal period. Indeed, 39 (5.3%) women reported having no access to a bed during their birth, and 11(1.5%) were unable to access a bed after birth, as presented in Table 4.3.

Table 4.3: *Mistreatment that women experienced during maternity care in health facilities of East Wollega Zone, Ethiopia, 2022 (n=753)*.

Categories of mistreatment	Sub-categories	Frequency (%)
Interpersonal abuse	**Any physical abuse, verbal abuse, stigma, or discrimination**	**284(37.4%)**
Physical abuse	**Any physical abuse**	207(27.2%)
	Denial of pain relief while in health facility	142(18.7%)
	Forceful abdominal downward pressure (fundal pressure)	77(10.1%)
	Hit or slapped or pinching or pinched by materials	70(9.2%)
	Gagged	20(2.6%)
	Forcefully held down to the bed	12(1.6%)
	Tied to the bed	3(0.4%)
Verbal abuse	Any verbal abuse	158(20.8%)
	Shouted, screamed, insulted, scolded, mocked, hissed at	150(19.7%)
	Negative comments	28(3.7%)
	Threatened	15(2.0%)
	Blamed	14(1.8%)
Stigma and discrimination	Any discrimination	36(4.7%)
	Negative comments (educational status, age, tribe, language, or economic status…)	19(2.5%)
	Felt discriminated	22(2.9%)
	Held back from asking concerns	5(0.7%)
Failure to meet professional standard	Overall failure of professional standard of care	227(29.9%)
	Lack of consented care	190(25.0%)
	Lack of information	185(24.3%)
	Lack privacy	31(4.1%)
	Ignored or neglected	21(2.8%)
	Non-confidential care	15(2.0%)
	Felt nuisance	8(1.0%)
Poor rapport with health care providers	Overall poor rapport b/n health care providers and women	387(50.9%)
	Lack of birth companion	329(43.3%)
	Not allowed to move during labour	48(6.5)
	Emotionally unsupported	29(3.8%)
	Did not receive response for concerns /questions	17(2.2%)
	My concerns were not heard	14(1.8%)
	Not allowed to eat	6(0.8%)

Health system conditions and constrains	Overall health systems constrain	47(6.2%)
	Lack of bed during PNC	39(5.3%)
	Lack of bed during labour & birth	11(1.5%)
	Bribe/asked for informal payment or gift	4(0.5%)
	Ordered to clean up after oneself	1

Factors associated with mistreatment of women

When comparing the standard logistic regression to the null multilevel mixed-effect binary logistic regression model, we found evidence of variation in women's mistreatment experiences across healthcare facilities (likelihood ratio test: $\chi 2 = 68.5$, df = 14, $p < 0.001$). This suggests that the multilevel mixed-effects model is a better fit. The null model yielded an Intraclass Correlation Coefficient (ICC) of 6.4%, indicating that approximately 6.4% of mistreatment variability in can be attributed to differences between the health facilities.

In the final multivariable multilevel mixed-effects model, several factors were found to be significantly associated with interpersonal abuses experienced by women in health facilities. These factors include the economic status of the women, the occurrence pregnancy or birth complications, previous history of stillbirth, mode of birth, and the presence of a companion during maternity care.

Women from different economic statuses experienced mistreatment to different extents. Specifically, women from the lowest economic status had 80% higher odds of experiencing mistreatment compared to those from higher economic backgrounds (AOR = 1.80, 95% CI: [1.06 – 3.04], p-value = 0.029). Among the pregnancy and birth related factors, the presence of any complications during a woman’s pregnancy or birth was associated with increased odds of mistreatment. Women who faced complications were 78% more likely to experience mistreatment compared to those

who did not encounter any complications (AOR= 1.78, 95%CI: [1.05 – 3.01], p–value = 0.031).

Previous history of stillbirth, mode of birth, and presence of a companion were associated with reduced occurrence of interpersonal abuses. Women with a prior stillbirth were 51% less likely to experience mistreatment (AOR= 0.49, 95%CI: [0.24 – 0.97]; p-value= 0.041). Similarly, women who had a caesarean section were 41% less likely to experience mistreatment compared to women who gave birth vaginally (AOR = 0.59, 95% CI: [0.36 – 0.98], p-value = 0.042). Furthermore, women who were allowed to have a companion of their choice during maternity care had 42% decreased odds of experiencing mistreatment compared to women who were not permitted (AOR= 0.58, 95%CI: [0.42 – 0.81]; p–value=0.001) (Table 4.4.).

Table 4.4: *Factors associated with mistreatment of women during maternity care in East Wollega Zone, Western Ethiopia, 2022 (n=752) - results from Mixed-Effects Logistic Regression Models*

Variables	Model I AOR [95%CI]	Model II AOR [95%CI]	Model III	
A. Fixed effects				
(Intercept)	**0.40[0.25 – 0.65]**	**0.15 [0.04 – 0.53]**	**0.14 [0.04 – 0.52]**	**0.003**
Woman's age (years)		1.03 [0.99 – 1.07]	1.03 [0.99 – 1.07]	0.140
Educational status				
Highschool and below		*Reference*	*Reference*	
College and above		0.88 [0.59 – 1.30]	0.86 [0.58 – 1.27]	0.440
Socio-economic status				
High		*Reference*	*Reference*	
Lowest		1.84 [1.09 – 3.09]	1.80 [1.06 – 3.04]	0.029
Low		0.61 [0.35 – 1.05]	0.62 [0.36 – 1.06]	0.081
Middle		0.94 [0.60 – 1.49]	0.93 [0.58 – 1.47]	0.746
History of stillbirth				
No		*Reference*	*Reference*	
Yes		0.50 [0.25 – 0.99]	0.49 [0.24 – 0.97]	0.041
Presence of complication				
No		Reference	*Reference*	
Yes		1.80 [1.06 – 3.04]	1.78 [1.05 – 3.01]	0.031
Mode of birth				
Vaginal birth		*Reference*	*Reference*	
Instrumental		1.41 [0.87 – 2.29]	1.54 [0.94 – 2.50]	0.085
Caesarean section		0.55 [0.34 – 0.90]	0.59 [0.36 – 0.98]	0.042
Birth companion				
No			*Reference*	
Yes			0.58 [0.42 – 0.81]	<0.001
Hospital versus health centre				
Health centre			*Reference*	
Hospital			2.20 [0.87 – 5.56]	0.096
B. Random effects				
Health facilities				
Variance	0.223	0.31	0.197	-
Intraclass correlation (ICC)	0.064	0.087	0.057	-
C. Model fitness				

Variables	Model I AOR [95%CI]	Model II AOR [95%CI]	Model III	
AIC	966	935	926	-
BIC	975	999	999	-
Log-Likelihood	-481	-453	-447	-
Deviance	962	907	894	-
P-value	-	<0.001	<0.001	-

Association between mistreatment of women and the maternal continuum of care

The association of mistreatment of women with the completion of maternal continuum of care was assessed while controlling for other variables, as presented in Table 4.5. In this context, completion of the continuum of care involves to meeting specific criteria specified in the methods section, including a minimum of four antenatal care check-ups, childbirth attended by skilled providers, and at least two postnatal care check-ups within the first week after birth. The final model yielded ICC of 25.4%, indicating that 25% of the variability in completing the continuum of care was attributed to the variation in health facilities.

Women who encountered physical abuse, verbal abuse, stigma, or discrimination during maternity care were found to have a significantly decreased likelihood of completing the continuum of care, with their odds reduced by half compared to those who did not experience such interpersonal abuse (AOR = 0.49, 95% CI: [0.29 – 0.83], p-value = 0.008). Although not statistically significant, the presence of poor rapport was also observed to be associated with reduced odds of completing the maternal continuum of care.

Among the social determinants of health, higher education attainment, specifically attending college and above, was found to significantly enhance the likelihood of completing continuum of maternity care. Women with a college education or higher

were 77% more likely to complete the continuum of care compared to those with an educational status below college level (AOR = 1.77, 95% CI: [1.01 – 3.10], p-value = 0.046). Additionally, the presence of complications during pregnancy or birth also emerged as another factor associated with completing the continuum of maternity care. Women who experienced pregnancy complications were three times more likely to complete the continuum of care than those without complications (AOR = 3.20, 95% CI: [1.73 – 5.94], p-value < 0.001). Additionally, receiving better-quality antenatal care during pregnancy was associated with 25% increased odds of completing the continuum of maternity care (AOR = 1.25, 95% CI: [1.03 – 1.51], p-value = 0.023).

Table 4.5: *Association between mistreatment of women and maternal continuum of care in East Wollega Zone, Western Ethiopia, 2022: A mixed-effects binary logistic regression analysis (n=752).*

Variables	Null model AOR [95%CI]	Model II AOR [95%CI]	Model III	
A. Fixed effects				
(Intercept)	0.04[0.01 – 0.19]	0.05[0.01 – 0.27]	0.00[0.00 – 0.04]	<0.001
Any interpersonal abuse				
Not experienced		*Reference*	*Reference*	
Experienced		0.49[0.30 – 0.80]	0.49[0.29 – 0.83]	0.008
Poor rapport between woman and healthcare providers				
Not experienced	-	*Reference*	*Reference*	
Experienced	-	0.70[0.44 – 1.10]	0.67[0.42 – 1.08]	0.101
Woman's age (years)	-	-	1.05[0.99 – 1.11]	0.098
Educational status				
Secondary school and below	-	-	*Reference*	
College and above		-	1.77[1.01 – 3.10]	0.046
Income				
Lowest	-	-	*Reference*	
Low	-	-	0.60[0.27 – 1.35]	0.220
Middle	-	-	1.01[0.50 – 2.03]	0.991
High	-	-	1.36[0.64 – 2.86]	0.425
Presence of complication				
No	-	-	*Reference*	
Yes	-	-	3.20[1.73– 5.94]	<0.001

Variables	Null model AOR [95%CI]	Model II AOR [95%CI]	Model III	
Quality of antenatal care*	-	-	1.25[1.03 – 1.51]	0.023
B. Random effects				
Health facilities				
Variance	1.94	2.31	1.12	-
Intraclass correlation (ICC)	0.370	0.412	0.254	-
C. Model fitness				
AIC	557	547	521	-
BIC	566	566	572	-
Log-Likelihood	-276	-269	-250	-
Deviance	553	539	499	-
P-value	-	0.002	<0.001	-

4.5. Discussion

In this study, we report on the prevalence of mistreatment of women during maternity care, factors associated with interpersonal abuse and the relationship between mistreatment of women and continuum of maternity care. More than a third of women encountered at least one instance of physical abuse, verbal abuse, stigma, or discrimination, with several factors associated with its occurrences. Nearly one-third of women did not receive care that met professional standards, and every other woman reported poor rapport with health care providers. Our study also suggests women were less likely to attend and finish the continuum of care if they endured mistreatment in their initial period of antenatal care or thereafter.

Previous studies have highlighted significant variation in the prevalence of mistreatment experienced by women during maternity care worldwide, ranging from

low rates in some countries (Keedle et al., 2024) to nearly universal experiences in others (Ukke et al., 2019). This study also demonstrates the significant problem of mistreatment, with varying magnitudes observed for different types of mistreatments. Ensuring care meets professional standards and upholds dignity, respect, confidentiality, and involving clients in the decision-making process are crucial for improving the quality of care, as outlined in WHO's *standards for improving quality of maternal and newborn care in health facilities* (World Health Organization, 2016c). However, the findings from this study reveals a substantial proportion of women experienced care that failed to meet these standards, along with experiencing nuanced interpersonal abuses, poor rapport with healthcare providers and health system related constrains. Identification of these varied categories of mistreatment in current study signifies the need to understand mistreatment of women as a product of complex personal, structural and system issues that need system-wide solutions (Kasaye et al., 2023; Lunze et al., 2015; World Health Organization, 2016c).

The occurrence of mistreatment during maternity care was associated with various characteristics of women, such as social status, education, and socioeconomic background, which have been documented to play a significant role (Bobo et al., 2019; Kruk et al., 2018c). Our study confirms those findings and identifies that women from the lowest income group had higher odds of experiencing interpersonal abuses. This highlights the inequality in care provision for marginalised and impoverished women(Asefa et al., 2020b), perpetuating mistreatment as both health care providers and women themselves normalise it. Constraints within the health care system and unequal power dynamics among providers hinder addressing these issues across the continuum of care (Asefa et al., 2020a).

Furthermore, women with complications during pregnancy or birth faced intensified interpersonal abuse, emphasising the greater vulnerability of those in need of additional physical and emotional care. Women who had a vaginal birth also faced higher odds of mistreatment compared to women who required a caesarean section, likely due to the increased pain and challenges of spontaneous labour, as reported elsewhere (Asefa et al., 2020d). Conversely, women who had a companion present had a lower risk of experiencing interpersonal abuse, underscoring the positive influence of having a supportive companion present during childbirth (Balde et al., 2020). These factors become more pressing in hospitals with higher patient ratios compared to health centres (Asefa et al., 2020a; Bobo et al., 2019), as women tend to bypass health centres, contributing to hospital congestion for various reasons, including perceptions of poor quality of care and infrastructure issues (Asefa et al., 2020a).

The occurrence of mistreatment in healthcare facilities undermines service utilisation, contributing to the discontinuation of completing continuum of care (Dadi et al., 2021; Oyedele et al., 2023). In our study, we found that half of the women who experienced physical abuse, verbal abuse, stigma, or discrimination discontinued maternity care. Women who have experienced mistreatment in any form during pregnancy may be more likely to discontinue prenatal care, even if they had initially intended to give birth at that facility. They prioritise giving birth in a dignified manner and prefer to avoid such mistreatment, despite recognising the potential impact of choosing a home birth. Demonstrating that women are reluctant to seek evaluation and assistance from health care providers who disrespect and abuse them, leading to mistrust, dissatisfaction and even depression (Paiz et al., 2022). This reluctance contributes to complications and hampers efforts to reduce maternal and neonatal mortalities, thereby impacting on the

global sustainable development goals (SDG) target of maternal health (Asefa et al., 2020c). The negative associations between mistreatment and the continuity of care highlight the need for comprehensive, system-wide interventions that go beyond educational measures, such as training, which have been found to be inadequate on their own (Asefa et al., 2020c).

Our study presents significant ongoing occurrences of mistreatment of women during maternity care requiring urgent change within the health care system. We acknowledge there are some limitations and strengths in our study. The limitation of this study is that the findings were based on participants only from four districts near the zonal capital city, this was due to challenges in accessing women from remote areas affected by ongoing unrest during data collection in the area. However, efforts were made to include women from rural areas who sought care in nearest health centre and hospital. We believe the occurrence of mistreatment and its effect would not differ significantly in the remaining district and primary hospitals from what observed in current study.

Another important limitation to consider in this study is that we recruited women during immunisation due to community unrest in the area. Current study participants may exhibit a higher health-seeking behaviour than those who did not come for vaccination, which could lead to an underestimation of the influence of mistreatment on the continuity of care. A community-based study could have offered a more accurate depiction of the relationship between mistreatment of women and continuity of care. Although over 97% of women in Ethiopia visit health facilities to have their children vaccinated (Ministry of Health, 2021a), potential participants may have been lost, and therefore, the findings from this study might not be generalisable to the broader population.

Additionally, the cross-sectional nature of our study design limits our ability to establish a causal association between mistreatment and continuity of care, as we were unable to determine whether experiences of mistreatment during previous pregnancies and births also contributed to the discontinuation of continuity of care or if it was solely influenced by the experiences during the current pregnancy and birth.

A notable strength of our study is the exploration of a previously unexplored aspect, the influences of mistreatment on the continuum of maternity care in Ethiopia. Additionally, we measured mistreatment in various categories, considering its multidimensionality and utilising validated survey tools, instead of reporting the magnitude as a single combined measure.

4.6. Conclusions

Mistreatment of women in maternity care is a pervasive issue that extends beyond labour and birth, encompassing antenatal and postnatal care as well. This mistreatment has significant negative consequences, hindering women's engagement and completion of the continuum of care and resulting in reduced utilisation of maternal healthcare services. Such trends have detrimental effects on overall maternal well-being. It is crucial to identify and address these gaps by avoiding interpersonal abuse, enhancing rapport through attitude and value transformation trainings. Such interventions should align with a system level actions, including enforcing respectful care as a competency of every provider, enhancing health centre functionality, improving the referral system, and influencing communities to demand respectful care. Such changes could promote positive maternal and neonatal health outcomes while fostering trust and respect between women and healthcare providers. Collaborative efforts involving healthcare providers, facilities, communities, and policymakers are

necessary to ensure equitable and respectful care for all women, irrespective of their social or medical circumstances.

4.7. Summary

In summary, this chapter addressed the perspectives of women regarding the mistreatment they experienced during maternity care. The next chapter will, present the results of a survey conducted among healthcare providers regarding their perceptions of mistreatment towards women in their respective health facilities, relating it to their working environment perceptions and empathy levels.

CHAPTER 5: FINDINGS—HEALTH CARE PROVIDERS' PERSPECTIVES

5.1. Chapter preface

The previous chapter addressed the findings from the survey of women's experiences of mistreatment, which addressed the issue of mistreatment from the standpoint of women. In this chapter, another perspective is presented: that of healthcare providers.

Health care providers, who may have been from various professional backgrounds but provide care to childbearing women, were approached to share their perspectives regarding mistreatment towards women in their respective health facilities. In addressing the magnitude of self-reported mistreatment, this chapter additionally directs attention towards the effects of healthcare providers' workplace perceptions and their levels of empathy for those they care for on the level of mistreatment within their respective facilities. This chapter is presented as a manuscript that has been published in *Women and Birth*, a midwifery Q1 journal.

> Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024). Health care providers' perspectives on the mistreatment towards women during maternity care: Do perceptions of the working environment and empathy level matter? Women Birth, 37(3), 101601. https://doi.org/10.1016/j.wombi.2024.101601

Abstract

Background: Mistreatment of women in maternity care violates human rights, erodes trust and disrupts the continuity of maternal healthcare services. Investigating Health Care Providers' (HCPs) perspectives is indispensable for uncovering drivers and designing targeted interventions.

Aim: To identify the roles of HCPs' perceptions of the working environment and levels of empathy on the mistreatment of women during maternity care.

Methods: We conducted a self-administered survey among 148 maternal HCPs practising in ten health centres and four hospitals in the East Wollega Zone, Western Ethiopia, from June to September 2022.

Findings: Most providers reported seeing other HCPs mistreating women (93.2%), while three-fourths (75.7%) admitted it as their actions. Violation of privacy and confidentiality was the most frequently reported category of mistreatment (44.6%), followed by physical abuse (37.1%) and verbal abuse (35.8%). The likelihood of mistreating women was reduced by 65% (AOR=0.35, 95% CI: [0.14, 0.86]) among individuals with positive perceptions of their working environment compared to those with negative perceptions. A unit increase in providers' empathy also led to a five per cent decrease in mistreatment (AOR=0.95, 95% CI: [0.91, 0.98].

Conclusions: HCPs' perceptions of their working environment and enhanced empathy levels were associated with the reduction of the odds of mistreatment of women. While empathic care should be cultivated as a component of HCPs' competencies, efforts should be made to improve the conditions of the demanding health system to realise a resilient, motivated, competent, and compassionate

workforce. The interplay between gender, profession, and mistreatment level requires further investigation.

Keywords: Maternal Health, Mistreatment of Women, Health Workforce, Workplace, Perceptions, Empathy

5.2. Introduction

Annually, nearly 140 million births occur in a world where significant disparities in equity and quality of care exist (United Nations, 2022a). These gaps in equity and quality of care persist globally despite recognising evidence-based, equitable, respectful, and compassionate care for all women and their babies in maternity care policies (Anindya et al., 2021). Unnecessary and excessive interventions are commonly practiced in middle-income and high-income countries. In contrast, many women and babies die because of limited access to essential interventions in resource-limited countries (Miller et al., 2016). Considering these widened gaps in service provisions, there has been a shift in the maternal, newborn, and child health care agenda, moving away from merely striving to improve survival with a focus on addressing drivers of thriving and transformation (Oladapo et al., 2018). One driver of inequality affecting this envisioned transformation and thriving is the prevailing mistreatment of women during maternity care (Bohren et al., 2015).

Mistreating women during maternity care violates human rights and influences women and their families to mistrust maternal health care services and drop from the continuum of care, even though they recognise its significance in their care (Kasaye et al., 2024b; Khosla et al., 2016). Several studies document that women do not want to seek care from *HCPs* who mistreat and abuse their dignity (Kujawski et al., 2015; Molla et al., 2017; Paiz et al., 2022; Silveira et al., 2019). A qualitative study found that

women who were mistreated during antenatal care avoided health facility births because of confidence and trust issues (Molla et al., 2017), which was also linked to a heightened risk of postpartum depression (Paiz et al., 2022; Silveira et al., 2019). Eliminating such impactful incidences in the continuum of care requires system-wide interventions based on first-hand evidence that incorporates the views of health care providers (Asefa et al., 2020a).

Most of the previous studies on mistreatment during maternity care were based on women's perspectives; however, some studies from various countries, including Ethiopia, have also reported that HCPs themselves have acknowledged the presence of mistreatment of women during maternity care, mostly reporting instances as unintentional (Burrowes et al., 2017; D.Zomeku et al., 2020; Shimoda et al., 2020). In a study where most service providers reported witnessing disrespectful care, Asefa et al. (2018) found that most HCPs believed that the absence of respectful care discourages women from seeking childbirth at health facilities. While HCPs recognise such negative impacts of mistreatment of women during maternity care, they find themselves unable to effectively prevent it (Asefa et al., 2018).

The health system and HCPs benefit from upholding the belief that there should be no justification for treating women with disrespect during maternity care. However, apprehension about being blamed for poor outcomes in maternal and neonatal health, coupled with the fragility of health systems characterised by limited infrastructure and resources in low-income countries, have frequently been cited as a driving factor behind the mistreatment of women (Dzomeku et al., 2020; Galle et al., 2020; Rominski et al., 2017). The presence of inadequate infrastructure, such as a limited number of skilled providers, can lead some women to feel neglected, even when the behaviour of providers is respectful. Such scenarios starkly contrast with instances of

interpersonal abuse, such as verbal or physical mistreatment, which often appear to be deliberate acts (Galle et al., 2020).

In addition to considering contextual factors within the health care system, it is also important to examine how HCPs' views on their working environment play a role in the mistreatment of women. The available evidence regarding how HCPs' overall perceptions of the actual working environment, their profession, and their relationship with other *HCPs* influence the mistreatment of women is limited. Generating such empirical evidence is crucial to understanding how the health system can be equipped with motivated, competent and compassionate health work forces, as envisioned by the Ethiopian Ministry of Health (Ministry of Health, 2021a). Hence, in this study, we aim to determine the extent of mistreatment as reported by HCPs—from their own actions or what they have witnessed from their colleagues. Furthermore, we sought to determine the roles of positive perceptions of the working environment and increased levels of empathy in the mistreatment of women during maternity care, as self-reported by HCPs, while controlling for the effects of other variables.

5.3. Methods

Study setting and population

This study was part of a larger study conducted in the East Wollega Zone, Oromia Regional State, Western Ethiopia, from June to September 2022. With an estimated 123 million people in 2022, Ethiopia is the second most populous country in Africa, with low economic, infrastructure, development, and health indices, including high maternal and child morbidity and mortality (United Nations, 2022a). Maternal and child health care services are provided by midwives, nurses, and medical doctors, among others. The health care delivery system in the country is structured into three tiers,

including primary-, secondary- and tertiary-level health care, through which preventive, curative and rehabilitative services are provided at health posts, health centres, primary hospitals, general hospitals, and specialised hospitals (Ministry of Health, 2021a).

Despite efforts being made to increase the availability and skill mix of the health workforce, Ethiopia has a health worker density estimated to be 1.0 per 1,000 population (midwives, nurses, medical doctors and health officers) (Ministry of Health, 2021/22), which is considerably lower than the 4.45 per 1,000 population standard proposed by the World Health Organisation (WHO) (World Health Organization, 2016a). There is an inadequate skill mix of professionals, where there is a relatively higher number of nurses, while there is a high shortage of physicians (one GP to ten thousand people) and midwives (one to six thousand people) (Ministry of Health, 2021/22; World Health Organization, 2016a).

To investigate the mistreatment of women by HCPs within health facilities, we conducted a cross-sectional survey involving maternal *HCPs* from six districts working in ten health centres and four hospitals. The survey was conducted among providers from these six districts with the aim of obtaining diverse participants from urban and semi-urban hospitals, as well as health centres given low number of the HCPs in each facility as discussed earlier. This approach allowed us to include HCPs from various professions. Although including HCPs from additional health facilities and districts could have been beneficial, we were unable to do so due to community unrest in the study area during data collection. The survey participants were midwives, nurses, medical doctors, health officers, and integrated emergency surgical officers. All maternal HCPs who were actively providing antenatal, birth and postnatal care were approached to participate in the study, while those who were not providing this care

but rather holding the duties of the office work at the district (Wereda office) and Zonal Health office, were excluded. Hence, a total of 170 survey questionnaires were distributed. Data were collected through self-administered surveys. Considering the sensitivity of the research topic, participants received surveys along with envelopes, and after completion, they returned the sealed surveys to a designated coordinator.

Measurements

Outcome variable: Mistreatment of women

The primary outcome variable of this study was the mistreatment of women in facilities, as reported by HCPs, either as they witnessed or admitted themselves as their own actions. To identify various forms of mistreatment towards women, participants were asked to evaluate the first-order encounters of mistreatment under seven constructs. The constructs encompassed various aspects: disrespectful and unfriendly care; verbal and physical abuses; discrimination based on social status; lack of privacy and confidentiality; neglect and abandonment; and loss of autonomy. These constructs align with the WHO's vision for the quality of maternal and newborn care under the categories of experiences of care (Tuncalp et al., 2015). The crucial components of quality maternal and newborn care involve effective communication and supportive emotional care that upholds respect and dignity. The absence of these elements indicates mistreatment in the care process, which is the response variable in this study.

Thirty questionnaire items were adapted from the Person Centred Maternity Care scale, which was previously validated in a study conducted in Kenya (Afulani et al., 2017). The items were tailored to capture HCPs' perspectives. Participants were asked to rate each item on a scale ranging from 0 to 3 (0 - No never, 1 - Yes, a few times, 2 - Yes, most of the time, 3 - Yes, all the time), representing the frequency of

the observed mistreatment. The questionnaire was administered in English and Afan Oromo through a self-administered survey. To assess the construct validity of the items, a factor analysis was conducted, resulting in four factors with eigenvalues above 1. All items were loaded on the first factor with a factor loading greater than 0.30 after the promax rotation of the factors. The internal consistency of the items was evaluated using Cronbach's alpha, resulting in an alpha value of 0.90, indicating good reliability.

In alignment with the World Health Organisation's stance to eradicate all forms of disrespect and abuse within health care facilities (World Health Organization, 2014), we classified any instance of mistreatment in at least one form as mistreatment, regardless of its frequency. Accordingly, to determine the proportion of self-reported mistreatment actions conceded by HCPs, we computed a binary indicator variable labelled *'Yes'* or *'No.'* If participants' responses indicated '*0–no, never*' concerning verbal abuse, physical abuse, breach of privacy or confidentiality, discrimination, neglect, and infringement upon autonomy, they were classified as '*No*' and coded 0. Conversely, if any of these forms of mistreatment were indicated as '*1–Yes, a few times, 2–Yes, most of the time,* or *'3–Yes, all the time,* the variable was categorised as *'Yes.'* We adopted this approach based on the belief that the presence of any of these forms of mistreatment, even if they occur infrequently, still implies a deficiency in providing respectful care.

Independent variables

Perceptions of the working environment

Perceptions of the working environment among individual HCPs were measured using a set of 16 items. These items were rated on a five-point Likert scale adapted from a Delphi study aimed at defining a positive working environment for health care

professionals (Maassen et al., 2021). The 16 items covered various aspects of the working environment, such as workload, patient-to-health care provider ratio, autonomy, professional development opportunities, relationships among professionals, teamwork, perceptions of their profession, and level of satisfaction with the service they were providing, among others. Participants were asked to rate each of the 16 items on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

The internal consistency of these items was good, with a Cronbach's alpha value of 0.8370. To assess the overall perception of the working environment, the scores of all the items were summed after missing values (one to three observations) were replaced with the mean of that specific variable, resulting in a possible total score ranging from five to 80. A lower sum score indicated a less positive perception of the work environment, whereas higher scores indicated a more positive perception. Perception of the working environment was dichotomised as negative if the sum score was less than the mean value and positive if the sum score was above the mean value. This binary variable was used in the final model that associates this variable with the odds of HCPs mistreating women.

Health care providers' level of empathy

The empathy levels of health care providers were evaluated using a 20-item self-reported Likert scale consisting of seven response options based on health professionals' Jefferson Empathy Scale (Hojat, 2016). The reliability and validity of the empathy scale for *HCPs* have been established in previous studies. Out of the 20 items, ten were positively formulated, while the remaining ten were negatively formulated. This approach aimed to minimise the potential influence of participants' monotonous responses. Each item was rated on a 7-point Likert scale ranging from 1

(*strongly disagree*) to 7 (*strongly agree*) for positively constructed items and the reverse for negatively constructed items. The internal consistency of these items was deemed acceptable, with a Cronbach's alpha coefficient of 0.73. Missing values for each item were replaced with the mean value of that specific item, following the recommendation of Hojat et al. (2001). The overall empathy level was then calculated as the sum of the scores across all the items, resulting in possible values ranging from 20 to 140. A higher score indicates a greater level of empathy, while a lower score indicates a lower level.

Other covariates

Individual demographic characteristics of the providers, such as age in years, sex, marital status, profession, monthly salary, years of experience, average number of births attended per day, and history of respectful maternity care training, were included in the analysis. Furthermore, contextual factors such as the types of facility they practice (hospital vs. health centre), presence and implementation of specific respectful maternity care policy in health facilities, and the presence of a redress system in health facilities were also evaluated and controlled in the regression model.

Statistical analysis

The responses of each participant were entered into Epi-info data entry software, Windows version 7 (Dean et al., 2011), and then exported to Stata 17 for data cleaning and analysis (Stata Corp, 2021a). Descriptive statistical summaries, including frequency and tabulations for factor variables and mean/median and standard deviations for continuous variables, were generated and presented in tables and graphs.

To predict the level of self-reported mistreatment of women from HCPs' positive perception of the working environment, empathy level, gender, profession, experiences, average number of childbirths attended per day and health facility type, a binary logistic regression model was used. The need for a mixed-effect model was checked for the clustering effects of being from the same health facilities or districts, and there was no evidence of correlation. There was no significant difference between the standard logistic regression model and the mixed effect model where health facilities were treated as an intercept variable (P-value = 0.333), and there was an avoidable intraclass correlation coefficient of approximately nil. Consequently, binary logistic regression was used to model factors associated with the proportion of mistreatment of women, as self-reported by HCPs. Model fitness was assessed using the Hosmer and Lemeshow goodness-of-fit test, and the model assumptions were assessed, and no violations were detected. Sensitivity analysis was conducted and the final result of the model of the associations between the outcome variable and independent variables were reported in the AOR with 95% confidence intervals, statistical significance level being 0.05 p value.

5.4. Results

Demographic description of the participants

Overall, 148 *HCPs* responses were analysed in this study out of the 170 distributed survey questionnaires. Almost two-fifths of the participants worked in a hospital (*n=63, 42.6%*). The gender distribution of the participating HCPs showed a slightly higher number of males (*n= 82, 55.4%*). The median age of the participants was 28 years, indicating that half of the individuals were younger than 28 years with an interquartile

range (IQR) of 3 years (27–30 years), representing the age range between the 25th percentile (27 years) and the 75th percentile (30 years).

Two-thirds of the study participants were midwives by profession (*n= 99, 66.9%*), while nearly three out of five of the study participants had work experience of more than five years (*n= 87, 58.8*%). There was high variation among individuals in the number of births attended per day by the health professionals, with an average of three births attended by HCPs daily, ranging from one to 12 births. One-third of the participants' primary work units were labour and birth (*n= 48, 32.4%*).

Almost half of the participants (*n=72, 48.6%)* did not receive any respectful maternity care-related awareness creation training, while two out of three participants reported that their health facility had respectful maternity care standards of care. Even though more than half of the participants reported that their health facilities have a legal redress system for complaints (*n= 77, 52.0%*), nearly half of the participants believe that women do not know about the presence of this redress system (*n= 37, 48.0%) (see* Table 5.1.).

Table 5.1: *Description of participants by demographics and service delivery characteristics, Western Ethiopia, 2022 (N=148)*

Characteristics	Frequency (%)
Health facility that they work	
Hospital	63 (42.57)
Health Centre	85 (57.43)
HCP's age (years): Median (IQR)	28 (27- 30)
HCP's gender	
Male	82 (55.41)
Female	65 (43.92)
Missing	1
Marital status	
Married	106 (71.62)
Single/separated/widowed	41 (27.70)
Missing	1
Religion of HCPs	
Protestant	108 (73.97)
Orthodox	26 (17.81)
Others (Muslim, Adventist, Wakeffata)	12(8.11)
Missing	2(1.35)
Ever had child	
Yes	101 (68.24)
No	47 (31.76)
Profession	
Midwife	99 (66.89)
Clinical Nurse	25 (16.89)
Obstetrician and Gynaecologist	10 (6.76)
Health officers	6 (4.05)
General practitioner	5 (3.38)
IESOs[4]	3 (2.03)
Work experiences	
Five years and less	61(41.22)
Above five years	87 (58.78)
Primary working unit	
Antenatal care (ANC)	51 (34.46)
Labour, birth (LB) and postnatal unit (PNC)	48 (32.43)
ANC, LB & PNC	49 (33.11)
Received RMC training	
Yes	76 (51.35)
No	72 (48.65)
Do health facility have specific RMC related policy	
Yes	95 (64.19)
No	53 (35.81)
Implementation of RMC standard in the facility	
Yes	82 (55.41)

[4] IESOs: Integrated Emergency Surgical Officers

Characteristics	Frequency (%)
No	66 (44.59)
Presence of redress system in the facility	
Yes	77 (52.03)
No	71 (47.97)
Women are aware of the presence of the redress (N= 77)	
Yes	40 (51.95)
No	37 (48.05)
Number of childbirths attended by HCPs/day: Mean (SD)	3 (±2)

Health care providers' perceptions of the working environment

Participants were asked to express their perception of a working environment, which could either be a health centre or a hospital. In response, 38 percent of participants strongly disagreed with the notion that the workload is not heavy. Approximately two-thirds of the participants (67%) also strongly disagreed with the notion relating to the adequacy of payment they receive relative to their workload. Another issue that reflects the perception providers have of their working conditions is the suitability of the working environment. More than one-third (37%) strongly disagreed regarding the appropriate structuring of the working environment, while another third (30%) of participants strongly disagreed with the availability of continuous professional development opportunities in the health system and the facility.

Furthermore, nearly one-third of participants strongly disagreed with the adequacy of the number of health care providers, the quality of health facilities' management support, the suitability of the unit where they work, the proportional size of the clients visiting the HF, the availability of continuous professional development opportunities and recognition and respect given for HCPs by managers. The overall mean score for perception of the working environment was 46.5, which ranged from 19 to 75, with a maximum possible score of 80 (see Table 5.2.).

Table 5.2: *Health care providers' perceptions of the work environment, East Wollega Zone, Western Ethiopia, 2022*

Items	Strongly disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly agree n (%)
Workload is not heavy	56(37.84)	33(22.30)	21(14.19)	22 (14.86)	16 (10.81)
Number of HCPs are adequate	45(30.41)	47(31.76)	18(12.16)	19(12.84)	19(12.84)
Number of clients that visit HF is not large	39(26.35)	37(25.00)	32(21.62)	24(16.22)	16(10.81)
HFs' management support is very good	47(31.76)	26(17.57)	30(20.27)	27(18.24)	18(12.16)
The unit where I work is structured in a suitable manner	56(37.84)	34(22.97)	27(18.24)	23(15.54)	8(5.41)
I am autonomous in accomplishing tasks and making decisions by myself	20(13.51)	24(16.22)	25(16.89)	41(27.70)	38(25.68)
The relation among HCPs is encouraging and welcoming	31(20.95)	23(15.54)	18(12.16)	45(30.41)	31(20.95)
The CPD opportunities are very good	45(30.41)	36(24.32)	27(18.24)	22 (14.86)	18(12.16)
There are equal and open (blame-free) communication and feedback	39(26.35)	35(23.65)	35(23.65)	23(15.54)	16(10.81)
The HCPs work in team respectfully for common goals	15(10.14)	16(10.81)	23(15.54)	55(37.16)	39(26.35)
Senior staffs (including physicians) respect junior staffs	18(12.16)	29(19.59)	21(14.19)	42(28.38)	38(25.68)
Women or attendants who come with clients treat HCPs with a respect	23(15.54)	22(14.86)	26(17.57)	45(30.41)	32(21.62)
The HF managers recognise staff's heavy duty, and they respect HCPs	42(28.38)	25(16.89)	31(20.95)	28(18.92)	22(14.86)
I am very happy with my profession	19(12.84)	13(8.780	11(7.43)	39(26.35)	66(44.59)
I am very satisfied in providing maternal health care	19(12.84)	10(6.76)	22(14.86)	44(29.73)	53(35.81)
The salary I receive is commensurate with the workload	100(67.57)	15(10.14)	15(10.14)	7(4.73)	11(7.43)
Overall perceptions of working environment (Mean= 46.06, SD=11.788)					
Negative perception (frequency (%))					71 (47.97)
Positive perception (frequency (%))					77 (52.03)

Health care providers' level of empathy

The overall sum score of the empathy level ranged from 68 to 138, with a mean empathy score of 105.66 (SD= 16.50). The mean item scores ranged from 3.66 for item number 18, "*I do not allow myself to be influenced by strong personal bonds between my patient and their family members*", to 6.0 for item number 5, "*I have a good sense of humour that I think contributes to better clinical outcome"*. The remaining indicators of empathy levels fell between these two extremes. The HCPs

demonstrated relatively encouraging levels in understanding patients' feelings, paying attention to patients' emotions, imagining themselves in their patients' shoes, and acknowledging the importance of empathy in patient treatment, as presented in Table 5.3.

Table 5.3: *Mean and standard deviation of health care provider empathy score, East Wollega Zone, Western Ethiopia, 2022 (N=148).*

Items	Mean	Std. dev.
My understanding of how my patients and their families feel does not influence treatment/care outcomes.	4.30	2.45
My patients feel better when I understand their feelings.	5.82	1.89
It is difficult for me to view things from my patients' perspectives.	4.84	2.20
I consider understanding my patients' body language as important as verbal communication in caregiver-patient relationships.	5.15	2.15
I have a good sense of humor that I think contributes to better clinical outcome.	6.02	1.63
Because people are different, it is difficult for me to see things from my patients' perspectives.	4.92	2.14
I try not to pay attention to my patients' emotions in history taking or in asking about their physical health.	5.82	2.06
Attentiveness to my patients' personal experiences doesn't influence treatment outcomes.	4.56	2.46
I try to imagine myself in my patients' shoes when providing care to them.	5.74	1.91
My patients value my understanding of their feelings which is therapeutic in its own right.	5.71	1.80
Patients' illnesses can be cured only by targeted treatment; therefore, my emotional ties to my patients do not have a significant influence in treatment outcomes.	5.16	2.38
Asking patients about what is happening in their lives is not helpful in understanding their physical complaints.	5.70	2.05
I try to understand what is going on in my patients' minds by paying attention to their nonverbal cues and body language.	5.26	2.11
I believe that emotion has no place in the treatment of medical illness.	5.94	1.85
Empathy is a therapeutic skill without which success in treatment/care is limited.	4.20	2.51
An important component of the relationship with my patient is my understanding of their emotional status, as well as that of their families.	5.70	1.88
I try to think like my patients in order to render better care.	5.49	2.07
I do not allow myself to be influenced by strong personal bonds between my patients and their family members.	3.57	2.32
I do not enjoy reading nonmedical literature or the arts.	5.41	2.10
I believe that empathy is an important factor in patients' treatment.	5.89	1.90
Overall Empathy score: Mean (SD)	105.66	16.50

Level of mistreatment of women reported by health care providers

Health care providers acknowledged the occurrence of mistreatment towards women in their health facilities. When asked about the treatment of women in a disrespectful manner in their facilities, 84% of the participants stated that women were treated this way '*a few times'*. Additionally, 72% reported witnessing women being treated in an unfriendly manner '*a few times*. Specific forms of mistreatment have also been reported as either witnessing other providers mistreating women or as self-committed, including verbal and physical abuse, provider prejudice, neglect, and abandonment.

For instance, half of the participants reported witnessing instances where other *HCPs* verbally abused women during maternity care. Furthermore, 49% of the participants reported observing at least one form of physical abuse, such as women being hit, pushed, or physically restrained. More than half (56%) of the *HCPs* reported witnessing differential care being practiced by others based on women's social attributes, 'a few times' or 'most of the time'. Neglect and abandonment were also reported, with 38 and 8% of participants stating that they had seen women being left alone or unattended 'a few times' and 'most of the time', respectively, as presented in Table 5.4.

Health care providers themselves admitted that they had mistreated women at some point in their care. Of the surveyed providers, 31% reported instances of verbally abusing women a few times during care provision, whereas the majority (64%) stated that they had never engaged in verbal abuse against women. Similarly, one-third of the providers (32%) reported that they had physically abused women during care provision. Additionally, 30% of the providers felt that they had treated women differentially on a few occasions without being aware of their bias.

Regarding the lack of privacy and confidentiality during care provision, more than half (55%) of the providers reported that they had never breached the privacy and confidentiality of women. However, providers reported feeling that they had breached privacy and confidentiality ‘a few times’ (30%), ‘most of the time’ (6%), and ‘all the time’ (9%). Health care providers also reported feeling that they violated women's autonomy, such as restricting their mobility without significant clinical indication and forcing them to stay in a health facility against their will. Overall, three out of four health care providers (n=112, 75.7%, 95% CI: [68.05 – 81.96]) reported mistreating women at least in one way or the other, including verbally, physically, discriminating against, violating their privacy and confidentiality, neglecting/abandoning, or restricting their autonomy, at least ‘a few times’ in their health facilities, as shown in Figure 5.1. and Table 5.4.

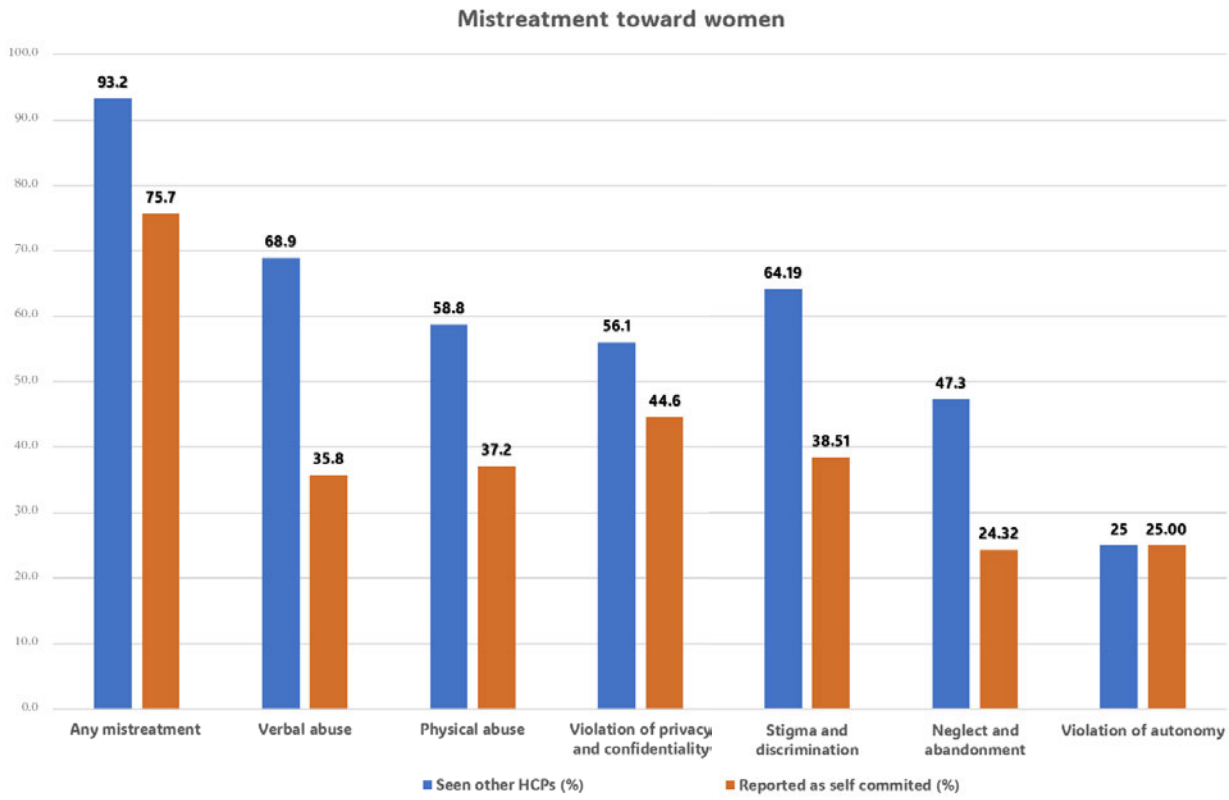

Figure 5.1: *Mistreatment toward women during maternity care: percentage of witnessed other HCPs mistreating women and self-committed at least few times (N=148)*

Table 5.4: *Health care providers' perspectives on the extent of mistreatment of women in their respective health facilities, East Wollega Zone, Western Ethiopia, 2022 (N=148).*

Construct	Questions	No, never, N (%)	Yes, a few times, N (%)	Yes, most of the time, N (%)	Yes, all the time, N (%)
Disrespectful and unfriendly care	*In your experience in your health facility, do Health Care providers (HCPs) treat women disrespectfully?*	*6 (4.06)*	*124 (83.78)*	*18(12.16)*	*0*
	Do HCPs at your health facility treat women in unfriendly manner?	*23 (15.54)*	*106 (71.62)*	*19 (12.84)*	*0*
Verbal abuse	*In your experience in this facility, do HCPs shout at, scold, insult, threaten or talk to women rudely?*	*72(48.65)*	*60 (40.54)*	*14 (9.46)*	*2 (1.35)*
	Do HCPs give negative comments about patients' or their baby's physical appearance (such as weight, private parts, sexual activity, cleanliness other aspects)?	*96 (64.86)*	*44 (29.73)*	*7 (4.73)*	*1 (0.68)*
	Do HCPs threaten women with any aspects (forcing to accept treatment they did not want, physical violence, withhold care, poor treatment outcome)?	*115 (77.70)*	*28 (18.92)*	*2 (1.35)*	*3 (2.03)*
	Do HCPs blame women for something that happened to them or their baby during their stay in the facility?	*74 (50.00)*	*50 (33.78)*	*11 (7.44)*	*13 (8.78)*
	In your experience at this facility, have you seen these happen?	*46 (31.08)*	*74 (50.00)*	*19 (12.84)*	*9 (6.08)*
	In your experience at this facility, have you ever verbally abused women?	*95 (64.19)*	*46 (31.08)*	*4 (2.70)*	*3 (2.03)*
Physical abuse	*Are women treated roughly like pushed, beaten, slapped, pinched, physically restrained, gagged, tied to bed when they are getting care in the health facility's team you serve?*	*109 (73.65)*	*33 (22.30)*	*2 (1.35)*	*4 (2.70)*
	Are women denied pain relief for any reason?	*89 60.14)*	*38 (25.67)*	*14 (9.46)*	*7 (4.73)*
	Do HCP in your facility practice fundal pressure during second stage of labour?	*71 (47.97)*	*64 (43.25)*	*9 (6.08)*	*4 (2.70)*
	In your experience at this facility, have you seen these happen?	*61 (41.22)*	*72 (48.65)*	*13 (8.78)*	*2 (1.35)*
	In your experience at this facility, have you ever done these physical abuses?	*93 (62.84)*	*48 (32.43)*	*6 (4.05)*	*1 (0.68)*

Stigma and Discrimination	*Will you say women are treated differently because of their personal attributes, like their age, marital status, number of children, education, wealth, ethnicity, their connections with the facility or things like that?*	*78 (52.70)*	*45 (30.41)*	*20 (13.51)*	*5 (3.38)*
	In your experience at this facility, have you seen when women are treated differently because of any their attributes listed above in your facility by other HCPs?	*53 (35.80)*	*68 (45.95)*	*15 (10.14)*	*12 (8.11)*
	Do you think you treat women differently based on some attributes like their education, wealth, ethnicity, age, marital status, their connections with the facility or things like that without being aware of it?	*91 (61.49)*	*44 (29.73)*	*8 (5.41)*	*5 (3.38)*
Violations of privacy, consented care and confidentiality	*During examinations in the health facility team you work, women are not covered up with a cloth or blanket or screened with a curtain so that they do not feel exposed?*	*80 (54.05)*	*40 (27.03)*	*12 (8.11)*	*16 (10.81)*
	HCPs do not ask women's permission before performing any examination? (eg. Abdominal or vaginal exam)	*59 (39.86)*	*40 (27.03)*	*21 (14.19)*	*28 (18.92)*
	HCPs do not explain to women why a procedure is done (eg. Abdominal or vaginal examination)?	*61 (41.22)*	*58 (39.19)*	*13 (8.78)*	*16 (10.81)*
	Do HCPs speak to women as load as other people not involved in their care can hear what they are discussing?	*78 (52.70)*	*50 (33.78)*	*15 (10.14)*	*5 (3.38)*
	Do you feel like women's health information is not kept confidential at this facility by other HCPs?	*65 (43.92)*	*59 (39.86)*	*20 (13.51)*	*4 (2.71)*
	In your experience at this facility, have you ever felt that you did not keep privacy and confidentiality of the client?	*82 (55.41)*	*44 (29.73)*	*9 6.08)*	*13 (8.78)*
Neglect and abandonment	*Do HCPs ignore women, refuse their request of help, or fail to respond to requests of help in a reasonable amount of time?*	*80 (54.05)*	*58 (39.19)*	*9 (6.08)*	*1 (0.68)*
	Do HCPs discourage a mother's companion to remain with her, whenever possible?	*85 (57.43)*	*45 (30.41)*	*13 (8.78)*	*5 (3.38)*
	In your experience at this facility, have you seen when women have been left alone or unattended by other HCPs?	*78 (52.70)*	*57 (38.51)*	*12 (8.11)*	*1 (0.68)*
	Do you feel you personally ignored women and left them unattended?	*112 (75.68)*	*27 (18.24)*	*7 (4.73)*	*2 (1.35)*
Loss of autonomy (detention)	*Do women instructed not to walk or move around during labour, not to eat without any clinical significance?*	*103 (69.59)*	*35 (23.65)*	*7 (4.73)*	*3 (2.03)*

	Are women forced to stay at the health facility against their will because they cannot pay?	*130 (87.84)*	*13 (8.78)*	*5 (3.38)*	*0*
	In your experience at this facility, have you seen when women's autonomy is violated by other HCPs as mentioned above?	*111 (75.00)*	*32 (21.62)*	*3 (2.03)*	*2 (1.35)*
	In your experience at this facility, have you ever felt that you violated women's autonomy that mentioned above?	*113 (76.35)*	*30 (20.95)*	*2 (1.35)*	*2 (1.35)*

Factors associated with self-reported mistreatment of women

The effects of *HCPs'* empathy levels and perceptions of the working environment were assessed using a multivariable logistic regression model. This assessment controlled for the effects of other variables, such as HCPs' age, gender, profession, years of experience, average number of childbirth attendances per day, and the type of health facility where they work. As presented in Table 5, health HCPs of their working environments, empathy score, and the interaction between gender and profession were statistically significantly associated with self-reported mistreatment of women.

The results of the multivariable logistic regression analysis showed that the likelihood of *HCPs* mistreating women during maternity care decreases based on the HCPs' positive perception of their working environment and their level of empathy. The odds of mistreating women decreased by 65%among providers who reported a positive perception of their working environment compared to those who viewed their working environment negatively (AOR= 0.35, 95% CI: [0.14, 0.86]). Similarly, a one-unit increase in HCPs' empathy score was associated with a 5% decrease in the odds of mistreatment of women during maternity care (AOR= 0.95, 95% CI: [0.91, 0.98]). Another factor found to be associated with self-reported mistreatment was the interaction of gender and the profession of the providers. The likelihood of mistreating women was found to be almost four times higher among male midwives than among female midwives (AOR= 3.73, 95% CI: [1.25, 11.20]) (Table 5.5.).

Table 5.5: *Factors associated with self-reported mistreatment of women by HCPs in Western Ethiopia and binary logistic regression model (N=146).*

Variables	COR [95% CI]	AOR [95% CI]	P values
Perceptions of working environment			
Negative	Reference	Reference	-
Positive	0.47 [0.21, 0.98]	0.35[0.14, 0.86]	0.023
Empathy score	0.96[0.93, 0.99]	0.95[0.91, 0.98]	0.008
Health facility type			
Hospital	Reference	Reference	-
Health centre	1.06[0.49-2.28]	1.49[0.58, 3.86]	0.406
Age in years			
23-29	Reference	Reference	
30 and above	1.15 [0.53, 2.52]	1.83[.74, 4.51]	0.188
Experience in years			
Five years and less	Reference	Reference	
Above five years	0.80 [0.37, 1.76]	0.65[0.25, 1.74]	0.398
Profession and gender*			
Female midwives	Reference	Reference	-
Male midwives	3.01[1.12, 8.14]	3.73[1.25, 11.20]	0.019
Female other profs	2.06[0.51, 8.31]	2.67[0.60, 11.98]	0.198
Male other profs	1.60[0.60, 4.32]	2.26[0.73, 6.98]	0.158
Average number of childbirths attended per day	0.98 [0.82, 1.17	0.98 [.80, 1.22]	0.919

5.5. Discussion

In this paper, we report on the mistreatment towards women by HCPs, encompassing instances of witnessing colleagues' mistreatment and self-admitted mistreatment towards women. A significant portion of providers, approximately three out of four, acknowledge engaging in mistreatment of women during care provision. Notably, our findings highlight an association between positive perceptions of the working environment, higher empathy

levels, and a reduced likelihood of mistreatment towards women. Furthermore, we identified the presence of disparities in the reported mistreatment toward women based on the interaction between profession and gender, with male midwives exhibiting higher odds of mistreatment than female midwives. These findings collectively contribute to a comprehensive understanding of the factors that contribute to the reduction of mistreatment in women within health care settings.

In this study, HCPs reported witnessing a higher proportion of mistreatment from other providers towards women than that they have self-reported. A significant majority of providers (93.2%) reported that they had observed other providers mistreating women, including verbal or physical abuse, privacy or confidentiality breaches, discrimination, neglect, and autonomy violations. However, fewer HCPs admitted to mistreating women themselves (75.7%), possibly attributed to a social desirability bias arising from a motivation to maintain a positive self-concept or to avoid potential embarrassment and repercussions linked to revealing their own involvement in disrespectful care (Tourangeau et al., 2007). Nonetheless, the extent of self-reported mistreatment toward women in this study was still higher compared to that reported in another study conducted in Ethiopia, despite differences in the tools and measurement methods used (Asefa et al., 2018). Self-reported physical abuse toward women (35.8%) was relatively lower than that reported in Kenya by Afulani et al. (2020) (45%) and comparable to self-reported verbal abuse in the same study and a study from Ghana (Moyer et al., 2021). Acknowledging the presence of such self-reported mistreatment towards women and recognising its detrimental impact imply that there is an opportunity to enhance the behaviours of service providers for the better.

A positive working environment is crucial for achieving organisational goals by enhancing employee commitment and their drive to achieve (Zhenjing et al., 2022). In this study, HCPs with positive perceptions towards their working environment conditions, including workload, adequacy of provider numbers, trust, teamwork, and supportive relationships with leaders, among other indicators of perception, were found to be associated with a two-thirds (65%) reduction in the likelihood of mistreatment occurrence compared to those with negative perceptions. Such an influence of a positive working environment was also highlighted in a previous qualitative study that focused on complex adaptive maternity care (Asefa et al., 2020a). The absence of a positive working environment was found to contribute to disrespectful care, impacting HCPs' motivation to implement respectful care. Similarly, instances where HCPs feel overlooked, lack support from the system, and work in a poor organisational climate marked by blame-shifting and the normalisation of mistreatment are identified as challenges to achieving respectful working environments (Nouri et al., 2019). It is valuable to recognise the significance of establishing a positive working environment to foster health facilities where a culture of respect and quality is ingrained.

Similar to a positive working environment, the empathy level of HCPs was also found to be correlated with mistreatment toward women. This study demonstrated that even a unit increase in HCPs' empathy leads to a five per cent decrease in the likelihood of mistreatment. Despite the challenge of nurturing empathy in a fragile workplace, it remains well established that higher empathy among HCPs enhances efficiency and is linked to more respectful care (Moudatsou et al., 2020). The origins of low empathy, whether inherent before joining the profession or as a result of a demanding environment,

are uncertain. However, solutions such as early-career empathy training (Williams et al., 2015) or in-service programs (Hurissa et al., 2023) were reported to elevate empathy levels. Notably, countries such as Germany recommend selecting students based on empathy to embed this competency (Kötter et al., 2022). Overall, promoting enhanced empathy holds undeniable importance in the ongoing effort to reduce mistreatment of women during maternity care.

The disparity in empathy levels among HCPs based on gender has been documented in previous studies, with females exhibiting higher levels of empathy (Surchat et al., 2022). In the current study, we did not find an interaction effect between empathy levels and gender on the mistreatment of women. Nevertheless, there was a noticeable difference in self-reported mistreatment toward women between male and female midwives: the likelihood of mistreating women was found to be four times higher among male midwives than among female midwives. It is worth noting that there are relatively comparable numbers of male and female midwives in Ethiopia, unlike in other parts of the world.

Health care providers in low resource countries, including Ethiopia, face challenges originating from the country's income status, administrative issues, and broader health system commitment (World Health Organization, 2016b). In addition to such resource related chronic issues, maternity service provision is documented to be filled with dilemmas and stress-inducing environments related to individual, interpersonal and institutional factors (Getahun et al., 2023). In the current study, HCPs reported issues such as, heavy workloads, reduced professional development opportunities, inadequate compensation, and dissatisfaction, contributing to providers to acquire negative perceptions which impacted upon their empathy levels. This underscores the need for a

comprehensive examination of factors affecting satisfactory working conditions. Therefore, we recommend the Ethiopian Ministry of Health and Oromia Regional Health Bureau to commits to implementing the planned Health Sector Transformation Plan II (Ministry of Health, 2021b) where job fairness, emotional wellbeing of providers and collaborative team efforts towards common goals are maintained through continuous monitoring and non-tolerance of instances of mistreatment. In addition to addressing resource-related constraints, it is essential not to overlook the importance of transforming HCPs' values and attitudes towards respectful maternity care through continuing professional development learning opportunities. Alternative measures like recruiting pre-motivated and empathic individuals toward training institution and also building empathy levels through in-service capacity building could be also practiced (Hurissa et al., 2023).

It is important to acknowledge the limitations in this study, where a high sample of participants could have enhanced the power of the study. Despite the efforts to increase the number of participants, some potential participants did not return completed surveys, and regional unrest hindered the inclusion of further HCPs from certain districts in the zone. Nevertheless, this study serves as driving evidence for the necessity of a detailed nationwide study on the impact of negative workplaces and reduced empathy in normalising mistreatment of women in health care facilities. The self-administered data collection method may have led to reporting bias due to social desirability, impacting completed survey rates. Still, the results are encouraging, with a significant number of providers acknowledging the presence of mistreatment towards women both from their personal perspective and based on what they have observed among their colleagues.

5.6. Conclusions

A substantial proportion of HCPs, comprising three-quarters of participants, acknowledged that they have engaged in mistreatment of women at least a few times in various ways during their practice. Recognising the importance of cultivating a positive working environment within health facilities, where a culture of respect and quality is deeply rooted, holds great value to reduce the occurrences of mistreatment of women in health facilities during maternity care. Efforts of enhancing positive workplace, the promotion of heightened empathy remains crucial in the ongoing endeavour to mitigate mistreatment of women during maternity care. Further investigation is warranted to delve deeper into the underlying drivers that contribute to the observed connections between gender, profession, and the probability of mistreatment towards women in the study area.

5.7. Summary

In summary, this chapter presented the survey conducted among healthcare providers regarding their perceptions of mistreatment towards women in their respective health facilities—relating it with their working environment perceptions and empathy levels. The next chapter delves into the qualitative findings.

CHAPTER 6: QUALITATIVE FINDINGS—WOMEN'S PERSPECTIVES

6.1. Chapter preface

This Chapter presents the qualitative part of the study. The women's narratives regarding the mistreatment they have experienced during maternity care, their perception regarding drivers of the mistreatment and the consequences of these mistreatment were explored. Based on the Socioecological Framework for the Violence against Women and WHO Quality of Care Framework were used to analyse the findings following thematic analysis of the in-depth interview data. Overall, two broader categories of mistreatment were identified—the mistreatment in the process of care and the interpersonal abuse during maternity care. These findings are presented as a published journal article in PLoS One Journal.

> Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. (2024b). Women's narratives of experiences, drivers and consequences of mistreatment during maternity care in western Ethiopia. *PloS one*, *19*(12), e0313217. https://doi.org/10.1371/journal.pone.0313217.

Abstract

Background: The mistreatment of women during maternity care hinders quality care globally and deter women from seeking health services. To implement necessary actions, it is essential to explore instances of mistreatment, their factors and negative outcomes.

This study explores the narratives of mistreatment experienced by women, its drivers e, as well as the consequences of mistreatment.

Methods: We conducted a descriptive qualitative study among women who had received maternity care from East Wollega Zone, Ethiopia. Data were obtained through in-depth interviews with purposively selected participants in Afan Oromo, each lasting, on average, 30 to 60 minutes. Interviews were conducted within three months of childbirth and discontinued upon reaching data saturation at seventeen interviews. All interviews were audio recorded, transcribed, translated into English, coded using NVivo 12 and analysed through thematic and framework analysis.

Results: Three main themes were identified in this study: experiences, drivers, and consequences of mistreatment of women during maternity care. The narratives of mistreatment fell into two sub-themes: interpersonal abuse and mistreatment in the process of care. Women described experiencing physical and verbal abuse, stigma, and discrimination, as well as neglect and abandonment, violations of privacy and confidentiality, and health facility failures related to resource limitations. These forms of mistreatment were perceived to arise from a complex interaction of factors at an individual, interpersonal, and facility level, as well as broader health system and societal norms, such as gender inequality. The identified consequences of mistreatment included fear of future childbirth, negative perceptions towards health facilities and healthcare providers, switching to home birth, and psychological stress.

Conclusions: This qualitative study presents women's first-hand experiences of mistreatment in health facilities, highlighting various forms stemming from interpersonal interactions and systemic deficiencies in care quality. These experiences lead to

significant negative consequences and implications on service delivery. The findings underscore the importance of understanding the complex factors driving mistreatment, extending beyond individual healthcare providers' behaviours to macro-level health system issues and general violence against women in society. This emphasises the importance of applying a systems-thinking approach to address the abuse and suffering women experience during maternity care in health facilities.

Keywords: Mistreatment of women, Violence against women, Socioecological framework, Quality of care, Qualitative Study, Framework analysis, Thematic analysis, Ethiopia

6.2. Introduction

In recent decades, a significant shift has transpired in the discourse regarding the mistreatment of women and the quality of maternal health services instigated by pivotal research and international initiatives (Bohren et al., 2015; Bowser et al., 2010; White Ribbon Alliance, 2011). Bowser and Hill's (2010) global investigation, the establishment of the Respectful Maternity Care (RMC) Charter by the White Ribbon Alliance (White Ribbon Alliance, 2011), and the World Health Organization's (WHO) condemnation of disrespect and abuse (World Health Organization, 2014), all signal a marked focus on systemic drivers of mistreatment of women experienced in childbearing and integration of RMC in WHO guidelines for positive childbirth experiences (World Health Organization, 2018b). Despite these activisms against the mistreatment of women during maternity care in health facilities, it remains a pervasive global issue for women (Bohren et al., 2019b).

Any childbearing woman can experience mistreatment when using health services (World Health Organization, 2014) and has been reported to affect up to 44% of women in Sub-Saharan Africa (Kassa et al., 2020), two out of every five women in Latin America (Tobasía-Hege et al., 2019), every five women in Europe (Lukasse et al., 2015), every six women in the United States of America (Vedam et al., 2019), and every ten women in Australia (Keedle et al., 2024). The widespread mistreatment of women highlights the urgent need for targeted interventions at individual and systemic levels. Focusing exclusively on system-level improvements risks overlooking the essential role of personal accountability in ensuring respectful care (Jewkes et al., 2015). Addressing and eliminating the mistreatment of women in maternity services requires a multifaceted approach involving systemic changes, policy interventions, and a cultural shift (Kasaye et al., 2023). Indeed, this underscores the requirement for individual health services to examine the unique contextual factors influencing instances of mistreatment within their respective settings (Jewkes et al., 2015). This paper focuses on the issue of mistreatment of women during maternity care, with a specific emphasis on its occurrence and consequences in Ethiopia.

In Ethiopia, the prevalent mistreatment of women during maternity care, which ranges from 2.0% to 79.0% (Kassa et al., 2019), undermines the national commitment to reducing maternal mortality (Ministry of Health, 2021b) by impeding the quality of essential, safe and respectful maternity care and potentially deterring women from seeking health services (Ababor et al., 2019; Kasaye et al., 2024b). Prior research in this domain has primarily concentrated on gaining insight through quantifying women's subjective experiences (Bobo et al., 2019; Hagaman et al., 2022). To understand its

nature, origins, and consequences comprehensively, it is crucial to consider how women describe their experiences throughout the entire continuum of maternity care rather than focusing solely on childbirth. Despite the essentiality and significance of women's perspectives, there needs to be an adequate exploration of the drivers of mistreatment beyond the level of the individual and the consequences of the mistreatment of women.

Given the nuanced and multifaceted nature of mistreatment, comprehensive research must now encompass all relevant stakeholders, including women, healthcare providers, senior management of healthcare facilities and the community at large (Savage et al., 2017). To present this comprehensive perspective in a manner that centres women's experience without attributing blame to any complex and context-specific group(Bohren et al., 2018), we adopted the term 'mistreatment of women' as well as in other publications that explore different facets of the mistreatment of women (Kasaye et al., 2024a, 2024b). Employing a qualitative design, this paper presents the findings of women's expectations of healthcare facilities, experiences of mistreatment, the underlying drivers, and perceived consequences. These insights were analysed using thematic analysis and deductively by integrating the Socioecological Framework for violence against women (Heise, 1998) and WHO quality of care frameworks (Tuncalp et al., 2015).

6.3. Methods

Study context, design and frameworks

This paper presents the qualitative segment of a broader research inquiry that investigated the mistreatment of childbearing women in Ethiopia. As part of a nested convergent mixed-method approach, a qualitative study was conducted in East Wollega

Zone, Oromia Regional State, Western Ethiopia, from September 2022 to December 2022. This region in Ethiopia is characterised by diverse Agro-ecological zones and a geographically challenging topography (Daba, 2018), impacting the availability and access to health infrastructure, particularly for rural people, where nearly 83% of the population is projected to live in rural areas in 2022 (Central Statistical Agency, 2013), with an estimated 1.80 million people in East Wollega Zone in 2022, representing 4.5% of the regional and 1.7% of the national population (Central Statistical Agency, 2013, 2022).

Oromia region has shown subpar performance in maternal and child health, as evidenced by statistics indicating that only 71% of pregnant women receiving antenatal, 44% of births were attended by skilled attendants, which mainly comprised of midwives both at health centres and hospitals, and 56% of women giving birth without the assistance of midwives or other trained birth attendants (Ethiopian Public Health Institute, 2021). Although zonal-level data was not publicly available, regional data shows that the area has the third-highest total fertility rate in the country, with 5.4 births per woman and an average household size of 5.2 people. In 2022, an estimated 3.9 million live births occurred in the country, with approximately 54,000 occurring in the East Wollega Zone (Centeral Statistical Agency, 2017; Ethiopian Public Health Institute, 2021). Of these, around 23,760 births took place in health facilities, with an annual average of 3,264 at Nekemte Specialised Hospital and 3,072 at Wollega University Referral Hospital, while the rest occurred at three district hospitals and 68 health centres (Ministry of Health, 2023). In our study, the majority of births (78.4%) occurred in a hospital, with 15.3% taking place in health centres and 1.7% in private clinics (Kasaye et al., 2024b).

Mistreatment during childbirth is conceptualised in this study as it parallels the violence against women in the community, emphasising the seriousness of the issue, particularly within the context of a critical period in a woman's life—pregnancy and birth (Jewkes et al., 2015). This framing positions mistreatment as actions or behaviours that inflict physical, emotional, or psychological harm and violations of the dignity and rights of women (World Health Organization, 2014). Woman-centred principles underpin the examination of the mistreatment of women and mandate that maternity care provision is both respectful and safe (World Health Organization, 2018b).

To explore how mistreatment arises from both abusive actions by healthcare providers and systemic failures in maternity care, we drew upon two conceptual frameworks: The Integrated Socioecological Framework for Violence Against Women (Heise, 1998) and the WHO Quality of Care Framework (Tuncalp et al., 2015). Both tools were used to understand the complex interplay of individual, interpersonal, community, and societal factors of the mistreatment of women in health facilities, and the rationale for selecting these frameworks are discussed in further details below.

Socioecological Framework of Violence Against Women

Mistreatment of women within the context of childbearing is challenging to investigate because of the numerous external factors beyond an individual woman's immediate context that indirectly influence an individual's experiences of pregnancy, birth and early mothering (Savage et al., 2017). Investigating a complex phenomenon using a concept that involves an interplay of various levels allows for a comprehensive understanding of the multifaceted factors contributing to the phenomenon and recognises the interconnectedness and mutual influence among the different levels (Asefa et al., 2020a).

The Socioecological Framework of Violence Against Women conceptualises violence against women as an interplay of various levels of influence, these being personal history, microsystem/interpersonal, mesosystem (health facilities), exo-system/health system, and macrosystem/societal domains (Heise, 1998). Figure 6.1 presents a pictorial representation of this framework. Adopting the Socioecological Framework enables a holistic perspective that recognises the multifaceted nature of mistreatment across health system, community, health facility, interpersonal, and individual levels. This framework facilitates the identification of drivers of mistreatment, contributing to the development of multifaceted interventions at various levels.

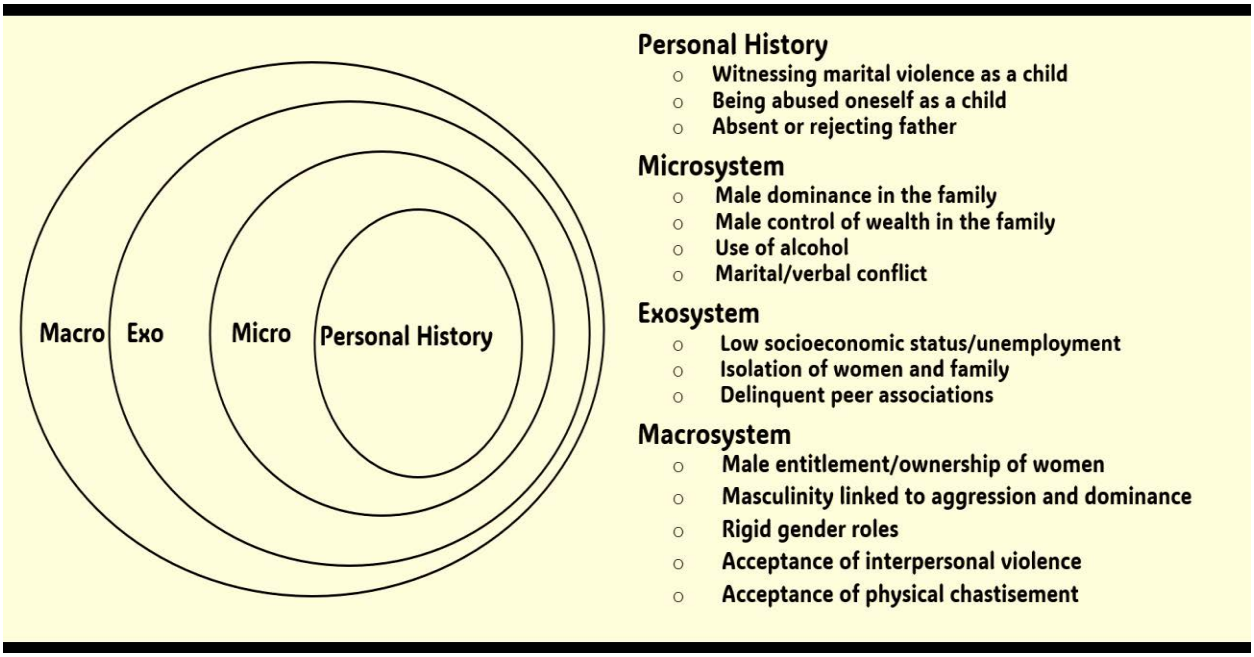

Figure 6.1: *Socioecological framework for the violence against women (Heise,1998)*

WHO's Quality of Care Framework

The WHO Quality of Care Framework conceptualises that the quality of healthcare for women and their babies emanates from structural and content conditions of the health system (Tuncalp et al., 2015). This framework is depicted in Figure 6.2.which is produced

from Tuncalp et al. (2015) allows for evaluating of the quality of women's and newborn healthcare services by emphasising safe and evidence-based woman-centred practices. Its relevance to mistreatment lies in its direct linkage of a woman's care experience to the care provided, positioning mistreatment as a potential outcome of engaging with health services (Tuncalp et al., 2015).

The Socioecological Framework provides a broader societal context for understanding violence, presenting the ways social structures, institutions, and interactions contribute to violent behaviour. In contrast, yet complementing the Socioecological Framework, the WHO Quality of Care Framework focuses more specifically on the organisational and structural aspects of healthcare, such as the process of care and desired health outcomes, ensuring a focus on evidence-based practices, safety, woman-centred care, timely access, and equitable delivery. The framework we developed by integrating these two frameworks is visually presented in the results section (Figure 6.3), with the corresponding findings detailed in each part.

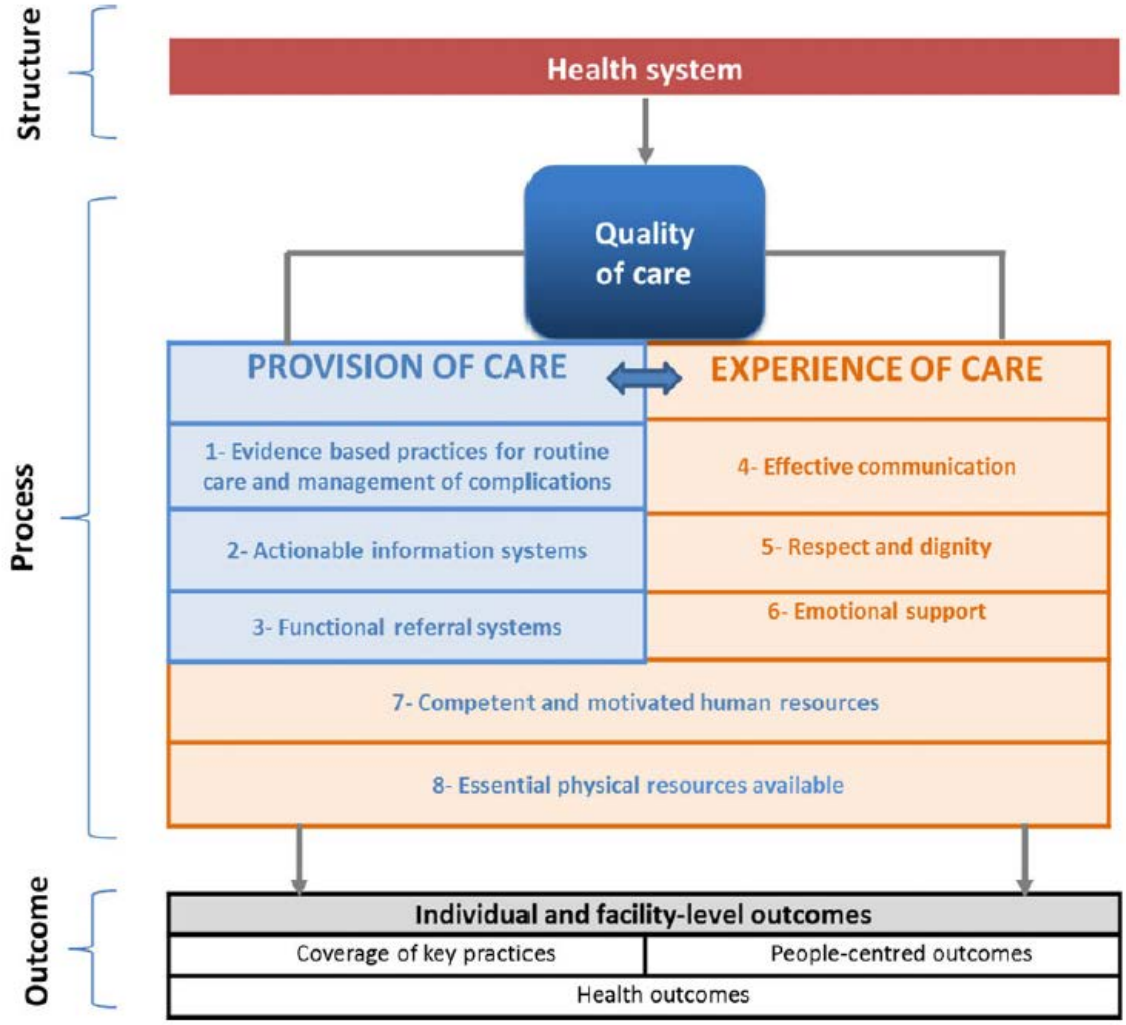

Figure 6.2: WHO Quality of Care Framework for maternal and newborn health

Recruitment and sampling

The qualitative data collection involved purposively selected participants from the quantitative phase of the larger study, conducted within three months of birth (Kasaye et al., 2024b). The participants had received at least one component of the continuum of care—antenatal, birth, or postnatal care. Healthcare providers were also interviewed; however, their results have been compiled in a separate report and are not included in this manuscript. Participants included women from diverse backgrounds (rural and urban

settings, younger and older, multiparous and primiparous) who were recruited and interviewed to provide a thorough understanding of the phenomenon. Telephone interviews were conducted at mutually agreeable times and were chosen due to the large geographical area and the ongoing civil conflict in Ethiopia. Data collection ceased after seventeen interviews when data saturation was reached, as no new insights emerged from adding further participants.

Data collection instruments

A semi-structured interview guide, aligned with the research aims, was formulated to elicit detailed insights from participants concerning the mistreatment of women, its drivers, and the consequences of mistreatment. The interview guide for both the women and healthcare professionals comprised of four domains focusing on (1) expectations from healthcare facilities during maternity care; (2) experiences and perceptions of mistreatment from healthcare providers in recent maternity care; (3) perceived factors influencing mistreatment; and (4) potential impacts of mistreatment on service utilisation.

Data collection procedures

Interview participants were informed of the voluntary nature of their participation, provided with a participant information sheet, and requested to complete consent forms if they wished to participate. Assurances of confidentiality were given, emphasising their ability to terminate the interview at any point without repercussions. Participants were also informed that the study's researchers were independent of healthcare facilities, and theirparticipation would not impact their healthcare utilisation. HK conducted in-depth interviews with women; all interviews were conducted in the Afan Oromo language. HK speaks the same language as participants, is part of their ethnic group, and deeply

understands the local service delivery system and the sociocultural context. HK was a PhD student at the time of data collection, trained in qualitative research under the supervision of experienced qualitative researchers (KB, VS and AS). Following data collection, the audio-recorded data were transcribed and translated into English to analyse and report the findings in collaboration with English-speaking authors (KB, VS, and AS). On average, each interview lasted between 30 and 60 minutes.

Data analysis

This study was analysed thematically using the Braun and Clarke data analysis framework (Braun et al., 2006). Thematic analysis is an inherently flexible method and is useful for identifying key themes, richly describing large bodies of qualitative data and highlighting similarities and differences in experience (Braun et al., 2006, 2021). The themes were then guided by the above-mentioned frameworks.

The interviews were transcribed verbatim into Afan Oromo and then translated into English for further analysis. The transcripts were read in their entirety whilst listening to the audio recordings to check for accuracy and begin comprehending and understanding this large data set. Line-by-line coding of the transcripts was conducted on sub-samples exported to the qualitative data management program NVivo (Version 12.) for coding. Descriptive coding, in-vivo and process coding of the participants' data were performed to the development of initial coding as recommended by Saldaña (Saldaña, 2021). The inductive themes identified from the data and deductive analytic approaches from the interview guide were employed. Hence, the parts related to the mistreatment experiences employed descriptive analysis, while the Socioecological Framework for Violence Against

Women(Heise, 1998) was used to explore the perceived drivers of mistreatment in health facilities.

Reflexivity

The primary researcher is a midwifery lecturer at the public university within the study area, with over a decade of midwifery experience. The supervisors are also academic supervisors in midwifery but are outsiders to the study context, having no prior exposure to the study area or its participants. The primary author conducted this research as part of his PhD studies in Midwifery. None of the participants had a prior relationship with the interviewer, the primary author. Participants were made aware of the purpose of the research and that their responses would be kept confidential before the interviews commenced.

The study took place during a period of civil unrest in the area, significantly impacting the conditions for research. The security situation posed serious challenges, making it difficult to move freely between districts and execute the study as initially planned, especially in engaging participants from rural areas. This contributed to the decision to perform the interviews over the phone for safety reasons, and this methodological adaptation raises awareness of potential limitations, such as the reduced capacity to capture non-verbal cues. This shift prompts reflection on the balance between accessibility and nuanced data collection in challenging contexts.

While conducting this study, even though the researcher perceives the presence of contributing health system and individual factors in the area as an insider, the primary author and the rest of the research team firmly believe there should be no justification for

instances of mistreatment. It is not something we should tolerate; instead, it requires collaborative efforts from all local and international actors.

Ethics approval and consent to participants

All participants were provided with information regarding the study in their preferred language to enable understanding. Participants were given sufficient time to ask questions and reflect on the information provided. Written informed consent was received from each participant, and they were informed that they were free to discontinue or withdraw from the study without any negative consequences. Ethical approval was granted from the local Institutional Review Committee in Ethiopia, Wollega University, and the Human Research Ethics Committee at the University of Technology Sydney, with the approval number of UTS HREC REF NO. ETH21-6587.

This study was reported in accordance with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

6.4. Results

Overview

Overall, seventeen in-depth interviews were conducted with women. The women's ages ranged from 20 to 33 years, including primiparous and multiparous women (2 to 4 births) and were from three districts (Nekemte, Diga and Wayyu Tuka) (Table 6.1.).

Table 6.1: Demographic characteristics of the women who participated in the in-depth interview (n=17)

	Categories	Frequency (%)
Age	18-24	4(23.5)
	25-29	7(41.2)
	30 and older	6(35.3)
Educational status	Primary	4(23.5)
	Secondary	6(35.3)
	College and higher	7(41.2)
Parity	Primiparous	8(47.1)
	Multiparous	9(52.9)

Data analysis resulted in three broader themes: experiences of mistreatment, perceived drivers, and consequences of mistreatment in health facilities. Codes under the themes of experiences of mistreatment were organised into categories aligned with the WHO's typology of mistreatment (Bohren et al., 2015), such as verbal and physical abuse, stigma, and discrimination—classified as interpersonal abuse within the Socioecological Framework (Heise, 1998). Other categories including privacy violation, poor rapport, neglect and abandonment, and health facility/system constraints grouped under the mistreatment in the care process, aligning with the broader Quality of Care Framework (Tuncalp et al., 2015).The drivers of mistreatment and the consequences of mistreatment were similarly Developed, with drivers analysed across individuals, interpersonal, health facility, health system, and societal levels. Overall findings are presented within an

integrated conceptual framework combining the Socioecological and the WHO's Quality of Care Frameworks, as illustrated in Figure 6.3..

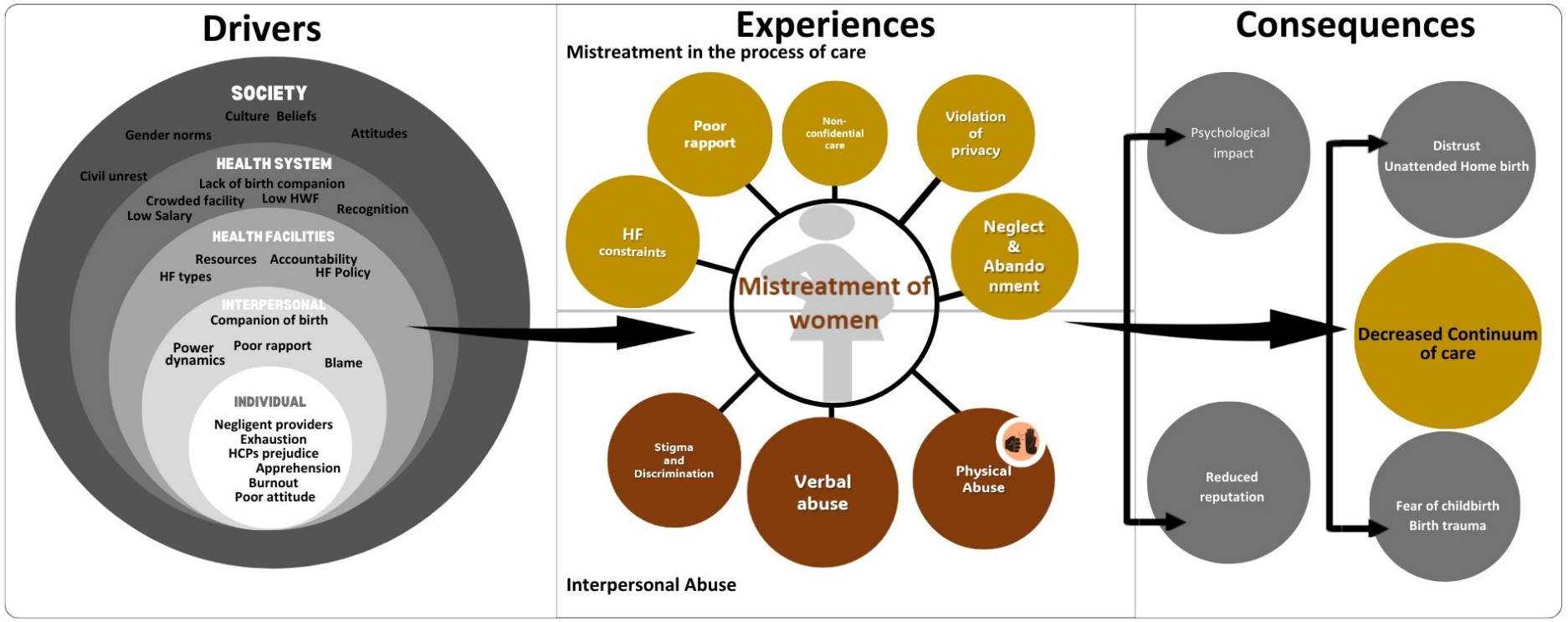

Figure 6.3: *Framework illustrating the mistreatment of women during maternity care, synthesised by integrating components from the Socioecological (Heise, 1998) and WHO Quality of Care Frameworks (Tunçalp, 2015).*

Narratives of mistreatment experienced

To understand women's experiences in health facilities, women were asked about their initial expectations from health facilities and what they found during their maternity care. Participants disclosed that all they required from both health facilities and healthcare providers was to obtain quality services that consider their psychological well-being aligning with health facilities' mission— "*initial promises*", as they expressed. For instance, while describing the services that women or the community require from health institutions and professionals, the following interview participant said:

> "*…What I mean is, irrespective of a person's circumstances, it would be nice if they greeted people with a friendly demeanour. It would be ideal if health care providers understood what patients are going through and treated them with the same warmth and empathy, in support of their mental wellness."* [IDI-WP-09]

The participants also emphasised the importance of receiving quality care, care that maintained professional, solid ethics. The experiences during antenatal care and private clinic were described as *"respectful"* and *"caring".* While describing the behaviours of health care providers, a 20-year-old primiparous woman referred to antenatal care service providers as *"courteous"* and mentioned them as an example of polite, well-mannered providers:

> *"…Um, I think... if they assist people in a good way instead of treating people disrespectfully, the women who come there are like their mothers and sisters, and they should be treated with kindness… yea, like the place where we received*

antenatal care, they were very helpful. We are very grateful to them; they were very courteous." [IDI-WP-08]

One woman who switched from a public hospital to private care due to her past negative experiences described her experience at the private clinic as excellent. She expressed it as follows:

"I opted for private care for birth because of the bad history I had previously. In the private facility, they have taken excellent care of me, provided medication, and ensured a smooth birth. After giving birth, they continued to care for my baby." [IDI-WP-06]

Categories of Mistreatment Experienced by Women

As participants shared their expectations and positive experiences with healthcare providers and facilities, the topic of mistreatment emerged spontaneously. Participants described the negative experiences they had encountered, witnessed, or heard about either secondary to interpersonal abuse or lack of quality of care during the care process, as presented accordingly in the following section.

Interpersonal abuses

Physical Abuse

Women participants raised concerns about physical abuse, describing instances where they had observed healthcare providers resorted to hitting women during childbirth due to perceived non-compliance. Participants also highlighted encountering painful procedures as a result of receiving pain-relieving analgesics or anaesthesia, as well as forceful shoving. While sharing her negative experience, a 20-year-old woman described

the behaviour of a healthcare provider who assisted in her birth, stating, *"She hit my thighs"* and "*tossed me back and forth."*.

> *"When she assisted with my birth, she hit my thighs with her hands and tossed me back and forth on the bed. She had the practice students take turns watching me. She told me that my baby was distressed and cut my body [episiotomy]. But she got up and moved away from me; she didn't seem to be trying to save my distressed baby. … she stepped away from me and said, 'Finish screaming first!'."* [IDI-WP-08]

Furthermore, instances of forceful pushing, hitting, or pinching with forceps during the second stage of labour were reported, either from personal experience or witnessing another woman being hit. One participant stated, *"They hit you with scissors"* and *"pinch you,"* and mentioned that she had personally experienced being struck by a healthcare provider [IDI-WP-06].

Even when it might not be intended to cause harm, forceful pushing and aggressively placing a woman's legs apart have been reported in situations where a woman did not comply with the orders given by health care providers. When asked if she had experienced anger or any physical aggression from healthcare providers, one participant described the situation as follows:

> *"If you scream or try to lift your legs from where they have positioned them, they will forcefully push your legs back down. This was clearly obvious."* [IDI-WP-02]

Lack of provision of local anaesthetic during perineal incision for episiotomy, as well as the omission of other forms of pain-relieving agents during instrumental birth and uterine

wiping, were reported to cause excruciating pain and discomfort for the women undergoing these procedures. Women who experienced such incidents suggested providers justified carrying out these painful procedures as a means to prevent the complications and fear of being responsible for poor outcomes, as witnessed in the underneath quote:

> *"The experience of restitching after the birth was very painful…She tried to clean me up, going in and out with her hands. This is what I still find troubling. The pain was intense when she reached into my sensitive womb."* [IDI-WP-03]

In addition to their personal experiences, some women also witnessed other women being physically abused. One woman described observing another woman being hit because she was tired and was unable to find the energy to push during childbirth:

> *"I witnessed them hitting another labouring woman at my side, but not me. … I saw her being beaten because she could not progress."* [IDI-WP-02]

Verbal abuse

Women detailed experiencing various forms of verbal abuse, including scolding, threatening, mockery, blame, disavowals, and other insulting remarks from health care providers and other supportive staff in the facility. They described enduring such verbal abuses throughout their stay in the healthcare facility, beginning from their initial visit for antenatal care for some women and often during labour at the time of birth. For instance, one woman reported being scolded, "*You are not even showing!*" when she first visited the hospital and then mentioned having to leave the hospital in a disappointed mood.

Participants frequently also mentioned being yelled at in derogatory terms, which they described as making them feel unwelcome. One mother described the unsympathetic and insensitive behaviour of a healthcare provider during labour, stating:

> *“My labour pain gets severe, and my husband came and held me up… ‘What! Why are you hanging on to her? Let her go. Is she the only one experiencing labour pain!’ said one provider to my husband as he supported me while I was in labour pain. Because it was my first time, I did not know how to handle the pain. After that, they became four [providers], and they said, ‘Her labour is not that severe; she does not require a bed,’ as they stood beside me, adding, ‘Is she superior to the rest? Why did the doctor assign her a bed?’ "* [IDI-WP-01]

Another primiparous mother shared her experience of being scolded mockingly throughout her birthing process, including targeted personal comments related to her appearance. She also talked about how her childbirth experience lacked informative support. Instead of receiving gentle and professional guidance, the healthcare providers were aggressive, and their communication style felt like yelling, which only added to the woman's distress during labour, making the situation *“quite worrisome.”*

> *“Right from the beginning, you approach the situation[labour] with a sense of anxiety. When the person working there shows anger, it becomes quite worrisome. Uhm…they express their scolds loudly, telling you not to shout and to push quietly. Throughout my birth, I heard her saying, "The baby is small, that's all she was struggling for."* [IDI-WP-02]

Health facilities, particularly hospitals, are sometimes overcrowded, and there may be insufficient resources to accommodate them. In these situations, women have reported experiencing being yelled at, feeling ignored, and receiving negative verbal responses when requesting post-natal beds. One woman recalled staying on the birthing couch throughout the night after giving birth and only being able to get up in the morning. When they asked for a bed, the healthcare provider responded saying:

> *"…'There are no beds; Should I give birth to it for you?'."* [IDI-WP-10]

Another form of verbal abuse reported by women includes being threatened and blamed for any negative outcomes that have occurred or were feared to be possible. These incidents were observed when women failed to cooperate with healthcare providers, indicating a lack of responsibility for any potential complications and depicting the provider's attitude as 'passing the buck'. For instance, one woman mentioned that she was told that if anything happened to her, they would not be liable. So, she needed to endure the pain and follow the provider's instructions:

> *"When I pleaded, 'Please, it is painful', she responded with 'Then sign a release so I won't be held responsible if you face any issues.'… I just watched. I wanted it to be over."* [IDI-WP-04]

Another woman also described such experience as follows:

> *"There are times when they say, 'Spread your legs,' and they purposely scold you even when you ask the right thing...and I take these all as serious problems."* [IDI-WP-04]

A mother who had lost her previous baby a few hours after birth described the situation, recalling her experience. She recounted how healthcare providers blamed her for her baby's feeding issues and discharged her without properly assessing the newborn's condition. While describing the situation she faced during the loss of her previous baby, she recounted it as follows:

> *"… when we informed them about the baby's difficulty in sucking, one of the healthcare providers there came and inserted her finger into the baby's mouth and said, 'The baby is healthy, but it is you who refused to breastfeed.' Afterwards, they asked us to leave… they discharged us even though we informed them that the baby was not breastfeeding. They said, 'Unless you have refused to give her, the baby is healthy and can latch.' She never had a proper latch and never breastfed."* [IDI-WP-06]

Stigma and Discrimination

Several women reported feeling discriminated against or receiving a lower level of attention compared to others. One woman reported perceiving discrimination when an attendant provided unequal care, favouring a non-labouring woman over those in distressing labour. She expressed frustration and concern over this unequal treatment, suggesting the reason for the preferential care might be related to personal connection or the role played by woman's notability. This differential treatment left the participant feeling disappointed and frustrated:

> *"I wanted to raise the issue of treating people unequally… I saw a nurse sitting next to a woman … cared well. I wished for such care. I know that person, maybe she is a famous person. While another mother was screaming in labour, the nurse*

was sitting and chatting with that woman without enquiring what was happening with the other woman screaming." [IDI-WP-02]

In relation to overcrowding in the facility, women reported that healthcare providers controlled and restricted birth companions in the labour and birthing ward but that this rule was applied inconsistently. Partiality in enforcing rules, possibly due to familiarity between clients and staff or other factors, left some women feeling neglected, helpless, unsupported, and confused during childbirth. One woman felt isolated and believed she was treated differently when it came to having a birth companion and described that the health care provider did not consistently enforce the same rule for everyone; they allow birth companions for some while they send other birth companions away:

"While sending out my companion, she did not do this for all… She would go and help the other woman in labour, saying, 'Cheer up, be strong.' I don't know if they knew each other or not. She even called someone for her, her companions, to help her, and they would reach out to her, offering encouragement. She was very helpful for her, but for me.... puu, nope." [IDI-WP-08]

Mistreatment in process of care

The mistreatment experienced by women in this category is not solely attributed to the individual behaviours of healthcare providers. Instead, these instances have emerged within the care process, stemming from compounded issues involving healthcare providers and the facility—in the lack of quality care perspective. These issues include violations of privacy, non-consented care, lack of confidentiality, neglect, abandonment, and poor communication. Delays in receiving midwifery care, lack of attention and

breaches of professional standards of care led to some women enduring life-threatening situations, as depicted below:

> *“They discharged me while I was still bleeding, before my condition had stabilised, and before I had changed my clothes. I gave birth at 8 o'clock, and I was discharged at 12 o'clock. They mentioned they would provide the necessary items like vaccination for the baby immediately after birth. However, later, as they saw me still lying there, they asked, "What are you doing here for so long?" So, I just left at that point.”* [IDI-WP-05]

Violation of privacy, confidentiality, and preferences

Another set of issues related to the structural arrangements of the labour and birthing unit, as well as the attitude of the health care providers, pertained to the failure to meet professional standards of care. This included the violation of privacy, confidentiality and the inability of women to participate in the decisions being made about their care. One woman, despite describing the service she received as 'good,' highlighted the lack of privacy and consented care during examinations:

> “*At the time they examined me, there were no curtains or screens. The way they accommodate you is good, but there was no privacy. When they examine my cervix, they remain silent, and no one asks you for your consent or preferences.”* [IDI-WP-04]

This lack of consent was not an isolated incident and was often accompanied by practices that violated the privacy of women during labour or childbirth. Associated with the uncomfortable setup of the health care facility, such as the absence of curtains or screens

and private rooms, there were reports of multiple people being present in a single small labour attendance unit. When a woman was asked if healthcare providers obtained her consent or provided an explanation before performing an episiotomy, she described that it was not the case and mentioned hearing the sound of cutting her body without explanation:

> *"…when I was giving birth... I recall being instructed to 'push... push.' I believe I was able to push the baby out, but while I was following their directions, they made an incision in my body, I just heard the 'snip' sound while they cut my body without saying anything to me. …They did not ask me anything of the sort. Around seven or eight apprenticeship students were standing around me, observing. She did not say anything to me– no explanation, no mention of doing stitches, and no pain relief medication."* [IDI-WP-03]

Besides the violation of privacy and confidentiality, women also reported unnecessary repeated examinations along with poor communication. One woman, while explaining that she had never experienced such mistreatment in her previous births, stated that several students repeatedly performed vaginal examinations on her without offering any explanations, all in front of the people present in the room.

> *"They repeatedly examined me without saying anything. Even many of the students who were practising there have also seen me right in front of the people, in front of everyone who came to visit other birthing women. There were many people present, and many women were lying; in front of everybody, they performed examination [vaginal examination]."* [IDI-WP-05]

Neglect and Abandonment

Feeling neglected and abandoned was identified as additional forms of mistreatment described by women during their care, attributed either to individual healthcare providers' attitudes or facility conditions. Some women emphasised that certain providers would occasionally ignore them, potentially worsening the women's conditions, which they reported as *'feeling left alone', 'ignored', 'neglected'* and *'abandoned'*, not only when they were alone but also when healthcare providers were present, expressing a sense of inattentive observation or using the woman's unborn baby as a tool to gain compliance. One woman shared her experience:

> *"… She turned to me and said, 'Your baby is dying, be strong.' But she moved away and started sitting. She told me that my fetus was distressed and cut my body [episiotomy]. But she got up and moved away from me, she did not seem to be trying to save my distressed baby."* [IDI-WP-08]

When the provider who initially admitted the mother left her alone, other providers often claimed that it was not their responsibility. This abandonment or lack of attention during labour led to women giving birth by themselves in the same place where they were labouring:

> *"I gave birth on the same bed I was lying on when I first arrived, and they did not even notice when I gave birth. I gave birth to my baby on my own pyjamas… It was not until the people in the room shouted, 'Please, she's giving birth here,' that the healthcare providers rushed in. When they arrived, I had already given birth right there. My child had water [amniotic fluid] in his nose. He even still struggles to breathe."* [IDI-WP-05]

The participants also reported instances where labouring mothers were intentionally abandoned, ignored, or neglected by the providers. One woman recounted an experience where she felt abandoned by a group of providers due to hierarchical issues among them. She mentioned that one provider prevented others from examining her during labour, insisting that she wanted to be examined only by a specialist doctor, contrary to her actual desire. She recalled it as:

> *"When another doctor came to examine me, one of them said, 'Leave her alone; there is no one other than the specialist doctor who checks her status.' She did this at least to two, and then they left me…while they came and assessed other labouring women repeatedly, they just ignored me."* [IDI-WP-01]

Exposed to unfair fees

Maternal and child health services in public facilities in Ethiopia are generally exempt from charges. However, some women have reported being unexpectedly subjected to outsourced fees. One woman complained that she was asked to purchase medications but did not receive them.

> *"Initially, they sent my husband to buy medication. After he made the purchase, they took it away and never returned it. We bought medication for 500 Ethiopian Birr and left without receiving it. They repeatedly asked him to bring medicine."* [IDI-WP-05]

Drivers of mistreatment

As participating women discussed their experiences during service utilisation, they also shared their perceptions of the drivers of these mistreatments. These perceived drivers within this theme were categorised based on their nature, ranging from individual to system and community-level drivers based on the Socioecological Framework and the WHO quality of care frameworks as presented in the following sections.

Ontogenic: Individual-level factors

Issues at the individual level that the women though to be influential the occurrence of mistreatment include *exhaustion*, *burnout*, *negligence*, *negative attitudes*, and *fear of poor outcomes*, among others.

One participant, reflecting on her own experiences during childbirth, mentioned that "*lack of empathy*" and "*attitude*" might have contributed to those behaviours rather than increased workloads. She also recognised that there were respectful providers among them when asked about the aspects contributing to these negative behaviours.

> *"I am not sure why they would behave like that. They might mention being busy, …umm…but you see only a few patients in the hospital when they themselves are being crowded. If it were really crowded, you would understand...I think it is a lack of empathy…Yes, their attitude is somewhat lacking. However, there are some who genuinely care for people and provide dedicated service. There are individuals who have strong desire among them."* [IDI-WP-05]

On top of impacted empathy and lacking attitude, exhaustion leading to despair was also perceived as one of the underlying reasons for mistreatment by other women. Participants

brought up the issue of exhaustion, which may affect the confidence and satisfaction that providers have in their service provision and their professional outlook when dealing with individuals of various personalities:

> *"I think it is because they work there every day, and it makes them exhausted. They, the workers seem desperate. I do not think they find satisfaction in performing their skilled tasks. Uhm... it looks like they lose their way and end up there in despair due to the intense experiences they go through. I wonder if these experiences with women could affect them and lead to improper behaviours. May be these leads them to be careless."* [IDI-WP-03]

Negligence arising from carelessness was also mentioned as a reason behind the behaviour of some providers and leading to mistreatment. Such behaviours are overall described as the loss of responsibility and accountability.

> *"I would say the problem lies in the lack of accountability. It is not just the health care professionals, but everyone working in the system who needs to take responsibility. I think they have forgotten their responsibilities. …. Even those who are passionate about their job and understand the excitement of a new life coming into the world seem to have forgotten this."* [IDI-WP-06]

Microsystem: Interpersonal

Interpersonal issues, whether between women and health care providers or among professionals themselves, were identified as contributing to negative experiences for women in healthcare facilities. One of these interpersonal issues, contributing to mistreatment, was poor communication during interactions. For instance, a woman who

felt impatiently treated by a midwife [the women mostly call/see midwives as nurses] during a labour examination reported that misunderstandings between her attendants and health care providers resulted in her being ignored by the care team. She recounted the nurse's nervousness as:

> *"It was my mother who accompanied me to the labour ward initially, after we arrived in there, I was sitting, and my mother was standing. Then they asked us…'what was your case?', my mother did not hear what they asked and replied 'uhh, what did you say' to the nurse who asked us, because she didn't hear what the nurse asked as she was facing toward me, and then the nurse said 'what does it mean to say 'uhh', just leave the room and stay outside', while getting nervous [laughter…]."* [IDI-WP-01]

Mesosystem: Health facility related issues

Various issues related to health facility conditions, ranging from health facility types, lack of conducive environment, facility-specific policies, crowdedness, delay and resource-related issues, were perceived by participants to act as a conduit for the occurrence of mistreatment.

Some women raised issues related to health facility policy, like lack of an adequate number of providers during holidays, poor regulation and control from the leaders, and lack of redress system, which all resulting in mistreatment. When recounting on the way providers handover cases, one woman said she was left alone because the one who were caring her left without reporting to others:

"*I got tired of asking for help. Those who were supposed to assist me just disappeared abandoning me, let alone helping me without my consent. Others would say, 'She's not mine, she belongs to Sister 'X', did she go off', by calling her name. They did come after many requests for help… I believe they swapped shifts, maybe she left during that time."* [IDI-WP-02]

A woman who believed that addressing patient complaints could enhance the health facility's shortcomings noticed a lack of initiatives aimed at assessing these weaknesses and striving for improvement. She observed a deficiency in feedback mechanisms from both health centres and the hospitals' leadership, which could have been used to address facility weaknesses in providing care.

"The organisation should address community complaints. I think that covers it. Unfortunately, in many places, there seems to be a lack of follow-up, and it appears that the leadership has forgotten its responsibilities. I haven't come across that. I've never seen any inquiries about whether we were receiving proper service or not, neither in the health centre nor in the hospital." [IDI-WP-06]

Lack of readiness of health centres in terms of resources was also cited to enhance occurrences of mistreatment by leading women to undermine services provided in health centres and leading them to opt for hospitals, resulting in over crowdedness of the hospital.

"There are some differences between the conditions at the health centre and the hospital. [Interviewer: I see.] It is difficult to say there is follow-up at the health

centre; the hospital is more equipped. It was only iron that you get from the health centre." [IDI-WP-04]

Exosystem: Health system

Several issues stemming from different levels of the health system influence the services offered to women by healthcare providers and facilities. These concerns are connected to the foundational aspects of quality care within the healthcare system, encompassing both organisational and physical elements that shape the care process. Overcrowding in health facilities, conflict arising because of hierarchy among providers, fear of blame, disabled functionality of the referral system, culture of blame, and lack of accountability among providers were highlighted to drive mistreatment. Power dynamics among providers marked by poor coordination, a lack of teamwork and respect often leave women feeling isolated and abandoned. These issues reflect deep-rooted problems in interdisciplinary collaboration, shaped by professional training norms, and hierarchical positions, such as those between doctors and midwives:

"… the providers became four, and they said, 'Her labour is not that much, and it does not necessitate a bed.' As they stood beside me, they added, 'Is she superior to the rest? Why did the doctor assign her a bed?'" [IDI-WP-01]

The fear of being held responsible for any negative outcomes that women and newborn babies might experience is found to influence how healthcare providers behave. Some women reported being threatened by professionals, who warned they would not be held responsible if anything went wrong with them or their babies. This behaviour reflects broader systemic issues, where the focus is placed on avoiding adverse outcomes, at the

expense of quality of the care provided. This issue is highlighted in a quote from a woman who underwent a painful procedure:

> *"…There was a saying from providers, 'If something happens to the child, it's not on me.'"* [IDI-WP-04]

Macrosystem: Society level

This category presents how societal factors, such as gender norms, beliefs, and community attitudes, influence how health facilities and healthcare providers deliver services. Structural gender inequality in society leads to the tolerance of violence against women. Consequently, mistreatment of women becomes normalised within health facilities, stemming from the belief that 'health care providers have the right to chastise women' during childbirth to ensure compliance with the birthing process. These circumstances render women in a passive role, disempowered from speaking out against abusive behaviours during service reception. Such normalisation and disempowerment of women could be seen when one woman recounted an incident where another woman was bitten and expressed the futility of lodging complaints by stating, 'no one hears you':

> *"…may be the hospitals are different, but in another hospital, I saw two midwives beating a woman who was bleeding while a tube was in her body, I saw it with my own eyes… when I witnessed those two midwives beating that woman, I wanted to retaliate physically if I could … if I were in that situation, I do not think I would stay quiet…What else can you do? No one hear you."* [IDI-WP-05]

Insecurity within the community due to ongoing unrest was another contextual issue found to have a substantial impact on the services tailored for women. This included restricted access and the reluctance of service providers, ultimately disrupting the referral system linking lower-tier facilities with higher ones. Reflecting on the challenges amplifying the constraints of rural health centres and health posts, a woman highlighted the scarcity of ambulances and instances where health facilities remained inaccessible, despite undertaking lengthy journeys to reach semi-urban district facilities.

> *"In our village?... [yes...], the problem is the one I mentioned to you now. If a pregnant woman goes into labour and if one calls for an ambulance, they'll tell you 'The ambulance was burned.' Even for the labouring woman herself, if they find a private car, they pay and take her to the facilities."* [IDI-WP-07]

Consequences

In response to inquiries about the repercussions of mistreatment within health facilities, participants expressed a spectrum of outcomes. These included psychological impacts, discontinuation of care, and a heightened fear of childbirth, all influencing their decisions regarding ongoing service utilisations.

> *"…Some opt to deliver at home, saying, 'It is better to stay at home than going hospital and get incised and sutured.' Why do you go to the health facility? Isn't it for better care, both for yourself and the baby? … If there is no better care at facilities; those with money go for private birth, while those without may choose to give birth at home, and I know someone who refused to go and gave birth at home."* [IDI-WP-06]

Another woman highlighted the impact of mistreatment on both the fear surrounding childbirth and the reputation of the health facility within the community, expressing her determination not to revisit the facility.

> *"We talk about it at home, 'maybe they were busy.' Even if they were busy, it shouldn't be like this. I have made up my mind not to go there again. It has completely turned me away from seeking their services, as to me."* [IDI-WP-02]

Some mentioned that mistreatment prompted them to choose private clinics, affecting the reputation of public health facilities and affecting. For those women who could not afford a private clinic or hospital, their alternative option to birthing in a public hospital was to give birth at home alone. One mother vividly described how having experienced mistreatment at one health facility, she contemplated avoiding giving birth at a health facility, stating:

> *"…on the first day, I went home because of the scolds. I mean, I made up my mind and decided home birth. My family objected and called for an ambulance. I think it might be the same for other people."* [IDI-WP-09]

In addition to driving women away from public health facilities, it was also reported to be related to the unfortunate death of newborns. A woman who experienced mistreatment in her previous birth mentioned that the outcome of her baby could have been different if the providers had responded to their requests:

> *"…I lost my child due to mishandling issues like this. If they had provided proper care during birth and had assisted us when we said the baby wasn't breastfeeding, the outcome might have been different."* [IDI-WP-06]

6.5. Discussion

This study explored the narratives of women's experiences, perceived drivers and consequences of mistreatment of women during maternity care in line with the Socioecological and WHO Quality of Care Frameworks (Heise, 1998; Tuncalp et al., 2015), following the initial development of themes from the women's in-depth interviews in East Wollega Zone, Western Ethiopia. The findings show the persistence of the mistreatment of women despite the attention given to eliminating it both globally and nationally (Ministry of Health, 2021b; World Health Organization, 2018b).

The narratives of mistreatment reported by women, whether from their personal experiences or observations of other women, include interpersonal abuse and mistreatment during the care process. Among these forms of mistreatment, the first three—physical abuse, verbal abuse or stigma and discrimination can be considered as intentional interpersonal abuse occurring between women and healthcare professionals and should be viewed as a subset of the violence against women in the community (Heise, 1998). The consideration that the mistreatment of women during maternity care aligns with violence against women in society is supported by previous work by Jewkes et al. (2015). Physical abuse, as reported by women in this study, includes acts of hitting, slapping, forceful pushing, and denial of pain-relieving agents. These are intentional actions, even if the motives of healthcare providers may stem from preventing bad outcomes rather than inflicting harm (Bohren et al., 2016). Similarly, verbal abuse, which encompasses negative comments, insults, mockery, and derogatory words, was also reported along with stigma and discrimination, which often arise from providers'

prejudices. These prejudices were perceived by women to originate from various factors such as favouritism toward individuals of higher social status (e.g., education and economic status), familiarity between the woman and healthcare providers, and partiality in implementing health facility policies (e.g., those related to birth companions). Such factors were identified as reasons predisposing women to discriminatory actions, consistent with previous studies(Abuya et al., 2015b; Balde et al., 2017; Bobo et al., 2019). These experiences of women have also been reported previously in earlier qualitative studies (Adinew et al., 2017; Balde et al., 2017; Bohren et al., 2017c; Lusambili et al., 2020; Warren et al., 2017), highlighting the sustained suffering of women during pregnancy and birth from interpersonal abuse.

The remaining forms of mistreatment align with health system failures and issues encountered during the processes of caregiving, which are closely related to the failure of overall quality of care (Tuncalp et al., 2015). Women reported being ignored or abandoned when requesting help, even when expressing concerns about complications. Some of these forms of mistreatment stemmed from deliberate malevolence, such as the collective abandonment of women by groups of professionals after labelling them as non-cooperative or non-respectful behaviour towards an individual midwife. Likewise, examining a woman in front of others without visual and auditory privacy, including confidentiality violation and failing to obtain informed consent before procedures, were also reported. Structural issues, such as the absence of curtains and the use of shared rooms, may have contributed to such mistreatment in the care process, as also mentioned in previous studies (Bohren et al., 2015; Mirzania et al., 2023). In most Ethiopian health facilities, it is common for many students from various disciplines to attend to a single

birthing mother in non-emergency situations, exacerbating overcrowding and repeatedly violating women's rights to dignified care and autonomy. These practices reinforce a lack of respect for privacy and informed consent, which should be recognised as breaches of women's autonomy, impacted professionalism and a challenge to the quality of care.

While there should be no justifications for mistreatment, multiple underlying factors were perceived as contributing to its occurrence. These driving factors manifest from various levels, including personal history and characteristics, interpersonal issues, concerns within healthcare facilities, broader health system factors, and societal influences, mirroring the pattern seen in general violence against women in the community (Heise, 1998). Personal history or the individual characteristics of healthcare providers, such as exhaustion, demotivation, and burnout, can lead to negligence and reduced empathy, directly ending with mistreatment. Such behaviours from healthcare providers may stem from high workloads and limited staffing (Warren et al., 2017). This implies that personal issues, when compounded with chronic health facility and system-related issues, worsen the mistreatment of women in health facilities. Women’s perception of poor-quality care at health centres, accompanied by the lack of resources and limited staff, leads them to bypass these centres and opt for hospitals, resulting in overcrowding and increasing the risk of mistreatment or neglect in emergencies (Asefa et al., 2020a). As expressed by study participants, health centres often remain empty due to these perceptions, with women fearing inadequate care and the unavailability of essential resources. Consequently, women prefer hospitals, exacerbating overcrowding and contributing to mistreatment.

In addition to personal and health facility-level factors, mistreatment can result from the interaction of drivers at macro-level factors—originating from societal norms and health system cultures (Jewkes et al., 2015). In Ethiopia, a significant proportion of women experience various forms of violence, including early unconsented marriage, multiple forms of domestic and intimate partner violence, and poor societal perception of women's education and work rights (Centeral Statistical Agency, 2017). These societal factors influence the healthcare providers' perceptions of women, compounded by health system issues such as inadequate recognition and unfair treatment from the leaders towards providers. When healthcare providers themselves feel disrespected by health system administrators and facility leaders, power dynamics strain relationships (Miltenburg et al., 2018; Okedo-Alex et al., 2020). This can lead providers at lower levels to exert control over women through mistreatment actions, including verbal or physical abuse, as also witnessed in a previous study (Galle et al., 2020).

During pregnancy and childbirth, women are vulnerable and often unable to defend and protect themselves from mistreatment. This mistreatment does not leave them unaffected; it can result in serious consequences for both the mother and the child (World Health Organization, 2015a). In this study, women reported various forms of consequences of mistreatment, including fear of childbirth in health facilities and switching to giving birth at home while knowing the consequences of unattended birth at home in the hands of unskilled relatives traditionally, failures of the reputations they have for health facilities and healthcare providers, and even neonatal loss. The findings also suggest that mistreatment led to psychological distress, with women reporting the effects of interpersonal abuse as well as feelings of being ignored and abandoned. Such instances

of mistreatment signify a lack of psychological support during labour and birth and have been linked to postpartum depression in previous study (Cho et al., 2022). Neglect or abandonment during labour and birth can result in devastating outcomes, including stillbirth, neonatal death, and maternal death if unanticipated obstetric emergencies, such as fetal distress or severe bleeding encounter. These devastating consequences of mistreatment highlight the urgency of prioritising this issue and necessitate policy intervention to ensure respectful and dignified care for all, regardless of circumstances.

The interviews conducted with women have provided valuable insights from diverse perspectives. However, despite efforts to engage participants from various community groups within the Zone, our initial targets were not fully met due to civil unrest in certain areas during data collection. We endeavoured to include rural participants through mobile phone interviews to address this challenge. However, conducting interviews via telephone limited our ability to grasp the nuanced nonverbal cues that often enrich communication and understanding. The benefits of conducting face-to-face interviews would have included an observation of nonverbal cues throughout the interviews, which could have led to further discussion in understanding the depth of negative consequences of mistreatment of women.

6.6. Conclusions

This qualitative study presents women's first-hand experiences of mistreatment in health facilities, where three main themes were explored: the experiences of mistreatment, the drivers of mistreatment, and the consequences of mistreatment in East Wollega Zone, western Ethiopia among women who received maternity care from health facilities. These experiences lead to significant negative consequences and implications on service

delivery. The findings highlight the need to understand the complex factors contributing to mistreatment, which go beyond individual healthcare providers' behaviours to macro–level health systems issues and an acceptance of societal violence against women. This emphasises the importance of applying a systems-thinking approach to address the abuse and suffering women experience when receiving maternity care in health facilities.

6.7. Summary

This chapter has explored and provided detailed accounts of women's personal experiences of mistreatment, its drivers and consequences. Women's experiences throughout their maternity care journey were explored — from their initial expectations to the actual encounters, exploring what they perceived as the underlying drivers contributing to mistreatment and identifying potential impacts on the healthcare quality care. All the interviewed women shared facing various forms of mistreatment ranging from interpersonal abuses—such as physical or verbal abuse, along with discrimination—to mistreatment during the care process including being neglected or abandoned due to limitations among service providers, issues related to lack of privacy and confidentiality, and even exposure to unfair fees. None of these experiences aligned with what they expected from health facilities and healthcare providers. Furthermore, the drivers of mistreatment in relation to various structural system levels, and the consequences of mistreatment, were also examined. In the next chapter, the views of HCPS will be addressed.

CHAPTER 7: QUALITATIVE FINDINGS—HEALTHCARE PROVIDERS PERSPECTIVES

7.1. Chapter preface

This chapter continues to delve into qualitative findings but redirects its attention to healthcare providers. Embodying the insights gleaned from women, healthcare providers also reported occurrences of mistreatment in health facilities, contextualising their analysis within the Socioecological and Quality of Care Framework. The origins and drivers of mistreatment within healthcare facilities were explored through the perceptions of the providers themselves. These origins were considered as underlying factors and were not construed or intended to justify the occurrence of mistreatment in any way.

> Kasaye, H., Scarf, V., Sheehy, A., & Baird, K. How under-resourcing, lack of recognition and gender-based oppressions drive mistreatment of women in maternity care in Ethiopia: a qualitative study (Submitted to the Journal of **Global Health Action**)

Abstract

Background: Mistreatment of women during maternity care is a pervasive global issue, often more pronounced in low- and middle-income countries where health disparities intersect with socio-cultural factors such as rigid gender norms, systemic gender inequality, and domestic violence. This paper illustrates how issues related to resource

constraints, leadership challenges and societal violence against women drive the mistreatment of women during maternity care.

Methods: A qualitative study was conducted among maternal healthcare providers (HCPs) in East Wollega Zone, Ethiopia. In-depth interviews were carried out with purposively selected participants in Afan Oromo. Each interview, averaging 30 to 60 minutes, continued until data saturation was reached at 20 interviews. The interviews were audio recorded, transcribed, translated into English, coded using NVivo 12 and analysed through thematic analysis guided by the Socioecological and Quality of Care frameworks.

Results: Twenty in-depth interviews were conducted with 12 midwives, four nurses, two health officers, and two physicians across two hospitals and six health centres. Five main themes emerged as drivers of the mistreatment of women: personal, interpersonal, facility-level, health system, and societal issues. Limited resources, including overcrowded facilities, staff shortages, and inadequate pay, contributed to professional burnout, often leading to mistreatment. A perceived lack of recognition from health facility administrators and professional hierarchies among staff also contributed to providers' feelings of hopelessness, which sometimes led to their frustrations and grievances being directed at women. Societal issues, such as gender-based violence, further amplified mistreatment, influencing providers' behaviours.

Conclusion: Mistreatment of women during maternity care remains a significant barrier and obstacle to providing quality care. Tackling gender inequality, enhancing healthcare professional motivation, and ensuring equitable treatment among healthcare staff are critical to promoting respectful maternity care and enhancing the quality of care. This

study offers insights to inform health policies and practices to improve service delivery by fostering a health system that supports its caregivers, engages communities, and eliminates gender-based violence.

7.2. Introduction

Maternal and child health challenges compound the difficulties of healthcare provision in developing countries, alongside a growing burden of non-communicable diseases and the continuing struggle with infectious diseases (Kruk et al., 2018b). Efforts to address these healthcare challenges must focus on the interplay of key underlying factors such as infrastructural limitations, an inadequate and under-capacitated workforce, financial instability, and disparities in the provision of essential health services (Ogugua et al., 2024). The intersection of these factors often leads to persistent health inequalities in low- and middle-income countries (LMICs), particularly in maternal and child health, where maternal and child mortality rates are disproportionately high compared to the developed world (Grépin et al., 2013). While preventing mortality and morbidity should remain a priority, maternity care provision must also focus on delivering women centred, holistic, high-quality care in an integrative manner to ensure positive experiences for all (Souza et al., 2024).

One significant factor that negatively affects women's experiences during pregnancy and childbirth is the occurrence of mistreatment during maternity care (Bohren et al., 2015). The occurrence of mistreatment during maternity care has been recognised as a major global issue, with its prevalence ranging from one in every ten women in Australia (Keedle et al., 2022) to two in five women in sub-Saharan Africa (Kassa et al., 2020). These instances of mistreatment are often exacerbated in countries where pre-existing health disparities intersect with socio-cultural issues such as rigid gender norms, gender inequality, and intimate/domestic violence against women, all of which continue to contribute to the broader inequalities women face in society (Jewkes et al., 2015). These

sociocultural factors indirectly influence HCPs' behaviour, shaping the way in which they deliver services. In such communities, violence, particularly against marginalised or 'othered' groups may be normalised, further embedding mistreatment in healthcare settings (Freedman et al., 2014b).

A range of factors can contribute to the mistreatment of women and their families during maternity care, even though most HCPs typically offer empathetic care, understanding their patients' pain and suffering while maintaining emotional boundaries (Eklund et al., 2021). In LMICs, many health facilities and professionals work under immense pressure due to underfunding, limited resources, and overwhelming demand for services (Kruk et al., 2018b). These challenging conditions can often blur the lines between HCPs and patients, resulting in indifference or inadequate responses from professionals to the needs and expectations of women and their families. HCPs in Ethiopia face dual challenges: working in under-resourced settings and combating societal gender-based oppression against women. Operating in an under-resourced environment not only poses challenges in delivering a service but also affects the resilience of HCPs, frequently leading to burnout and reduced quality of care as a result of compassion fatigue (De Hert, 2020; Garnett et al., 2023). In addition to resource constraints, issues such as strained relationships among various healthcare professionals, inadequate funding, and a lack of recognition can further impact the quality of care offered (Kasaye et al., 2024a).

In Ethiopia, violence against women is normalised at a societal level, with various forms of violence, physical, sexual, and emotional, affecting up to 4-34% of women. This violence is often perpetrated by male partners or others, alongside non-consensual and unlawful child marriages (Centeral Statistical Agency, 2017). Since healthcare

professionals are also part of society, these harmful societal practices can influence their behaviour toward women in the healthcare facilities where they work. This is especially true when these societal norms intersect with challenges within the health system, such as resource shortages and poor governance by managers, which can all lead to the normalisation of mistreatment and violence.

The normalisation of violence against women, combined with systemic health inequalities, creates an environment where mistreatment during maternity care is more likely to occur and persist. Addressing these deeply rooted societal norms, along with improving the health system's infrastructure and governance, is critical to reducing mistreatment and enhancing the overall quality of maternal healthcare. While understanding how societal gender inequality, resource limitations, and professional dynamics all contribute to mistreatment is essential for informing policy and practice, evidence in this area remains limited.

Using data obtained from HCPs this qualitative study explores how gender-based violence in society, along with health system resources, governance issues and inter-professional relationships, contribute to the mistreatment of women in Western Ethiopia.

7.3. Methods

Study design, context and population

In this study, we present the qualitative findings from a larger mixed methods study conducted on the mistreatment of women during maternity care in East Wollega Zone, Western Ethiopia, from women's and HCPs' perspectives from February to December 2022. The qualitative data from HCPs including midwives, nurses, physicians

(Obstetrician and Gynaecologists) and health officers were analysed to understand their experiences and the underlying causes of mistreatment towards women. The HCPs who participated in the interviews were working in hospitals and health centres. The findings support the survey findings published in Women and Birth Journal (Kasaye et al., 2024a).

Guided by a pragmatist worldview, data from HCPs were analysed using two frameworks: the Socioecological Framework (SEF) for violence against women (Heise, 1998) and the World Health Organization's (WHO) Quality of Care (QoC) framework for maternal and child health (Tuncalp et al., 2015). The SEF conceptualises gender based violence as a multifaceted phenomenon influenced by personal, situational and socio-cultural factors (Heise, 1998). Meanwhile, the WHO's Quality of Care Framework (Tuncalp et al., 2015), a conceptual framework outlines how the quality of care provided for women and newborns can be improved using a structure-process-outcome model.

These two frameworks can elucidate the multilevel determinants and comprehensive dimensions of mistreatment within maternity care. WHO's QoC framework identifies the importance of having competent and motivated human power and essential physical resources, as well as good leadership/governance in the health system, which acts as the building blocks to ensure quality of care (Tuncalp et al., 2015). The lack/inadequacy of these essential components leads to poor quality of care for women and newborns. The attitude and behavioural parts that drive the mistreatment of women, especially during critical periods of pregnancy and childbirth, parallel with the violence towards women in society. The integration of both frameworks provided a theoretical foundation and structured lens for interpreting and understanding the mistreatment of women, particularly emphasising instances of mistreatment not only as a result of abusive actions

by HCPs but also as the consequences of health system constraints, including governance/leadership in the health system.

Recruitment and sampling

Following the completion of a self-administered survey (Kasaye et al., 2024a), HCPs were invited to participate in in-depth interviews. The selection criteria were targeted diverse professions within maternity care sector, varying experiences, facility location, and levels of care, including health care centres, district hospitals, and referral/specialised hospitals. Participants included midwives, nurses, physicians and health officers, were included to ensure a diverse perspective on the mistreatment of women. The interviews concluded after 20 interviews, as no new insights emerged indicating data saturation.

Data collection instruments and processes

An interview guide, aligned with the research objectives, was designed to explore the participants' perceptions and experiences of mistreatment of women, its drivers, and consequences. The interview guide focused on four main areas: (1) expectations of healthcare facilities during maternity care, (2) experiences with different forms of mistreatment (3) perceived factors influencing mistreatment, and (4) potential impacts of mistreatment on service utilisation.

Participants were informed their participation was voluntary. They all received a participant information sheet and asked to complete a consent form. if they chose to take part at the end of the survey responses. Their response to take part in in-depth interviews was collected separately to ensure confidentiality. All the interviews were conducted over the phone and with permission were digitally recorded and all interviews took place at a

mutually agreed time. HK, a PhD student at the time of data collection, conducted all the in-depth interviews and all the interviews were conducted in Afan Oromo. The interviewer was trained in qualitative research methods and was supervised by experienced qualitative researchers (KB, VS and AS). Following data collection, the audio recordings were transcribed and translated into English to facilitate the analysis and reporting in collaboration with English-speaking authors (KB, VS, and AS). The length of the interviews ranged from 30 to 60 minutes.

Data analysis

To analyse the interview findings, a hybrid technique combining inductive and deductive analysis was used (Proudfoot, 2022). In the inductive bottom-up approach, the interviews were analysed using the six stages of Braun and Clarke's (2006, 2021) thematic analysis to generate themes. Thematic analysis is a flexible method that helps identify key themes, richly describe large bodies of qualitative data and highlight similarities and differences in experiences (Braun et al., 2006, 2021). In the deductive analysis, themes developed from the data were reassessed using the SEF and the QoC frameworks.

The interviews were transcribed verbatim into Afan Oromo and subsequently translated into English to facilitate analysis and collaboration among the English-speaking research team. To ensure the accuracy and interpretation of the large data set, the transcripts were thoroughly reviewed while listening to the corresponding audio recordings. Line-by-line coding was conducted on selected sub-samples, which were imported into the qualitative data management software NVivo (Version 12) for coding and initial analysis. Descriptive, in-vivo, and process coding methods were applied to the participants' data, following the guidelines recommended by Saldaña(2021). Both inductive themes that emerged from

the data and deductive approaches based on the interview guide were used in the analysis. Accordingly, the focus of this report is on the exploration of the drivers of the mistreatment of women during maternity care from the provider's perspective.

Reflexivity

The primary author (HK) acknowledges his insider role in this context, recognising that the prior experiences and interactions with HCPs in health facilities could influence both the study's focus and the perceptions of participants. Previous engagement in frequent discussions before this study with HCPs about the importance of respectful maternity care and the extent of disrespectful practices has been integral. Furthermore, the primary author has previously conducted training sessions with HCPs in collaboration with the Ethiopian Midwives Association and the Ministry of Health, to advance respectful maternity care. This previous engagement may have influenced the behaviours or responses of healthcare provider participants during the research, potentially leading them to exhibit more respectful behaviours to align with the research team's expectations. While participants were encouraged to openly discuss their experiences, acquiescence bias might have influenced their responses. To address such instances, this study made consistent efforts to maintain neutrality and critically reflect on personal positionality. This was done by journaling and listening to the recording, asking open-ended questions and avoiding leading questions throughout the interview. Furthermore, given the possibility of courtesy biases from participants, the author, as an interviewer, has avoided judgments throughout the discussion.

The study took place during a period of civil unrest in the area, significantly impacting upon the conditions for conducting the research, particularly during the data collection

phase. The security situation posed serious challenges, making it difficult to move freely between districts and execute the study as initially planned, especially in engaging participants from rural areas. This contributed to the decision to perform the interviews by phone for safety reasons. This methodological adaptation raises awareness of potential limitations, such as the reduced capacity to capture non-verbal cues. This shift prompts reflection on the balance between accessibility and nuanced data collection in challenging contexts.

While conducting this study, the researcher, as an insider, acknowledges the presence of contributing health systems and individual factors in the area. However, the primary researcher and the research team firmly believe there should be no justification for mistreatment. It should not be tolerated and requires collaborative efforts from all local and international actors.

Ethical considerations

All participants were provided with information about the study in their preferred language to ensure full understanding. They were provided with sufficient time to ask questions and reflect on the information before proceeding to interview. They were informed of their right to withdraw or discontinue their participation at any time without any negative consequences. Ethical approval for the study was granted by the local Institutional Review Committee in Ethiopia at Wollega University, and by the Human Research Ethics Committee at the University of Technology Sydney, under approval number UTS HREC REF NO. ETH21-6587. The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

7.4. Results

Overall, twenty interviews were conducted with maternal HCPs. The interviews included twelve midwives, four nurses, two health officers, and two physicians working across two hospitals and six health centres. Their clinical experience in providing maternity care ranged from three to fifteen years.

Following thematic analysis, five themes were identified as drivers of the mistreatment of women. They included personal, interpersonal, health facility level issues, health system and societal issues, as presented in (Kasaye et al., 2024c)for the overall analysis of the mistreatment, its drivers and consequences.

Healthcare providers' views on drivers of mistreatment

Most HCPs believed they were providing good quality care; nevertheless, concerns related to mistreatment appeared spontaneously throughout the interview discussions. Most participants reported witnessing or hearing about the various forms of mistreatment in health facilities, including physical, verbal as well as neglect and abandonment. They described these situations as difficult for mothers seeking maternity services. One midwife explained that abuse or other forms of mistreatment often arise when women's/family's expectations do not align with the reality of what they experience during maternity care:

> *"Sometimes, it's not easy for mothers, for example, when they seek maternity services... mothers in labour, even also a family member who accompanies them heard while they say 'I have to give birth now' as soon as they arrive at the health facility. When the service provider arrives late, there might be a bit of*

disappointment, and that can cause frustration among mothers. Customers often mention that they were treated scornfully because of this." [IDI-HCPs-03]

Personal

One of the personal factors raised as contributing to the mistreatment by HCPs was the age of the women attending care. In instances where teenage or young women arrived at the facility to give birth, some providers mentioned the presence of experiencing feelings of anger towards the situation of bringing a baby into the world at such a young age as well as showing hostile behaviour towards young women. They reported such reactions were to impress upon the women the importance of understanding that having a child at a young age is not ideal. One midwife stated that such occurrences could be aimed at advising the young women involved:

"…Sometimes, incidents like these occur. For example, comments about a mother's age when she might be considered too young for certain responsibilities. Providers might advise her, saying things like, 'Why did you get pregnant at this age? This is the time when you're expected to focus on education and personal growth.' While advice for the future might be intended as constructive, at times, it exceeds reasonable boundaries, leading to disagreements" [IDI-HCPs-02]

Lack of cooperation from women, particularly in scenarios involving young women or when women were perceived as 'uncooperative individuals', was also identified as a contributing factor to physical or verbal abuse. HCPs described instances where young pregnant women unexpectedly pregnant and reluctant to have the child, arrived to give birth. In some cases, midwives recounted using forceful birth assistance which they

deemed necessary to save the baby's life. Additionally, there were reports of some women displaying indifference or explicitly expressing a desire not to give birth to a live baby. Consequently, interventions by midwives and other HCPs sometimes escalated into physical and verbal altercations:

> *"…there are times when we seek help from another professional to safeguard the child's well-being. For instance, in a situation where the mother intends harm, we have to call for assistance promptly and they help as in holding her legs here and there…and we assist like that because she intends to harm the child"* [IDI-HCPs-01]

Interpersonal

Lack of cooperation and failure to comply with HCPs were cited as factors contributing to mistreatment. One participant implied some women do not perceive or respect HCPs as professionals, which can foster mutual disrespect, leading to a normalisation of such behaviours between women and HCPs. A participant described this reciprocal tension as:

> *"When mothers receive orders, they don't comply to that, it can stem from various reasons maybe. Uhm, when these mothers don't comply with the providers' instructions, it often results in conflict or disagreement. I believe this happens because some mothers may not fully accept or respect the provider as an expert professional, which in turn affects the service provided to them."* [IDI-HCPs-12]

Another interpersonal issue contributing to mistreatment was the aggressive behaviour displayed by professionals toward women and their families when conflicts arise with

health facility management. Aggression is not limited to verbal or physical abuse; it can also take the form of neglect in service provision. For instance, some professionals reported instances where repeated requests from women or their families, were ignored, particularly during night shifts, when staff sometimes prioritised 'sleeping' over fulfilling their professional responsibilities. One midwife noted that dissatisfaction with night duty pay often resulted in unacceptable behaviour, such as ignoring mothers' requests for support and care:

> "*… when their night shift pay is not provided as legally agreed, they express frustration towards the service…some may resist providing services and choose to sleep. But it is incorrect to attribute all the harm to mothers and children solely for personal reasons; it is seeking benefits or simply laziness which causes the problem to mothers and children.*" [IDI-HCPs-02]

It is well known that effective communication between healthcare professionals, as well as with women and their families, is crucial for ensuring quality care and the well-being of mothers and newborns, especially during critical periods such as childbirth and postnatal care. Case handover between professionals during shift changes are a crucial communication method; but poor handover practices can result in the neglect of both mother and baby. One provider shared an incident where a baby became critically ill due to a delayed initiation of early breastfeeding:

> "*Yes, that's unfortunately a real scenario we encountered. There was a situation where one midwife attended a birth around 5:30 PM but left before handing it over to the duty midwife. The newborn didn't start feeding, and the incoming midwife*

was unaware of the situation. Around 8:00 PM, upon checking, the baby was in a critical condition due to the lack of feeding until that point." [IDI-HCPs-01]

Health facility and health system:

Some participants highlighted the shortage of HCPs in maternal and child health units. One midwife noted that in their health centre, only two midwives are available per shift to manage antenatal, birthing, and postnatal care. Consequently, this shortage often results in many pregnant women not receiving the necessary care they require, with so being abandoned at the antenatal care unit, resulting in dissatisfaction. As a result, women may hesitate to return to the facility after experiencing inadequate services during previous visits.

"…from the follow-up stage, there were instances where, for example, we were two individuals at our station [two midwives at health centre]. One works at night, and the other works during the day. If the one who works during the day attending labour and birth, it means that mothers who come for pregnancy follow-ups end up disappointed…a risk that those in follow-up left with nobody to give care. When they come today and miss out, and then come tomorrow and waste their time… this leads to a decline in Antenatal Care (ANC) attendance as a reason." [IDI-HCPs-01]

In addition to low staffing numbers of the HCPs trying to provide care, high patient flow numbers were also reported as a challenge to respectful care:

"*The patient flow often exceeds expected levels. For instance, during the night shift, when there is just one midwife available, there might be five or six births.*

There is usually only one midwife, and when there are three women in active labour, complications like fetal distress or maternal bleeding strain the available resources. Even when additional providers are called in (health officers on call), this problem persists, especially during evening shifts, causing challenges in the provision of professional care." [IDI-HCPs-06]

Participants also raised concerns about perceived insufficient compensation among midwives who manage busy and high-risk night shifts. Midwives reported working in particularly demanding and unsupported environments compared to other professionals, whose workloads were often lighter than those in labour and delivery units. They emphasised that managers failed to acknowledge their exhausting working conditions, despite receiving the same or less compensation than other healthcare professionals. These challenging conditions are often framed as serving the community rather than being fairly compensated for their work. One midwife reflected on this issue stressed that the health system administration lacks the 'moral stance' to adequately recognise providers' efforts:

"…Working all night with a high level of risk for multiple births should be appropriately compensated, but unfortunately, it's not. When compared to someone who rests the whole night, a midwife standing through the challenges of attending five or six babies overnight, facing significant risks, receives minimal consideration for their efforts and benefits… we are serving because of the willingness to serve the community, the government lacks the moral stance to acknowledge and provide adequate payment." [IDI-HCPs-06]

A lack of sufficient attention and recognition for midwives, as well as other HCPs, was identified as a demotivating factor contributing to a reduced commitment. Limited and insufficient professional development opportunities were also highlighted, with one participant noting that offering only two educational opportunities per year creates a desperate situation, particularly when career advancement is tied to earnings:

> *"… there is a lack of diverse opportunities for health professionals. For example, in East Wollega, with about fifty health centres and five hospitals, there are only two midwifery educational opportunities available each year. This shortage poses a serious problem."* [IDI-HCPs-02]

A lack of attention stemming from governance issues was also considered as the underlying cause of the occurrence of mistreatment. These systemic issues were seen as catalysts for disappointment, dissatisfaction with service delivery, and an overall sense of disenchantment among providers. This is compounded by both overcrowded and overworked conditions, significantly exacerbating mistreatment, despite providers' intentions and efforts to meet women's expectations. These systemic challenges created turmoil and tested both providers and patients. One provider highlighted this issue noting that healthcare workers are neglected by the government and receive less attention compared to other public sector employees, such as teachers:

> *"The health professionals are not compensated adequately, at least not at the level of diploma teachers, for their efforts. Providers face severe good governance issues within the district and zonal health offices. The federal government doesn't prioritise the needs of health workers; instead, attention and resources seem to be directed towards its cabinets. With the work solely led by managers, this lack of*

support leaves no avenue for professionals to voice their grievances or concerns." [IDI-HCPs-19]

Community and the Society

Another important theme to emerge from the analysis was community and society-related drivers. Participants highlighted how systemic and societal factors can contribute to mistreatment and impact upon the quality of care provided. One midwife recounted a tragic incident where road closures between the health centre and the hospital, resulted in a delay reaching the referral centre, leading to the loss of a mother's life. In another instance the same midwife described a mother in prolonged labour, who had been transported to the hospital on a cart due to the lack of proper transport, resulting in a similar tragic outcome. These challenges underscore the critical and indispensable role of community infrastructure in supporting equitable healthcare delivery:

"*So, she experienced prolonged labour and when referred from the health centre, they had nothing to transport her with, so they took her to the Arjo Hospital in a cart. Uhm...She did not stay for more than an hour; as soon as she got off the cart and entered the hospital…she passed away. It was her first birth."* [IDI-HCPs-01]

Collective categories of drivers per the SEF and QoC Frameworks

The driving factors contributing to mistreatment during maternity care are classified using the SEF and QoC frameworks. The factors discussed in the preceding section are proximal drivers at the personal, interpersonal, health facility/system, and societal levels contributing to the mistreatment of women. Although these factors are categorised under distinct themes based on thematic analysis, they often interact and may originate from

broader underlying issues. These drivers are broadly classified into three categories: resource-related issues, leadership and governance, and gender-based operations, as illustrated in Figure 1.

Issues such as underpayment, a limited number of midwives or other health professionals and overcrowded facilities due to high patient flow all stem from a common root cause, under-resourcing within the healthcare system. Conversely, concerns raised by individual professionals, such as a lack of recognition, perceived unfair treatment, along with poor shift management at a facility and system levels are tied to governance challenges. Additionally, personal biases and behaviours displayed by healthcare professionals, such as prejudices against young or unmarried women and a lack of supportive attitudes toward women overall, can be attributed to the broader issue of gender-based violence and entrenched societal norms. These themes are further synthesised and discussed in the discussion section, where they are connected to the existing body of literature.

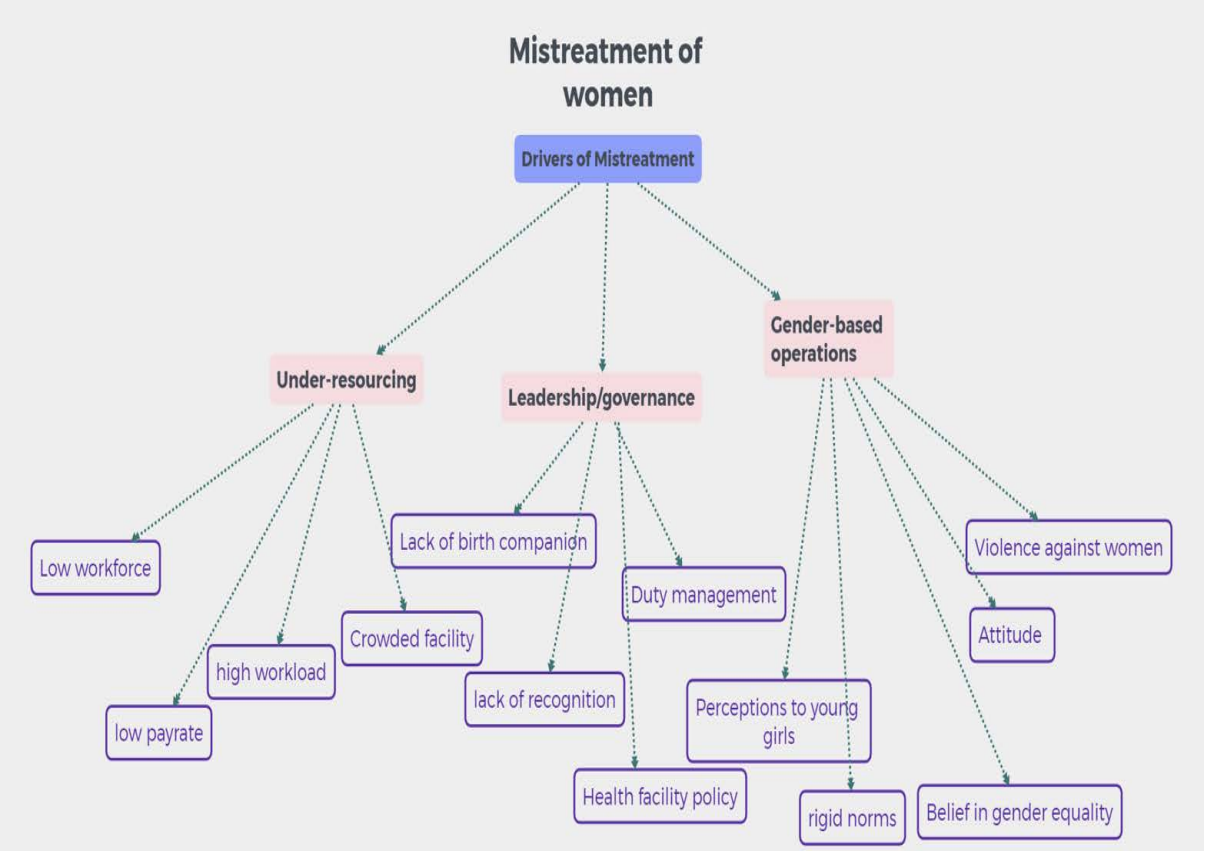

Figure 7.1: Drivers of mistreatment of women during maternity care based on the socioeconomic and quality of care framework.

7.5. Discussions

This study explored the factors driving the mistreatment of women during maternity care in Western Ethiopia from the perspectives of HCPs. These factors stemmed from professionals' biases towards women's personal characteristics and societal norms rooted in gender inequality. Additionally, mistreatment was linked to interpersonal interactions, resource constraints within health facilities, the broader health system governance issues through which services are delivered, and the societal context shaping maternity care in Ethiopia.

Physical and verbal abuse and discrimination against women in health facilities share characteristics with broader societal violence against women, rooted in structural gender inequality, where women are perceived as subordinate in society (Jewkes et al., 2015). For example, age-related prejudice leading to the mistreatment of young women in this study reflects societal views on marital status and sexuality. Interviews with HCPs revealed that younger women were more vulnerable to verbal and physical abuse, often due to judgments about pre-marital sexual activity and early pregnancy. Despite the legal marriage age being 18 (Federal Democratic Republic of Ethiopia, 2000), many girls marry earlier due to cultural norms, gender inequality, and societal pressures, including those in the study area and Ethiopia (Centeral Statistical Agency, 2017; Ethiopian Public Health Institute, 2021). Early marriages often lack consent, and it is thought that many young women may accept marriage to avoid being labelled as "unwanted" in society (Marshall et al., 2016). Although laws against child and forced marriages exist in Ethiopia, enforcement is weak, and violence against women remains normalised leading to a manifestation and acceptance of violence within health facilities. HCPs, despite being aware of community violence, often mistreat young women, by blaming them for early marriage and pregnancy. Midwives and other HCPs frequently question young women's readiness for parenthood and emphasise the importance of prioritising education and personal growth over early marriage and pregnancy. While framed as advice, this is a form of verbal abuse that has been reported in other studies as well (Amroussia et al., 2017; Maya et al., 2018).

Additionally, HCPs often label young or first-time mothers as non-tolerant and uncooperative, using these perceptions to justify their mistreatment towards them (Balde

et al., 2017). Such behaviours of the HCPs align with the violence against women in the community. The 2016 Ethiopian Demographic and Health Survey reported that 23% of women aged 15-49 experienced physical violence, 10% experienced sexual violence, 4% faced physical violence during pregnancy, and 34% of married women suffered physical, sexual, or emotional violence from partners (Centeral Statistical Agency, 2017). While the community tolerates various forms of violence, it is particularly intolerant of premarital pregnancy, which is socially and religiously condemned (Baraki et al., 2023; Molla et al., 2008).

As observed by Bohren et al. (2015) societal norms can influence the behaviour of HCPs, who are part of the same community. Preconceived beliefs about premarital sex and pregnancy also contribute to the mistreatment of young women. Women often experience sexual violence, which can lead to an unintended pregnancy, creating a double burden of abuse both in the community and in healthcare settings. Similarly, mistreatment based on age, and her woman's marital status can influence how HCPs treat her. Some HCPs hold a belief that young, unmarried women either do not want or deserve a baby, which can result in mistreatment during pregnancy and childbirth. While data on unmarried women giving birth is limited, unintended pregnancies are common in Ethiopia, with a prevalence of 23.5% among unmarried and formerly married women (Tebekaw et al., 2014). This is partly due to inadequate access to contraceptives, with only 60% of contraceptive needs being met nationwide (Centeral Statistical Agency, 2017). Some HCPs rationalise mistreatment by assuming that these women might intentionally harm their babies, using verbal or physical abuse as a way to "protect" the child (Afulani et al., 2020; Dzomeku et al., 2020; Orpin et al., 2018). However, many fail to recognise that

these pregnancies could result from rape or sexual violence, in such situations where support and counselling are needed (World Health Organization, 2014). Ethical guidelines from both the International Confederation of Midwives and the Ethiopian Midwives Association emphasise the importance of providing psychological support and upholding ethical standards, to ensure that no woman or girl is harmed during pregnancy or childbirth (Ethiopian Midwives Association, 2021; International Confederation of Midwives, 2014).

Another driver of mistreatment stems from chronic resource shortages, which negatively affect the emotional well-being of the HCPs. Feelings of despair and hopelessness among midwives and other HCPs were linked to the perceived lack of recognition from the government and senior leaders regarding their challenging working conditions. In addition, difficult living conditions were worsened by high inflation and an ongoing civil war, although it is important to acknowledge that mistreatment in maternity care existed prior to the conflict. In July 2023 Ethiopia's inflation rate was 28.8%, one of the highest in Africa, while the average monthly salary for HCPs was 7301.24 Ethiopian Birr (about 200 AUD), just above the extreme poverty line of $2.15 a day (The World Bank, 2023). Economic pressures, along with perceived low wages, pay disparities, and lack of recognition, have intensified feelings of frustration and stress among HCPs (Afulani et al., 2021). These stressors may lead HCPs to project their grievances onto women, contributing to mistreatment and normalising such behaviour.

In Ethiopia, midwives are the primary maternal and child HCPs, with an average of three midwives per health centre working 24-hour shifts (Ministry of Health, 2021a, 2021b). Due to the limited number of midwives, women often reported inadequate care in smaller

health centres and, therefore, often transferred to a larger hospital, where mistreatment was more commonly reported, as reported in several earlier studies (Asefa et al., 2015; Bobo et al., 2019; Sheferaw et al., 2017). In addition to a national shortage of midwives, they also face significant challenges, including high workloads, lack of professional recognition, and blame for negative birth outcomes. They are frequently overlooked as essential workers by the health system. Similar findings have been found in other low- and middle-income countries (World Health Organization, 2016b). Midwives experience stressors that lead to frustration, feelings of helplessness, and diminished self-worth. A power imbalance also exists within the health system, where doctors viewed as superior to nurses and midwives, resulting in further disparities in treatment, incentives, and allowances. A report from The World Bank (2023) indicates that medical specialists earn 77% more than midwives and nurses, reinforcing the occupational and class divide. This inequality, combined with the psychological strain of negative working experiences, could be a factor contributing to the mistreatment of childbearing women in Ethiopia's health facilities, though it should not displace the responsibility or excuse such behaviour as widely reported in previous literature (Bradley et al., 2019; Jewkes et al., 1998; Schaaf et al., 2023; World Health Organization, 2016b).

Strengths and limitations study

This study highlights that the factors contributing to mistreatment are complex and multifaceted, extending beyond individual provider behaviour or interpersonal misunderstandings. While the findings address key issues related to violence against women, resource limitation, and governance, a more comprehensive understanding could have been achieved by including views from community representatives and health

facility managers. Additionally, the civil war hindered our ability to conduct in-person interviews and focus-group discussions as originally planned. Nonetheless, to our knowledge, this paper is the first to explore the relationship between society-level violence against women, health system challenges, and midwives' experiences, emphasising the need for collaborative efforts to eliminate the mistreatment of women in healthcare facilities.

7.6. Conclusions

In conclusion, mistreatment of women during maternity care remains a significant barrier to quality care. This mistreatment stems from broader issues, including violence against women in society, under-resourcing at both the health facility and system levels, and leadership challenges that influence HCPs' behaviour. These findings highlight the need for comprehensive, multilevel interventions. Addressing gender inequality, improving HCPs motivation, and ensuring equal treatment among various professionals are all crucial for promoting respectful maternity care and improving the overall quality of maternity care. Fostering a supportive health system that engages with the community, supports and values caregivers, develops health polices and strives to eliminate gender-based violence are indispensable for an improved service delivery and promoting respectful maternity care.

7.7. Summary

In this chapter, healthcare providers acknowledged the existence of mistreatment in the health facilities they worked in, attributing it to unintended consequences influenced by unsatisfactory working conditions such as high workload, inadequate compensation, and

lack of recognition from the health facility managers. The power dynamics inherent in dealing with grievances contributed to the normalisation of mistreatment. Furthermore, the effects of general violence against women in society has been also explored in this chapter. This highlights the pressing need for strategic interventions aimed at equipping health facilities with motivated, competent, and compassionate providers.

In the next chapter, the overall findings from both qualitative and quantitative are merged narratively by highlighting important findings with implications.

CHAPTER 8: INTEGRATION OF QUANTITATIVE AND QUALITATIVE FINDINGS

8.1. Chapter preface

This chapter serves as the bridge, connecting the quantitative and qualitative findings of the thesis. Its main goal is to capture a clear and detailed understanding of the overall results. The findings align closely with the objectives, visible across all data, enriching the conclusions from both methods. In essence, this chapter integrates the main explorations from both quantitative and qualitative parts, focusing on their interpretation and practical implications for the entire research project.

8.2. Quantitative findings

Quantitative surveys were carried out among two distinct groups: women who had given birth within three months preceding the data collection period after receiving at least one component of care (including antenatal, labour and birth, or postnatal care) from health facilities within East Wollega Zone, Oromia Regional State, Western Ethiopia. Concurrently, the second segment of the survey was conducted among maternal healthcare providers. This group included midwives, nurses, medical doctors, health officers, and integrated emergency surgical officers actively practising within the health facilities of East Wollega Zone.

In the survey with women, we aimed to assess the extent of mistreatment experienced in health facilities, identify individual and contextual factors associated with mistreatment,

and explore the influences of these mistreatments during service reception on the continuum of maternity care. In the healthcare providers survey, conducted as a self-administered survey due to the sensitivity of the issues, mistreatment was reported as either witnessing instances involving other providers or self-committed acts. This survey also examined how healthcare providers' perceptions of their work environment and levels of empathy influenced the occurrence of mistreatment. The findings from survey this, along with those from the women's survey are presented and discussed in Chapters four and five. A further synthesis of these results with existing literature is provided in Chapter 9.

8.3. Qualitative findings

Parallel to the quantitative surveys, qualitative studies were undertaken among selected participants from the survey participants. In-depth interviews were independently conducted with voluntary individuals from two distinct groups—the women and maternal healthcare providers. The qualitative part aimed to complement and enrich the quantitative findings, offering a nuanced exploration of the prevalent issue within the study area. For the women, the interviews sought to uncover their experiences, perceptions of the underlying drivers leading to mistreatment, and the consequential outcomes. Similarly, interviews with maternal healthcare providers were carried out to reveal their observations of mistreatment, their perceptions concerning the determinants driving such behaviours, and their ideas to mitigate these pressing concerns.

Purposively selected women and healthcare providers who participated in in-depth interviews reported experiencing/witnessing mistreatment in various ways. The overall

stories collected from their interviews revealed a spectrum of encounters: some women unexpectedly faced mistreatment, while there were women who recalled respectful experiences. Through a combined inductive and deductive analysis of the women's experiences, three major themes aligning with the research question were constructed: experiences of the dissonance between expectations and reality, perceived drivers of mistreatment, and the consequences. The interviews from healthcare providers, as presented in Chapter 7—explored the drivers behind the occurrences of mistreatment where issues related to the resources, good governance and violence in society were manifested to influence occurrences of mistreatment.

8.4. Convergence of the quantitative and qualitative findings

As outlined in the preceding sections, findings from both datasets revealed the pervasive mistreatment of women during maternity care, highlighting the necessity for urgent interventions. This chapter aims to narratively, present the convergence of these findings, considering the extent of mistreatment, its underlying drivers, and the resulting consequences on service utilisation. Moreover, it delves into the overall relationship between women and healthcare providers or health facilities within the system.

Magnitude of the mistreatment

The survey conducted among women revealed that nearly all typologies of mistreatment identified by the WHO research team (Bohren et al., 2015) were reported by women, except for sexual abuse. Among various types of interpersonal abuse (n=284, 37.4%), physical abuse (PA) emerged as the most prevalent (*n*=207, 27.2%), followed by verbal

abuse (VA) (*n*=158, 20.8%), and perceived discrimination (*n*=36, 4.7%). The most frequently reported abuses included instances of being shouted at, screamed at, insulted, scolded, mocked, and hissed at (VA), denial of pain relief (PA), forceful abdominal downward pressure (PA), and being hit, slapped, pinched, or painfully pushed with materials (PA).

Healthcare providers also reported instances of mistreatment, either as observers of their colleagues' mistreating women or acknowledging their own actions. While most providers reported witnessing mistreatment by others (93%), three out of four providers (75 %) admitted to mistreating women at least once. Among self-reported mistreatment, stigma and discrimination (38%) were relatively more prevalent, followed by instances of physical abuse (37%) and verbal abuse (35%). Providers also acknowledged other forms of mistreatment, such as perceived violations of privacy and confidentiality (44%), breaches of autonomy (25%), and instances of neglect and abandonment (24%). These admissions align with the mistreatment observed within the care process.

The presence of mistreatment during maternity care was also confirmed through in-depth interviews with both groups. Clear indications of this emerged from the in-depth interviews; where all 17 women interviewed as part of this study reported experiencing at least one negative interaction with healthcare providers. Consistent with the survey findings, it was observed that most interpersonal abuses occurred more frequently during labour and birth compared to during antenatal care or postnatal care. Some women noted that they received 'good' care during antenatal visits. The following quotes recount specific instances of interpersonal abuse reported by women, aiming to draw comparisons between the survey and qualitative findings.

Physical abuse was most commonly reported type of abuse in the survey, and women in the in-depth interviews also recounted surviving physical abuse. Their experiences ranged from witnessing other women being abused physically to enduring it themselves. One woman who witnessed another mother being physically abused recalled the situation as:

> *"…Not to me, but they hit someone once while I was there… One provider was hitting her with her hands while she was giving birth."* [IDI-WP-09]

Women who experienced abuse firsthand also shared their stories. They reported that such mistreatment, including being hit, often happened during the intense labour pain widely recognised as one of the most excruciating painful experiences, especially in the later stages of childbirth. In cases where no pain relief was available, instead of offering emotional support, some healthcare workers resorted to physical abuse. Accounts from both survey and interviews revealed incidents were mothers were physically assaulted, including being pinched with objects like clamps:

> *"When she assisted with my birth, she hit my thighs with her hands and tossed me back and forth on the bed…"* [IDI-WP-08]

> *"When it hurts a lot, they hit you with scissors, pinch you with the clampers. I can only speak about my own experience, yes, they physically struck me."* [IDI-WP-06]

Along with physical abuse, verbal abuse is another common form of mistreatment that often happens at the same time as physical abuse and is seen both in the survey and in-depth interviews. Different forms of verbal abuse were reported, including insults, mockery, and threats of potential harm to the women or their babies if they didn't comply

with professionals' advice. Verbal abuse was also mentioned alongside other forms of mistreatment, such as dismissing birth companions, which made women feel lonely at a time when they needed the most support. Although dismissing companions might be due to overcrowded rooms, it should not come at the cost of leaving women alone and unsupported. One woman shared her experience of verbal abuse as follows:

> *"They were speaking to me in an angry manner, saying things like 'don't scream at us, just lay down.' They also dismissed my husband and sister from being with me…."* [IDI-WP-05]

Verbal abuse was not limited to the women themselves; it was also reported to extend to their accompanying family members, as shown in the quotes below:

> *"…after that it became severe…my labour pain… 'What, why are you hanging on to her? let her go; is she the only one who experiences labour pain?" said one provider to my husband as he supported me while I was in labour pain. Because it was my first time, I did not know how to handle the pain."* [IDI-WP-01]

Another form of interpersonal abuse reported by women in both the survey and interviews was stigma and discrimination. This happens when HCPs treat women differently while providing care. Although the reasons for this unequal treatment are unclear, some women believed that it may be due to social connections or familiarity between the staff and certain women or other socio-economic factors. One mother shared her experience of being treated partially by the nurse/midwife:

> "… *I myself was shouting, saying 'my child's head is coming out,' the nurse with the other woman, who wasn't in labour, acted as if nothing had happened and*

continued talking and providing care for that woman without [labour] pain. I was disappointed to see this…" [IDI-WP-02]

Another category of mistreatment experienced by women involves incidents occurring within the care process. As discussed in previous sections, this classification of mistreatment comprises occurrences during service provision, often unintentional and perceived as not aimed at causing harm by healthcare providers. These incidents may arise from drawbacks within the health system. Among the identified mistreatment categories are poor rapport between healthcare providers and women (50.9%), which encompasses situations such as the lack of a birth companion, restrictions on movement during labour, and a perceived lack of emotional support. Furthermore, failures to maintain professional standards of care (29.9%) were identified, including instances of care delivered without proper consent, inadequate provision of information, violations of privacy and confidentiality, and instances where women felt ignored or neglected. Additionally, health system constraints (6.2%) were highlighted, such as inadequate availability of beds during labour, birth, and the postnatal period.).

Although effective communication between women and HCPs is crucial for quality care and the well-being of mothers and their newborns, some reports highlight poor rapport between women and their HCP. These negative interactions have led to a lack of positive engagement and instances of mistreatment as illustrated in the following quote:

"I didn't say anything else. I only mentioned that I had an appointment to come in. After she reacted that way, I said, 'Why are you in a service profession if you're going to respond with anger and insults?'..." [IDI-WP-09]

Case handover issues were also reported to lead to neglect and abandonment of women, particularly when midwives or others changed shifts:

> *"I got tired of asking for help. Those who were supposed to assist me just disappeared, abandoning me, let alone helping me without my consent. Others would say, 'She's not mine, she belongs to somebody else, did she go off?', ask themselves by calling her name. They did come after many requests for help."* [IDI-WP-02]

As highlighted in the survey findings, women also reported violations of their privacy and confidentiality. These incidents occurred during physical examinations where their privacy was comprised with the presence of many people in the room at the time of the examination:

> *"Repeatedly, they would look at me without saying anything. Even the students who were practising there would gaze at me, right in front of the people, in front of everyone who came to visit other birthing women. There were many people present, and many women were lying; in front of everybody, they performed examination [vaginal examination]."* [IDI-WP-05]

The other picture of the mistreatment needing attention is the health system level mistreatments, apart from the individual HCP's behaviours. These include health system constraints, like lack of adequate resources including workforce, inadequate payments for the HCPs that, in return, affect how they provide services:

> *"…in government hospitals, there's a lack of certain things like iron; you don't find it in public hospitals. You must buy from a private pharmacy. That will even happen*

if they tell you; mostly, they don't. They might tell you 'Pay for it yourself'." [IDI-WP-04]

Drivers of mistreatment

In the surveys with women, various women-related individual characteristics were identified to associate with occurrences of interpersonal abuse. These include the economic status of the women, their religious affiliation, the presence of complications during pregnancy or birth, previous history of stillbirth, mode of birth, and the presence of a companion. Even though the findings from interviews did not directly show these specific issues, women perceived some provider prejudice predisposed them to mistreatment. Despite HCPs being required to provide equitable care for all women, regardless of their identity, prejudgment about the identity of the women leads to the abandonment of the women:

"… they said, 'Her labour isn't that much, and it doesn't necessitate a bed.' As they stood beside me, they added, 'Is she superior to the rest? Why did the doctor assign her a bed? Leave her alone; there is no one other than a specialist doctor who checks her status!'... I think they assumed the doctor was my relative." [IDI-WP-01]

Another factor contributing to the mistreatment of women is with HCPs' prejudice towards those perceived as those who appear to be lacking physical cleanliness. This is often due to their inability to care for themselves, which may be the result of being in pain or being confined to the bed.

"…the bed she was lying on, her blankets, her dresses..., were stained with blood, and even the blood also touched the nurse's cloth, that was why she yelled at her like that." [IDI-WP-08]

Survey findings among healthcare providers revealed that both empathy levels among healthcare professionals and their perceptions of the working environment significantly influenced the occurrence of mistreatment in health facilities. An increase in providers' empathy levels was linked to enhanced respectful behaviour, whereas individuals with comparatively lower levels of empathy were identified as more likely to perpetrate mistreatment.

Additionally, perceiving the working environment as characterised by high workloads, disproportionate client-to-provider ratios, a perceived lack of supportive leadership, and inadequate salaries, among other factors were identified as indicators influencing a positive perception of the work environment. This positive perception, in turn, was observed to affect the occurrence of mistreatment. Notably, individuals with positive perceptions of their workplace were found to be 65% less likely to engage in mistreatment against women during their practice.

Parallel to this, findings from qualitative interviews, both from women and healthcare providers, support the importance of attitudes expressed as a lack of empathy and negative perceptions of the working facility as well as the entire system. The authenticity of the providers' reasons for their behaviour, which seems to justify the occurrence of mistreatment, was raised by women. This implied that true empathy would involve a deeper understanding and consideration of women's experiences, even if they differ from providers' own perceptions of their working conditions and perceptions of quality of care.

These could be witnessed in the following quotes from the interviews where HCPs' burnout, empathy and negative perceptions of the working environment led to the mistreatment of women. As shown in the findings from the HCPs' survey in Chapter 5, staff perceptions of their working conditions, including relationships with co-workers and interactions with managers, were found to impact on how they delivered care. Positive working relationships and a supportive physical environment led to greater respectful care. Conversely, dissatisfaction with their roles and negative perceptions of the work environment often result in increased mistreatment behaviours, as reported in both the survey and the interviews:

> *"I think it is because they work there every day, and it exhausts them. They, the workers, seem desperate. I don't think they find satisfaction in performing their skilled tasks. Uhm...it looks like they lose their way and end up there in despair due to the intense experiences they go through. I wonder if these experiences with women could affect them and lead to improper behaviours. Maybe this leads them to be careless."* [IDI-WP-03]

Negative perceptions of their working environment and conditions were also reported by midwives during in-depth interviews. Their dissatisfaction with the work environment was evident in how they discussed inadequate compensation for services, particularly for extra shifts during the night. Midwives compared their recognition and need for incentives with others whose workload was not as demanding. This sentiment is reflected in the following quote from a midwife describing the situation:

> *"…Working all night with a high level of risk for multiple births should be appropriately compensated, but unfortunately, it's not. When compared to*

someone who rests the whole night, a midwife standing through the challenges of attending to five or six babies overnight, facing significant risks, receives minimal consideration for their efforts and benefits… we are serving because of the willingness to serve the community, the government lacks the moral stance to acknowledge and provide adequate payment." [IDI-HCPs-06]

Similar to the negative perceptions related to the workplace, HCP's levels of empathy were identified to lead to mistreatment. Women also questioned empathy levels of the HCPs when they were asked about the underlying factors behind the mistreatments, especially in the absence of other pushing factors like the crowdedness as depicted in the following quote:

"I'm not sure why they would behave like that. They might mention being busy, …umm…but you see only a few patients in the hospital when they themselves are being crowded. If it were really crowded, you'd understand...I think it's a lack of empathy." [IDI-WP-04]

Consequences of mistreatment

In the survey involving women, it was highlighted that experiencing interpersonal abuse significantly affected the continuity of maternity care, not only within the same facility but potentially across different facilities as well. Women who encountered interpersonal abuse along this continuum experienced a stark decrease in the likelihood of completing the maternal continuum of care, nearly halving their chances of completing care up until the second postnatal check-up within the first week of their birth compared to those who did not face such abuse (AOR = 0.49, 95% CI: [0.29 – 0.83], p-value = 0.008).

Such negative outcomes of the mistreatment of women on the continuum of care were highlighted during qualitative interviews along with other consequences. When women were asked whether experiencing mistreatment affected their decisions regarding ongoing care or led to any other consequences during their care experiences, they expressed concerns about its effect on the reputation of healthcare providers and facilities. This influenced their resolve regarding future birthing decisions and their inclination to switch health facilities, and resulted in psychological impacts, among other perceived consequences. Some of these views were reflected in the following quotes:

Prefer homebirth:

> *"…It is possible to give birth with more comforting care at home. If there's so much bleeding, if there's so many insults in hospital, why would you be there and suffer. It's possible to give birth even at home with more emotional support. You would have relatives beside you, your own family saying, 'Be strong, don't be afraid!'."* [IDI-WP-02]

Impacted reputation of the providers and health facility:

> *"When I talk to others about it, some say, 'Why did you go there? They don't treat people properly. The health centre here is very good, but the hospital has become chaotic, a complete mess.' So, I think it is common, and everyone knows it."* [IDI-WP-05]

Psychological and attitude consequences:

> *"…I have been disappointed psychologically. Additionally, it negatively affects their own reputation… Had the nurse treated me well, I wouldn't have been so*

distressed—I would have remembered her positively. They should work with integrity and transparency to uphold their reputation." [IDI-WP-03]

Birth injuries to the baby and women:

"…because they didn't come early at birth, my baby's umbilicus wasn't clamped early, it was swollen, and it still presents and noticeable…it was stretched too much" [IDI-WP-07]

"*I gave birth my baby on my pyjama's… When they saw what had happened, the people there shouted, 'Please, she's giving birth here,' and the health care providers heard and came. When they arrived, I already gave birth right there. My child had water in his nose, and he still struggles to breathe."* [IDI-WP-05]

A pictorial summary of the findings from both quantitative and qualitative methods is presented in the Figure 8.1, which aimed to display the merged findings from both groups.

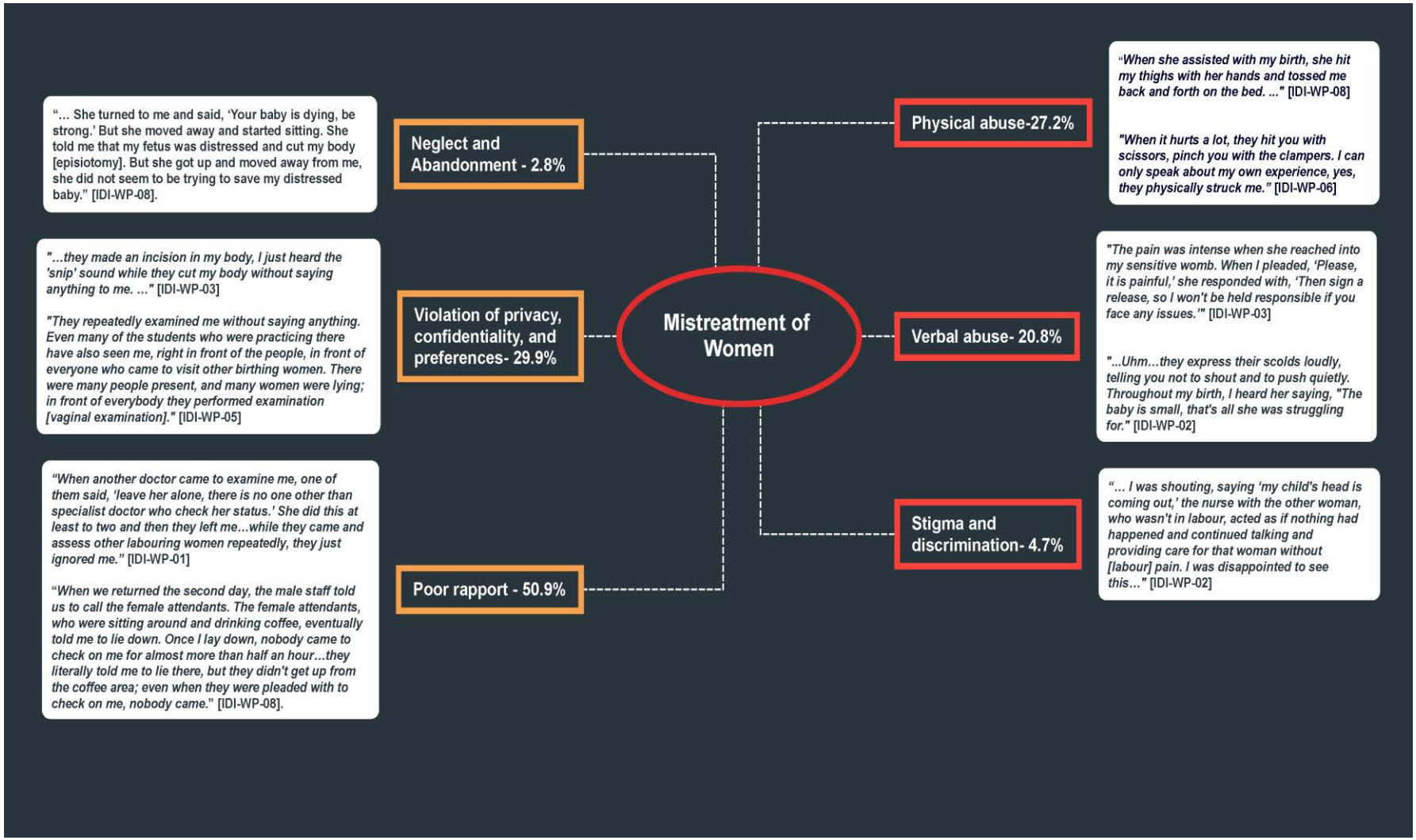

Figure 8.1: Merged display from quantitative and qualitative findings from mistreatment of women during maternity care in East Wollega Zone, western Ethiopia, 2022

8.5. Summary

The overall study identified mistreatment of women as a pervasive issue, acting as a barrier to the provision of maternal healthcare services. The survey results and interview findings highlighted various forms of mistreatment, encompassing intentional abuses such as interpersonal abuse, as well as mistreatment occurring during the care process. The occurrences of mistreatment were attributed to several underlying drivers, including providers' prejudices toward women, provider burnout, negligence, fear of blame for negative outcomes, reduced empathy levels, negative perceptions of the working environment, lack of accountability and responsibility from leadership, and disproportions in client-provider ratios.

The mistreatment of women has been identified as resulting in various influences. It affects the continuity of maternity care, undermines trust between providers and women, and leads to short-term psychological impacts that influence long-term decisions regarding future births. Overall, these findings suggest that the mistreatment of women during maternity care stems from a variety of complex factors. Addressing this issue requires immediate collaborative efforts involving healthcare providers, health facilities, researchers, government entities, and communities to eliminate such practices. It calls for the establishment of a culture of respectful care characterised by mutual respect.

A detailed discussion of these overall findings and their practical implications based on the study's results is provided in the next chapter.

CHAPTER 9: DISCUSSION, IMPLICATIONS AND CONCLUSIONS

9.1. Chapter preface

The previous five chapters have presented the findings of research that examined and explored the mistreatment of women during maternity care from both the women's and healthcare providers' perspectives. This discussion chapter will support the study's findings by comparing, exploring and examining the findings in relation to pertinent and contemporary global literature regarding the mistreatment of women during maternity care from across the world, with a primary focus on low- and middle-income countries. The chapter begins with a brief overview of overall findings and then delves into a discussion on the magnitude, drivers, and consequences of the mistreatment of women during maternity care. It also explores the implications of the findings. Finally, the chapter closes by presenting the strengths and limitations of the research, offering recommendations for future work, and summarising conclusions regarding the overall research aims.

In alignment with the researcher's epistemological stance, the mistreatment of women continues to be regarded as a by-product of multiple drivers involving various actors in the health system, creating a complex barrier to the quality of maternal and childcare. This philosophical underpinning guided the integration of the Socioecological Framework of Violence Against Women (Heise, 1998) and the WHO's Quality of Care Framework (QoC) (Tuncalp et al., 2015) to explore the core concept of the mistreatment of women.

Hence, in this study, the 'mistreatment of women during maternity care' encompasses abusive personal experiences and perceptions of women, any deviation from the professional standard of care, including service conditions, treatments women experience, and humiliating interactions between women and healthcare providers. This perspective avoids assigning personal blame and focuses on what women experience during service reception, its drivers and consequences, and the way forward.

For noting and clarity, the term ‘health care providers’ or ‘HCPs’ refers to a multi-professional team, including midwives, obstetricians, nurses, and health officers. When the midwife is the sole carer, this distinction will be consistently maintained throughout the chapter, which is the case for the entire thesis as well.

9.2. The magnitude of mistreatment of women during maternity care

The findings of this study highlight the range of mistreatment experienced by women in health facilities during antenatal, birth and postnatal care. As outlined in the WHO’s typology of mistreatment of women (Bohren et al., 2015), mistreatment encompasses verbal abuse, physical abuse, sexual abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and healthcare providers, and health facility or system-related constraints. Consistent with these classifications of mistreatment, all forms of mistreatment, except for sexual abuse, were reported in both the quantitative and qualitative findings of this study.

Among these forms of mistreatment, the first three, physical abuse, verbal abuse or stigma and discrimination were considered as intentional and, therefore, align with the

societal context of violence against women (Heise, 1998). The deliberation that the mistreatment of women during maternity care aligns with violence against women in the society is supported by the previous work by Jewkes et al. (2015), who considered mistreatment of women during childbirth as a subset of violence against women. The remaining forms of mistreatment align with health system failures and issues encountered during the process of caregiving, which is closely related to the overall quality of care (Tuncalp et al., 2015). Therefore, the following discussion of the magnitude of mistreatment will be organised around these two main categories: interpersonal abuse and mistreatment in the process of care.

9.2.1. Interpersonal abuse

A significant proportion of women in this study reported encountering interpersonal abuse during their recent antenatal care, birth, or postnatal care experience. Approximately two out of every five women (37%) who participated in the survey reported being exposed to interpersonal abuse, including 27% experiencing physical abuse, 21% experiencing verbal abuse, and 5% encountering perceived stigma and discrimination. Most of the abuse (87%) was reported exclusively to occur only during labour and birth, with the remaining incidents distributed across all care periods, including during antenatal care, birth, and postnatal care.

Women who participated in the study shared their experiences of mistreatment, primarily during their labour and birth. They reported instances where healthcare providers physically hit them, exposed them to painful procedures, and subjected them to frequent verbal abuse, such as insults, yelling, mockery, and negative comments related to their characteristics. Additionally, they reported perceived discriminatory actions. These

findings indicate that, despite efforts to promote respectful maternity care, mistreatment of women continues to be a daily reality that many women experience during service utilisation at public health facilities.

A direct comparison of the prevalence of interpersonal abuse revealed in this study with the magnitude found in previous studies is not possible due to variations in the research tools used to measure mistreatment, as well as differences in the contexts of data collection and reporting. For instance, the results reported from direct observation, exit interviews of women during discharge, and community (home) surveys were found to yield different magnitudes of mistreatment, even in studies conducted with the same participants and facilities but at different data collection contexts (Ajayi et al., 2023; Banks et al., 2018; Sando et al., 2016; Ukke et al., 2019). Furthermore, most of previous studies report mistreatment as "any form of disrespect and abuse", conflating various forms such as verbal, physical, or discriminatory acts with facility failures like the lack of beds or giving birth on the floor while in the facility (Bekele et al., 2020; Sheferaw et al., 2019; Siraj et al., 2019). While such an approach may increase the overall sensitivity towards any aspect of mistreatment, aggregation without considering the multidimensionality of the constructs makes it challenging to compare the extent of mistreatment and to identify and implement targeted interventions (Bohren et al., 2018; Sando et al., 2017).

In general, the specific types of mistreatment reported in this study were also found in previous studies with variances in the extents of mistreatments (Ahmed, 2022; Bobo et al., 2019; Bohren et al., 2019b; Wassihun et al., 2018). The prevalence of physical abuse in the current study (27%) was lower relative to previous studies conducted in Ethiopia, where the prevalence ranged from 37-57% (Bobo et al., 2019; Mihret, 2019; Wassihun et

al., 2018). The extent of physical abuse was also lower than that reported in other sub-Saharan African countries, such as Tanzania, Ghana, Guinea, and Nigeria, where it ranged from 36-50% (Bohren et al., 2019b; Sando et al., 2016). However, it was observed to be higher than other previous findings where the prevalence of physical abuse were revealed to be 2% in Ethiopia (Sheferaw et al., 2019), 5% in Tanzania (Kruk et al., 2018c; Sando et al., 2016), and 24% in Iraq (Ahmed, 2022).

While contextual and methodological variations might have contributed to the observed variation in the extents of physical abuse, including and excluding of sub-types or specific indicators of mistreatment also contributes for the variations in extents between studies. For instance, Sheferaw et al. (2019) measured physical abuse only depending on whether the women was 'hit /slapped/pinched by the provider'. This undermines the true degree of mistreatment, as physical abuse is not solely related to being hit, slapped, or pinched; it also encompasses the acts of forceful pushing, fundal pressures, and denial of pain-relieving agents, among others, as observed in this study.

Similar to physical abuse, verbal abuse and discrimination were also observed to varying degrees, although the rates vary when compared with previous research. In the present study, 21% of women reported experiencing some form of verbal abuse, including being shouted/screamed at, insulted, scolded, mocked, hissed at, referred to with negative comments, threatened, or being blamed. This rate is lower than prevalence in studies conducted in Ethiopia by Bobo et al. (2019) —35% and Bekele et al. (2020) —37%, and higher than in studies conducted by Sheferaw et al. (2019) —8%, Wassihun et al. (2018) —8%, and Shemelis et al. (2022), 15%. These variations could be the result of contextual differences in the indicators believed to demonstrate verbal abuse, while variations in

study areas and other contexts could be a factor. For instance, Wassihun et al. (2018) and Shemelis et al. (2022) conducted their studies in relatively urban areas, contributing to lower occurrences of mistreatment than the current findings. Living in rural or slum areas, or being perceived as "dirty" or unkempt, were identified as factors linked to an increase in the humiliating experiences that women encounter with increment of humiliating experiences women encounter (Bohren et al., 2015).

Interpersonal abuse, which encompassed instances of non-dignified care such as verbal abuse and physical abuse which included the act of hitting a woman to enforce compliance with orders, is not a new finding or phenomenon, these types of behaviours have been reported previously in earlier qualitative studies (Adinew et al., 2017; Balde et al., 2017; Bohren et al., 2017c; Lusambili et al., 2020; Warren et al., 2017). Negative comments related to a woman's lack of cleanliness, and staff favouritism based on high social status (such as education and economic status), familiarity between the woman and health care providers, and partiality in relation to implementing health facility policies (e.g., related to birth companions) were all identified as reasons predisposing to discriminatory actions in line with previous studies (Abuya et al., 2015b; Balde et al., 2017; Bobo et al., 2019). In multi-diversified areas, racial variations were also cited as a factor contributing to care provider prejudice, which further increased a woman's risk of mistreatment (Mohamoud, 2023; Vedam et al., 2019). However, in this particular study, no discriminatory action based on a woman's ethnicity was observed in either the qualitative or quantitative data.

The variations observed in the extent of mistreatment between the current study and previous studies could be correlated with various issues, ranging from methodological

differences such as tools used, data acquisition methods, and the context in which the study was conducted to changes in practices related to the recommended policy changes taken in some facilities. Although the overall magnitude of mistreatment in the current study appears to have slightly declined in comparison with some of earlier studies (Bekele et al., 2020; Bobo et al., 2019), it does not reflect the ambition envisioned by the Ministry of Health in successive transformational agenda that aims to equip health facilities with companionate, respectful, motivated and committed workforce (Ministry of Health, 2015, 2021b).

9.2.2. Mistreatment in the process of care

The instances of abuse experienced by women in relation to their experience of care appeared to be associated with the by-products of how services were set up and provided rather than the behaviours of specific individual care providers. These instances were confirmed by both qualitative and quantitative findings. Some forms of mistreatment stemmed from deliberate malevolence, such as collective abandonment of women by groups of providers after labelling them as non-cooperative or non-respectful behaviour towards an individual nurse, or midwife. Around one third of women (30%) reported being exposed to occurrences which could be categorised under the failure to maintain professional standards of care, where non-confidentiality, privacy violations, non-consented care, negligence and abandonment were also practised. Additionally, issues such as lack of adequate information or misinformation due to poor rapport (51%), along with health facility-related failures originating from limitations in infrastructure and overcrowding (6%) were revealed.

Maintaining professional standards of care is a crucial aspect in achieving quality care, and is a standard that should be valued and upheld by every healthcare provider (World Health Organization, 2018b). The omission of essential components of standard care regarding patient safety indicates a lack of quality care and, of course, mistreatment itself. Such failures in professional standards of care, such as breaches of privacy, confidentiality, and unconsented care, were widely reported in previous studies (Banks et al., 2018; Bobo et al., 2019; Shemelis et al., 2022). In this study, women reported being examined in front of others, where both visual and auditory privacy including confidentiality were disregarded and violated, this included the disregard of obtaining a woman's informed consent before certain procedures were carried out. Structural issues such as the absence of curtains and screens, and multiple individuals being accommodated in a single room contributed to a lack of dignity. To further complicate the over crowdedness related to the number of women in a single room, in most Ethiopian health facilities, including the hospitals and health centres included in this study, it is common to observe a high number of students from multiple disciplines including midwives, nurses, medicine, health officer students, in a non-emergency situation with a single birthing mother. This practice adds to the repeated violation of the rights of women to be free from non-dignified care and autonomy. Such and a continued practice reinforce the lack of respect and dignity to a woman's right to privacy and informed consent. Such neglect should be upheld as a breach of woman's autonomy and fragility in professionalism, regardless of physical environment and situation.

Respectful and effective communication between a midwife and/or other health care professional and a woman will support the autonomy of women while addressing their

emotional and psychological needs by informing them of what to expect, what is happening, while seeking their preferences about the care they would like to receive (Tuncalp et al., 2015). Common understanding between a woman and midwife, effective communication can also create a personal bond to enhance women's confidence in the care they receive (Horwood et al., 2019). However, around half of the surveyed women in this study reported a lack of emotional support, voicing that they felt their concerns were not heard. Women were also restricted from moving during labour and prevented from having a companion accompany them to their appointments and birth, resulting in woman being left alone during labour, with their calls for help being ignored despite repeated requests.

Women were not provided with an explanation, neither was consent sought before and after invasive procedures such as a vaginal examination or episiotomy were performed. The findings from this study confirm the previous findings of inadequate communication in several other studies (Sethi et al., 2017; Sheferaw et al., 2019; Vedam et al., 2019), where some HCPs mentioned being so 'caught up' with the procedure, they failed to maintain good communication between themselves and the woman (Kruger et al., 2009). Despite effective and honest communication being a cornerstone of good quality care, and its absence considered mistreatment Garcia-Jorda and colleagues report that obstetricians viewed communication explaining 'what is done' and 'why it is done to each patient' as a repetitive and exhaustive duty (Garcia-Jorda et al., 2012).

A failure to meet quality standards of maternity care, and system and process failures in the healthcare system should not be overlooked, especially when it leads to women experiencing mistreatment related to the health system (Freedman et al., 2014b).

Findings from the interviews and surveys described a lack of physical resources for privacy/confidentiality as described earlier, the absence of beds for women to birth on or sleep in resulting in women being left alone overnight on couches where they gave birth. Additionally, it is a common occurrence for there to be inadequate essential drugs and medical supplies available even in emergency lifesaving situations, forcing midwives to care for women without the basic essential resource, including caring for women with retained placenta without the use of analgesics/anaesthesia. Furthermore, a lack of referral ambulances to transport women living in rural areas to the hospital, or those in health centres to hospitals, disrupted the timely and quality care that every woman deserved from facilities, which was exacerbated more related to the instability in the area.

These indicate a failure of the health system when most women are encouraged to come to health facilities to give birth without adequate readiness on the part of the health system to handle the overwhelming number of women seeking their services. It could be suggested that such ongoing system failures impact and influence the behaviour of midwives (primary maternal care providers) in addition to the stress filled setting (Getahun et al., 2023), paving the way for interpersonal abuse and creating a situation where women feel uncared for. This highlights the importance of building a resilient and responsive health system with policies that adapt and transition to the growing challenges and demands.

Such health system-related failures are indicative of Ethiopia's struggles in maternal and child health, particularly in the Oromia Region where this study was conducted. In Oromia Regional State, key indicators confirm only 71% of pregnant women received ANC, 44% had a birth attended by a midwife and other HCPs, which was below the national average

of 48%, 26% received postnatal care, and 56% of women gave birth without the assistance of midwives in the Oromia Region (Ethiopian Public Health Institute, 2021). Currently the country is experiencing critical health workforce density issues, where it is estimated to be 1.0 per 1,000 population (midwives—0.17 per 1,000 population, nurses—0.56 per 1000 population, medical doctors—0.10 per 1,000 population and health officers—0.14) (Ministry of Health, 2022), which is substantially lower than the recommended 4.45 per 1,000 population standard determined by the WHO (World Health Organization, 2016a). Moreover, there is an inadequate skill mix of professionals, with a relatively higher number of nurses and a significant shortage of midwives (one midwife to six thousand people) all contributing to the low quality of care and mistreatment of women who already came to the facility, and continue to be a barrier to continuity of care (Ministry of Health, 2022; World Health Organization, 2016a). The consequences of such deficiencies in health system, in terms of lack of adequate health workforce on the extents of mistreatment will be explored hereafter.

9.2.3. Healthcare providers reported the magnitude of mistreatment

Supporting the findings in Chapter Five, HCPs, including Midwives, Doctors, Nurses, and Health Officers, acknowledged instances of mistreatment in the facilities where they worked. They reported occurrences of self-committed mistreatment and instances where they had observed their colleagues' mistreating women, underscoring the significance of mistreatment against women in healthcare facilities. Alarmingly, three out of four HCPs (76%) admitted mistreating women in a variety of ways at least once, while almost all HCPs (93%) reported witnessing such behaviours from their colleagues.

Although there is variation in the methods used to measure mistreatment in this study and previous studies, findings from both Ethiopia (Asefa et al., 2018), and other SSA countries (Afulani et al., 2020; Moyer et al., 2021; Shimoda et al., 2020) underscore the significance of the mistreatment. Notably, in Ethiopia Asefa et al. (2018) found that 25% of respondents witnessed physical abuse during maternity services. Additionally, in other SSA countries, Afulani et al. (2020) observed 45% mistreatment self-disclosure among midwives and nurses in Kenya, Moyer et al. (2021) reported 39% in Ghana, and Shimoda et al. (2020) noted an alarming 96% self-disclosure of mistreatment in maternity services among healthcare professionals in Tanzania.

Such reports suggest health care providers acknowledge the existence of negative behaviours and practices in their facilities which could be considered as an important starting point to commence and intervention to alleviate its occurrence. However, it may also reflect the normalisation of mistreatment without a commitment to condemn its occurrence. An explanation frequently offered for this abusive behaviour is the influence daily working conditions including a busy and demanding working environment leading to an increase HCPs' stress and burnout levels as suggested by Nutor et al. (2022). This perception becomes more of a reality when many HCPs, who participated in the interviews for this study, expressed a sense of despair and hopelessness regarding the working environment and current situation in their facilities.

This section of the discussion provided an explanation of extents of mistreatments from women’s and various maternal HCPs perspectives’ including Midwives, Nurse, Doctors and Health Officers. The next section of the discussion will consider the main drivers of mistreatment of women.

9.3. Drivers of the mistreatment of women

Regardless of the circumstances, there is no justification or defence that supports or excuses midwives or any other health care professionals mistreating women at any time particularly during a vulnerable time such as pregnancy and birth. It is, however, important to identify the driving factors that can lead to the acceptance or the normalisation of such behaviours. The Socioecological Framework with multifaceted and interconnected viewpoints, as described by Heise (1998), have been adapted to understand the drivers of mistreatment in maternity services as identified in the research. The drivers behind the mistreatment of women were found to originate from the personal or individual characteristics and beliefs held by HCPs and included factors related to interpersonal interactions, contextual factors within health facilities where care is provided, and the health system through which service delivery is being implemented, and the societal context in which maternity care is delivered in Ethiopia.

In this research, one of the personal level factors, which relates to the macrolevel factors of predisposing violence against women, can be considered in terms of the shared public perception in Ethiopia of the marital status and sexuality of young women in society. Qualitative data from HCPs suggested younger women were more prone to verbal and physical and interpersonal abuse. The mistreatment experienced by young women can be attributed to the personal views and judgments of HCPs/midwives about pre-marital sexual activity and pregnancy at a young age influenced by community perception regarding these factors. In Ethiopia, according to the Ethiopian Demographic and Health Survey (EDHS) (Centeral Statistical Agency, 2017; Ethiopian Public Health Institute, 2021) the median age at first sexual intercourse is 16.6 years, and the age of their first

birth would be 18.7 years among women aged 25-49. This contrasts with the legal age of marriage of 18 years and above, as stipulated by Revised Family Code Proclamation No. 213/2000, Article 7 (Federal Democratic Republic of Ethiopia, 2000). Distressingly, 10 to 15 years after the proclamation of the law, between 2011 and 2016, 40% of young women under the age of 18 and 14% continue to be married before their 15th birthday (Jones et al., 2016). Early marriage often occurs forcefully without consent, driven by gender inequality and a societal patriarchal acceptance that girls are somehow inferior to boys, and consequently, a low value is placed on girls' education. Girls and young women live in fear of risked abduction and rape; some live and grow up in a cultural and gender norm that accepts marriage at 15 as customary and view women as too old if they do not agree to marry early. Such conventional behaviours lead to some young women choosing to marry early accepting it as normal and will agree to an early marriage to avoid gossip or being labelled as 'unwanted' (Marshall et al., 2016). Despite the availability of laws that criminalise child and forced marriages (Federal Democratic Republic of Ethiopia, 2000), only one-quarter of those exposed to physical or sexual violence sought help, which highlights the normalisation of violence against women in the community and a weakness to reinforce the law (Centeral Statistical Agency, 2017). While midwives and other HCPs recognise the presence violence against women in the community, they chastise and are disrespectful towards young married women as if they were wilfully married or become pregnant and that is mistreatment toward young women.

Although there is no national representative study exposing the prevalence of gender-based violence against women in Ethiopia, the 2016 EDHS (Centeral Statistical Agency, 2017) reported that 23% of women aged 15-49 experienced physical violence, 10%

experienced sexual violence, 4% experienced physical violence during pregnancy, and 34% of married women experienced partner physical, sexual, or emotional violence. While this community tolerates various forms of violence against women, including early marriage, the societal view becomes markedly intolerant when young women were found to be unintentionally pregnant before marriage, which is considered unacceptable both socially and religiously (Baraki et al., 2023; Molla et al., 2008). This societal perspective towards premarital sex and pregnancy may influence the behaviours exhibited by HCPs, given the fact that they are also part of the society. The preconceived notions and unacceptability surrounding sexual activity and pregnancy, particularly among unmarried women, can contribute to the mistreatment of younger women, as also reported by Bohren et al. (2015). It is essential to emphasise that the possibility exists that unmarried young women may also be exposed to sexual violence in the community, leading to unintended pregnancies.

While midwives or other HCPs expressed their interaction with younger women by asking young women, “why did you get pregnant at this age; you should have focused on education and personal growth; you are not ready for the bigger responsibilities of having child”, such intended advice is a form of verbal abuse, which has been commonly reported in other studies as well (Amroussia et al., 2017; Maya et al., 2018). Healthcare providers often also characterise young and primiparous women as non-tolerant and uncooperative, frequently using these perceptions and beliefs to justify mistreatment (Balde et al., 2017).

Similar to the age-related abuse, the marital status of women, was also a factor in mistreatment of women. The belief held by some HCPs that young unmarried women do

not want or deserve a baby, were purported by healthcare providers as a reason why some unmarried birthing women encountered mistreatment during their pregnancy and birth. While national data on the prevalence of unmarried women giving birth is lacking, the incidence of unintended pregnancies is notably high in Ethiopia, reaching an overall prevalence of 23.5% among formerly married and unmarried women (Tebekaw et al., 2014). This could be influenced by inadequate access to contraceptives, with only six out of ten women's demand for contraceptive use being reported as satisfied nationally (Centeral Statistical Agency, 2017). Based on interview data and supported by previous studies, some HCPs justified mistreatment by suggesting that young, unmarried women might engage in behaviours harmful to the baby intentionally. The rationalisation offered from some midwives suggested they believed using physical or verbal abuse to control young women was carried out in the belief that they are saving the baby's life (Afulani et al., 2020; Dzomeku et al., 2020; Orpin et al., 2018). Instead, there was no awareness that the pregnancy could be the result of rape or relationship sexual violence. In such circumstances and in line counselling and psychological support rather than mistreatment should be offered (World Health Organization, 2014). Both the International Confederation of Midwives and Ethiopian's Midwives Code of Conduct outlines that all midwives are expected to uphold ethical standards in meeting diverse needs of women, including those who need psychological support with a motive of no woman or young girl should be harmed by pregnancy or childbearing (Ethiopian Midwives Association, 2021; International Confederation of Midwives, 2014).

In this research perpetrators of mistreatment were found to exist in all professional groups including Doctors, Midwives, Nurse and Health Offices, however, there were relatively a

higher number of complaints from women directed towards midwives, as reported in a previous study by Galle et al. (2020). This could be attributed to it is midwives who are often the main provider who interacts most closely with women and their families, particularly in health centres where obstetricians are absent. Conversely, hierarchical power dynamics in larger facilities may enhance the probability of lower-level providers in the hierarchy mistreating women (Bradley et al., 2019; Galle et al., 2020; Rominski et al., 2017). Stressful working environments including busy health care centres, lack of staff and resources may be a factor leading to the mistreatment of women especially when the providers themselves experience mistreatment from higher/senior providers or even clients (Asefa et al., 2018).

Another microlevel factor influencing whether some women may experience mistreatment is the presence of a companion during maternity care. In this study, the presence of a companion was found to decrease the likelihood of mistreatment, which is consistent with earlier studies (Balde et al., 2020; Bobo et al., 2019; Wahdan et al., 2023). Although the presence of a companion during labour and birth has been shown to enhance the well-being of both the woman and her baby by providing continuous psychological care (Bohren et al., 2019a; Bohren et al., 2017a), yet despite this evidence the findings from this research show instances of inequality in implementing companion-related policies between different health centres and hospital. Despite being recommended to be an integral components of respectful maternity care by Ministry of Health (Ministry of Health, 2021b; Ministry of Health, 2017), there is no national policy that enforces the implementation of companionship and this results in an individual facilities ignoring or developing their own policy. Women in this study perceived the lack of opportunity to have

a birth companion with them as an inequality and discrimination. While it may be challenging to implement the policy of every woman having the option of a birth partner due to operational and structural challenges such as small birthing rooms and the business of the birthing unit, with very low midwife-to-population density in the country (0.17 midwives per 1000 population) (Ministry of Health, 2021a). This denies women the option of choice and companionship during an emotional, and for some, a fearful and challenging time in which they continue to face childbirth on their own without support (Singh et al., 2021).

Globally, maternal and child health care and midwifery practice, is considered as challenging and replete with dilemmas and stressful situations (Getahun et al., 2023; Hunter, 2004). In this study HCPs reported experiencing daily stressful working conditions in their facility, which they indicated was a factor in driving mistreatment of women. According to the survey findings, HCPs with positive perceptions for working environment and higher levels of empathy were less likely to engage in mistreatment towards women compared to their counterparts. The interviews strengthened these findings, revealing healthcare providers' neglected self-perception, were influenced by working conditions such as overwork, underpayment, lack of institutional recognition, exhaustion, burnout, and negligence, all which predisposed them to mistreat women in their care. Providing care in such psychologically stressful conditions were reported to negatively affect providers' empathy levels, leading to dissatisfaction and a sense of despair which were reflective of the care they provided (Birhanu et al., 2018; Getahun et al., 2023; Nutor et al., 2022).

Recognising and empowering midwives in such demanding working conditions have been documented to enhance the quality of care provided to women (Brodie, 2013; Filby et al., 2016). This is an area, despite the Ministry of Health's ambitious plan to create motivated, competent, and compassionate midwives and other HCP Ethiopia continues to fall short (Ministry of Health, 2021b). A lack of empowerment results in demoralisation, frustration and even cognitive fatigue overtime (Zhou et al., 2021), all which were factors discussed in this study. In such circumstances, perhaps it is not surprising to find that mistreatment becomes normalised both by midwives and women.

Issues related to resources in health facilities were also identified as situational drivers of mistreatment at health facilities level. Rural-based HCPs, particularly midwives, reported acute shortages of staff, where it is normal for a single midwife to bear the responsibility of providing services and care to all women seeking antenatal, labour and birth care, and postnatal care for both women and their babies. In such situations, the midwife would be expected to provide care based on a priority of need, meaning if a midwife found themselves occupied providing care for a woman or women in active labour and giving birth, women who are visiting the health facility for antenatal care or in the early stages of labour would feel neglected and abandoned. Galle et al. (2020) found similar findings in their study which explored the situation that lack of adequate personnel and emergency encounters all leads to expose women being disrespected or abandoned.

In Ethiopia, the primary maternal and child healthcare providers are midwives (Ministry of Health, 2021b), with an average of three midwives in each health centre providing care over a 24 hour shift pattern (Ministry of Health, 2021a). Related to this low number of midwives, women in this study reported a lack of adequate care and service at smaller

health centres and preferred to transfer to larger hospitals, leading to an increased flow of pregnant women attending the larger hospitals, where interpersonal and other forms of mistreatment were frequently reported (Asefa et al., 2015; Bobo et al., 2019; Sheferaw et al., 2017). This emphasises the need for significant attention to resolving the limited resources including human resources in smaller health centres to enhance their women centred responsiveness and functionality.

The WHO, in its global survey among midwives, revealed midwives in some low to middle-income countries, despite the daily working challenges they faced, were committed to providing quality care. The challenges included a lack of recognition, disrespect at work and in the community, and under-remuneration that failed to meet basic needs (World Health Organization, 2016b). Healthcare providers in this study faced the same stressful working environments; and midwives in particular raised concerns about high workloads, lack of recognition, blame, and feelings of being ignored by the health system and the government—which is similar in most public health facilities of the country administered under the same health system creating culture across all facilities. Midwives who practice in continuous stressful conditions can become frustrated and develop a sense of helplessness when they feel unable to change or influence their own working environment, leading to feelings of diminished self-worth and feelings of fear and powerlessness within service provision.

In the Ethiopian health system, doctors are perceived more superior to nurses and midwives, creating a power imbalance in health facilities. This study highlights such perceptions as raised by midwives, indicating disparities in the treatment from managers including incentives and risk-related allowances. High variation in salary was also

recognised in a World Bank report— which highlighted that Medical Specialists (Obstetricians) earn 77% more than Midwives and Nurses (World Bank groups, 2023), which creates a class divide between midwives and doctors. Unfair treatment and favouritism in health facilities leads to a large power imbalance and divide within the hierarchical class of the health system, combined with the psychological impact of negative experiences, all which can contribute to the mistreatment of childbearing women (Bradley et al., 2019; Jewkes et al., 1998; Schaaf et al., 2023; World Health Organization, 2016b).

Previous literature has reported on the normalisation and acceptance of mistreatment (Balde et al., 2017; Maung et al., 2020). Mistreatment of women was reported as acceptable both by women and HCPs when it was deemed to be necessary when a woman was found to be 'uncooperative' and 'disobedient' during birth (Balde et al., 2017; Hagaman et al., 2022). In contrast to previous studies, the women interviewed in the current study reported on the unacceptability of mistreatment towards them, whether directed towards them or others, regardless of any underlying factors. In this study and confirmed in a previous study by Maya et al. (2018), some HCPs associated mistreatment with taking charge and vindicated their behaviour as being related to saving lives and believing that their actions were carried out as a result of being in an ethical dilemma, between respecting woman's dignity versus saving a baby in an obstetric emergency, as well as preventing adverse outcomes (Maya et al., 2018).

When contemplating mistreatment during maternity care, the role that gender and gender inequality play must be considered. Kiftew as early as 2006 discussed the relationship between gender norms, the impact of violence against women and gender inequalities in

Ethiopia (Kifetew, 2006). In this study, the research did not uncover any great difference in the gender of HCPs perpetrating mistreatment. However, the survey findings revealed more male midwives self-reported more mistreatment actions than female midwives. During the interviews, both male and female HCPs reported witnessing mistreatment from both gender groups. Rigid gender norms in the community were cited as a significant factor influencing the equity of women, which has been also linked to the mistreatment of women in health facilities (Betron et al., 2018; Jewkes et al., 2015). Despite limited evidence, Betron et al. (2018) reported a connection between gender inequality and mistreatment. Both current and previous studies lack sufficient evidence to explain how gender inequality and violence against women manifest themselves in health facilities and contribute to the mistreatment of women. Further focused studies are needed on the intersectionality of social and gender norms in relation to the mistreatment of women in health facilities.

Effective leadership is a crucial component of health system function and is considered essential for the quality of services provided in health facilities globally, not just only in Ethiopia (Sfantou et al., 2017). Health system should reinforce accountability and responsibility, as highlighted by Brinkerhoff (2004). Beyond rhetoric and blaming, the implementation of accountability measures would address inappropriate behaviours and, at the same time, champion those practising in a respectful manner (Hilber et al., 2016). Despite well-documented evidence and institutional acceptance of the importance of accountability and responsibility in health facilities, breaches of accountability and responsibility were also identified as driving factors for mistreatment in this study. In this study, negative perceptions among healthcare providers towards their workplace and

senior management were found to increase the likelihood of mistreatment and serve as driving factors for the poor quality and mistreatment of women. These findings imply a struggling leadership group unable or unwilling to call out mistreatment occurring among its workforce indicating a lack of accountability and responsibility from all levels of the organisation.

The profound feelings of despair and hopelessness were attributed to the perceived lack of recognition of midwives' and other HCPs' working conditions and roles from the government and senior leaders in the healthcare system. As well as the lack of recognition, HCPs in the country are grappling with challenging living conditions, aggravated by high market inflation and an ongoing civil war, although it should be acknowledged mistreatment during maternity care was occurring before the outbreak of the civil war in Ethiopia. Ethiopia reported a year-on-year general inflation rate of 28.8% in July 2023, and ranking as the fifth-highest inflation rate in Africa according to the Ethiopian Statistical Service (2023). To provide some further context regarding low wages, the mean monthly salary of survey participants in this study was 7301.24 Ethiopian Birr, approximately equivalent to 200 Australian Dollars per month (6.67AUD ≈ 4.37USD per day), which is little higher than extreme poverty line of $2.15 a day (The World Bank, 2023). This economic strain, coupled with perceptions of low payment, disparities in payment between groups of professionals and lack of recognition further intensify feelings of despair and unequal power dynamics, increasing psychological and physiological stress among HCPs (Afulani et al., 2021). One suggestion is that HCPs can project their grievances onto women (Afulani et al., 2020), leaving women feeling powerless to confront or report such conditions. The HCPs' attempt to control women

through mistreatment, could lead to mistreatment being viewed as normal and accepted behaviour (Freedman et al., 2018).

In the preceding discussion section, factors contributing to mistreatment were examined and discussed. The following section will explore issues related to the repercussions of the mistreatment of women in health facilities and consequences of the mistreatment.

9.4. Consequences of the mistreatment of women

Mistreatment of women in health facilities is often not an isolated incident or occurs without lasting consequences. Women remember their birth experience for a long time. Mistreatment poses a real threat and critical challenge to the woman's experience and overall satisfaction in quality of care while impacting on the delivery of women centred dignified care. This study identified various potential and actual consequences of mistreatment, including it being a barrier to maternity service utilisation, complications to the birth process, negatively impacting the psychological well-being of women and eroding the trust and reputation of the healthcare system, health facilities, and importantly, HCPs.

Mistreatment of women was found to negatively affect the continuity of maternity care in this study, cited as a deterrent to health service utilisation (Ababor et al., 2019; Kujawski et al., 2015; Leite et al., 2022). Nearly 50% of women who had experienced at least one form of interpersonal abuse, such as verbal abuse, physical abuse, or stigma and discrimination during any maternity care visit (antenatal care, labour, birth, or postnatal care), were found to disengage from the services altogether and discontinue seeking maternity care. This could explain what is driving the observed maternal care

discontinuation in Ethiopia, where of the 74% of women who commence antenatal care, only 48% gave birth in a healthcare facility, and 34% engaged in postnatal visits and checks between the years of 2017 and 2019 (Ethiopian Public Health Institute, 2021). This would suggest that mistreatment of women hinders women from engaging with and completing the continuum of care, resulting in reduced reputation and utilisation of maternity care despite its availability to most women.

When asked about the effects of mistreatment, women in the current study confirmed they were reluctant to continue to engage with the same facility where they had experienced mistreatment, opting instead to seek care at another public facility or through private services. The woman's decision to disengage or change health facilities influenced by the fear of future mistreatment and psychological anxiety has been confirmed by previous research (Adinew et al., 2017; Maya et al., 2018; Mayra et al., 2022).

The decision to change health facilities in itself is not a concern, as long as women continue to receive care from skilled providers. However as verified in this study and supported by Gebremichael and colleagues (2018) when pregnant women are mistreated, they will make a decision to give birth at home without the help or support of a qualified midwife rather than return to the health care facility or hospital when they have been mistreated. Women who are financially resourceful and have means to pay for a private clinic may make the decision to switch to private health care. However, for many women in Ethiopia, changing to a private health care facility and provider is not a viable option, rather women in less financially capable situations are left with no other option than to make the decision to remain at home and give birth unaided, with the potential

risk and consequences of an obstetric emergency such as a postpartum haemorrhage. Currently, Ethiopia does not offer the option of providing birthing at home with a midwife (Ministry of Health, 2021b), so if a woman chooses to stay at home, she does so without the support of a midwife or skilled birth attendant. Regardless of the risks involved it would appear birthing alone with support from family and friends or a traditional birth attendant was preferable to receiving care in a facility where the woman was at risk of receiving mistreatment from the very care providers who should care and protect her. Such scenarios and perceptions are posing critical challenges to both healthcare facilities and HCPs reputation.

Mistreatment not only drives a woman away from engaging with healthcare facilities and qualified midwives but also has a profound psychological impact on their well-being. The psychological consequences secondary to feelings of shame and regret from mistreatment are unimaginable, increasing the risk of postnatal depression, which is prevalent in LMICs (Gelaye et al., 2016). A psychological effect of mistreatment was an increase in the likelihood of developing postpartum depression (Silveira et al., 2019) and women who experienced mistreatment during birth had a 50 to 69% increased prevalence of symptoms suggestive of postpartum depression (Paiz et al., 2022). Although this study did not measure postpartum depression, qualitative findings suggest mistreatment led to psychological distress, with women reporting the effects of interpersonal abuse as well as feelings of being ignored and abandoned. The women's distress a lack of social support, a factor documented to contribute to postpartum depression (Cho et al., 2022).

Another consequence of mistreatment is women being left alone during labour and birth which can result in unanticipated obstetric emergency, including fetal non-reassuring

conditions in utero or severe bleeding, which can rapidly lead to a woman's or fetal compromise (World Health Organization, 2005, 2017). The unpredictable nature of complications makes it crucial to identify and address emergencies promptly. However, neglecting or abandoning women during labour and birth can result in devastating outcomes, including stillbirth, neonatal death, and maternal death. Some women in the current study reported a history of neonatal deaths in their previous births, attributing it to a lack of response from healthcare providers indicating negligence, abandonment, or caregivers with the necessary skills to identify a deteriorating woman and/or foetus (Leite et al., 2023; Taghizadeh et al., 2021). This emphasises the severity and consequences of mistreatment, potentially leading to both maternal and and/or neonatal deaths (Ministry of Health, 2021b; World Health Organization, 2018b).

This section of the discussion focused on the consequences of mistreatment. The next part of the thesis will delve into the implications of the study, exploring its impact on policy, practice, and further research.

9.5. Implications of the study

The findings from this study suggest that the mistreatment of women manifests either as direct interpersonal abuse or mistreatment during the provision of maternity care. While the findings in this research build on existing evidence, it also found that mistreatment of women does not only occur during birth but also during the delivery of antenatal and postnatal care. Accordingly, the focus of policies that aim to eliminate mistreatment and enhance respectful maternity care should include antenatal and postnatal care as well.

Findings from both the qualitative and quantitative data imply that there are several factors that impact the mistreatment of women. It results from the interplay of various interacting drivers within the healthcare delivery system including the social status of the women in terms of violence against women in the community, provider prejudice, attitudes, and perception issues. Interpersonal conflicts, resource constraints, salary, low staffing, weak policy enforcement, governance issues, and civil unrest further complicate the problem, hindering providers' resilience to offer respectful care. Therefore, this study implies that the efforts to improve respectful care and reduce mistreatment need to balance the micro- and macro-level factors without overshadowing one another.

The mistreatment of women has been identified as a factor undermining service utilisation from health facilities where skilled HCPs like midwives, nurses, and doctors deliver services. If the current trend of mistreatment during maternity care persists, it will continue to have a detrimental impact on the utilisation of the maternal continuum of care. This concerning trend of mistreatment, in turn, jeopardises the achievement of the set targets to reduce the MMR to 279 per 100,000 live births and the Neonatal Mortality Rate to 21 per 1,000 live births by the year 2025 (Ministry of Health, 2021b). Therefore, addressing and sustaining the momentum to equip health facilities with competent, compassionate, and motivated midwives and other healthcare cadres is imperative.

Addressing the mistreatment of women during maternity care requires comprehensive committed efforts from many, including healthcare providers, health facilities leaders, the community, the health system, the government and national and international stakeholders through directed interventions (Kasaye et al., 2023). Health system/facility constraints, such as resource limitations and lack of adequate staffing, may not be directly

related to mistreatment, however, they significantly impact the way healthcare providers behave, often resulting in interpersonal abuse. While it is crucial to embrace the principle of 'working with what you have,' as advocated by Ndwiga et al. (2017), the lasting effects of chronic limitations within the health system cannot be overlooked, as they erode the providers' resilience over time. A commitment from Ministry of Health, Regional Health Bureau and all health facility administrators across the health system is required to improve the working environment regarding resources, job fairness, and the emotional well-being of health care providers.

The result from the reviews of interventions, presented in Chapter 2, highlight the importance of taking multi-component interventions to reduce promote a culture of respectful care in health facilities. These findings align with findings from the later chapters, where emphasise the need to improve working conditions for HCPs. This includes recognising their positive contributions, supporting them in delivering respectful care, strengthening their empathy and encouraging sensitivity to violence against women in society.

9.6. Recommendations from the study

Preventing the mistreatment of women and ensuring respectful maternity care should not be a future vision or goal; it should be the minimum standard of care delivered in every health facility for all women and families right now. Interventions that incorporate addressing the diverse drivers of mistreatment through multicomponent strategies, including individual behaviours, attitudes, health facilities, health systems, and community advocacy for respectful care, have been found to reduce the occurrence of mistreatment

and enhance the culture of respectful maternity care in low-and-middle-income countries based on the systematic review conducted in this thesis (Kasaye et al., 2023). Therefore, the following recommendations are put forward for policy, practice, education, and future research work to alleviate the occurrence of mistreatment of women in the area and beyond.

9.6.1. Policy Development

The Ethiopian Ministry of Health, the Ethiopian Midwives Association, and other stakeholders have been actively working to enhance the culture of respectful maternity care and improve positive childbirth experiences in the country. However, the mistreatment of women during maternity care in Ethiopia remains a pervasive issue along the care continuum. Therefore, HCPs, health facility leaders, regional health bureaus, the Ministry of Health, and other professional associations should be called on to reassess their approaches to service provision.

Improving the health system to ensure the safe delivery of clean, woman-centred services is essential. However, it is also recognised that the presence of funds or adequate resources and qualified personnel does not guarantee the removal of mistreatment and the delivery of respectful maternity care. This realisation will only be achieved through individual professionals' goodwill, commitment, and professionalism. Caring for the caregivers should not be overlooked as this is equally important. Healthcare providers who provide maternal and child health care, in particular midwives, often work in overburdened circumstances, continuously responding to and addressing challenges of anxious clients and managing life-threatening cases. This demands a '24/7' commitment, deserves respect, recognition and support from managers and health care organisations.

Supporting HCPs so that they provide care, compassion and kindness in a respectful and dignified manner is essential and could be realised through a multi-pronged effort. Firstly, the implementation of multi-component interventions, which include transforming the values of providers, engaging women and communities in how the maternity service is delivered. Secondly, establishing policies that recognise and champion high-performing providers, and addressing issues observed by enforcing respectful care policies and empowering lower-level providers should be considered to overcome the suffering of women in health facilities.

Creating awareness about respectful maternity care and the impacts of mistreatment across healthcare facilities is not sufficient. A dedicated Respectful Maternity Care Protocol should be independently designed and implemented in all health facilities, involving the active participation of all healthcare providers. The success of its implementation should also be monitored.

Monitoring the implementation of the RMC protocol and instances of mistreatment is essential. This can be achieved through the systematic collection of data from women, and establishing means for reporting occurrences of mistreatment, such as a reporting redress system or designated hotspots for complaints. Additionally, encouraging the community to demand respectful maternity care and facilitating legal actions against any outrageous abusive actions in health facilities are crucial steps in ensuring accountability and promoting a culture of respectful and dignified maternity care.

High rates of mistreatment and complaints from women were observed from individuals who received maternity care in hospitals, highlighting its significance in facilities where higher caseload, emergency conditions, and complications are anticipated. For this

reason, it is recommended that health facilities, especially hospitals, serve as role models for health centres by promoting respectful care as a competency required from every healthcare provider and by strengthening accountability within the facility. Additionally, we propose enhancing health centre functionality by improving the referral system, fostering positive feedback mechanisms and supportive supervision between hospitals and health centres, and influencing communities to demand respectful care.

9.6.2. Practice

The mistreatment of women was found to be associated with negative workplace perceptions and decreased empathy levels among healthcare providers. While the importance of maintaining a positive workplace perception and increased empathy levels in maternal healthcare provision could be intuitionally recognisable, it is essential to investigate the underlying factors that contribute to negative perceptions and declining empathy levels at the individual level. Therefore, we recommend that health facilities audit healthcare providers' workplace perceptions, issues predisposing providers to possess negative perception and lowered empathy levels and thereby design innovative ways to improve working conditions as well as empathy levels. One of the actions could be providing awareness creation workshops with health professionals regarding the importance of re-evaluating one's empathy while providing care.

All midwives and other maternal HCPs should adopt a nuanced and sensitive approach when supporting young women by prioritising psychological support and well-being during antenatal care, labour, birth, and afterward, assisting them in adapting to becoming a mother.

Furthermore, to address the often unnoticed or unreported issue of women's mistreatment, health facilities should consider implementing ways for women and others to independently provide feedback on the behaviour of professionals, the services provided by the facility, and any other encounters within the health facility. This could include establishing a hotline reporting centre, a redress system, and a feedback book where individuals can share their experiences and file complaints independently.

9.6.3. Education

Another potential issue requiring consideration is how healthcare providers' education and training are approached and delivered in the country. Currently, the curricula used to train healthcare providers predominantly focus on the skill acquisition and the biomedical aspects of maternity care. Healthcare training institutions in Ethiopia, including universities and colleges, must broaden their focus to include the development of graduates' abilities in humanistic aspects of care and enhanced empathy, in addition to the good beginning of integrating respectful care in the content of training. While preventing adverse outcomes and complications is important, it is insufficient to focus on that aspect of care alone.

Graduating Midwives/ other HCPs should also demonstrate a high sense of empathy that enables them to understand the psychosocial aspects affecting patients, in this case women, newborns and the family.

9.6.4. Research

In recent years, especially during the COVID-19 pandemic, there have been reports of increased incidences of sexual violence/rape worldwide which also results in unplanned

pregnancies (Singh et al., 2023), including in Ethiopia, where pre-existing violence against women is known to be a pervasive societal issue(Wood et al., 2022). As evidenced in the current study, young unmarried mothers were at an increased vulnerability to mistreatment during childbirth when accessing health facilities. Studies that focus on reporting the double burden of sexual violence in the community and the mistreatment of women in health facilities are required to reinforce respectful and dignified care in health facilities and to address the pervasive violence against women throughout the community.

Ethiopian health facilities are unique in that they have many male midwives relative to the rest of the world(Sannomiya et al., 2019). In this study, an increased prevalence of self-reported mistreatment was observed among male midwives compared to their female counterparts. Further investigation is warranted to delve deeper into the underlying drivers that contribute to the observed connections between gender, profession, and the likelihood of mistreatment towards women in the study area, as well as the country.

A decrease in empathy levels among HCPs was found to be associated with the mistreatment of women in this study. In midwifery and other caring professions having a higher level of empathy is considered a necessary competency, yet nationally representative data seems to suggest that the empathy levels of HCPs are low. Therefore, interventional studies demonstrating strategies to enhance empathy levels are required to improve HCPs empathy levels. For instance, one such strategy could involve assessing the possibility of recruiting students based on their empathy levels (at the time of recruitment), especially those aspiring to join the midwifery profession.

9.7. Researcher Reflexivity

As a deeply passionate midwife, the decision to investigate the mistreatment of women during maternity care as my PhD project originated from professional and personal motivations. Before starting my research journey, I had an opportunity to consider and explore the ongoing global and national focus of maternity care, and the importance and the necessity of having a compassionate, respectful, and caring health workforce, and the importance of respectful maternity care in midwifery.

Reviewing and hearing scenarios related to instances of violence, including physical, verbal, and discriminatory actions within health facilities where I work as a midwife tutor, evoked profound distress in me. As an insider in the study area and being a midwife currently working in the midwifery profession, I was not only privy to the prevalence of mistreatment but witnessed the consequences, leaving me with a sense of responsibility to shine a light on this critical issue. I also felt it was time to start my journey toward my doctorate with the aim of exploring its magnitude while listening to the voices of both women and healthcare professionals to understand the phenomenon of mistreatment while seeking solutions.

Before embarking on the research journey, I grappled with a range of emotions, anticipating the challenges inherent in investigating a matter so deeply intertwined with my professional identity. The prior awareness of mistreatment motivated me to initiate the study, yet I could not escape the concern that my pre-existing relationships within the field might influence the responses I would receive. I remember discussing this issue with my supervisors and opting not to include participants known to me or have another data

collector/interviewer. Another two data collectors have assisted me in collecting survey data from women and conducting some of the face-to-face interviews.

The fear of interviewing colleagues whom I might know personally loomed large. There was genuine concern that their responses could be swayed by the familiarity of our relationship, either in an attempt to please or to avoid potential judgment. This concern materialised during the data collection phase, with noticeable reluctance among some healthcare providers to participate in the study. Considering I had been working in the area as a midwife tutor for more than ten years at that time, the probability of being known by many midwives was very high, and I proceeded with contacting participants over the phone for an interview. The hesitancy to share contact information after taking part in the survey suggested a reserve that might have arisen from the discomfort of discussing sensitive topics with someone they knew and a fellow midwife. To overcome this barrier, I tried to ask about instances of mistreatment that they have heard or seen from other colleagues rather than directly asking them about whether they have mistreated women or not. This approach helped to show the extent of mistreatment in their facilities, while all healthcare providers responded to the self-administered survey questions by reporting their own mistreatment actions.

In the face of these challenges, I remained committed to maintaining the integrity of the research, ensuring that the voices of women experiencing mistreatment during maternity care were heard and that the findings contribute meaningfully to the broader discourse on improving maternal healthcare experiences. One unforgettable issue arose during data collection: a feeling of disappointment and shame as a midwife upon learning that many mothers were hesitant to seek healthcare, opting for home births due to concerns

about mistreatment. This disclosure and hearing the women's voices about their own experiences of mistreatment caused me sleepless nights, but my motivation persisted. I hoped to share their experiences, and break the silence surrounding mistreatment, and contribute to positive change.

As a male midwife born in a community where women are often treated as inferior, I feared any unconscious influence on my perception of the problem. I endeavoured to maintain authenticity, hear voices, and share their feelings. Some women might face a double burden—the violence (domestic or intimate partner) and the mistreatment in health facilities.

The other side of the story involves the challenges faced by healthcare providers, particularly midwives: unfavourable working environments, lack of recognition, financial instability, and job safety concerns. They appear to be in a state of hopelessness and despair, needing emotional stability and counselling themselves. Balancing these perspectives was challenging. I tried not to justify the working conditions health workers face with the mistreatment of women seeking help.

I had hoped to find relief from listening to the distressing experiences of women and midwives once the data collection was completed. However, hearing the recordings, translating and reading transcripts, and engaging in data analysis brought back those feelings. The question remains: when will we build a health system that responds to the needs of the community and prioritises the well-being of care providers? How long can the 'work with what you have' motto be sustained without breaking the hope and resilience of healthcare providers? These questions persist, and I continue to seek answers.

In reflecting on my personal experiences, I am reminded of the profound impact that tragedies such as the loss of my aunt and now my own sister while writing this thesis have had on my professional journey. The untimely death of my aunt, a result of mistreatment during childbirth, and the enduring suffering of my sister, who was trapped in an abusive marriage, serve as constant reminders of the urgency and significance of my research on the mistreatment of women during maternity care. These experiences have fuelled my determination to shed light on the systemic and structural issues that contribute to such injustices and to advocate for the voices of those who have been silenced by mistreatment. They have strengthened my resolve to create a healthcare system that prioritises compassion, respect, and dignity for all individuals, regardless of their circumstances. My personal tragedies serve as a constant motivation to drive positive change and to ensure that no one else experiences the same pain and loss that my family has endured.

9.8. Strengths and Limitations of the study

The strength of this research lies in the utilisation of data from both healthcare providers and women and the employment of a mixed methods approach, which enabled a detailed and in-depth analysis of the subject of mistreatment of women across the continuum of maternity care. Moreover, the mistreatment of women was measured using a survey tool based on the WHO typology of mistreatment which was developed through evidence-based investigation (Bohren et al., 2015). All domains were assessed to be valid and reliable in measuring women's experiences and healthcare providers' perspectives.

To the best of my knowledge, this study is the first to reveal the link between mistreatment and the completion of maternal continuum of care. It addresses critical gaps in the evidence by demonstrating an association between the mistreatment of women in health facilities during maternity care and subsequent maternal withdrawal from any further maternity care. Additionally, the study explores the correlation between healthcare providers' perceptions of the working environment and the mistreatment of women, as well as the link between mistreatment and empathy levels. These findings contribute to a more comprehensive understanding of the factors influencing the occurrence of mistreatment in health facilities.

Previous studies in Ethiopia have primarily focused on women's perspectives through exit interviews. While this approach may reveal the immediate situations women undergo, the psychological impact of their experiences might hinder them from discussing their experiences, particularly when they are approached early in the postnatal period and/or while still in the health facility. This was identified in previous studies, where the discrepancy in the extent of mistreatment reported by the same participants at exit interviews and a community survey was evident (Sando et al., 2016). In contrast, this research involved approaching women during their baby’s immunisation period, between six weeks and three months after birth, potentially allowing women time to overcome any anxiety or fear that it would impact their ongoing care.

The research also has several limitations. Firstly, this study was not able to associate mistreatment with individual health facility-level factors. These factors might have exposed why there were disparities in mistreatment observed among different facilities. Apart from the data obtained by qualitative interviews in this study, an observational

health facility assessment study that assesses the conditions of health facilities using tools that reveal limitations, such as Service Availability, Health Facility Readiness (World Health Organization, 2015b), and Service Provision Assessments (The DHS Program, 2022), in relation to the presence of mistreatment in a specific facility could have been informative also for the identification of the reasons behind negative workplace perceptions of providers.

Conducting interviews via telephone limited the ability to grasp the nuanced nonverbal cues that often enrich communication and understanding. In addition, to avoid social desirability biases, HCPs were asked about instances of mistreatment that they had heard or seen from other colleagues rather than directly asking them about whether they have mistreated women or not. Although they have responded in a survey, this might undermine the possibility of self-reported mistreatment.

It is not possible to generalise the findings of this study to the rest of the target population. Even though approaching women at immunisation clinics might be considered an option to increase the probability of exposing what women experienced during maternity care, selection bias remains due to the potential of lost participants who may not utilise immunisation clinics. It is also important to acknowledge that women who attend immunisation clinics might have relatively increased health-seeking behaviour than others in the target population, which includes those who prefer home birth and could have less health-seeking. Hence, the extent of dropout from the maternal continuum of care could be higher than what was identified in the current study. Lastly, the causal relationship between mistreatment and the discontinuation of the maternal continuum, the low empathy levels and mistreatment of women, and the negative perception of HCPs

towards their workplace and the mistreatment of women were not fully established due to the nature of the study design.

9.9. Conclusions

Despite national and global efforts to combat the mistreatment of women during maternity care, a significant number of women in this study reported experiencing mistreatment during antenatal, birth, or postnatal care, highlighting the urgent need for further action in this area. The continuation of mistreatment reduces the trust that women have in health services, further hindering the delivery of continuity of midwifery care. Women experiencing abuse during their care are less likely to continue with the recommended number of antenatal appointments, prefer to birth at home unassisted without midwife services and will avoid engaging in postnatal care for themselves and their babies.

The mistreatment of women originates from factors aligning with personal, micro-, meso, exo- and macro-level factors, which necessitate integrated multi-component interventions that target individual value transformation, health facility readiness and responsiveness, health system policy that enforce and enable the provision of respectful maternity care.

This is the final chapter of the thesis, which has summarised the overall findings of the study, identified the merits and limitations of the research and provided recommendations for policy development, practice, education, and future research. As previously mentioned, this study is the first study to reveal the link between mistreatment and the completion of the maternal continuum of care. The impact of reduced empathy levels, as well as healthcare providers' negative perceptions of their working environment, was also identified as a predisposing factor for the mistreatment of women by healthcare providers.

While this thesis represents a significant contribution to understanding the mistreatment of women during maternity care, further work should seek means through which health professionals' empathy levels and perceptions of their working environment and other contributing factors, including the violence towards women in the community, can be improved. Overall, eliminating mistreatment from health facilities cannot be achieved solely by focusing on changing individual healthcare professionals' attitudes and behaviours. Instead, collaborative commitment from all stakeholders—including health facility administrators, policymakers, professional associations, and the entire community—is necessary with the goal of achieving respectful care for all, regardless of circumstances.

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APPENDICES

Appendix 1: Distress protocol

MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY

The following protocol was followed should a participant became distressed and require additional or ongoing assistance. The interview and survey participant information sheet contain information regarding community counselling services available in the community. Should participating women become distressed during the interview, notification of this information will be verbally given during and following the interview.

STRATEGIES TO ASSIST THOSE DISTRESSED DURING SURVEY / AN INTERVIEW

Should a participant become uncomfortable or distressed while discussing their experience mistreatment during maternity care, the following actions will be taken by the data collectors and the researcher conducting the interview:

1. The researcher will pause the interview and offer the participant the option of stopping the interview, regrouping or continuing. If the participant chooses to continue, the researcher will remind the participant of the support services available to them and that they can stop the interview at any time. If the distress is mild and likely to be transient, the researcher will encourage the participant to share their feelings with their regular support network and to continue to monitor their feelings over the next two days to see whether they resolve, continue or worsen. They will also be reminded at the end of the interview of the option for seeking further support (as described below).

The researcher will follow up with the participant as described below. If the participant chooses to stop the interview or regroup:

- The researcher will ask the participant how they would like to proceed, e.g., take a short break, reschedule the remainder of the interview for another day/time, or cease participation altogether.
- Before interview termination, time will be spent with the participant and assistance provided, within the scope of the interviewer's abilities and scope of ethical research, to discuss their concerns and support them, if deemed appropriate by the interviewer.
- The participant will be recommended to speak to a mental health professional and be directed to the health centre and linked to the nearby district hospital or specialised hospital in Nekemte, as the need arises.
- If the participant has a personal phone the researcher will make a follow-up phone call the following day to ensure that the participant is okay. During this call, the information previously provided regarding counselling services will be reinforced.

2. If the participant's distress reflects **acute distress** or a safety concern, the researcher will:
    - Cease the interview
    - Seek a Subjective Units of Discomfort (SUD) rating from the participant (i.e., on a scale of 1-10, where 0 = no distress and 10 = extreme distress) to establish the severity of distress

- Immediately contact the Chief Investigator (who is a trained/experienced researcher) for advice
- The participant will be recommended to speak to a mental health professional and be directed to the health centre and linked to the nearby district hospital or specialised hospital in Nekemte, as the need arises.

Ceasing participation

Further to the above strategies, if a participant ceases participation, they will be offered the option of having their data (collected to date) removed from the project.

CONTACT DETAILS PROVIDED TO DISTRESSED PARTICIPANTS

If any distressed participants require further help, they will be referred to Nekemte Specialised Hospital or Wollega University Hospital, both found in Nekemte, the capital of the East Wollega Zone. Both facilities offer professional counselling services.

It is important to note that it is unlikely that these interviews will result in a distressing result for the participant; however, it is understood that it is the interviewer's duty of care to the participant to put these strategies in place prior to commencing the interview interviews.

Distress and Safety Protocol: Researcher (PhD student)

The following protocol will be put in place should the researcher become distressed or be at risk during field work and require emergency, additional or ongoing assistance:

1. The researcher will have regular meetings with their supervisors

2. The researcher will be referred to UTS counselling service to discuss their concerns or a referral made to their Employee Assistance Program

3. The researcher will always carry a mobile phone while working in the field and will share the contact details and location of the interviews with research team

Appendix 2: Participants Information Sheet for women

[ETH21-6587] MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY

Who is conducting the research?

This research project is being conducted by researchers from the University of Technology Sydney, Centre for Midwifery, Child and Family Health, Faculty of Health. We are conducting research in East Wollega Zone, Oromia Regional State, West Ethiopia, 2021. You are invited to participate in this study.

What is the research about?

The research explores the mistreatment of women when they access maternal health care at health facilities during 2021 in East Wollega Zone, Oromia Regional State, Western Ethiopia. It also looks at the effect of this mistreatment on women's decision to continue using their maternity care services. The study will have two parts; the first is a survey, while the next is a qualitative interview.

Why have I been asked?

You have been invited to participate in this study because, as a woman who received maternal care from these health facilities, you may have experienced, witnessed or observed mistreatment of women in health facilities. If you gave birth during last three months and have received maternity care during this pregnancy, birth and postnatal period from public health facilities of East Wollega Zone, you are eligible to take part in this study. If you are, the researchers would be keen to have you participate in the study.

If I say yes, what will it involve?

If you decide to participate, the research assistant/data collector will provide you with consent form. You will be also given a survey to complete, either independently or, if you

prefer, with the help of a data collector. The survey will take about 20 minutes. Upon completing the survey, you will be asked if you are willing to participate in an interview. In that case, the lead investigator, Habtamu Kasaye, whose address is given at the end of this information sheet, will contact you to arrange a date an

time to conduct an interview.

What does the interview involve?

Participation in the interview is also entirely voluntary. It is up to you whether you participate or not. The interview will be conducted by specially trained interviewers and will take between 30 to 40 minutes in privacy. The focus of the interview is the same as the surveys, however the interview process will allow for in-depth discussion on the subject matter. There are no negative consequences to you if you decide not to participate in the interview stage of this study

Are there any risks/inconveniences or benefits?

You will be asked if you experienced mistreatment during pregnancy, childbirth, and postpartum from health facilities for you this last child. The risk of psychological harm due to participating in this study is small. This is because if you feel uncomfortable or distressed during the study, you can conclude the interview at any time without any negative consequences. Individualised counselling services are offered at this health centre / hospital. If you feel uncomfortable or stressed and willing to seek counselling, data collector or interviewer will be helping you access a counselling service from professionals in this health centre or Nekemte Specialised Hospital as per the requirement.

You will not be obliged to give any information which you don't want to answer. COVID-19 prevention practices will be adhered during this period. For being involved in this study, there is no payment you will be granted with, and no special privilege is also given to you. Perhaps, participating and giving information for the questions being asked plays a pivotal role in the effort made to identify the level and drivers of mistreatment that women experience in health facilities during maternity care and its effect on continued utilization of continuum of maternity care from health facilities during pregnancy, childbirth and postnatal care.

Do I have to say yes?

Participation in this study is entirely voluntary. It is up to you whether you participate or not.

What will happen if I say no?

If you decide not to participate, it will not affect your future health service utilisation or health centres/hospital's service provision. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

Confidentiality

By signing the consent form, you consent to collecting and using personal information about you for the research project. All this information will be de-identified and treated confidentially, and your name will not be mentioned anywhere. Your survey response will be given a code and will be combined with other participants' responses. The researchers will use this combined data for the analysis and dissemination of the study. Your information will only be used for this research project, and it will only b

disclosed with your permission, except as required by law. The researchers hope to highlight the results via publication in peer-reviewed journals and research conferences. If the research findings are circulated, information will be provided so that you cannot be identified.

What if I have concerns or a complaint?

This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines. It is also approved by Wollega University Institutional Research Ethics Committee. If you have any concerns or complaints about any aspect of the conduct of this research that you wish to raise independently of the research team, please contact Wollega University Ethical Review Committee chair at phone: +251(0)911780637 email [girmayek@gmail.com] or the UTS Ethics Secretariat

on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au] and quote the UTS HREC reference number ETH21-6587. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Name	Cell phone	Email
1. Habtamu Kebebe Kasaye	+2519XXX	Habtamu.kasaye@student.uts.edu.au; Production Note: email address removed prior to publication.
2. Prof. Kathleen Baird		Kathleen.baird@uts.edu.au
3. Dr Vanessa Scarf		vanessa.scarf@uts.edu.au
4. Dr Annabel Sheehy		Annabel.Sheehy@uts.edu.au

Odeeffannoo Hirmaatotaa-haadholiidhaf

Qorannoo kana eenyutu hojjataa jira?

Pirojektiin qorannoo kun hojjatamaa kan jiru qorattota Yuunivarsiitii Teknoolojii Siydiniitti, Giddugala Midwayferii, Fayyaa Ijoolleeti fi Maatiitti, Faakaltii Fayyatiin. Qorannoon kun Lixa Itiyoophiyaa, Bulchiinsa Motummaa Naannoo Oromiyaa jalatti kan argamtu, Godina Wallaggaa Baahaa keessatti bara 2022 ALAtti geggeeffama jira. Isinis qorannoo kana irratti akka hirmaattaniif kabajaadhan affeeramtaniirtu.

Qorannoon kun waa'ee maaliiti?

Qorannoon kun waa'ee cunqursaa dubartoota irra yeroo isaan yaala haadholii buufataalee fayyaa Godina Wallaggaa Bahaa keessatti argaman keessaa argatan irra gahu gad-fageenyaan adda baasa. Akkasumas dhiibbaa cunqursaan kun murtee dobartoonni tajaajila yaala haadholiidhaf walitti fufiinsaan kennamu ittii fufanii fudhachuu irratti qabaachuu danda'us ni ilaallata. Qorannoon kun kutaalee lama qaba, inni duraa sarvey yoo ta'u, inni itti aanu ammo af-gaaffii dha.

Ani maliifan gaaffatame?

Akka tajajilamaa tokkootti yemmuu tajaajila haadholiidhaaf bufatalee fayyaa keessatti kennaman hordoftan, cunqursaa dubartoota irra bufataale fayya kessatti irra gahuu arguu yookiis raga bahuu waan dandeessaniif. Ofii kessaniifis waan isin mudate dubbachuu ni dandeessu. Sababa kanaafi dha kan isin akka qorannoo kana irratti akka hirmaattan gaafatamtaniif. Yoo ji'oota sadan darban kana keessa kan deessan fi yoo xinnaate si'a tokko tajaajila da'uumsa duraa, da'uumsaa yookiin kan da'uumsa boodaa bufata fayyaa hospitaala irraa fudhattaniirtu yoo ta'e, ulaagaa hirmaatotaa waan guuttaniif, qoratonni akka isin hirmaattan barbaadu.

Yoon ani tole jedhe achi booda maaltu ta’a?

Yoo isin isin hirmachuudhaf murteesitan, namni odeeffannoo sassaabu unka walii galtee isiniif laata. Unki walii galtee isinii latamee kana erga mallateessitanii booda waraqaa gaaffii fi deebii dhuunfaa keessaniin yookiis namni odeeffanno sassabu isin gargaaruudhan akka gaffilee achirra jiran guuttan ni taasifama. Tilamaamatti gaffilee kanniin debstanii xumuruudhaaf hanga daqiiqa 20 isinitti fudhachuu ni danda’a. Erga guuttanii fixxanii booddee, af-gaffii irratti hirmaachudhaaf fedha akka qabdan ni gaafatam u. Fedha yoo qabaattan dursaan qorannoo kanaa Obboo Habtaamuun, teessoon isaanii kan dhuma waraqaa odeeffannoo kana dhuma irratti kan laatame isin qunnamuudhan af-gaaffichaf haala mijeessuun akka af-gaaffichi geggeefamu ni taasisu.

Af-gaaffiin maal fa’a of keessaa qaba?

Af-gaaffiin kunis fedha irratti hundaa’uudhan kan geggeffamu dha. Af-gaafficha kan geggeessu nama addaan lenji’ee yoo ta’u, tilmaaman hanga daqiiqaa 30-40 fudhachuu danda’a. Xiyyeffannan af-gaaffii kanaa kan gaaffii fi deebii wajjiin wal fakkaatus, mata-duricha irratti gad-fageenyaan mari’achuudhaf kan dhimmame dha. Yoo hirmaachuu hin barbaadne rakkoo tokko malee dhiisu ni dandeessu.

Wanti rakkisuu fi miidhaan inni qabu jiraa?

Hamma tokko wanti dubbachuudhaaf mijataa hin taane jirachuu ni danda’a. Kuniis waan walitti dhufeenya isin ogeessota fayyaa wajjiin yeroo da’uumsa dura, da’uumsaa fi da’uumsa booda buufataalee fayyaa keessatti qabdan gad-fageenyaan akka dubbattan gaafatuufi dha. Kana wajjiin wal-qabachuudhaan cunqursaalee ogeessota fayyaa fi haadholee giddutti uumamu irratti yaada akka kennitan gaafatamu ni dandeessu.

Haata'uutii yeroo af-gaaffichi geggeffamu yoo dhiphini isinitti dhagahame, rakkoo tokko malee af-gafficha addan kutuu ni dandeessu. Namni af-gaafficha geggessu fi dursaan qorannicha garagaasa isin barbaachisu danda'u irratti isin wajjiinin jiru. Tajaajilli gorsaa nama kamuufu haala isaan barbaachisuun laatamu bufata kanaafi Hospitaalota akka Naqamtee Ispeshalaziditti ni laatama. Yoo mirrii gaarii hin taane isinitti dhagahame isin cinqu jiraateef, Gargaarsa gorsaas ta'e kan biroo, buufata fayyaa kantti yookiin hospitaala isinitti dhihoo jiru haala barbaachisuun isiniif

mijeessudhaaf qophaa'oo dha.

Tole jechuun qaba?

Hirmaannan qorannoo kanaa kan fedha irratti hundaa'e dha. Kanaafuu murteen hunduu kan keessani dha.

Yoo ani lakki jedhe maaltu dhufa?

Yemmuu isin lakki hin hirmaadhu jettan, wanti kana wajjiin walqabatee haala kamiinuu isin qaqabu tokkoyyuu hin jiraatu. Akkasuma hirmaachuu dhabuun keessan, gara Yuunivarsiitii Teknoolojii Siydiiniitin qorattota irra qaqqabu hin jiraatu. Al-tokko hirmaachu erga egaltanii booddees, yeroo kamuu sababa ibsuun osoo isin hin barbaachisne addaan kutuu ni dandeessu.

Icciitii

Unka walii-galtee yemmuu mallatteesitan, fedha keessaniin odeeffannon isin wajjin wal-qabatu qorannoo kanaaf akka fayyaduuf eyyamamaa ni taatu. Odeeffannoleen kunniin kan enyuu irraa kan funaanaman ta'uu isaa akka addan baasuun hin danda'amnetti sassaabamu. Maqaan kessaan yookiin wantii addatti isin wajjiniin walqabatu tokkoyyu

hin fudhatamu. Deebiin isin gaaffiileedhaaf kennitan koodiin erga laatameefi booddee kan warren biroo irraa sassabaman wajjiin walitti makama. Kana booddee qorattonni qorannoo kana

ursaa jiran odeeffannolee kanniin walitti qabuudhan ni xinxalu. Odeffannon isin wajjiin wal-qabatu sababa qorannoo kanaatiif qofa oola. Bu'aa qorannoo kanaa qorattonni gara maxxansaalee idil-addunyaa ta'anii fi konfiransiilee gara gara irratti dhiheessuudhaaf abdii qabu. Yeroo kamuu yemmuu bu'aan qorannoo kanaa dhiyaatu, enyumman namoota qorannicha irratti hirmaatanii akka hin beekkamnetti ta'a.

Yoon yaada kennuu yookiis gaaffii gaaffachuu barbaade hoo?

Qorannoon kun koree naamusa qorannolee elaaludhaan ragasisan kan Yuniivarsiitii Wallaggaati fi Yuniivarsiitii Teknoolojii Sidynii biyya Awustraliyaatti aragamuun elaalamee kan raggasifame dha. Yoo yaadaa fi gaaffii qabaattan karaa tessoo namoota asii gaditti kennameen qunnamu ni dandeessu. Yoo yaada qoranicharratti qabaattan, Yunivarsii Wallaggaatti (Dayrektera qorannoo fi innoveshiinii akkasumas dura ta'aa koree naamusa qo'annoo fi qorannoo: [redacted] imeelii: [redacted] Yookiin Yuunivarsitii Teknolojii Awustaraliyaatii gara emeelii (research.ethics@uts.edu.au) ykn bilblilaan +61 2 9514 2478 qunnamu/hasofsiisu ni danddeessu. Yemmuu haala Kanaan nu haasofsiisu barbaadan, lakkofsa adda baastuu qorannoo kanaa kan ta'e UTS HREC ETH21-6587 kana fayyadamuun nuuf ergaa. Yaadni isin qabdan hundi iccittiin isaa eegamuudhan ni kessisamtu.

Maqaa	Lakk. bilbilaa	Imeelii
1. Habtamu Kebebe Kasaye	+2519XXX	Habtamu.kasaye@student.uts.edu.au; [redacted]
2. Prof. Kathleen Baird		Kathleen.baird@uts.edu.au

3. Dr Vanessa Scarf vanessa.scarf@uts.edu.au
4. Dr Annabel Sheehy Annabel.Sheehy@uts.edu.au

Appendix 3: Participants Information Sheet-Health Care Providers

MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY

Who is conducting the research?

This research project is being conducted by researchers from the University of Technology Sydney, Centre for Midwifery, Child and Family Health, Faculty of Health. We are conducting research in East Wollega Zone, Oromia Regional State, West Ethiopia, 2022. You are invited to participate in this study.

What is the research about?

The research explores the mistreatment of women when they access maternal health care at health facilities during 2022 in East Wollega Zone. It also looks at the effect of this mistreatment on women's decision to continue using their maternity care services. The study will have two parts; the first is a survey, while the next is a qualitative interview.

Why have I been asked?

You have been invited to participate in this study because, as a maternal health care provider in public health facilities of East Wollega Zone (midwife, nurse, medical doctor/obstetrician, emergency surgical officer, health officer), you may have witnessed or observed the occurrence of mistreatment of women in health facilities. You are eligible to participate in the study, and the researchers would be keen to have you in the study.

If I say yes, what will it involve?

If you decide to participate, you will be asked to contact the lead investigator, Mr Habtamu Kasaye, by email or telephone or text on telegram, whose contact details are supplied below. The lead investigator will then organise to contact you in person in the health

facility where you are working. At initial contact, you will be provided with a consent form along with a self-administered survey paper that you will undertake independently. You can do this at a time convenient for you. It will take you approximately 20 minutes. Once you finalise the response, you are kindly required to return the survey paper to Mr Habtamu Kasaye. Upon completing the survey, you will be asked if you are willing to participate in an interview.

What does the interview involve?

Participation in the interview is also entirely voluntary. The interview will be conducted by specially trained interviewers and will take between 30 to 40 minutes approximately. The focus of the interview is the same as the surveys, however the interview process will allow for in-depth discussion on the subject matter. There are no negative consequences to you if you decide not to

participate in the interview stage of this study.

Are there any risks/inconveniences or benefits?

Yes, there may be some inconvenience. You will be asked to share details of interactional experiences with women during antenatal care, birth and postnatal care. You may be asked to reflect on occurrences of mistreatment between health care providers and women that may provoke some emotional distress. If you feel uncomfortable or distressed during the study, you can stop completing the survey at any time without any negative consequence. The interviewer or the lead investigator will help you if you need support to handle stress. For being involved in this study, there is no payment you will be granted with, and no special privilege is also given to you. Perhaps, participating and giving information for the questions being asked plays a pivotal role in the effort made to identify the level and drivers of mistreatment that women experience in health facilities

during maternity care and its effect on continued utilization of continuum of maternity care from health facilities during pregnancy, childbirth and postnatal care.

Do I have to say yes?

Participation in this study is entirely voluntary. It is up to you whether you participate or not.

What will happen if I say no?

If you decide not to participate, it will not affect you either in your employment or your profession. There will be no negative consequence from the researchers at the University of Technology Sydney. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

Confidentiality

By signing the consent form, you consent to collecting and using personal information about you for the research project. All this information will be de-identified and treated confidentially, and your name will not be mentioned anywhere. Your survey response will be given a code and will be combined with other participants' responses. The researchers will use this combined data for the analysis and dissemination stages of the study. Your information will only be used for the purpose of this research project, and it will only be disclosed with your permission, except as required by law. The researchers hope to highlight the results via publication in peer-reviewed journals and research conferences. At any time, when research findings are circulated, information will be presented in such a way that you cannot be identified.

What if I have concerns or a complaint?

This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines. It is also approved by Wollega University Institutional Research Ethics Committee. If you have any concerns or

complaints about any aspect of the conduct of this research that you wish to raise independently of the research team, please contact Wollega University Ethical Review Committee chair at phone: +251(0)XXXX email [redacted] or the UTS Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au] and quote the UTS HREC reference number ETH21-6587. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

This research project was reviewed and approved by the institutional ethical committee of Wollega University and the University of Technology Sydney. If you have any questions, you can contact any of the following individuals at any time you want. If you have any concerns about the research, you can get either of these researchers or the Wollega University or UTS Ethics Secretariat (research.ethics@uts.edu.au).

Odeeffannoo Hirmaatotaa- Ogeessota Fayyaatiif

Qorannoo kana eenyutu hojjataa jira?

Pirojektiin qorannoo kun hojjatamaa kan jiru qorattota Yuunivarsiitii Teknoolojii Siydiniitti, Giddugala Midwayferii, Fayyaa Ijoolleeti fi Maatiitti, Faakaltii Fayyatiin. Qorannoon kun Lixa Itiyoophiyaa, Bulchiinsa Motummaa Naannoo Oromiyaa jalatti kan argamtu, Godina Wallaggaa Baahaa keessatti bara 2021 ALAtti geggeeffama jira. Isinis qorannoo kana irratti akka hirmaattaniif kabajaadhan affeeramtaniirtu.

Qorannoon kun waa'ee maaliiti?

Qorannoon kun waa'ee cunqursaa dubartoota irra yeroo isaan yaala haadholii buufataalee fayyaa Godina Wallaggaa Bahaa keessatti argaman keessaa argatan irra gahu gad-fageenyaan adda baasa. Akkasumas dhiibbaa inni murtee dobartoonni tajaajila yaala haadholiidhaf walitti fufiinsaan kennamu ittii fufanii fudhachuu irratti qabuus ni ilaallata. Qorannoon kun kutaalee lama qaba, inni duraa sarvey yoo ta'u, inni itti aanu ammo af-gaaffii dha.

Ani maliifan gaaffatame?

Isin kan qorannoo kana irratti akka hirmaattan afferramtaniif waan isin akka ogeessa fayyaa (Midwayfarii, Narsii, Doktara Ispeshalistii gadamessaa, Qondaala baqaqsaanii yaaluu hatattamaa, Qondaala Faayyaa) haadholiif tajaajila kennitaniiti, cunqursaa dubartoota irra bufataale fayya kessatti irra gahuu arguu yookiis raga bahuu waan dandeessaniif. Ulaagaa hirmaatotaa waan guuttaniif, qoratonni akka isin hirmaattan barbaadu.

Yoon ani tole jedhe, maal of keessatti qabata?

Yoo isin isin hirmachuudhaf murteesitan, dursaa qorattota kan ta'e Obbo Habtaamuu Kaasayee karaa imeelii, bilbilaa fi telegraamaatiin walqunnamu qabdu. Lakkoofsii fi

imeeliin isaanii unka kana irratti kennameera. Achi booda, dursaan qorattota buufata fayyaa/hospitaala isin itti hojjatanitti isin qunnamuudhaaf haala ni mijeessa. Jalqabarratti, unki walii galtee isinii latamee erga mallateessitanii booda waraqaa gaaffii fi deebii dhuunfaa keessaniin dubbisuudhaan deesbstan isiniif laatama. Isa kana yeroo isi

iif mejataa ta'etti guutu ni dandeessu. Tilamaamatti gaffilee kanniin debstanii xumuruudhaaf hanga daqiiqa 20 isinitti fudhachuu ni danda'a. Erga guuttanii fixxanii booddee, waraqaa gaaffii fi deebii sana Obboo Habtaamuutti akka deebistan ni gaafatamtu.

Af-gaaffiin maal fa'a of keessaa qaba?

Af-gaaffiin kunis fedha irratti hundaa'uudhan kan geggeffamu dha. Af-gaafficha kan geggeessu nama addaan lenji'ee yoo ta'u, tilmaaman hanga daqiiqaa 30-40 fudhachuu danda'a. Xiyyeffannan af-gaaffii kanaa kan gaaffii fi deebii wajjiin wal fakkaataa ta'uus, mata-duricha irratti gad-fageenyaan mari'achuudhaf mijataa dha. Yoo hirmaachuu hin barbaadne rakkoo tokko malee dhiisu ni dandeessu.

Wanti rakkisuu fi miidhaan inni qabu jiraa?

Hamma tokko wanti dubbachuudhaaf mijataa hin taane jirachuu ni danda'a. Kuniis waan walitti dhufeenya isin hadhoolii wajjiin qabdan kan yeroo da'uumsa dura, yeroo da'uumsaa fi da'uumsa booda gad-fageenyaan akka dubbattan gaafatuufi dha. Kana wajjiin wal-qabachuudhaan cunqursaalee ogeessota yaala fi haadholee giddutti uumamu irratti yaada akka kennitan gaafatamu ni dandeessu. Haata'uutii yeroo af-gaaffichi geggeffamu yoo dhiphini isinitti dhagahame, rakkoo tokko malee af-gafficha irratti hirmaachuu addan ku

uu ni dandeessu. Namni af-gaafficha geggessu fi dursaan qorannicha garagaasa isin barbaachisu danda'u irratti isin wajjiinin jiru.

Tole jechuun qaba?

Hirmaannan qorannoo kanaa kan fedha irratti hundaa'e dha. Kanaafuu murteen hunduu kan keessani dha.

Yoo ani lakki jedhe maaltu dhufa?

Yemmuu isin lakki hin hirmaadhu jettan, wanti kana wajjiin walqabatee isin irraatti haala kamiinuu isin qaqabu tokkoyyuu hin jiraatu. Akkasuma hirmaachuu dhabuun keessan, gara Yuunivarsiitii Teknoolojii Siydiiniitin qorattota irra qaqqabu hin jiraatu. Al-tokko hirmaachu erga egaltanii booddees, yeroo kamuu sababa ibsuun osoo isin hin barbaachisne addaan kutuu ni dandeessu.

Icciita

Unka walii-galtee yemmuu mallatteesitan, fedha keessaniin odeeffannon isin wajjin wal-qabatu qorannoo kanaaf akka fayyaduuf eyyamamaa ni taatu. Odeeffannoleen kunniin kan enyuu irraa kan funaanaman ta'uu isaa akka addan baasuun hin danda'amnetti sassaabamu. Maqaan kessaan yookiin wantii addatti isin wajjiniin walqabatu tokkoyyu hin fudhatamu. Deebiin isin gaaffiileedhaaf kennitan koodiin erga laatameefi booddee kan warren biroo irraa sassabaman wajjiin walitti makama. Kana booddee qorattonni qorannoo kana

ursaa jiran odeeffannolee kanniin walitti qabuudhan ni xinxalu. Odeffannon isin wajjiin wal-qabatu sababa qorannoo kanaatiif qofa oola. Bu'aa qorannoo kanaa qorattonni gara maxxansaalee idil-addunyaa ta'anii fi konfiransiilee gara gara irratti dhiheessuudhaaf abdii qabu. Yeroo kamuu yemmuu bu'aan qorannoo kanaa dhiyaatu, enyumman namoota qorannicha irratti hirmaatanii akka hin beekkamnetti ta'a.

Yoon yaada kennuu yookiis gaaffii gaaffachuu barbaade hoo?

Qorannoon kun koree naamusa qorannolee elaaludhaan ragasisan kan Yuniivarsiitii Wallaggaati fi Yuniivarsiitii Teknoolojii Sidynii biyya Awustraliyaatti aragamuun elaalamee

kan raggasifame dha. Yoo yaadaa fi gaaffii qabaattan karaa tessoo namoota asii gaditti kennameen qunnamu ni dandeessu. Yoo yaada qoranicharratti qabaattan, Yunivarsii Wallaggaatti (Dayrektera qorannoo fi innoveshiinii akkasumas dura ta'aa koree naamusa qo'annoo fi qorannoo: [redacted] imeelii: [redacted] Yookiin Yuunivarsitii Teknolojii Awustaraliyaatii gara emeelii (research.ethics@uts.edu.au) ykn bilblilaan +61 2 9514 2478 qunnamu/hasofsiisu ni danddeessu. Yemmuu haala Kanaan nu haasofsiisu barbaadan, lakkofsa adda baastuu qorannoo kanaa kan ta'e UTS HREC ETH21-6587 kana fayyadamuun nuuf ergaa. Yaadni isin qabdan hundi iccittiin isaa eegamuudhan ni kessisamtu

Name	**Cell phone**	**Email**
1. Habtamu Kebebe Kasaye	+2519XXX	Habtamu.kasaye@student.uts.edu.au; [redacted]
2. Prof. Kathleen Baird		Kathleen.baird@uts.edu.au
3. Dr Vanessa Scarf		vanessa.scarf@uts.edu.au
4. Dr Annabel Sheehy		Annabel.Sheehy@uts.edu.au

Appendix 4: Participants Consent Form – Survey

MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY

I, _____, agree to participate in the research project *Mistreatment of women during maternal health care utilisation in Ethiopia, a mixed-method study* being conducted by Habtamu Kasaye and the team.

I have read the participant information sheet.

I understand the purposes, procedures and risks of the research as described in the participant information sheet.

I have had an opportunity to ask questions, and I am satisfied with my answers.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers, health facility or my health care utilisation.

I understand that I will be given a signed copy of this document to keep.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

I am aware that I can contact either researcher or the Wollega University or UTS Ethics Secretariat, if I have any concerns about the research. The researchers can be contacted by these methods:

Mr Habtamu Kasaye (Habtamu.kasaye@student.uts.edu.au; +251 9XXX

Professor Kathleen Baird kathleen.baird@uts.edu.au +61 (02) XXX

Dr Annabel Sheehy annabel.sheehy@uts.edu.au +61 (02) XXX

Dr Vanessa Scarf vanessa.scarf@uts.edu.au +61 (02) XXX

_____

____/____/____

Name and Signature [participant] Date

_____

____/____/____

Name and Signature [researcher] Date

UNKA WALII-GALTEE HIRMAATTOTA- KAN SARVEEY

Ani, _____, qorannoo mata dureen isaa *Cunqursaalee haadholii irra yeroo isaan fayyaa hadholiitiif kennamu buufataalee fayyaa irraa argatan irra qaqabu Itoophiyaatti* jedhu irratti Habtaamuu Kaasayetii fi garee isa wajjiinin jiraniin geggeffamu irratti hirmaachudhaaf walii nan gala.

Waraqaa odeeffannoo hirmaattotaaf qophaaye dubbiseen jira.

Sababa qorannoon kun geggeffamaa jiruuf, haala inni ittiin gegeffamuu fi faayidaa fi dhiibbaa inni qaqabsiisu danda'u odeeffanno hirmaatotaaf qopha'e kanarra adda baasee bareen jira.

Gaaffii gaaffachudhaaf carraan naaf laatameera, akkasumas deebii quubsaan naaf laatameera.

Akkuma ibsamuudhaf yaalame, dhiibbaa tokko malee hirmaachudhaf yemmuun waliigalu akkasumas yeroo kamuu osoo inni dhiibbaa ana irratis ta'ee hariiroo ani qorattota wajjiin qabu irratti hin qabaatin hirmaannaa koo addaan kutuu/dhaabuu akkan danda'us hubadheen jira.

Akka koppiin unka walii-galtee kun erga mallatteffamee booda naaf kennamu naaf galeera.

Odeeffannon qoranno kana keessatti ana irraa funaanamu maxansaalee addaa addaa irratti kara enyumman koo hin baramneen akka inni maxxanfamu walii-galeera.

Yoon yaadaa fi gaaffii qabaadhe qorattota yokiinis Yunivarsitii Wallaggaa yookiin Yunvarsiitii Teknolojii Siydniitti garee namusa qorannoo fi qo'annoo qunnamu akkan danda'us naaf ifoomsameera. Qorattota argachuudhaaf, Habtamu Kasaye (Habtamu.kasaye@student.uts.edu.au; +251 9XXX), Professor Kathleen Baird (kathleen.baird@uts.edu.au; +61 (02) XXX), Dr Annabel Sheehy (annabel.sheehy@uts.edu.au; +61 (02)XXX), and Dr Vanessa Scarf (vanessa.scarf@uts.edu.au)

_____
____/____/____
Maqaa fi Mallattoo [hirmaataa] Guyyaa

_____
____/____/____
Maqaa fi Mallattoo [qorata/bakka bu'aa] Guyyaa

Appendix 5: Verbal consent script for survey

[ETH ETH21-6587] - *MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY*

Hello, my name is _____. I am a data collector for the research project being conducted by researchers from the University of Technology Sydney, Centre for Midwifery, Child and Family Health, Faculty of Health. This research is being conducted in East Wollega Zone, Oromia Regional State, Western Ethiopia, 2022. I would like to invite you to participate in survey and follow up in-depth interview. You have the option to decide to participate in the survey only.

The research explores the mistreatment of women when they access maternal health care at health facilities. The research survey and in-depth interview will take approximately 30-40 minutes each. You have been invited to participate in this study because you may have experienced, witnessed or observed mistreatment of women in health facilities.

As part of our formal study, I will be asking you to complete interviewer-administered survey questionnaire and an in-depth interview about your experiences. If you agree to participate the survey and the interview, the interview will be carried out on a different day and time when you attend the clinic. There is a possibility that some of these questions may make you uncomfortable or distressed; if so, please let me know. You don't have to answer all the questions if you don't want to. If you feel uncomfortable or upset by taking part in the study, and are willing to seek counselling support, a data collector or interviewer will be help you to access a counselling se

vice from professionals in the health centre or Nekemte Specialised Hospital.

All the information collected will be confidential and will only be used for the purposes of the study. All responses from participants will group in a de-identified format may be included in a written report, and/or papers. If you agree to participate in this study, you are providing us with permission to collect, use and share your unidentifiable information. If you have any concerns about the research, you can contact (Habtamu Kasaye – researcher) at [redacted]. If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772 or Research.ethics@uts.edu.au and quote this number [UTS HREC ETH21-6587] or Wollega University Ethical Review Committee chair at phone: +251(0)9XXX email

Do I have your permission to begin asking you questions?

- If the participant declines to provide verbal consent, thank the participant for their time.
- If the participants have had the verbal consent script read to them and agree to participate in the study, proceed to the questions.

_____

____/____/____

Name and Signature [researcher/data collector] Date

_____

____/____/____

Name and Signature [witness*] Date

* Witness to the consent process

This form could be witnessed by an independent person over the age of 18. The data collector may not act as a witness to the consent process. By signing the consent form, the witness attests that the information in the participant information sheet and consent form was accurately explained to, and understood by the participant (or representative) and informed consent was freely given by the participant (or representative)

ODEEFFFANNOO UNKA WALII-GALTEE AFAANIN KENNAMU

[ETH ETH21-6587] - *MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY*

Nagaan isiniif haa ta'u. Maqaan koo _____ jedhama. Ani garee pirojektiin qorattota Yuunivarsiitii Teknoolojii Siydiniitti, Giddugala Midwayferii, Fayyaa Ijoolleeti fi Maatiitti, Faakaltii Fayyatiin nama raga sassaba jiru dha. Qorannoon kun Lixa Itiyoophiyaa, Bulchiinsa Motummaa Naannoo Oromiyaa jalatti kan argamtu, Godina Wallaggaa Baahaa keessatti bara 2022 ALAtti geggeeffama jira. Isinis qorannoo kana irratti akka hirmaattaniif kabajaadhan affeeramtaniirtu.

Qorannoon kun waa'ee cunqursaa dubartoota irra yeroo isaan yaala haadholii buufataalee fayyaa Godina Wallaggaa Bahaa keessatti argaman keessaa argatan irra gahu gad-fageenyaan adda baasa. Gaafif deebii fi af-gaaffi gad-fageenyaan geggeffamu kan xumurudhaaf daqiiqa 30-40 fudhachuu ni mala. Akka nama tajaajila dubartootaf mana yaalatti kennamu fudhate tokkootti, cunqursaale hadholii irra gahuu danda'an arg

tanii yookiin isin qunamu danda'uutti yaadamuudhan akka hirmattaniif afferamtaniirtu.

Yoo heyamamaa taatan gaffii isiniif dubbifamaa deebistanii fi fedha keessani irratti hundaa'uudhan af-gaffii gad-fagenyaan geggefamu irratti akka hirmaattan ni taasifama. Gaafii fi deebii isiniif dubbifamu erga deebistanii booddee, ji'a booda fedha kessaniratti hunda'uudhan af-gaffii gad-fagenyaan tasifamu irrattis hirmachu ni maltu. Gaaffilee gafatamtan dubbachudhaf isin cinquu mala. Haata'uutii yeroo af-gaaffichi geggeffamu yoo dhiphini isinitti dhagahame, rakkoo tokko malee af-gafficha addan kutuu ni dandeessu. Namni af-gaafficha geggessu fi dursaan qorannicha garagaasa isin barbaachisu danda'u irratti isin wajjiinin jiru. Tajaajilli gorsaa nama kamuufu haala isaan

barbaachisuun laatamu bufata kanaafi Hospitaalota akka Naqamtee Ispeshalaziditti ni laatama. Yoo mirrii gaarii hin taane isinitti dhagahame isin cinqu jiraateef, Ggargaarsa gorsaas ta'e kan biroo, buufata fayyaa kantti /yookiin hospitaala isinitti dhihoo jiru

haala barbaachisuun isiniif mijeessudhaaf qophaa'oo dha.

Unka walii-galtee yemmuu mallatteesitan, fedha keessaniin odeeffannon isin wajjin wal-qabatu qorannoo kanaaf akka fayyaduuf eyyamamaa ni taatu. Odeeffannoleen kunniin kan enyuu irraa kan funaanaman ta'uu isaa akka addan baasuun hin danda'amnetti sassaabamu. Maqaan kessaan yookiin wantii addatti isin wajjiniin walqabatu tokkoyyu hin fudhatamu. Deebiin isin gaaffiileedhaaf kennitan koodiin erga laatameefi booddee kan warren biroo irraa sassabaman wajjiin walitti makama. Kana booddee qorattonni qorannoo kana

ursaa jiran odeeffannolee kanniin walitti qabuudhan ni xinxalu. Odeffannon isin wajjiin wal-qabatu sababa qorannoo kanaatiif qofa oola. Bu'aa qorannoo kanaa qorattonni gara maxxansaalee idil-addunyaa ta'anii fi konfiransiilee gara gara irratti dhiheessuudhaaf abdii qabu. Yeroo kamuu yemmuu bu'aan qorannoo kanaa dhiyaatu, enyumman namoota qorannicha irratti hirmaatanii akka hin beekkamnetti ta'a.

Gaaffii biro qabduu? Yoo gaaffii qabaattan, dursaa qorannichaa kan ta'an Obbo Habtamu Kasaye dubbisuu ni dandeettu. Lakkoofsa bilbilaa (+2519XXX). Yoo garee namusa qorannoo Yunivarsiitii dubbisuu barbaadan 02 9514 9772 or Research.ethics@uts.edu.au lakkofsa galmee qorannicha fayyadamuudhan [UTS HREC ETH21-6587] qunnamuu ni danddessu yookiin Yuunivarsiiti Wallaggaatti dura ta'aa koree naamusa qorannoo kan ta'an lakkoofsa bilbilaa isaanii +251(0)9XXX yookiin imeelii isaniitiin [redacted] qunnamuu ni dandeessu.

Qorannicha irratti hirmaachuudhaf heeyyamamoo taataniirtu?

Yoo hirmaataan heyyama hin laatne ta’e, galateeffachudhan gara nama itti aanutti darbaa.

Yoo hirmaataan fedha guutuudhan hirmachuuf murteessan, galateefachuudhan gara gaffifi deebitti darbaa.

_____

____/____/____

Maqaa fi mallattoo [qorataa/nama raga sassaabuu]

Guyyaa

_____

____/____/____

Maqaa fi mallattoo [raggaasisaa*] Date

* Nama walgateen kun ta’uu ragaasisuu

Yoo hirmaataan unka kana dubbisuu hin dandeenye ta’ee fi namni raga bahu dnda’u akka jiraatu barbaadan, walii-galteen kun nama umriidhaan 18 ol ta’een ragga’uu qaba. Namni daataa sassaabu akka ragaatti tajaajiluu hin danda’u. Unka kana irratti abbaan raga ta’e sun yemmuu mallateessu, odeeffannoon unka kana irratti dhihaatee fi kanneen barreffaman haala quubsaa ta’een hirmataadhaaf ibsamuu isaa fi hirmaachuudhaaf fedha guutuurratti hundaa’uudhan akka ta’e raga ba’u.

Appendix 6: Participants Consent Form- interview

MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY

I, _____, agree to participate in the research project *Mistreatment of women during maternal health care utilisation in Ethiopia, a mixed-method study* being conducted by Habtamu Kasaye and the team.

I have read the Participant Information Sheet.

I understand the purposes, procedures and risks of the research as described in the Participant Information Sheet.

I have had an opportunity to ask questions, and I am satisfied with my answers.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers, health facility or my health care utilisation.

I understand that I will be given a signed copy of this document to keep.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

I am aware that I can contact either researcher or the Wollega University or UTS Ethics Secretariat, if I have any concerns about the research. The researchers can be contacted by these methods – Mr Habtamu Kasaye (Habtamu.kasaye@student.uts.edu.au; +251 9XXX), Professor Kathleen Baird (kathleen.baird@uts.edu.au; +61 (02) XXX), Dr Annabel Sheehy (annabel.sheehy@uts.edu.au; +61 (02) XXX); and Dr Vanessa Scarf (vanessa.scarf@uts.edu.au;)

_____

____/____/____

Name and Signature [participant] Date

_____

____/____/____

Name and Signature [researcher] Date

UNKA WALII-GALTEE- KAN AF-GAAFFII

Ani, _____, qorannoo mata dureen isaa *Cunqursaalee haadholii irra yeroo isaan fayyaa hadholiitiif kennamu buufataalee fayyaa irraa argatan kan Itoophiyaatti* jedhu irratti Habtaamuu Kaasayetii fi garee isa wajjiinin jiraniin geggeffamu irratti hirmaachudhaaf walii nan gala.

Waraqaa odeeffannoo hirmaattotaaf qophaaye dubbiseen jira.

Sababa qorannoon kun geggeffamaa jiruuf, haala inni ittiin gegeffamuu fi faayidaa fi miidhaa inni qaqabsiisu danda'u odeeffanno hirmaatotaaf qopha'e kanarra adda baasee bareen jira.

Gaaffii gaaffachudhaaf carraan naaf laatameera, akkasumas deebii quubsaan naaf laatameera.

Akkuma ibsamuudhaf yaalame, dhiibbaa tokko malee hirmaachudhaf yemmuun waliigalu akkasumas yeroo kamuu osoo inni dhiibbaa ana irratis ta'ee hariiroo ani qorattota wajjiin qabu irratti hin qabaatin hirmaannaa koo addaan kutuu/dhaabuu akkan danda'us hubadheen jira.

Akka koppiin unka walii-galtee kun erga mallatteffamee booda naaf kennamu naaf galeera.

Odeeffannon qoranno kana keessatti ana irraa funaanamu maxansaalee addaa addaa irratti kara enyumman koo hin baramneen akka inni maxxanfamu walii-galeera.

Yoon yaadaa fi gaaffii qabaadhe qorattota yokiinis Yunivarsitii Wallaggaa yookiin Yunvarsiitii Teknolojii Siydniitti garee namusa qorannoo fi qo'annoo qunnamu akkan danda'us naaf ifoomsameera. Qorattota argachuudhaaf, Habtamu Kasaye (Habtamu.kasaye@student.uts.edu.au; +251 9XXX), Professor Kathleen Baird (kathleen.baird@uts.edu.au; +61 (02) XXX), Dr Annabel Sheehy (annabel.sheehy@uts.edu.au; +61 (02) XXX); and Dr Vanessa Scarf (vanessa.scarf@uts.edu.au;)

_____
____/____/____
Maqaa fi Mallattoo [hirmaataa] Guyyaa

_____
____/____/____
Maqaa fi Mallattoo [qorata/bakka bu'aa] Guyyaa

Appendix 7: Verbal consent script for interview

[ETH ETH21-6587] - *MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY*

Thank you so much for taking part in the survey and agreeing to participate in interview. This in-depth interview is a continuation of the survey research being conducted in East Wollega Zone, Oromia Regional State, Western Ethiopia, 2022.

The research explores the mistreatment of women when they access maternal health care at health facilities. This interview will take approximately 30-40 minutes. You have been invited to participate in this study because you may have experienced, witnessed or observed mistreatment of women in health facilities.

I will be asking you about your experiences of your pregnancy and birth. There is a possibility that some of these questions may make you uncomfortable or distressed; if so, please let me know. You do not have to answer those questions if you don't want to. If you feel uncomfortable or upset by taking part in the study, and are willing to seek counselling, I will help you to access a counselling service from professionals in the health centre or Nekemte Specialised Hospital.

The interview will be audio recorded to accurately record your responses. All the information will be strictly confidential and will only be used for the purposes of the study. All the responses from participants will grouped in a deidentified format, and may be included in a written report, and/or papers. If you agree to participate in this study, you are providing us with permission to collect, use and share your unidentifiable information.

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772 or Research.ethics@uts.edu.au and quote this number [UTS HREC ETH21-6587] or Wollega University Ethical Review Committee chair at phone: +251(0)XXX email

Are you still willing to be interviewed?

- If the participant declines to provide verbal consent, thank the participant for their time.
- If the participants have had the verbal consent script read to them and agree to participate in the study, proceed to the interviews.

_____

____/____/____

Name and Signature [interviewer] Date

_____

____/____/____

Name and Signature [witness*] Date

* Witness to the consent process

This form will be witnessed by an independent person over the age of 18. The data collector may not act as a witness to the consent process. By signing the consent form, the witness attests that the information in the participant information sheet and consent form was accurately explained to and understood by the participant (or representative) and informed consent was freely given by the participant (or representative).

Odeefffannoo Unka Walii-galtee afaanin kennamu

[ETH ETH21-6587] - *MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY*

Nagaan isiniif haa ta'u. Yeroo darbe gaaffifi deebii kutaa qorannoo Lixa Itiyoophiyaa, Bulchiinsa Motummaa Naannoo Oromiyaa jalatti kan argamtu, Godina Wallaggaa Baahaa keessatti bara 2022 ALAtti geggeeffama irratti hirmaachuu keessaniif hedduu galatooma.

Qorannoon kun waa'ee cunqursaa dubartoota irra yeroo isaan yaala haadholii buufataalee fayyaa Godina Wallaggaa Bahaa keessatti argaman keessaa argatan irra gahu gad-fageenyaan adda baasa. Af-gaaffi gad-fageenyaan geggeffamu kan xumurudhaaf daqiiqa 30-40 fudhachuu ni mala. Akka nama tajaajila dubartootaf mana yaalatti kennamu fudhate tokkootti, cunqursaale hadholii irra gahuu danda'an argitanii yookiin isin qunamu danda'uutti yaadamuudhan akka hirmattaniif afferamtaniirtu.

Muddannolee keessan wajjiin wantoota walqabatan irratti gafiilee adda addaan isiniif kaasa. Gaaffilee gafatamtan dubbachudhaf isin cinquu mala. Haata'uutii yeroo af-gaaffichi geggeffamu yoo dhiphini isinitti dhagahame, rakkoo tokko malee af-gafficha addan kutuu ni dandeessu. Ani garagaasa isin barbaachisu danda'u irratti isin wajjiinin jira. Tajaajilli gorsaa nama kamuufu haala isaan barbaachisuun laatamu bufata kanaafi Hospitaalota akka Naqamtee Ispeshalaziditti ni laatama. Yoo mirrii gaarii hin taane is

nitti dhagahame isin cinqu jiraateef, Ggargaarsa gorsaas ta'e kan biroo, buufata fayyaa kantti /yookiin hospitaala isinitti dhihoo jiru haala barbaachisuun isiniif mijeessudhaaf qophaa'oo dha.

Deebilee kessan sirritti qabachuudhaaf, af-gaaffiin kun sagaleedhan ni waraabama. Af-gaaffii kana irratti hirmaachudhaf yemmuu murteessitan, fedha keessaniin odeeffannon isin wajjin wal-qabatu qorannoo kanaaf akka fayyaduuf eyyamamaa ni taatu. Odeeffannoleen kunniin kan enyuu irraa kan funaanaman ta'uu isaa akka addan baasuun hin danda'amnetti sassaabamu. Maqaan kessaan yookiin wantii addatti isin wajjiniin walqabatu tokkoyyu hin fudhatamu. Deebiin isin gaaffiileedhaaf kennitan koodiin erga laatameefi booddee kan warren biroo irraa sassabaman wajjiin walitti makama. Kana booddee qorattonni qorannoo kana dursaa jiran odeeffannolee kanniin walitti qabuudhan ni xinxalu. Odeffannon isin wajjiin wal-qabatu sababa qorannoo kanaatiif qofa oola. Bu'aa qorannoo kanaa qorattonni gara maxxansaalee idil-addunyaa ta'anii fi konfirasiilee gara gara irratti dhiheessuudhaaf abdii qabu. Yeroo kamuu yemmuu bu'aan qorannoo kanaa dhiyaatu, enyumman namoota qorannicha irratti hirmaatanii akka hin beekkamnetti ta'a.

Gaaffii biro qabduu? Yoo garee namusa qorannoo Yunivarsiitii dubbisuu barbaadan 02 9514 9772 or Research.ethics@uts.edu.au lakkofsa galmee qorannicha fayyadamuudhan [UTS HREC ETH21-6587] qunnamuu ni danddessu yookiin Yuunivarsiiti Wallaggaatti dura ta'aa koree naamusa qorannoo kan ta'an lakkoofsa bilbilaa isaanii +251(0)XXX yookiin imeelii isaniitiin [redacted] qunnamuu ni dandeessu.

Qorannicha irratti hirmaachuudhaf heeyyamamoo taataniirtu?

- Yoo hirmaataan heyyama hin laatne ta'e, galateeffachudhan xumuraa
- Yoo hirmaataan fedha guutuudhan hirmachuuf murteessan, galateefachuudhan gara af-gaaffichaatti darbaa.

_____

____/____/____

Maqaa fi mallattoo [qorataa/nama raga sassaabuu]

Guyyaa

_____

____/____/____

Maqaa fi mallattoo [raggaasisaa*] Date

* Nama walgateen kun ta’uu ragaasisuu

Yoo hirmaataan unka kana dubbisuu hin dandeenye ta’ee fi namni raga bahu dnda’u akka jiraatu barbaadan, walii-galteen kun nama umriidhaan 18 ol ta’een ragga’uu qaba. Namni daataa sassaabu akka ragaatti tajaajiluu hin danda’u. Unka kana irratti abbaan raga ta’e sun yemmuu mallateessu, odeeffannoon unka kana irratti dhihaatee fi kanneen barreffaman haala quubsaa ta’een hirmataadhaaf ibsamuu isaa fi hirmaachuudhaaf fedha guutuurratti hundaa’uudhan akka ta’e raga ba’u.

Appendix 8: Data collection tool for Survey with women

SCREENING

1. a) Did you attend antenatal care or give birth or received care after birth in a Health Centre or hospital in this district/woreda/ for your last pregnancy?
    a. No
    b. Yes

    b) Give childbirth in the past three months?
    c. No
    d. Yes

    c) Are you >= 18 years old?
        a. No
        b. Yes

    d) Are you staff or have a direct relationship with a staff member at this facility?
        a. No
        b. Yes

    e) Are you willing and able to participate in an interview?
        a. No
        b. Yes

Women are eligible to participate if they:

Q1a = Yes [attended antenatal care or give childbirth or received postpartum], AND

Q1b = Yes [childbirth in the past three months], AND

Q1c = Yes [Are >= 18 years old], AND

Q1d = No [Are staff or a first degree relation to a staff member at this facility], AND

Q1e = Yes [Are willing and able to participate in an interview].

f) Is the woman eligible?

a. Not eligible

b. Eligible

If the woman is eligible, offer consent form and provide time to the woman to review consent form, if woman is unable to read, read for her or find someone to assist.

Name of the hospital / HC _____	**District:_____**		
Section 1: Sociodemographic variables			**Remark**
S101	**Age of respondent in years**	_____	
S102	**Marital status of respondent:** 1. Single……..[ ] 2. Married ……[ ] 3. Divorced……[ ] 4. Widowed …….. [ ] 5. Cohabiting….[ ] 5. Separated ……[ ] 6. Other…….. [ ] 7. Unknown …..[ ]		
S104	**Religion:** **1.** Muslim ……[ ] 2. Orthodox……[ ] 3. Protestant……[ ] 4. Catholic…[ ] 5. Others(specify)_____		
S105	**Ethnicity of respondents:** **1.** Oromo ……[ ] 2. Amhara……[ ] 3. Tigray……[ ] 4. Wolayita……[ ] 5. Others (specify) …… [ ]		
S106	**Occupational status of respondent** 1. Housewife……[ ] 2. Farmer ……[ ] 3. Government employee……[ ] 4. Private employee……[ ] 5. Unemployed……[ ]		
S107	**Educational status of respondents:** **1.** No formal education ……[ ] 2. Able to read and write …[ ] 3. Primary school …[ ] 4. Secondary school ……[ ] 5. Above secondary school …[ ]		
S108	Average monthly family income in Ethiopian Birr	_____	
S109	**Husbands/partner's educational status: 1.** Unable to read and write ……[ ] 2. Able to read and write ……[ ] 3. Primary school……[ ] 4. Secondary school..[ ] 5. College and above ……[ ]		
S110	Residence of the respondents: 1. Rural ……[ ] 2. Urban ……[ ]		
S111	Approximately how many minutes' drive/walk is your house from the hospital where you gave birth? _____ minutes		
SECTION 2: Pregnancy, birth and postpartum care related			
O101.	Your last pregnancy was	1. Wanted and planned …….. …[ ] 2. Wanted but unplanned …… …[ ] 3. Unwanted and unplanned …….. …[ ]	
O102.	Was your pregnancy supported from partner or household members	1. Yes…… …[ ] 2. No…….. …[ ]	
O103.	Total number of pregnancy/birth	1. Total number of pregnancy…… ……[ ] 2. Total number of birth (including stillbirth). ……[ ] 3. No of Life Births …… ……[ ]	
O104.	Did you experience complications in your last pregnancies?	1. Yes …… ……[ ] 2. No …… ……[ ]	If no, skip to O105.
O105.	If yes, what was the complication?	Specify_____	
O106.	Did you receive ANC in this last pregnancy	1.Yes…… ……[ ] 2. No…… ……[ ]	If no, skip

				to O112.
O107.	If Yes, where did you receive ANC	1.Health center…… 2.Hospital…… 3.Private clinic……	……[ ] ……[ ] ……[ ]	
O108.	How many weeks pregnancy were you when you first received antenatal care for this pregnancy		…[ ][ ]	
O109.	Total number of visit ……		…[ ][ ]	
O110.	Which services did you receive during the antenatal period?	1.Blood pressure measured ..... 2.Tetanus toxoid immunisation ..... 3.Iron/ folate……..... 4.Advised on danger sing of pregnancy …….. 5.Nutritional advise .....……..... 6.Blood sample collected.....……... 7.Urine sample collected.....…… 8.Birth preparedness & complication readiness. 9.Drug taken for intestinal parasite…..... 10. Tested for HIV/AIDS ……..	……[ ] ……[ ] ……[ ] ……[ ] ……[ ] ……[ ] ……[ ] ……[ ] ……[ ] ……[ ]	
O111.	Where did you give birth?	1. At health centre …….. 2. District hospital…… 3. Referral hospital…….. 4. Health post…… 5. My own home ……. 6. Home (relatives/ parents) ……. 7. Home (traditional birth attendants)……..	……[ ] ……[ ] ……[ ] ……[ ] ……[ ] ……[ ] ……[ ]	
O112.	Mode of birth	3. Vaginal birth 2. Assisted instrumental birth 3. Caesarean section		
O113	Time of birth	1. Day …….. 2. Night ……	……[ ] ……[ ]	
O114	Day of birth	1. Weekday ……. 2. Weekend …….	……[ ] ……[ ]	
O115.	Have you received postnatal care for you and your child during ?	24 hours of birth…….. Three days (48-72 hours) …….. Between days 7–14 after birth…… Six weeks after birth …….	……[ ] ……[ ] ……[ ] ……[ ]	

MISTREATMENT OF WOMEN

Some women tell us when they receive maternity service from health facilities, they are mistreated or treated with disrespect while in the hospital or health center. We would like

to know how common this problem is, so we would like to ask you your own experiences with antenatal care, birth and postnatal period.

There are no right or wrong answers to these questions. It is only important to us that we understand your experiences. Nothing you tell us will be linked to your name, your hildren's names, or the ability of you or your family members to access health care in the future. Some of these questions may be upsetting or stressful. As I said before, you can skip any question you are not comfortable answering, and you can stop the interview at any point.

At any time during your time in the hospital or health centre, did any of the following events occur?			
Events (**Physical abuse**)	Response	If 'Yes', When did this happen?	If 'Yes', Who did this to you?
1. Did health worker or other staff physically abused you (pinched, kicked, slapped, punched, or hit you with instrument)	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. Unknown
2. You were gagged (eg: something put across or in your mouth to prevent you from speaking or making noise) by a health worker or other staff?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
3. You were physically tied to the bed by a health worker or other staff?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown

4. You were held down to the bed forcefully by a health worker or other staff?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
5. You had forceful downward pressure placed on your abdomen before the baby came out (fundal pressure)?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
6. Were you denied pain relief for any reason?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
7. You had another form of physical force used against you (please specify)? _____	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
Verbal abuse			
8. You were shouted or screamed, insulted, scolded, mocked, hissed at by a health worker or other staff?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
9. Negative comments about your or your baby's physical appearance (such as your weight, private parts, sexual activity, cleanliness other aspects of the baby)?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff

			f. unknown
10. Threatened you with any aspects (to force you to accept treatment you did not want, physical violence, withhold care, you or your baby would have poor outcome)?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
11. The health worker or other staff blamed you for something that happened to you or your baby during your time in hospital:	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
12. Other use of verbal abuse against you (please specify)_____	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
Stigma and Discrimination			
13. Negative comments to you regarding your ethnicity, race, tribe or culture, religion, age, marital status, level of education, economic circumstances or health status (HIV status)	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
14. I held back from asking questions or discussing my concerns because I felt discriminated against	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
15. During my pregnancy I held back from asking questions or discussing my concerns because my care provider used language I could not understand.	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees

			e. Non-clinical staff f. unknown
Neglect and abandonment			
16. HCPs ignored you, refused your request for help, or failed to respond to requests for help in a reasonable amount of time	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
17. I felt that my presence was a nuisance for the health workers or staff:	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
Lack of informed consent and confidentiality			
18. HCPs did not explain to me why a procedure is done (eg. Abdominal or vaginal examination) ?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
19. HCPs did not ask you permission before performing any examination? (eg. Abdominal or vaginal exam)	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e.Non-clinical staff f. unknown
20. HCPs did not conducted examinations privately (in a way that other people could see)?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees

			e. Non-clinical staff f. unknown
21. Did a staff member discuss your private information about your health in a way that others could hear?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
Poor rapport between women and provider			
22. I felt emotionally unsupported	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
23. I was not listened to my concerns	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
24. I did not receive a response to my questions or concerns:	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e.Non-clinical staff f. unknown

25. Did staff suggest or ask you (or your family or friends) for a bribe, informal payment or gift?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
Loss of autonomy			
26. Were you or your baby detained in the hospital due to inability to pay hospital bills?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e.Non-clinical staff f. unknown
27. Were you told not to eat?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
28. Were you told that you could not walk or move around during labour?	a. No b. Yes	a. Antenatal care b. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
Health facility/ system failure			
29. Did not have a chair/sit during antenatal care?	a. No b. Yes	a. Antenatal care	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown

30. Did not have a bed to yourself during labour and birth?	a. No b. Yes	a. b. Intrapartum b. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
31. Did not have a bed to yourself after you delivered (postpartum period)	a. No b. Yes	a. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
32. At any time, did you have to share a bed with another woman or women?	a. No b. Yes	a. Intrapartum c. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
33. After the birth, were you instructed to clean up your own blood, urine, faeces or amniotic fluid?	a. No b. Yes	a. Intrapartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
34. During your time in HC/hospital, were you allowed to have a birth companion present? For example, this includes your husband, a friend, sister, mother-in-law, etc.?	a. No b. Yes	a. Intrapartum b. Postpartum	a. Midwife b. Nurse c. Doctor d. Trainees e. Non-clinical staff f. unknown
Future childbirth intention			
35. In the future, I would like to have another child:	a. No b. Yes		
36. Based on your most recent pregnancy and childbirth	a. Same hospital/ b. Different hospital		

experience in this hospital, where would you choose for your antenatal care and next childbirth?	c. At my home/ d. At somebody else's home/ e. Other f. Refuse/ g. Don't know/Unknown/
37. Do you agree or disagree with this statement: "I would recommend this hospital to a sister or friend"	a. Agree b. Neutral c. Disagree d. Strongly disagree

SURVEY WITH WOMEN- AFAAN OROMO VERSION
[ETH21-6587] MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY

ULAAGAALEE HIRMAANNAADHAAF GUUTAMUU QABAN

Hordoffii ulfa, ykn da'uumsaa ykn da'uumsa boodaa fudhataniiru **(eeyyee=*a / lakkii = r*)**	Baatiilee sadii darban keessa kan dahan (***a ykn r***)	Umriin isaanii waggaa 18 fi ol (***a ykn r***)	Firoomina dhihoo ogeessa as hojjatu wajjiin kan hin qabne (***a ykn r***)

Ulaagaleen hunduu guutuu

a. Kaadhimamoo dha è Odeeffanno hirmaattotaa fi unka walii-galtee ittii laachuudhan akka dubbisanii hubatan taasisaa. Yoo isaan dubbisuu hin dandeenye ta'an, odeeffanno hirmaatotaa fi unka walii-galtee afaaniinii isaaniif dubbisuudhan akka isaan hubatan gargaara.

Ulaagaleen hin

b. Kaadhimamoo miti èGalateeffachuudhaa n asumatti dhaabaa)

Maqaa Hospitaalicha/ Buufata faayyaa _____ Aanaaa: _____			**Ibsa**
Kutaa 1: Wantoota hawaas-diinagdee ibsan			
S101	**Umrii waggaadhaan**	_____	
S102	**Haala gaa'elaa:**	Kan hin fuune---------- 1 Gaa'ela qabu---------- 2 Kan wal-hiikan---------- 3 Kan irraa du'e---------- 4 Gaa'ela malee kan wajjiniin jiraatan---------- 5 Gargara kan jiraatan ---------- 6	
S103	**Amantaa**	Proteestantii ----------1 Ortodoksii ---------- 2 Musliima ---------- 3 Kaatolikii ---------- 4 Kan biro (ibsaa)_____ ---------- 5	
S104	**Saba/ qomoo:**	Oromoo---------- 1 Amhaara---------- 2 Tigraawaye---------- 3 Walayittaa---------- 4 Kan biro (ibsaa)---------- 5	
S105	**Haala dalagaa/hojii**	Haadha manaa----------1 Qotee-bulaa---------- 2 Hojjetaa mootummaa----------3 Hojjetaa dhuunfaa---------- 4 Kan hin qacaramne/hoji-dhabaa---------- 5 Kan biro (ibsaa)_____6	
S106	**Sadarkaa barumsaa**	Barumsa idilee kan hin qabne ---------- 1 Dubbisuu fi barreessuu kan danda'an---------- 2 Sadarkaa jalqabaa ---------- 3 Sadarkaa lammataa ---------- 4 Kollejjii fi isaa ol ---------- 5	
S108	**Galii maatii giddu-gallessan ji'an hammami**	_____ qarshiidhan	
S109	**Sadarkaa barumsaa abbaa warraa/ hiriyaa:**	Barumsa idilee kan hin qabne ---------- 1 Dubbisuu fi barreessuu kan danda'an---------- 2 Sadarkaa jalqabaa ---------- 3 Sadarkaa lammataa ---------- 4 Kollejjii fi isaa ol ---------- 5	
S110	Iddoo jireenyaa:	Baaddiyya ----------1 Magaala ---------- 2	
S111	Mana keessanii ti hamma buufata/hospital isinniti dhiyoo jiruu qaqqabuuf daqiiqa hammamii isinitti fudhata?	Miilaan _____daqiiqaa Konkolaataadhan _____ daqiiqaa	
Kutaa 2: Haalota yeroo ulfa, da'uumsaa fi da'uumsa booda jiran wajjiin walqabtan			***Skip to***
O201	Ulfi keessan inni dhumaa	Kan barbaadamuu fi karooran ture ---------- 1 Kan barbaadamu garuu karoora malee ture --------- 2 Kan hinbarbaadamne fi karooraan ala ture ---------- 3	

O202	Ulfi keessan sun abbaa warraa ykn hiriyaa keessaniins ta'ee maatiidhan kan deegarame turee?	Eeyyee----------1 Lakkii---------- 2	
O203	Baay'ina ulfaa fi da'uumsaa	Waligalatti lakkofsa ulfa ---------- [___] Lakkofsa da'imman lubbudhan dhalatanii------- [___] Yoo jiraate kan lubbuu malee dhalate ---------- [___]	
O204	Yeroo ulfa isa dhumaa kana turtan rakkoon isin mudate tureera?	Eeyyee----------1 Lakkii---------- 2	èO206
O205	Eeyyee yoo jettan rakkoon isin mudatee ture maal ture?	Ibsaa_____	
O206	Hordoffii da'uumsa duraa/yeroo ulfaa hordoftanii turtanii?	Eeyyee----------1 Lakkii---------- 2	èO211
O207	Hordoffii ulfaa eessaatti hordoftan?	Buufata fayyaa---------- 1 Hospitaala---------- 2 Kilinika dhunfaa---------- 3	
O208	Yemmuu hordoffii ulfaa eegaltan ulfa torbee meeqaa turtan	Ji'aan ---------- [___] Torbeedhaan ---------- [___]	
O209	Waliigalatti yeroo meeqa hordoffii ulfaa kana fudhattan	Si'a/yeroo (Lakkoofsaan)---------- [___]	
O210	Yeroo hordoffii ulfaa kana argattan tajajila akkamii/maal fa'a argattan?	Dhiibbaa dhiigaa koo elaalamuu ---------- 1 Talaallii teetanasii fudhachuu ---------- 2 Ayiraaniii hanqina dhiigaatii---------- 3 Mallatolee hamaarratti gorsa argachuu---------- 4 Gorsa nyaata irratti---------- 5 Samuda dhiigaa kenneera---------- 6 Saamuda fincaanii kennuu---------- 7 Qophii balaa qaqqabuu danda'uu fi da'uumsaaf tasifamu irratti gorsa argachuu---------- 8 Qoricha raammoolee garaa keessaf kennaman argachuu---------- 9 Qorannoo HIV/Eedisii aragachuu---------- 10	
O211	Eessatti daa'ima keessan deessan?	Buufata fayyaa ---------- 1 Hospitaala Aanaa ---------- 2 Hospitaala riferraalaa---------- 3 Keellaa fayyaa---------- 4 Mana koo keessatti ---------- 5 Mana maatii/firaa tti---------- 6 Mana oggeettii fayyaa aadaatti)---------- 7	
O212	Haala da'uumsaa	Kara gadaamessaa miixuudhan ---------- 1 Meeshaa waldhansaan gargaaramuudhan ---- 2 Baqaqsaanii yaaluun---------- 3	
O213	Yeroo da'uumsaa	Guyyaa ---------- 1 Halkan ---------- 2	
O214	Guyyaa da'uumsaa	Guyaa hojii ---------- 1 Sanbattani irra---------- 2	

O215	Erga deessanii booda tajaajila da'umsa booda argattaniirtuu?	Sa'aa 24 keessatti---------- 1 Guyyaa sadi boodaa (sa'aa 48- 72)---------- 2 Guyyaa 7 fi 14 gidduutti ---------- 3 Torbee ja'a booddee ---------- 4	

Kutaa 3: Dararaalee Dubartoota Irra Gahu: ()

- Dubarttoonni tokko tokko yemmuu buufataalee fayyaa irraa tajaajila argatan, darara yookiin haala gaarii hin taaneen tajajila argachuu nutti himu. Nutis yaalli akkasii kun hammam kan baratamee fi gosoota dararaa/cunqursaalee kanniinii baruu waan barbaannuuf, isinis muuxannoolee isin irra ga'e yookiin kan beektan isin gaafachu barbaadna. Dararaaleen kunnin kan yeroo hordoffii ulfaa, yeroo da'uumsaa yookiin kan da'umsa boodaa ta'uu ni danda'a.
- Gaaffilee gaafatamaniif deebiin sirrii yookiin sirrii hin taane je
- hamu hin jiru. Nuuf muuxannoolee keessan baruu qofti ga'aa dha. Wantoonni isin nutti himtan kamuu maqaa kessanis ta'ee kan daa'ima kessanii wajjiinis, tajaajila yaala fayyaaf gargaarsa isin bufata fayyaa/hospitaala kanarra booddee argataniin tasuma wal hin qabatu. Gaaffii isinitti hin tolle, yookinis kan deebisuu hin barbaannee irra ni dandeessu.

Taatee (Dararaa qaamaa)		Deebii	Eenyutu kana isinirratti qaqabsiise	Eeyye yoo jettan yoom dha?
M301	Dhibbaan/dararaan qaamaa isin mudateeraa (rukutamuu, kan akka qimmidamuu, kabalamuu, meeshaleedhan rukutamuu)	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M302	Afaan keessan humnaan cuqqaalameera (fkn- Akka isin hin dubbanne yookiin sagalee hin dhageessisne wanti ta'e afaan keessan keessa yookin naannawa afaan kessanii kaa'ameeraa?)	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M303	Qaamni keessan sireetti hidhameeraa?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M304	Humnaan gara sireetti gad-qabamtaniirtuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M305	Osoo daa'imni keessani hin dhalatin dura, humnaan garaa keessan irra qabanii gad isin dhiibaniiruu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M306	Qoricha dhukkubbii hadoochadhaf ta'u akka hin fudhanne dhoorkamtaniirtuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3

			Hojjattota biroon------- 6 Hinbeekne---------- 7	
M307	Dhiibbaa qaamaa kanaan alaa ta'e qabduu (maaloo addaan nuuf baasaa) _____	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Dararaa afaanii/dubbiidhan qaqabu				
M308	Isinitti iyyanii yookiin wacanii, isin arrabsanii/ abaaranii, isinitti gungumanii yookiin isin hifatanii beekuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M309	Jecha gaarii hin taanee isiniin jedhanii beekuu waa'ee keessaniif yookiin mucaa keessaniin kan walqabate (ulfina qaama, qulqullina qaamaa/uffataa, qaama keessan wajjiin wal qabatee)	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M310	Isin sodaachisanii beekuu (akka isin waldhaansa hin barbaanne fudhattaniif, miidhaa qaaman, tajaajila isinii laachuu dhiisudhaaf, yaaliin isin yookiin daa'imni keessan argattan kan gad-bu'ee ta'uu danda'a jechuudhan)	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M311	Wanta isin yookiin daa'ima keessanirra gaheef isin akka sababa taatanitti qeeqamtaniirtuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M312	Miidhaa/dararaa afaaniini kan biro (maaloo ibsaa)_____	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Loogii fi gargara baasuu/qoqooduu				
M313	Sababa qomoo kessaniitiin yookiin gosa isin irraa dhuftaniif, ykn aadaa, amantaa isin hordoftaniif, umrii, haala gaa'ela, sadarkaa barnoota, sadarkaa dinagdee ykn fayyummaa keessaniirra kan ka'e qeeqamtanii beektuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M314	Sababa loogiin/adda foo'amuun natti dhagahamuuf gaaffii	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2	Hordoffii ulfaa-----1 Da'uumsaa---------2

	yookiin maree qabu osoon hin baasiin dhiiseen jiira.		Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Da'uumsa booda--3
M315	Yeroon tajaajila argachaa ture sababa namni na gargaaru(ogeessi fayyaa) afaan ani hin beekne haasa'aniif gaaffii gaafachu qabu irraa of qusadheera.	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Gatamuu/irranfatamuu				
M316	Ogeessoni/ogeessi fayyaa akka isin gargaaraniif yemmuu gaafattan isin didaniiruu/ yeroodhan isin qaqabuu hin dandeenye.	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M317	Akka achitti argamuun ko ogeessa fayyadhaaf gatii hin qabneetti natti dhhagahameera	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Fedha fi icciitii kan hin qabne				
M318	Ogeessonni fayyaa sababa waan tokko godhaniif natti hin himanu (yemmuu garaa ykn gadaamessa koo ilaalan) ?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M319	Ogeessonni fayyaa fedha koo nah in gaafatan/ gaafanne? (fkn: yemmuu garaa ykn gadaamessa koo ilaalan)	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M320	Ogeessonni fayyaa haala namnii biro qaama koo hin agarreetti nah in sakaattane/ilaalle	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M321	Ogeessonni fayyaa waa'ee fayyina keessanii akkaataa namoonni biro itti dhagahanitti dubbatanii beekuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Walitti dhufeenya haadhaa fi ogeessotaa kan gad-bu'aa ta'e				

M322	Xiin-sammuudhan akkan hin deegaramneetti natti dhagahama	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M323	Waa'een koo naaf hin dhagahamne	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M324	Wantan ani gaafadhee fi barbaaduuf deebiin naaf hin laatamne	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M325	Ogeessi fayyaa kafaltii isaaniif hin malle, ykn kennaa isin yookiin maatii keessan gaafataniiru?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Ofii keessanii ofirratti murteessuu dadhabuu				
M326	Isin ykn daa'imni keessan fedha keessan malee sababa kafaltii wajjiin walqabtuuf akka hospitalaa/buufata fayyati hin bane taasifamtaniirtuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M327	Akka nyaata hin nyaanne taasifamtaniirtuu?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M328	Yeroo miixuu irra turtan akka hin deemne/sochoone isinitti himamee tureeraa?	Eeyyee---1 → Lakkii---- 2	Midwayfarii---------- 1 Narsii---------- 2 Doktora----------3 Q/fayyaa ---------- 4 Leenjitoota----------5 Hojjattota biroon------- 6 Hinbeekne---------- 7	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Dadhabina buufata fayyaa/kufaatii qindoominaa				
M329	Taa'umsa kan hin qabne ture, yeroo hordoffii ulfaa	Eeyyee---1 → Lakkii---- 2	Buufata fayyaatti----- 1 Hosp. aanaatti-------- 2 Hosp. riferraalaatti----3	Hordoffii ulfaa-----1
M330	Siiree mataa keessanii yeroo ciniinsuu/miixuu isiniif kennameera?	Eeyyee---1 → Lakkii---- 2	Buufata fayyaatti----- 1 Hosp. aanaatti-------- 2 Hosp. riferraalaatti----3	Da'uumsaa----------1

M331	Erga deessanii booddee sireen isiniif qofa ta'e isiniif kennameera?	Eeyyee---1 → Lakkii---- 2	Buufata fayyaatti----- 1 Hosp. aanaatti-------- 2 Hosp. riferraalaatti----3	Da'uumsa booda--1
M332	Yeroo kamuu haa ta'u, siree tokko nama biro wajjiniin akka qooddattan taasifamtaniirtuu?	Eeyyee---1 → Lakkii---- 2	Buufata fayyaatti----- 1 Hosp. aanaatti-------- 2 Hosp. riferraalaatti----3	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
M333	Erga deessanii booddee akka dhiiga, fincaan, bobbaa ykn bishaan buubbee qulqullesitaniif ajajamtaniirtuu?	Eeyyee---1 → Lakkii---- 2	Buufata fayyaatti----- 1 Hosp. aanaatti-------- 2 Hosp. riferraalaatti----3	Da'uumsaa---------1 Da'uumsa booda--2
M334	Yemmuu hospitaala/ buufata fayyaa turtanitti namni isin wajjiniin akka taa'u isiniif eyyamamee tureera (haadha, abbaa manaa keessan, obboleettii…ykn nama kamuu haa ta'u)	Eeyyee---1 → Lakkii---- 2	Buufata fayyaatti----- 1 Hosp. aanaatti-------- 2 Hosp. riferraalaatti----3	Hordoffii ulfaa-----1 Da'uumsaa---------2 Da'uumsa booda--3
Haala da'uumsaa fuulduraaf				
M335	Kana booddedhaaf mucaa/daa'ima godhachuu ni barbaaddu?	Eeyyee----------1 Lakkii---------- 2		
M336	Haala qabuumsa hospitaala / buufata fayyaa kanarraa yeroo ulfa turtanii fi yeroo da'uumsaa argattan wajjiin walbira qabuudhan, eessatti tajaajila akkanaa argachuu barbaaddu fuulduraaf?	Hospitaaluma sana/ Hospitaala gara biraa Mana koo keessa/ Mana nama biroootti/ Kan biroo Diduu/ Hin beeku/hin beekamne		
M337	Hima kana irraatti walii ni galtu moo hin galatan?: "Hospiitaala/Buufata fayyaa tajajila an irraa argadhe kana tajaajila akka argattuuf obboleettii koo ykn hiriyaa koo nan gorsa"	Eeyyee----------1 Lakkii---------- 2		

Appendix 9: Survey with HCPs

[ETH21-6587] MISTREATMENT OF WOMEN DURING MATERNAL HEALTH CARE UTILISATION IN ETHIOPIA, A MIXED-METHOD STUDY

Eligibility Criteria

Are you currently providing maternal health care at ANC, labour and delivery OR postnatal care?

Eligible è Please confirm your willingness to participate by reading and signing consent form below.

Not eligible éThank you for your time.

Please check the consent form to proceed!

Part 1: Socio-demographic and service-related characteristics of health care providers

S.No.	Characteristics	Responses	Remarks
S101.	Respondents' health facility	Hospital----------1 Health centre ----------2	
S102.	Age	_____ years	
S103.	Gender	Male----------1 Female ---------- 2	
S104.	Marital Status	Unmarried ----------1 Married ----------2 Divorced ----------3 Separated ----------4 Widowed ---------- 5	
S105.	Religion	Protestant ---------- 1 Orthodox ----------2 Muslim----------3 Catholic ----------4 Adventist ---------- 5 Others _____	
S106.	Ever had a child	Yes ----------1 No----------2	
S107.	Profession	Midwife----------1 Clinical Nurse---------- 2 Gynecologist ---------- 3 Health Officer----------4 Medical Doctor (GP)------ 5 IESO----------6	
S108.	Service year with current profession in years	_____ years	
S109.	Years served in this facility	_____ years	
S110.	Your current salary monthly	_____birr	
S111.	Where is a primary duty in health facility's MCH setting (answer all apply)	Antenatal care clinic--------1 Labour and birth ward----- 2 Post-natal ward---------- 3	
S112.	Estimated service hours per day	_____ hours	
S113.	The estimated average number of childbirths you attend per day	_____ (in number)	
S114.	Number of childbirths you attended last month	_____ (in number)	
S115.	Estimated number of antenatal clients you care for per day	_____ (in number)	
S116.	Have you ever taken respectful maternity care training?	Yes---------- 1 No---------- 2	
S117	In your health facility, do you have RMC standard of care?	Yes---------- 1 No---------- 2	
S118	Do you believe that it has been under implantation to the standard?	Yes---------- 1 No---------- 2	
S119	Is there formal system through which women complaint about the treatment they received?	Yes---------- 1 No---------- 2	
S20	If your answer for Q S119 above is Yes, are women aware about the presence of this formal complaint mechanism?	Eeyyee---------- 1 Lakkii---------- 2	

Part 2: Health care providers' perception of their health facility and system: Please rate the level of your agreement or disagreement with the statements given in this section.

S.No.	Characteristics	Scales (tick a inside the column you choose)				
		Strogly disagree	disagree	Neutral	Agree	Strongly Agree
P201.	The workload where I work is not heavy.					
P202	The number of health care providers are adequate.					
P203.	The number of clients that visit health facility is not large.					
P204.	The support/ facilitation that health facility's management gave us is very good.					
P205.	The unit at which I work is structured in a suitable manner					
P206.	I am autonomous in accomplishing tasks and making decisions by myself (within my work area and scope of practice)					
P207.	The relation among HCPs in our facility is encouraging and welcoming, which is based on mutual respect and trust (relational atmosphere)					
P208.	The opportunities present in our facility for developing competencies, expertise, and skills needed for professional development is very good (CPD).					
P209.	There are equal and open (blame-free) communication and feedback between professionals and different organizational levels in our health facility.					
P210.	The HCPs in our health facility work in team related to respectful, effective, and efficient cooperation on a common purpose? (teamwork)					
P211.	Senior staffs (including physicians) respect joiner staffs.					
P212.	Women or attendants who come with clients treat health care providers with a respect.					
P213.	The health facility managers recognise staff's heavy duty, and they respect the health care providers.					
P214	I am very happy with my profession.					
P215	I am very satisfied in providing maternal health care.					
P2016	I am very satisfied with the content of the work, and salary I obtain.					

Part 3: Health care providers empathy scale: please indicate your agreement or disagreement with each of the following statements by marking the appropriate scale from 1-7 (a higher number on the scale indicates more agreement)

T.lak.	Gaaffilee	Qabxilee madallii						
		1-Tasumaa walii hin galu	2	3	4	5	6	7-Baay' ee walii nan gala
E301	My understanding of how my patients and their families feel does not influence treatment/care outcomes.							
E302	My patients feel better when I understand their feelings							
E303	It is difficult for me to view things from my patients perspectives							

E304	I consider understanding my patients' body language as important as verbal communication in caregiver-patient relationships.							
E305	I have a good sense of humor that I think contributes to better clinical outcome.							
E306	Because people are different, it is difficult for me to see things from my patients' perspectives.							
E307	I try not to pay attention to my patients' emotions in history taking or in asking about their physical health.							
E308	Attentiveness to my patients' personal experiences doesn't influence treatment outcomes.							
E309	I try to imagine myself in my patients' shoes when providing care to them.							
E310	My patients value my understanding of their feelings which is therapeutic in its own right.							
E311	Patients' illnesses can be cured only by targeted treatment; therefore, my emotional ties to my patients do not have a significant influence in treatment outcomes.							
E312	Asking patients about what is happening in their lives is not helpful in understanding their physical complaints.							
E313	I try to understand what is going on in my patients' minds by paying attention to their non-verbal cues and body language.							
E314	I believe that emotion has no place in the treatment of medical illness.							
E315	Empathy is a therapeutic skill without which success in treatment/care is limited.							
E316	An important component of the relationship with my patient is my understanding of their emotional status, as well as that of their families.							
E317	I try to think like my patients in order to render better care.							
E318	I do not allow myself to be influenced by strong personal bonds between my patients and their family members.							
E319	I do not enjoy reading non-medical literature or the arts.							
E320	I believe that empathy is an important factor in patients' treatment.							

Part 3: Health care providers experiences of mistreatment of women in their health facility

S.No.	**Characteristics**	**Responses**	**Remark**
Some health care providers tell us that women experience mistreatment when they receive maternity service from health facilities, they are mistreated or treated with disrespect while in the hospital or health centre. We would like to know how common this problem is, so this part has questions related to your own experiences with antenatal care, birth and postnatal period. There are no right or wrong answers to these questions. It is only important to us that we understand your experiences. Nothing you tell us will be linked to your name, your professional services. It will be only used for this study.			
Non-dignified care			
ND1	In your experience in your health facility, do Health Care providers (HCPs) treat women disrespectfully?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times----------3	

		No, never----------4	
ND2	Do HCPs at your health facility treat women in unfriendly manner?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times----------3 No, never----------4	
Verbal abuse			
VA3.1.	In your experience in this facility, do HCPs shout at, scold, insult, threaten or talk to women rudely?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times----------3 No, never----------4	
VA3.2.	Do HCPs give negative comments about patients' or their baby's physical appearance (such as weight, private parts, sexual activity, cleanliness other aspects)?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times----------3 No, never----------4	
VA3.3.	Do HCPs threaten women with any aspects (forcing to accept treatment they did not want, physical violence, withhold care, poor treatment outcome)?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times----------3 No, never----------4	
VA3.4.	Do HCPs blame women for something that happened to them or their baby during their stay in the facility?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never----------4	
VA3.5.	In your experience at this facility, have you seen these happen?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
VA3.6.	In your experience at this facility, have you ever done this?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times----------3 No, never----------4	
Physical abuse			
PA4.1	Are women treated roughly like pushed, beaten, slapped, pinched, physically restrained, gagged, tied to bed when they are getting care in the health facility's team you serve?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times---------- 3 No, never---------- 4	
PA4.2.	Are women denied pain relief for any reason?	Yes, all the time ----------1 Yes, most of the time----------2 Yes, a few times----------3	

		No, never----------4	
PA4.3.	Do HCP in your facility practice fundal pressure during second stage of labour?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
PA4.4.	In your experience at this facility, have you seen these happen?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
PA4.5.	In your experience at this facility, have you ever done this?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
Consent, Privacy and Confidentiality			
NC5.1.	During examinations in the health facility team you work, women are not covered up with a cloth or blanket or screened with a curtain so that they do not feel exposed?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NC5.2.	HCPs do not ask women's permission before performing any examination? (eg. Abdominal or vaginal exam)	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NC5.3.	HCPs do not explain to women why a procedure is done (eg. Abdominal or vaginal examination)?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NC5.4.	Do HCPs speak to women as load as other people not involved in their care can hear what they are discussing?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NC5.5.	Do you feel like women's health information is not kept confidential at this facility by other HCPs?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NC5.6.	In your experience at this facility, have you ever felt that you did not kept confidentiality of the client?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	

Stigma and Discrimination			
SD6.1.	Will you say women are treated differently because of their personal attributes, like their age, marital status, number of children, education, wealth, ethnicity, their connections with the facility or things like that?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
SD6.2.	In your experience at this facility, have you seen when women are treated differently because of any their attributes listed above in your facility by other HCPs?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
SD6.3.	Do you think you treat women differently based on some attributes like their education, wealth, ethnicity, age, marital status, their connections with the facility or things like that without being aware of it?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
Neglect and abandonment			
NA7.1.	Do HCPs ignore women, refuse their request of help, or fail to respond to requests of help in a reasonable amount of time?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NA7.2.	Do HCPs discourage a mother's companion to remain with her, whenever possible?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NA7.3.	In your experience at this facility, have you seen when women have been left alone or unattended by other HCPs?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
NA7.4.	Do you feel you personally ignored women and left them unattended?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
Loss of autonomy (detention)			
A8.1.	Do women instructed not to walk or move around during labour, not to eat without any clinical significance?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
A8.2.	Are women forced to stay at the health facility against their will because they cannot pay?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3	

			No, never---------- 4	
	A8.3.	In your experience at this facility, have you seen when women's autonomy is violated by other HCPs as mentioned above?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
	A8.4.	In your experience at this facility, have you ever felt that you violated women's autonomy that mentioned above?	Yes, all the time ---------- 1 Yes, most of the time---------- 2 Yes, a few times---------- 3 No, never---------- 4	
	Effects of mistreatment of women			
E9.1.	What do you think may predispose the occurrences of mistreatment of women/disrespect and abusive care in health facilities? (**please give your view by writing inside the space**)			
	E9.2.	Do you believe mistreatment of women is a factor which discourages women from coming to health facilities for maternity care?	Yes----------1 No----------2	

Thank you for taking part in this survey.

Are you willing to participate in an in-depth interview that the researcher kin to conduct with you?

1. **Yes, please leave your address (_____) or contact the researcher (09**XXX **)**
2. **No, Thank you!**

ULAAGAALEE HIRMAANNAADHAAF GUUTAMUU QABAN

Tajaajila hadholiidhaf yeroo ulfaa, da'uumsaa fi da'uumsa boodaa kennamu laataa jirtuu?

Kaadhimamoo dha è Odeeffanno hirmaattotaa fi unka walii-galtee kanaa gaditti kenname kana dubbisuudhan hirmaatudhaf fedha keessan nuuf mirkaneessaa.

Kaadhimamoo miti èGalatoomaa.

_____

____/____/____

Mallattoo [hirmaataa] Guyyaa

Kutaa 1: Gaafilee haala hawaasumma ogeessaa fi kenniinsa tajaajila fayyaa waliin wal qabatan— deebii kessaan, lakkofsa filattan irratti maruun deebisaa

S.No.	Gaaffiilee Eenyummaa	Deebiilee	Remarks
S101.	Dhaabbata fayyaa amma keessa hojataa jirtan	Hospitaala----------1 Buufata fayyaa ----------2	
S102.	Umrii	_____ waggaa	
S103.	Saala	Dhiira----------1 Dhalaa ---------- 2	
S104.	Haala gaa'ilaa	Ga'eela kan hinqabne ---------1 Ga'eela kan qabu/qabdu------2 Kan wal-hiikan----------3 Gargar kan jiraatan ----------4 Kan irraa du'e/duute ----------5 Kan gargara bahan----------6	
S105.	Amantaa	Protestantii ----------1 Ortodoksii----------2 Musliima----------3 Kaatolokii ----------4 Adveentistii ---------- 5 Kan birooo (ibsaa) _____	
S106.	Kanaan dura mucaa/ijoollee qabduu?	Eeyyee ----------1 Lakki----------2	
S107.	Gosa ogummaa	Midwayfii----------1 Narsii----------2 Hakima gadamessaa --------- 3 Qondaala fayyaa----------4 Hakima waliigagaa (GP)------ 5 IESO ---------- 6	
S108.	Gosa ogummaa keessan kanaan waggaa meeqa hojjatan	_____ waggadhaan/ _____Ji'aan	
S109.	Turtii hagamiif dhaabbata fayyaa amma keessa jirtan kana keessatti hojjattan?	_____ waggadhaan	
S110.	Mindaan keessan ji'aa hangami?	_____qarshiidhaan	
S111.	Kutaan rammaddii hojii keessanii si'anaa kanneen keessaa isa kami?	Hordoffii ulfaa----------1 Kutaa ciniinsu fi da'uumsaa--2 Kutaa da'uumsa booda------- 3	
S112.	Giddu galaan guyyaatti sa'aa meeqa hojii irratti dabarsitu?	_____ sa'aatiidhan	
S113.	Guyyaatti giddu-galeessaan isin dhuunfaadhan deessuu meeqa deesistu/hordoftu?	_____ (lakkoofsaan)	
S114.	Baatii /ji'a darbe kana, dhunfaa keessaniin da'uumsa meeqa hordoftan?	_____ (lakkoofsaan)	
S115.	Giddu-galeessan hordoffii ulfaa meeqa guyyaatti dhuunfa keessaniin ilaaltu?	_____ (lakkoofsaan)	
S116.	Leenjii kunuunsi ulfina qabeessi hadholiidhaaf akka kennamu taasisuuf kennamu fudhattanii beektuu? (RMC training)	Eeyyee---------- 1 Lakkii---------- 2	
S117	Akka dhaabbata fayyaa keessaniitti, standardiin kunuunsa ulfina qabeessa hadholiidhaaf ittiin kennamu jira? (RMC standard of care)	Eeyyee---------- 1 Lakkii---------- 2	
S118	Akka dhaabbata fayyaa keessanii kanaatti, kunuunsi ulfina qabeessi hadholiidhaaf	Eeyyee---------- 1 Lakkii---------- 2	

	akkuma standardii isaatti rawwatamaa jira jettanii yaadduu?		
S119	Dhaabbata fayyaa keessan kanatti haalli haadholiin tajaajila argatan irratti yoo yaada qabaatan gaafachuu/ iyyatuu barbaadan ittiin dhiheeffatan jiraa?	Eeyyee---------- 1 Lakkii---------- 2	
S20	Yoo deebiin gaaffii S119 Eeyyee ta'e, hadholiin ykn tajajilamtonni hunduu akkaata isaa beekuu?	Eeyyee---------- 1 Lakkii---------- 2	

Kutaa 2 Gaaffilee hubbannoo oggeessonni fayyaa naannoo hojii isaaniif qaban ilaalchisee: yaadota asii gaditti dhiyaatan kana irratti walii galtee keessan iskeelii kennaman kessaa kan madaalu filachuudhan deebisaa (Mallattoo *a kana bo'oo filattan keessa kaa'a*).

S.No.	Madaallii ilaalchaa	Iskeelii (qixa deebii kessanii mallattoo a kaa'aa)				
		Baay' ee walii hin galu (1)	2	3	4	Baay' een walii gala(5)
P201.	Baay'ini hojii kutaa ani itti hojjachaa jiruu salphaa dha / hin baay'atu.					
P202	Kutaa ani itti hojjadhu keessa baay'ini ogeessotaa gahaa dha.					
P203.	Baay'ini haadholii kunuunsa argachuuf kutaa ani itti hojadhuu dhufan gar-malee baay'ee miti.					
P204.	Deegarsi yookiin tumsi hogantootni hospitaala/buufata fayyaa kanaa nuuf taasisan baay'ee gaarii dha.					
P205.	Kutaan ani itti hojjachaa jiru kun haala mijataa ta'een kan qindaa'e dha.					
P206.	Kutaa fi ramaddii hojii caasaadhaan naaf laatame irratti ofii kooti murteessuu nan danda'a (sadarkaa ga'uumsa kooti irratti)					
P207.	Hariiroon ogeessota hospitaala/buufata fayyaa kanaa gidduu jiru walkabajaa fi wal-amanataa irratti kan hundaa'e dha.					
P208.	Halli ogummaa fi dandeettiin ogeessotaa walitti fufiinsaan akka foyya'uu fi guddatu taasisu mijataa dha (CPD).					
P209.	Ilaalcha walqixxummaa fi cephoo malee mariin ogeessotaa fi caasalee garagaraa gidduutti ni taasifama.					
P210.	Ogeessonni ani wajjiniin hojjadhu— gareedhaan galma tokkoof walkabajaadhan ni hojjatu.					
P211.	Ogeessonni buleeyyiin (senior) haakimoota dabalatee, ogeessota juunerii ta'an kabajaadhan qabu.					
P212.	Haadholiin yookiin namonni isaan wajjiniin dhufan, ogeessotaaf kabaja malu ni laatu.					
P213.	Hogantonni dhaabbata fayyaa kanaa, ulfaatina hojii ogeessotaa ilaaluudhan kabajaa fi iddoo gaarii ni kennu.					
P214	Oggummaa (profession) amma ittiin tajaajila laachaa jiru kanatti ani baay'een itti gammada.					
P215	Tajaajila kunuunsa hadholiidhaaf laataa jiru kanatti ani baay'een itti quufa dha (satisfied in service provision)					

P216	Mindaan/kafaltiin ani argadhu ulfaatina hojii wajjiin kan wal madaalu dha.					

Kutaa 3ffaa: Gaaffilee ogeessonni fayyaa hammam akka namaaf yaadan/empathy/ madaaluuf gargaaran— Himoota gabatee armaan gadii keessatti kennaman hammam akka itti walii galtan ykn walii hin galle skeelii 1-7 kennaman irraa filachuudhan deebisaa (qabxii olaanaan daraan/sirritti akka walii galatan ibsa- Mallattoo*akana bo'oo filattan keessa kaa'udhan deebisaa*)

T.lak.	**Gaaffilee**	**Qabxilee madallii**						
		1-Tasumaa walii hin galu	**2**	**3**	**4**	**5**	**6**	**7-Baay' ee walii nan gala**
E301	Hubannon ani miira yaalamtoota kootiifis ta'ee kan maatii isaaniitif qabu dhiibbaan innii bu'aa yaalaa irratti fidu hin jiru.							
E302	Yeroon ani miira yaalamtoota kootii hubadhu, miirri gaariin isaanitti ni dhaga'ama.							
E303	Eddoo yaalamtoota bu'uun wantoota ilaaluun na rakkisa.							
E304	Eergaalee mallattoodhan /afaan qaamaatiin (*nonverbal / body language*) yaalamtoonni koo dabarsan hubachuun koo qixuma isa dubbachuudhan darbuu hariiroo ogeessa fi yaalamtoota gidduutti barbaachisaa dha.							
E305	Miira nama booharsuu qabachuun koo, bu'aan yaalaa akka fooyya'uuf ni gumaacha jedheen yaada.							
E306	Namoonni gara gara waan ta'aniif, eddoo yaalamtoota kootii bu'uudhaan waa ilaaluun natti ulfaata.							
E307	Yeroon seenaa yalamtoota fudhadhu (*history taking*) ykn waa'ee fayyaa qaama isaanii gaafadhu miira dhukkubsattoota kootitif xiyyeeffannoo kennuu dhiisuudhafan yaala.							
E308	Muuxannoo dhuunfaa yaalamtoota kootiif xiyyeeffannoo kennuun bu'aa wal'aansaa irratti dhiibbaa hin taasisu.							
E309	Yeroon kunuunsa yaalamtoota kootiif kennu, bakka yaalamtoota koo of kaa'udhaaf nan yaala.							
E310	Yaalamtoonni koo hubannoo ani miira isaaniitiif qabu, kan mataa isaatiin wal'aansa ta'eef, iddoo guddaa kennu.							
E311	Dhukkubni/rakkoon dhukkubsattootaa wal'aansa xiyyeeffannoo qabu qofaan fayyuu danda'a; kanaaf, walitti dhufeenyi miira dhukkubsattoota koo wajjin qabu bu'aa wal'aansaa irratti dhiibbaa guddaa hin qabu.							
E312	Yaalamtoota jireenya isaanii keessatti waantota ta'amaa jiranii gaafachuun rakkoo qaamaa (*physical problem*) isaanii hubachuuf hin fayyadu.							
E313	Eragaalee mallattodhaa fi sochii qaama isaniitiin darbaniif xiyyeeffannoo kennuudhaan waan sammuu yaalamtoota koo keessa deemaa jiru hubachuuf nan yaala.							
E314	Wal'aansa dhukkuba/rakkoo fayyaa wajjiin walqabatu keessatti, miirri bakka hin qabu jedheen amana.							
E315	Namaaf yaaduu/mararfannaa (empathy) jechuun ogummaa wal'aansaa yoo ta'u, isa malee milkaa'inni yaalaa/kununsaa ni dangeffama.							

E316	Hariiroo yaalamtoota koo wajjin qabu keessatti wantoota barbaachisan kessaa, haala miirri isaanii fi kan maatii isaanii irra jiruu hubachuun koo isa tokko dha.							
E317	Kunuunsa fooyya'aa ta'e kennuudhaaf akka yaalamtoota kootitti yaaduuf nan yaala.							
E318	Walitti dhufeenya/boondii dhuunfaa cimaa yaalamtoota koo fi miseensota maatii isaanii gidduu jiru irraa ka'ee dhiibbaan akka na qaqabu hin eeyyamu.							
E319	Barruulee fayyaa/yaalaa kan hin taane ykn kan aartii dubbisuun natti hin tolu.							
E320	Wal'aansa yaalamtootaaf taasifamu keessatti namaaf yaaduun waan barbaachisu ta'uusaa nan amana.							

Kutaa 4 Gaaffilee muxaannoo ogeessonni fayyaa Midhaa/dararaa/cunqursaa/hacuccaa haadhollii yeroo dhabbata fayyaa keessa turan waliin kan walqabtu

Ogeessonni tokko tokko yemmuu haadholiin dhaabbata fayyaa irraa tajaajila argatan, dararaan ykn hacuuccaan akka isaan irra gahu nutti himu. Nutis yaalli akkasii kun hangam kan baratamee fi gosoota dararaa/cunqursaalee kanniinii waan beektanii fi muuxannoolee qabdan akka nuutti himtan barbaanna. Wantoonni kunnin kan yeroo hordoffii ulfaa, yeroo da'uumsaa ykn kan da'umsa boodaa ta'uu ni danda'u. Gaaffilee kanniiniif deebiin sirrii yookiin dogogora jedhamu hin jiru. Isin muxannoo keessaniin waan beektan irratti hundaa'uudhan dhiibbaa tokko malee akka nuuf deebstan isin gaafanna. Deebii kessaan, lakkofsa filattan irratti maruun deebisaa.

S.No.	Amaloota	Deebii	Yaada
Kabaja malee kunuunsa kennuu /Non-dignified care			
NDC1	Buufata ykn hospitaala kana keessatti ogeessonni fayyaa tokko tokko haadholii tajajjilaaf gara keessan dhufan kabaja malee ni kessummessuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
NDC2	Buufata yookiin hospitaala kana keessatti ogeessonni fayyaa haala hiriyyummaa hin taaneen *(unfriendly care)* hadholii ni keessummessuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
dhiibbaa arrabaan taasifaman/ Verbal abuse			
VA3.1.	Akka yaada keessaniitti, buufata yookiin hospitaala kana keessatti ogeessonni hadholiitti sagalee olkaasanii *dheekamu, arrabsu, sodachisu yookiis haala kabaja hin qabneen ni hasofsiisuu*?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
VA3.2.	Ogeessonni bifa qaama hadholii yookiin daa'imman isaanii *(ulfaatina qaama isaanii, qaama saalaa, qulqullina qaama, walqunnamtii saalaa isaan rawwatan) wajjiin walqabachuudhan, kan yaada/jecha gaarii hin taaneen ni dubbisuu*?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
VA3.3.	Waan kamuu wajjiin walqabsiisuudhan hadholii ni sodaachisuu (*gosa yaalaa isaan hin barbaanne akka fudhatan tasissuun, miidhaa qaamaa, tajaajila yaalaa dhoorkuu, firiin yaala isaanii gaarii akka hin taane sodachisuu)?*	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	

VA3.4.	Turtii mana yaalaa keessa turanitti waan isaan ykn mucaa isaanii mudateef hadholii itti gaafatamoo ni taasisuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
VA3.5.	Hospitaala/buufata kanatti muxannoo qabdan irraa ka'uudhaan, wantoonni kunniin yeroo mudatan argitanii beektuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
VA3.6.	Hospitaala/buufata kanatti muxannoo qabdan irratti, wantoota kanneen ofii keessanii rawwattanii beektuu? (*dheekkamuu, sodachisuu, haala gaarii hin taaneen dubbisuu…)*	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
Dhiibbaa qama / Physical abuse			
PA4.1	Hospitaala/buufata kanatti haadholeen yemmuu/yeeroo tajaajila yaalaa argatan, ogeessotaan dhibbaan qaamaa irra ni gahaa? 9Kunniinis kan ta'uu danda'aan— *Dhiibamu, rukutamu, kabalamu, qimmidamuu, humnaan akka hin warraqne taasifamuu, sagaleen isaanii akka hin bane ukkafamu, siree irratti hidhamu)*	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
PA4.2.	Sababa kam malee qoricha dhukkuba hadoochu dhoowwachuun jiraa?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
PA4.3.	Ogeessota buufata kanaa kessaa kan gadaamessa hadhaa yeroo da'umsaa gad-dhiibu jiraa (fundal pressure)?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
PA4.4.	Hospitaala/buufata kanatti muxannoo qabdan irraa ka'uudhaan, wantoonni kunniin yeroo mudatan argitanii beektuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
PA4.5.	Hospitaala/buufata kanatti muxannoo qabdan irratti, wannen kanniin isin rawwattanii beektuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
Fedha, icciittii dhunfaa isaanii eeguu/ Consent, Privacy and Confidentiality			
NC5.1.	Kutaa hojjatanitti, hadholiin yeroo ilaalaman akka qaamni isaanii hin saaxilamneef uffataan yookiin haguugduudhan osoo hin dhoksamne ilaalamu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
NC5.2.	Ogeessonni yemuu sakatta'uudhaaf qama hadholii ilaalan, fedha hin gaafatan? (fkn. Garaa ykn gadaamessa yemmuu ilaalan)	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko----------3 Lakki, tasumaa----------4	
NC5.3.	Ogeessonni fayyaa sababa sakatta'iinsi yookiin dalagaan tokko geggefamuuf hadholii ykn nama isaan wajjiin jirutti hin himan (fkn. Garaa ykn gadaamessa yemmuu ilaalan)?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	

NC5.4.	Ogeessonni yemmuu hadholii wajjiin haasa'an akka namonni yaala wajjiin wal hin qabanne dhagahanitti ni dubbatu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
NC5.5.	Ogeessota biroo odeeffannoo yaala hadholii iccitiidhaan hin qabne jiru jettanii yaadduu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
NC5.6.	Muxannoo kessan keessatti yeroon isin odeeffannoo yaala hadholii icittiin isaa akka hin eegne isinitti dhagahamee beekaa?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
Qoolliffannaa fi loogii ilaachise/Stigma and Discrimination			
SD6.1.	Sababa eenyummaa isaaniirra ka'uudhaan hadholiin tajaajila gara garaa ni argatu jettanii yaadduu? (*umrii, sadarkaa barumsaa, gaa'ila, saba, amantaa, fira/soshaaliii ogeessaa/ waan ta'aniif*)	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
SD6.2.	Muxannoo qabdan irraa ka'uudhan yemmuu/yeroo hadholiin ogeessota birootiin sababa armaan olitti kaafaman kana wajjiin walqabachuudhan tajaajila gara garaa argatan argitanii beektuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
SD6.3.	Osoo hin beekne, isin ofii kessanii sababoota armaan olii kana wajjiin walqabachuudhaan tajaajila gara garaa laattanii beektuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
Tuffatamuu fi dhiifamuu/ Neglect and abandonment			
NA7.1.	Ogeessonni yeroo hadholiin gargaarsa barbaadaniif yeroo muraasa keessatti gargaarsa osoo hin laatiniif ni turuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
NA7.2.	Bakkaa fi haala mijataa ta'e keessatti, namni haadholii wajjiin akka hin taane/turre ni tasiifamaa? (*Abbaa manaa, haadha, obbollettii ykn hiriyaa deessuu wajjin dhufe fin kan biroos haa ta'u*)	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
NA7.3.	Muxannoo qabdan irratti hundaa'uudhaan, yemmuu hadholiin ogeessota birootiin osoo hin gagaramin qophaa isaanii dhiifaman argitanii beektuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
NA7.4.	Isin ofii keessanii hadholii oso gargaaru qabdanuu, qofaa isaaniiti dhiistanii beektuu? (sababa garagaraatiin)	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
Mirga ofiin murteessuu haadholii ilaalchisee/ Loss of autonomy (detention)/			
A8.1.	Sababa yaalaa wajjiin oso wal hin qabatin, haadholiin yeroo ciniinsuu ykn da'uumss ykn achi booda akka hin sochoone ni dhoorkamuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
A8.2.	Sababa kafaltii hin kaffalleef hadholiin akka hospitaala/buufata fayyaatii hin baane ni dhorkamuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3	

		Lakki, tasumaa----------4	
A8.3.	Muxannoo qabdan irraa ka'uudhaan, yeroon bilisaan socho'uun haadholii dhoorkamu argitanii beektuu?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
A8.4.	Muxannoo qabdan irraa ka'uudhaan, yeroon isin haadholiin akka bilisaan hin sochoone taasiseera jettanii yaaddan jiraa?	Eeyyee, yeroo hundaa----------1 Eeyyee, yeroo baay'ee----------2 Eeyyee, al tokko tokko----------3 Lakki, tasumaa----------4	
Sababoota fi dhiibbaa/midhaa qabiinsa akka malee (mistreatment) haadholii irran gahu			
E9.1.	Akka yaada keessaniitti wantoonni kunuunsi gaarii hin taane hadholii irra akka gahu taasisan maal fa'a ta'uu danda'u jettanii yaaddu? (**barressudhan deebisaa**)		
E9.2.	Cunqursaaleen haadholii irra yeroo tajaajila argatan irra gahu, murtee isaan gara fuulduraa yaala haadholiidhaaf bufatalee/ hospitaalotatti laataman hordofuu irratti dhiibbaa qaba jettanii yaadduu?	Eeyyee----------1 Lakki---------- 2	

Waan hirmaattaniif hedduu galatoomaa.

Af-gaaffii mata duree kana wajjiniin wal-qabatu irratti hirmaachuudhaaf fedha qabduu?

Eeyyee, maaloo lakkofsa bilbilaa keessan asirratti (_____) kaa'udhaan yookiin bilbila dursaa qorannicha kan waraqaa odeeffannoo hirmaattotaa irratti kenneme fayadamaa.

Lakkii, galatoomaa!

Appendix 10: In-depth interview guide

In-depth interview guide was used with women aged 18 years old and above and who received maternity care from a facility and gave birth in the past three months in East Wollega Zone, Oromia Regional State, Western Ethiopia, 2022

Direction for data collectors who will conduct the interview when the researcher is unable (due to knowing the woman/healthcare provider)

Step 1: Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain oral/written consent.

Step 2: Ask the participant to identify herself and fill out the table below on sociodemographic information prior to beginning the interview.

Step 3: Conduct the interview. Please remember to audio record the interview.

Step 4: Complete the form at the end of the interview guide.

Woreda/district		Remarks
Participant #		
Age		
Marital Status	Single ……[ ] Married/……[ ] Divorced……[ ] Widowed……..……[ ] Others _____	
Educational Status	No formal education[ ] Primary……[ ] Secondary……[ ] >Secondary……..[ ]	
Number of births in a health facilities		
Number of births at home		
Residence	Urban……..[ ] Rural……...[ ]	

Start time: _____
Interviewer: _____
Interview date: __ __/__ __/____
DD / MM / YY

Interview discussion guide

A. Decision-making process to deliver at a facility during the most recent birth: Please take a moment to think about your most recent delivery.

1. Why did you decide to visit a health facility?
2. Who was involved in making this decision about where to give birth?
3. Were you planning to give birth in that health facility? [were you referred to/from another health facility?]

B. Experiences and perceptions of care provided at the most recent facility based delivery, focusing on treatment by providers and the facility environment.

4. What were your expectations when you gave birth at the health facility?
5. In your opinion, what do you need from your midwife, nurse or doctor in a health facility in order to receive respectful care during maternity care?
6. In your opinion, how are women treated by staff [administrators, midwives/nurses, physicians] in the facility when they come to get maternity care [from admission to discharge]?
7. In your opinion, how were you treated by the health workers during your most recent antenatal care, labour, birth and postnatal care? Please explain. [If the participant says that she was treated well, ask her if her family and friends had a similar experience as she did. Please explain.]

C. Elements of mistreatment of women.

Sometimes women are mistreated or poorly treated during maternity care by health workers and health staff at health facilities. This mistreatment may take several different forms. Now, I would like to discuss some of these forms of mistreatment with you.

8. In your opinion, did you experience mistreatment or poor treatment during your most recent pregnancy and childbirth? Ask also during antenatal care and postnatal care) [if the participant says no, ask if she has ever experience mistreatment during any of h
9. r deliveries. If the participant says no, ask if any of her family or friends have ever experienced mistreatment during their delivery.]

a. Could you explain the situation?

b. Who was involved in the situation?

c. How were you [friend/family] mistreated?

d. When did it happen? [time of day, during antenatal care, labour, during delivery or postpartum].

e. How often did it happen? [just once or more often].

*** If the participant describes a situation related to verbal mistreatment, physical mistreatment, or poor communication between the patient and provider, then explore the following accordingly:

Verbal mistreatment	**Physical mistreatment**	**Poor communication between the women and health care provider**
Did the HCP raise his/her voice?	Did that include pinching?	Were there any problems with the language of communication?
What types of comments were made?	Did that include slapping?	If so, was a translator available?
Were these comments made to threaten with Poor outcomes?	Did that include beating?	Was the poor communication related to lack of consent for a test or procedure?
Were these comments judgmental/ derogatory in nature?	Did that include kicking?	
Were these comments	Did that include	

based on her age or her number of children?	hitting?	
Did the provider blame her for getting pregnant?		

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

Now I would like to ask your opinion on the treatment of women during labour and delivery.

10. Are there any situations where it would be acceptable for a health worker to pinch or slap a woman during delivery? Please explain. [how would you feel if this happened to you? Explain.]
11. Are there any situations where it would be acceptable for a health worker to not ask for the patient's consent before a test or procedure when the patient is conscious? Please explain. [how would you feel if this happened to you? Explain.]
12. Are there any situations where it would be acceptable for a health worker to tell the woman she will have a poor outcome if she does not cooperate? Please explain. how would you feel if this happened to you? Explain.]
13. Are there any situations where it would be acceptable for a health worker to physically restrain a woman during labour or delivery? [how would you feel if this happened to you? Explain.]

D. Effect of Mistreatment on continued use of maternity care

14. Do you think that experiencing mistreatment at one point during maternity care (antenatal care, birth and postnatal care) will influence your decision not to use care again from health facility? Please explain. Probing questions could be:

a. In your opinion, does experiencing mistreatment during antenatal care be a reason not to visit that health facility or other facility for further antenatal care or childbirth, or postnatal care?
b. In your opinion, does experiencing mistreatment during birth in health facility deter women from coming again to that facility for postnatal care?
c. In your opinion, does experiencing mistreatment during all maternity care become obstacle for the future maternity care utilisation from health facilities?

15. In your opinion, what could be done to improve the treatment of women during labour and delivery?

E. Perceived factors that influence disrespect and abuse in the facilities

16. In your opinion, what are the factors that influence the mistreatment of women during labour and delivery? Please explain:

a. Related to supplies (availability of medication, equipment)
b. Related to health provider staffing (number of staff, attitude towards patients)
c. Related to patient load (number of patients, overcrowding)

17. In your opinion, what could be done to address these factors so that women are treated better during labour and delivery?

When the interview appears to have finished, ask participant if there is anything that you have misunderstood or that they would like to add. Thank the participant for his/her time. Remind them that the information will be kept confidential.

End time: ☐☐ : ☐☐☐☐ : ☐☐

IN-DEPTH INTERVIEW GUIDE—AFAAN OROMO VERSION

QAJEELFAMA AF-GAAFFII GAD-FAGEENYAAN OGEESSOTA FAYYAA FI DUBARTOOTA WAJJIIN

GODINA BAHA WALLAAGGAATTI BARA 2022TTI GEGGEFFAMUUF TAJAAJILAN.

- ◊ Eenyummaa keessan of-barsiisaa.
- ◊ Kaayyoo qorannoon kun geggeffamuf odeeffannoo hirmaattotaa fi unka walii galtee kennuudhan ibsaafi.
- ◊ Walii-galtee hirmaannaa mallattesisaa.
- ◊ Wantoota eenyummaa isaanii adda baasan kannen armaan gadii guutaa.

HUB- AF-GAAFFICHA SAGALEEDHAN WARAABUU AKKA HIN IRRAANFANNE.

Aanaa_____ Lakk. Hirmaataa_____ Umrii_____Haala gaa'elaa_____ Sad.barnootaa_____ Baay'ina ijoolee dahanii qabanii_____ Iddoo jireenyaa_____

Yeroo itti jalqabame: _____

Gaafficha kan gaggeesse: _____

Guyyaa af-gaaffiin itti gaggeeffame: __ __/__ __/____

GG / JJ / BB

Yeroo itti dhumate: _____

Kutaa 1: Murtoo tajaajila argachuu irratti qaban: Kunuunsa hadholiidhaaf yeroo ulfaa, da'uumsaa akkasumas isa booda buufata fayyaatti laatamu argachuudhaaf

1. Maaltu akka buufata fayyaa/hospitaala dhaqxanii kunuunsa argattan isin taasise? (**rakkoon jira ture moo ciniinsuun isin qabnaan dhaqxan**)

2. Dhabbata fayyaa mucaa keessan itti deessan kana akka dhaqxanii kunuunsa/tajaajila argattaniif, murtee irratti eenyutu hirmaate, murtee dhuma namni dabarse hoo?

3. Jalqabumarraa kaatanii buufata fayyaatti mucaa keessan da'uudhaaf karoorfattanii turtanuu? **[Buufata/mana yaala biro irraa riferii taataniiti moo?]**

Kutaa 2: Muxannoo fi Ilaalcha kunuunsa haadholiidhaf bufataale fayyatti kennamu ilalchisee

1. Yemmuu bufataale fayyaatira tajaajila da'uumsaas haa ta'u kan yeroo ulfa turtan argattan, **bufaticharra maal eegdu**? (Probe— ***haala kenniinsa kunuunsaa/tajaajila ilaalchisee- dhaabbata fayyaa sanirra maal eegdu?)***

2. Akka yaada keessaniitti, tajaajila kabaja qabeessa ta'e tokko argachuudhaaf ogeessota fayyaa isin yaalan kan akka **midwayfarii, narsii ykn doktoraarra** maal eegdu?

3. Akka yaada keessaniititti, haalli qabiinsaa istaafiin buufataale fayya dubartoota kunuunsa yeroo ulfaa fi da'uumsa dubartootaf taasifamu maal fakkaata [hogantoota, midwayfarii/narsoota, haakimota **[simannarra kaase hamma bahuumsaatti]**?

4. Akka yaada keessaniitti, haalli isin *hordoffii ulfaa/ da'uumsaa / da'uumsa booda* isa dhiheenya kanaa ittiin argattan/yaalamtan maal fakkaata? Maaloo naaf ibsaa**. [Yoo hirmaataan af-gaaffichaa sirrittin/ sirnaanan yaalame jedhan, maatii yookiin hiriyaan isaaniis tajaajila walfakkata argatu isaanii gafadha]**

<u>Kutaa 3: Akaakulee dararaa dubartoota/haadholii irra qaqabu.</u>

Al tokko-tokko, dubartonni ogeessota fayyaatiin ykn hojjattoota birootiin (kana akka waardiyyaa, qulqullesitootatiin) ni dararamu ykn haala gaariidhaan hin qabaman. Dararaaleen/ cunqursaaleen hadholiirra gahan kunniin bifoota garagaraatiin muldhachuu ni danda'u. Amma, bifoota dararaalee kanniinii irratti isin wajjinin mari'ana.

1. Akka yaada keessaniiti, **dararaan yookiin qabiinsi gaarii hin taane isin mudatee beeka,** keessumayyu yeroo ciniinsuu fi da'uumsaa mucaa keessani isa as dhihoo kana? Akkasumas haala yaala yeroo hordoffi ulfaa fi da'uumsa boodaas gaafadhu) [**Yoo dararaan isaan mudate akka hin jire himan, kanaan dura yeroo ijoolle isaan kanneen biro argatan isaan mudatee beekaa jechuun gaaffadha. Akkasumas maatiin isaanii yookiin hiriyaan isaanii dararaan isaanirra ga'uu beekuu?**]
    a. Haalichi akkam akka ture natti himuu dandeessuu?
    b. Eenyutu haalicha keessaatti qooda qaba ture?
    c. Haala kamiin isin/ hiriyaan keessan dararamtan/dararaman?
    d. Yoom ture kun kan isin mudate? [yeroo hordoffii ulfaa, da'uumsaa /da'uumsa boodaa, guyyaa/halkan?].
    e. Hammam deddeebi'ee isin mudate? [al tokko qofaa moo irra deddeebiidhaan?].

***** Yoo hirmaatan haala ture san karaa dararaa afaaniin, miidhaa qaamaa, yookiin walitti dhufeenya gaarii hin taane/gad-bu'aa ta'een ibsan, haala armaan gadii kanaan sirritti gad-fageenyaan ilaala:**

Dararaa afaaniini	**Dararaa miidhaa qaama fidu**	**Walitti dhufeenya/haasaa gadi-bu'aa te'e- haadholee fi ogeessota fayyaa gidduu**
◊ Ogeessi fayyaa **sagalee isaanii** ol-kaasanii turanii? – sirritti iyyuudhanii? ◊ Waan akami isiinin jedhan? ◊ Bu'aan yaala keessanii gaarii ta'uu hin danda'u jechuudhaan isin sodachisaniiruu / doorsisaniiruu? ◊ Wantoota umaman maraaf itti gafatama isin tasiisaniiru, isin busheessu/xinneessu turee? ◊ Wantoonni isiniin jedhaman kunniin umrii fi baay'ina ijoolle	◊ Qimmiiduu/qun xuuxuu ni dabalata turee? ◊ Kaballaa/ harkaan fuula keessa rukutuu ni dabalata turee? ◊ Ciniinnaa ni dabalata turee? ◊ Dhiitu ni dabalata turee? ◊ Rukuttaa ni dabalata turee?	◊ Afaan walii-galuuf ittiin hasa'an/ dubbatan wajjiin walqabatee rakkoon ni jira turee? ◊ Waldhagahuu/ afaan isin hin beekneen hasofsiifamu. ◊ Akkas taanaan, namni isiniif hiiku jira tureeyi? ◊ Rakkoon marii gad-aanaa ta'e akka uumamu kan taasise, yeroo isin ilaluuf/sakata'uudhaf jedhan

isin qabdan wajjiin walqabata turee? ◊ Waan isin ulfooftaniif isin komataniiruu/?		fedha keessan waan isin hin gaffannefi dha?

2. Akka yaada keessaniitti rakkoon isin kaastan kun **hammam deddeebi'ee muldhata?** Yaaddessaa dhaa? **[Yeroo baay'ee irra deddebidhaan rakkoo nama mudatu dhaa?]**

Kutaa 4: Mudannollen kunniin hammam fudhatama qabu

1. Akka yaada keessanitti ogeessonni fayya yeroo da'uumsaa fi isa boodarratti yeroon isaan haadholii **qimmiduu/kabaluu qabu jedhamu jira- fudhatama qabaatu jiraa? [wanti akkasii osoo isin mudatee maal gootu, maaloo ibsaa.]**

2. Haala dhukkubsataan/yaalamaan of-beeku tokko irra jiru ilaluudhaan dura **fedha/eyyama** nama sanaa gaffachuu dhabuun ogeessota fayya yeroo inni fudhatama qabaatu jira jettanii yaaddu? **[Maaltu isinitti dhaga'ama osoo wanti akkanaa isin mudatee? Naaf ibsaa.]**

3. Haalli yeroo ogeessi fayyaa haadha tokkoon sababa isheen isa/isaan gargaaru diddeef haalli/bu'aan yaala ishee gaarii ta'uu hin danda'u jedhanii itti himuu/**doorsisuun** fudhatama qabaatu jira jettanii yaadduu? Maaloo naaf ibsaa**. [Wanti akkanaa osoo isin mudatee maaltu isinitti dhaga'ama?]**
4. Halli ogeessi fayyaa haadha tokkoo humnaan ishee cinquudhan akka hin warraqne taasisu fudhatama qabaatu taasisu jira jettanii yaadduu? **[Wanti akkanaa osoo isin mudatee maaltu isinitti dhaga'ama?]**

Kutaa 5: Dhiibbaa dararaaleen dubartoota irra tajaajila irratti qabaatu

1. Dararaaleen hadholiirra irra gahu kunniin, fula duraaf dhibbaan inni tajaajilale kannen **(hordoffii ulfaa, da'uumsa fi da'uumsa boodaa)** irran gahuu danda'a jettanii yaaddan jiraa? Maaloo ibsaa, gaaffileen kakakasuudhaaf gaafatamu danda'an:
    a. Akka yaada keessaniitti, dararaan hadholiirra yeroo ulfaa mudatu akka isaan bufata fayyatti hin deenyeef isaan dhoowwuu ni danda'a jettanii yaadduu?

b. Akka yaada kessaniitti, hadholiin yeroo dahan cunqursaaleen/dararaaleen isaan mudachuun isaa hordoffii da'uumsa boodaaf mana yaalaa sanatti akka isaan hin deebine ni taasisaa?
c. Akka yaada keessaniitti, yeroo kamuu dararaan hadholii irra gahu haadholiin ulfa/da'uumsa gara fula duraatiif bufataalee fayyaa kennani irraa tajaajila akka isaan hin fayyadamne ni tasisaa?

2. Haala qabiinsa hadholiidhaaf taasifamu fooyyessuudhaaf maaltu godhamuu qaba jettanii yaaddu?

<u>Kutaa 6: Wantoota dararaalee haadholii irra gahan wajjiin walqabatan</u>

1. Akka yaada keessaniitti, wantoonni akka haadholiin yeroo miixuu fi da'uumsaa dararaman taasisan maal fa'a jettu? Maaloo babal'oomsaa:
   b. Dhiheessii wajjiin walqabatee (argama qorichaalee, meeshaalee yalaa)
   c. Ogeessota fayyaa wajjin walqabatee (baay'ina hojjatoota, ilaalcha isaan yaalamadhaaf qaban)
   d. Baay'ina yaalamtoota wajjiin walqabatee (baay'achuu yaalamtoota, namaan cinqamuu bufataale faayya)
2. Wantoonni dhiibbaa geessisuudhan dararaan haadholii irra akka gahu taasisan kana furuudhaaf maaltu fudhatamuu qaba jettanii yaaddu?

- **Yoo mariin/afgaaffichi gara dhumaa irra gahuu hubattani,** wanti isin kara sirrii hin taanen hubbataniirtu jettani yaaddan yoo jiraate akka kaasan haala mijeessa, yookiin wanti dabalamu qaba jettan/hafuu hin qabu jettan dabala.
- Hirmaanna isaniitif galateffachuudhan akka yaadni isaanii hunduu iccittidhan qabamu irra deebi'uun yaadachiisa.

IN-DEPTH INTERVIEW GUIDE_HCPS

DIRECTIONS

- ◊ Introduce yourself to the participant.
- ◊ Describe the purpose of the interview and how information will be used.
- ◊ Obtain oral/written consent.
- ◊ Fill the identity form
- ◊ Conduct the interview. Please remember to audio record the interview.
- ◊ conclude the interview as it appears to be.

Participant number _____District_____ Health facility _____ Age_____Profession_____

Start time: _____

Interviewer: _____

Date: __ __/__ __/____

Ending time: _____

Part 1: General Views and Experiences Regarding Maternity Care

1. In your opinion, what are the expectations of women when they visit the Hospital/Health Center for pregnancy, birth, and postnatal care? (Probe: Specifically, what do they expect regarding care delivery at the health facility?)

2. In your opinion, what do you believe mothers expect from health professionals (midwives, nurses, or doctors) to ensure they receive respectful care?

3. In your opinion, how do you perceive the care that maternal healthcare providers are providing during pregnancy and childbirth care? Do you believe women are receiving the services they deserve in the manner they expect, including from managers, midwives/nurses, doctors, guards, and cleaners (from admission up to the point of discharge)?

4. In your opinion, as you offer pregnancy, birth, and postpartum follow-up, do you believe you are providing the service that women/mothers need or expect from you? Please explain. [If the participant responds as providing good care, inquire whether their friends are providing similar treatment/services.]

Part 2: Categories of mistreatment towards women

Sometimes, women express dissatisfaction with the care they receive, citing unmet expectations and poor treatment in health facilities. These issues related to care can manifest in various forms. Now, let's delve into these concerns.

1. Based on your experience, have you ever witnessed or heard of instances of mistreatment or disrespect of mothers, particularly during pregnancy, childbirth, and the postpartum period? [If the participant responds hasn't personally observed such instances, inquire whether they've heard such information from other professionals or if they've ever heard mothers or their families expressing such concerns.]
    A. Could you explain the situation?
    B. Who was involved in the situation?[Whether professionals or other supportive staff)
    C. How did it occur?
    D. When did it happen? [time of day, during antenatal care, labour, during delivery or postpartum].

Verbal abuse	**Physical abuse**	**Poor communication between the women and health care provider**

◊ Did the health professionals raise their voices? – screaming /yelling? ◊ Is there a insults in bad words? ◊ Have they been threatened that their treatment may be not good? ◊ They made the women responsible for everything that happened, intimidating ? ◊ Were these things said by women related to the age and number of children they had? ◊ Because they are pregnant — (because they are pregnant early, without a husband/?	◊ Did it involve pinching? ◊ Did it entail a slap? ◊ Would it involve biting/hitting? ◊ "Did it result in swelling?" ◊ Did it involve a kick?	◊ Were there any problems with the language of communication? ◊ If so, was a translator available? ◊ Was the poor communication ◊ related to lack of consent for a test or procedure?

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

Part 3: Acceptability of the mistreatment

1. Do you believe there is ever an acceptable time to exert mistreat women by maternal health professionals, be it during labor or birth? If this were to happen to you, how would you respond?
2. In your opinion, are there situations in which it is acceptable for health professionals not to seek the consent of a self-conscious patient before taking action?
3. Can you envision a scenario in which it would be acceptable for providers to threaten a patient by suggesting that treatment outcomes might be unfavourable due to a disagreement? Please explain.

4. Under what circumstances do you believe it would be acceptable for a health professional to resort force a woman not to move?

Part 4: Consequences/impact of mistreatment on continuity of care or other effect

d. Do you believe that acts of mistreatment against mothers could have future implications for the services provided, such as pregnancy, childbirth, and

postpartum follow-up? If so, what specific impacts might arise? Consider the following probing questions:

a. In your opinion, could the mistreatment of women during pregnancy dissuade them from seeking care at health centres?
b. Do you think the mistreatment experienced by mothers during childbirth might hinder their return to the clinic for postpartum follow-up?
c. In your view, does maternal abuse deter mothers from utilising health facilities for future pregnancies or births?

2. What measures do you believe should be taken to enhance the treatment of mothers?

Part 5: Drivers of mistreatment- contributing factors

1. In your opinion, what are the reasons/factors that cause mothers to be mistreated during labour and delivery? Please explain:
    a. Supply-related (availability of medicines, medical devices)
    b. Related to health professionals (number of staff, their attitudes towards treatment)
    c. Related to the number of patients (overcrowding, crowding of health facilities)
2. What do you think should be done to address the factors that influence maternal mistreatment?

- If you notice that the discussion/question is ending, ask them to raise anything you believe you have misunderstood, or think should be added/omitted.
- Thank them for their participation and remind them that all their comments will be kept confidential.

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QAJEELFAMA AF-GAAFFII GAD-FAGEENYAAN OGEESSOTA FAYYAA WAJJIIN GODINA BAHA WALLAAGGAATTI BARA 2022TTI GEGGEFFAMUUF TAJAAJILAN.

- ◊ Eenyummaa keessan of-barsiisaa.
- ◊ Kaayyoo qorannoon kun geggeffamuf odeeffannoo hirmaattotaa fi unka walii galtee kennuudhan ibsaafi.
- ◊ Walii-galtee hirmaannaa mallattesisaa.
- ◊ Wantoota eenyummaa isaanii adda baasan kannen armaan gadii guutaa.

HUB –AF-GAAFFICHA SAGALEEDHAN WARAABUU AKKA HIN IRRAANFANNE.

Lakk. Hirmaataa_____Aanaa_____ Bufata fayyaa_____ Umrii_____Ogummaa_____

Yeroo itti jalqabame: _____

Gaafficha kan gaggeesse: _____

Guyyaa af-gaaffiin itti gaggeeffame: __ __/__ __/____

GG / JJ / BB

Yeroo itti dhumate: _____

Kutaa 1: Muxannoo fi Ilaalcha kunuunsa haadholiidhaf bufataale fayyatti kennamu ilalchisee

1. Akka yaada keessaniitti, dubartoonni yemmuu bufataale fayyaatira kunuunsa yeroo ulfaa/da'umsaa fi da'uumsa boodaa argachuudhaf dhufan, Hospitala/Bufata fayyaa irraa maal waan eegan isinitti fakkata? (Probe— ***haala kenniinsa kunuunsaa ilaalchisee- dhaabbata fayyaa sanirra maal eegu?)***

2. Akka yaada keessaniitti, **tajaajila kabaja qabeessa** ta'e tokko argachuudhaaf ogeessota fayyaa kan akka (**midwayfarii, narsii ykn doktoraarra)** irraa haadholiin maal waan eegan isiitti fakkaata?

3. Akka yaada keessaniititti, **haalli qabiinsaa** istaafiin buufataale fayya kunuunsa yeroo ulfaa fi da'uumsa dubartootaf taasifamu maal fakkaata, akkaata itti eegan sanitti tajaajila isaanif malu argachaa jiru jettanii yaadduu [hogantoota, midwayfarii/narsoota, haakimota, wardiyaa, qulqullesitootas dabalatee—**simannarra kaase hamma bahuumsaatti]**?

4. Akka yaada keessaniitti, haalli isin ***hordoffii ulfaa/ da'uumsaa / da'uumsa boodaa*** yemmuu kennitan, dubartonni/hadholiin kunuunsa isaan barbaachisu ykn isinirraa eegan sana kennaafin jira jettanii ni yaadduu? Maaloo naaf ibsaa. [Yoo hirmaatan af-gaaffichaa sirrittin kennaara jedhan, hiriyyonni isaaniis yaala akkana/ tajaajila walfakkata akkasii laataa jiraachuu isaanii gaaffadha]

Kutaa 2: Akaakulee dararaa dubartoota/haadholii irra qaqabu.

Al tokko-tokko, dubartonni kunuunsa eegaan akka hin argannee fi halli qabinsa dhabbata fayyaa keessatti argatan **gaarii akka hin taanetti ni isbu**. Rakkoon kunuunsa wajjiin wal qabatanii ka'an kunniin bifoota gara garaatiin ni muldhatu. Amma wa'ee kanniini irratti dubbana.

5. Muxannoo qabdan irraati— Dararaan ykn qabiinsi gaarii hin taane yemmuu haadholii mudatu argitanii, dhageessanii beektuu? keessumaayyuu yeroo ulfaafi da'uumsaa fi achiin booddee?) **[Yoo ofii isaaniti akka hin agarre kaasan, wantoonni ogeessonni biro irraa dhagahanii akka beekani gaaffadhaa?, haadholiin ykn maatiin isaanii yemmuu dubbatan dhageessanii beektuu?]*****
    A. Haalichi akkam akka ture natti himuu dandeessuu?
    B. Eenyutu haalicha keessaatti qooda qaba ture? [ogeessota kessays haa ta'u kannen biro keessaa kan akka qulqullesitoota fi kan biroo)
    C. Haala kamiin qabiinsi gaarii hin taane kun mudate?
    D. Yoom ture kun kan mudate? [yeroo hordoffii ulfaa, da'uumsaa moo tajaajila/hordoffi da'uumsa boodaa?].

Dararaa afaaniini	**Dararaa miidhaa qaama fidu**	**Walitti dhufeenya/haasaa gadi-bu'aa te'e- haadholee fi ogeessota fayyaa gidduu**
◊ Ogeessi fayyaa **sagalee isaanii** ol-kaasanii turanii? – sirritti iyyuudhanii? ◊ Jecha gaarii hin taaneen wal hifachuun jiraa? ◊ Yallii isaaniif kennamu gaarii ta'uu mala jechuudhaan sodachisaniiruu / doorsisaniiruu? ◊ Wantoota umaman maraaf itti gafatama isin tasiisaniiru, isin busheessu/xinneessu turee? ◊ Wantoonni dubartootaan jedhaman kunniin **umrii fi baay'ina ijoolle** isaan qaban wajjiin walqabata turee? ◊ Waan isaan ulfa ta'aniif —(**yeroo malee, abbaa manaa osoo hin qabaatin ulfaa'uu isaniitiif jecha/?**	◊ **Qimmiiduu**/qunxuuxuu ni dabalata turee? ◊ **Kaballaa**/ harkaan fuula keessa rukutuu ni dabalata turee? ◊ **Ciniinnaa** ni dabalata turee? ◊ **Dhiitu** ni dabalata turee? ◊ **Rukuttaa** ni dabalata turee?	◊ **Afaan walii-galuuf** ittiin hasa'an/ dubbatan wajjiin walqabatee rakkoon ni jira turee? ◊ Waldhagahuu/ **afaan** isin hin beekneen hasofsiifamu. ◊ Nama Afaan hin beekne yoo jiraate ni hikamaafii? ◊ Osoo fedha isaanii hin gaafatin sakata'an mirri gaariin isanitti ni dhaga'ama jettanii yaadduu

4. Hammam baratamaa/yaaddessaa dha? Maal wajjiin walqabachuu danda'a jettanii yaaddu? **[al tokko qofaa moo irra deddeebiidhaan?].**

Kutaa 3: Mudannolleen kunniin hammam fudhatama qabu

5. Akka yaada keessaniitti yeroon itti ogeessonni fayya haadholii **qimmiduu/kabaluu qabu jedhamu jira- fudhatama qabaatu jiraa?—Ciniinsuurrattis haa ta'uu da'uumsa irrattis [wanti akkasii osoo isin mudatee maal gootu, maaloo ibsaa.]**
6. Haala dhukkubsataan/yaalamaan of-beeku tokko irra jiru ilaluudhaan dura **fedha/eyyama** nama sanaa gaffachuu dhabuun ogeessota fayyaa yeroon inni itti fudhatama qabaatu jira jettanii yaadduu?
7. Haalli yeroo ogeessi fayyaa sababa walii galuu hin dandeenyeef bu'aan yaale ishee gaarii ta'uu akka hin dandeenye ittiin **doorsisuun** fudhatama qabaatu jira jettanii yaadduu? Maaloo naaf ibsaa**.**
8. Halli ogeessi fayyaa haadha tokkoo humnaan ishee cinquudhan akka hin warraqne taasisu fudhatama qabaatu taasisu jira jettanii yaadduu?

<u>Kutaa 4: Dhiibbaa dararaaleen dubartoota kunniin tajaajila irratti qabaatu</u>

i. Dararaaleen hadholii irra gahu kunniin, fula duraaf dhibbaan inni tajaajilaale kannen **akka hordoffii ulfaa, da'uumsa fi da'uumsa boodaa** irraan gahuu danda'u jira jettanii yaadduu? Yoo jiraate maal fa'a? Maaloo ibsaa, gaaffileen kakakasuudhaaf gaafatamu danda'an:
    e. Akka yaada keessaniitti, dararaan hadholiirra **yeroo ulfaa mudatu** akka isaan **bufata fayyatti hin deenyeef isaan murteessisuu ni danda'a jettanii** yaadduu?

    f. Akka yaada kessaniitti, hadholiin yeroo dahan cunqursaaleen/dararaaleen isaan mudachuun isaa hordoffii da'uumsa boodaaf mana yaalaa sanatti akka isaan hin deebine ni taasisaa?
    g. Akka yaada keessaniitti, yeroo kamuu dararaan hadholii irra gahu haadholiin ulfa/da'uumsa gara fula duraatiif bufataalee fayyaa kennani irraa tajaajila akka isaan hin fayyadamne ni tasisaa?

ii. Haala qabiinsa hadholiidhaaf taasifamu fooyyessuudhaaf maaltu godhamuu qaba jettanii yaaddu?

<u>Kutaa 7: Wantoota dararaalee haadholii irra gahan wajjiin walqabatan</u>

5. Akka yaada keessaniitti, wantoonni akka haadholiin yeroo miixuu/ciniinsuu fi da'uumsaa dararaman taasisan maal fa'a jettu? Maaloo babal'oomsaa:
    e. Dhiheessii wajjiin walqabatee (argama qorichaalee, meeshaalee yalaa)
    f. Ogeessota fayyaa wajjin walqabatee (baay'ina hojjatoota, ilaalcha isaan yaalamadhaaf qaban)
    g. Baay'ina yaalamtoota wajjiin walqabatee (baay'achuu yaalamtoota, namaan cinqamuu bufataale faayya)
6. Wantoonni dhiibbaa geessisuudhan dararaan haadholii irra akka gahu taasisan kana furuudhaaf maaltu fudhatamuu qaba jettanii yaaddu?
    - **Yoo mariin/afgaaffichi gara dhumaa irra gahuu hubattani,** wanti isin kara sirrii hin taanen hubbataniirtu jettani yaaddan yoo jiraate akka kaasan haala mijeessa, yookiin wanti dabalamu qaba jettan/hafuu hin qabu jettan dabala.
    - Hirmaanna isaniitif galateffachuudhan akka yaadni isaanii hunduu iccittidhan qabamu irra deebi'uun yaadachiisa.

Appendix 11: Ethics approval letter

HREC Approval Granted - ETH21-6587

From: Research.Ethics@uts.edu.au Research.Ethics@uts.edu.au
To: Research Ethics research.ethics@uts.edu.au, Kathleen Baird Kathleen.Baird@uts.edu.au, Habtamu Kasaye Habtamu.Kasaye@student.uts.edu.au
Sent: Thursday, 16 December 2021, 1:06 am

Dear Applicant

Re: ETH21-6587 - "Mistreatment of women during maternal health care utilisation in Western Ethiopia"

Thank you for your response to the Committee's comments for your project. The Committee agreed that this application now meets the requirements of the National Statement on Ethical Conduct in Human Research (2007) and has been approved on that basis. You are therefore authorised to commence activities as outlined in your application.

You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.

Your approval number is UTS HREC REF NO. ETH21-6587.

Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.

The following standard conditions apply to your approval:

- Your approval number must be included in all participant material and advertisements. Any advertisements on Staff Connect without an approval number will be removed.
- The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat.
- The Principal Investigator will notify the Committee of any event that requires a modification to the protocol or other project documents, and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.
- The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property.

- The Principal Investigator will report to the UTS HREC or UTS MREC annually and notify the Committee when the project is completed at all sites. The Principal Investigator will notify the Committee of any plan to extend the duration of the project past the approval period listed above.
- The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations).
- The Principal Investigator will notify the Committee of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be
undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please don't hesitate to contact the Ethics Secretariat and quote the ethics application number (e.g. ETH20-xxxx) in all correspondence.

Yours sincerely,
The Research Ethics Secretariat

On behalf of the UTS Human Research Ethics Committees
C/- Research Office
University of Technology Sydney
E: Research.Ethics@uts.edu.au

Ref: E38

Appendix 12: Paper 1:-Systematic Review

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BMC Pregnancy and Childbirth

RESEARCH Open Access

The roles of multi-component interventions in reducing mistreatment of women and enhancing respectful maternity care: a systematic review

Habtamu Kasaye[1,2*], Annabel Sheehy[1], Vanessa Scarf[1] and Kathleen Baird[1]

Abstract

Background Despite recognition of the adverse impacts of the mistreatment of women during pregnancy, labour and birth, there remains limited evidence on interventions that could reduce mistreatment and build a culture of respectful maternity care (RMC) in health facilities. The sustainability of effective individual interventions and their adaptability to various global contexts remain uncertain. In this systematic review, we aimed to synthesise the best available evidence that has been shown to be effective in reducing the mistreatment of women and/or enhancing RMC during women's maternity care in health facilities.

Methods We searched the online databases PubMed, CINAHL, EBSCO Nursing/Academic Edition, Embase, African Journals Online (AJOL), Scopus, Web of Science, and grey literature using predetermined search strategies. We included cluster randomized controlled trials (RCTs) and pre-and-post observational studies and appraised them using JBI critical appraisal checklists. The findings were synthesised narratively without conducting a meta-analysis. The certainty of evidence was assessed using GRADE criteria.

Results From the 1493 identified records, 11 studies from six sub-Sahara African countries and one study from India were included: three cluster RCTs and nine pre- and post-studies. We identified diverse interventions implemented via various approaches including individual health care providers, health systems, and policy amendments. Moderate certainty evidence from two cluster RCTs and four pre- and post-studies suggests that multi-component interventions can reduce the odds of mistreatment that women may experience in health facilities, with odds of reduction ranging from 18 per cent to 66 per cent. Similarly, women's perceptions of maternity care as respectful increased in moderate certainty evidence from two cluster RCTs and five pre- and post-studies with reported increases ranging from 5 per cent to 50 per cent.

Conclusions Multi-component interventions that address attitudes and behaviors of health care providers, motivate staff, engage the local community, and alleviate health facility and system constraints have been found to effectively reduce mistreatment of women and/or increase respectful maternity care. Such interventions which go beyond a single focus like staff training appear to be more likely to bring about change. Therefore, future interventions should consider diverse approaches that incorporate these components to improve maternal care.

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Keywords Mistreatment of women, Respectful maternity care, Multi-component interventions

Introduction

Pregnancy, childbirth, and the early parenting period are remarkable events in a woman's life, with women encountering a range of experiences such as joyful, positive transitions through to periods of trauma and vulnerability [1, 2]. To enhance positive outcomes, health systems and health care providers (HCPs) must ensure high-quality, equitable, evidence-based, and respectful maternity care (RMC) for all women [3]. The absence or deficiency of RMC manifesting as the mistreatment of women diminishes the quality and efficacy of maternity care across all cultures [4]. Mistreatment is perceived when the provision of maternity care is perceived by women to be disrespectful, abusive, neglectful, or undignified [4, 5]. The prevalence of women experiencing at least one form of mistreatment ranges from 17.3 per cent in the United States of America to 44 per cent in sub-Saharan African (SSA) [6–10]. Despite the contextual variation between settings and across countries, it is important to note that mistreatment is any humiliating encounter that women experience in a health facility [4, 5]. It is important to note that perceived mistreatment can have long-lasting negative impacts on a woman's dignity and self-esteem and negatively impact mothering and decisions for future childbearing [11–13].

Mounting evidence demonstrates varied adverse impact of the mistreatment of women and its deterrence of women's utilisation of maternal health care. Experiences of mistreatment result in dissatisfaction of received care and lower confidence in maternity care, and curtail subsequent health-seeking behaviours [14–17]. In particular, perceptions of distrust of health care facilities by women in low- and middle-income countries have been shown to override socio-cultural beliefs about the importance of accessing maternity care [18]. Even though the impact of mistreatment is known, there is limited specificity of information for developing ameliorative strategies to build a culture of RMC in maternity services and prevent cultures of mistreatment and clinical encounters within which women are disrespected, abused, neglected, and/or degraded.

Organisations such as the White Ribbon Alliance and the World Health Organization (WHO) highlight the urgent requirement for all women to have access to maternity care that is safe and respectful [19–21], however, there is a lack of practical and sustainable interventions which enhance respectful care and reduce mistreatment of women. Studies from low-income countries suggest that training interventions aimed at transforming attitudes, values and behaviours of health care providers can bring about some positive effects in maternity care [22, 23]. Similarly, the mobilisation of communities to demand RMC, as well as dispute resolution strategies for women who have experienced mistreatment can result in changes which may minimise abusive care [22, 23]. In a systematic review comprising of five African studies, Downe et al. [24] concluded that policy interventions could generate changes to minimise the mistreatment of women during maternity care. However, it is uncertain from this review as to the degree of effectiveness of specific components of the interventions, and their sustainability and adaptability to varying global contexts, especially communities with resource limitations [24]. A recent mixed-method review which focused on educational interventions for health care providers was shown to understanding of RMC by staff, yet Dhakal et al. [25] concluded that it was not evident whether the included interventions impacted women's perceptions of actual mistreatment.

Reducing mistreatment is complicated and requires strategies that focus beyond health care providers' attitudes, behaviours and actions [26]. At the institutional and policy level, the resource constraints and staffing deficits of health facilities and health systems significantly worsen the experiences of women and families [4, 27]. Research examining the phenomenon of mistreatment of women from various viewpoints is therefore required. Identifying specific components of RMC interventions that successfully and sustainably reduce women's mistreatment is necessary. This systematic review aimed to synthesise the best available evidence on such interventions which utilise differing approaches to address the issue of mistreatment. The effectiveness of these interventions in reducing the mistreatment of women and/or enhancing respectful maternity care in health facilities was also examined.

Methods

A systematic review was performed in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis-2020 (PRISMA-2020) guideline [28], as shown in supporting file S1 Table, and also followed the systematic review protocol registered in the International Prospective Register of Systematic Reviews (PROSPERO) with registration number— CRD42021287049.

Eligibility criteria

As described below, the studies were selected according to the PICOS (participants/population, intervention, comparisons, outcomes, and study designs).

Population

The study population was women receiving maternity care from health facilities and maternal health care providers. Although respectful care and mistreatment-free services are equally important for other health care recipients from health facilities, our focus in this review is on services provided to women during maternity care. Studies that evaluated outcomes reported by women who received maternal health care from health facilities or health care providers were included.

Interventions

Studies that evaluated the effectiveness of RMC interventions at any level including the community, health facility, and individual health care providers in reducing mistreatment of women and/or enhancing respectful maternity care were included. The interventions were included in the review based on the outcome that they intended to evaluate. Hence, interventions which targeted various levels and components to change health care providers' attitudes and behaviours, health facilities and system failures, and change how women react to the abusive and disrespectful care were included. We excluded interventions that did not primarily focus on reducing mistreatment of women and/or enhancing respectful care, but instead aimed exclusively at achieving unrelated outcomes such as increasing service utilisation or decreasing specific interventions of childbearing.

Comparator

The effectiveness of the RMC interventions was compared with the standard usual routine care which existed prior to the implementation of the RMC interventions.

Outcomes

The primary outcome sought in this systematic review was whether the level of mistreatment that women experienced could be reduced secondary to the implementation of the interventions. Mistreatment was defined as explicit experiences in childbirth, such as verbal, sexual, and physical abuse, neglect, stigma and discrimination, poor communication, and/or other forms of mistreatment related to health care providers or health care facilities, as described in Bohren et al.'s [4] and Bowser and Hill's [5] global reviews. Articles which evaluated the occurrence of any of these disrespectful and abusive care were included. Hence, studies which included evaluations of the intervention, either as observations of the levels of women's mistreatment between the two groups or those that included the self-reported experiences of women themselves, were also included. Overall mistreatment of women could be measured as occurrences in any form or the proportion of occurrences of each component, such as physical abuse, verbal abuse (also known as non-dignified care, non-consented care, nonconfidential care, discrimination, neglect, or abandonment of care), and detention in health facilities. It could also extend to poor rapport/communication between women and health care providers.

Another outcome of interest was respectful maternity care, as reported by women or observed by the investigators. Respectful maternity care is a woman-centred maternity care that is organised for, and provided to, all women by upholding their privacy, confidentiality, and dignity, protecting women from harm and mistreatment through the provision of continuous support and enabling active decision making by women throughout their pregnancy, childbirth and during postnatal care [29]. Respectful maternity care improvement is measured as changes in the domains of respectful maternity care which include being free from harm and mistreatment, the protection of dignity, privacy and confidentiality, informed consent, and respect for their preferences among others as suggested by Shakibazadeh et al. [30]

Types of studies

Cluster RCTs and pre-and-post interventional studies with and without control groups were included in the review.

Database selection and search strategy

The search was conducted from 10 November 2021 through December 13, 2021, to retrieve both published and unpublished studies. An initial search of PubMed and CINAHL databases was performed based on the eligibility criteria mentioned under eligibility criteria. After analysing the text and terminology used in potential studies identified from PubMed and CINAHL databases, a second search was undertaken using all identified keywords and index terms performed in EBSCO Nursing/Academic Edition, Ovid Embase, African Journals Online (AJOL), Scopus, Web of Science, and Google Scholar.

Manual searches of the reference lists of all identified papers and previous systematic review papers were performed to identify studies cited within the selected papers. Searches for unpublished studies in ProQuest's dissertation and thesis database, grey literature from

search engines such as Google, WHO Global Health Library websites, White Ribbon Alliance, and the International Confederation of Midwives were also performed. The keywords used in the initial search included *'mistreatment'*, 'respectful maternity care', *'maternity care'*, and 'interventions'. The details of the database search strategies are provided in the supporting file S2 Table.

Data management and study selection

The results from all database searches were exported to Endnote version X9 [31] for storage and management. The results were labelled in Endnote as either originating from the database or manually searched. Bibliographies captured in Endnote were then exported to the Covidence Systematic Review software (Veritas Health Innovation, Melbourne, Australia; available at www.covidence.org) for the screening and identification of relevant studies, and duplicates were removed.

The remaining titles and abstracts were assessed for relevance to the eligibility criteria independently by HK and VS. Following title and abstract screening, papers deemed relevant to the review were then reviewed in full-text form. Further review by KB and AS resolved any discrepancies within the initial review process.

Data collection and analysis

Assessment of methodological quality

Papers selected for retrieval were assessed independently by HK and AS to ensure methodological quality using standardised critical appraisal instruments from the JBI System for the Unified Management, Assessment, and Review of Information (JBI SUMARI; JBI, Adelaide, Australia) for quasi-experimental (for pre-and-post non-randomised interventional studies) and RCTs [32]. Differences in opinion between the two reviewers were resolved through discussion, and a consensus was reached with the involvement of KB and VS. No studies were excluded based on the results of the critical appraisal.

Data collection and synthesis

Data were extracted from the included studies using a checklist developed for this purpose by HK and VS, and agreement reached by consensus by re-examination of the queried studies by AS and KB. Data were only used when there was consensus from all the authors. The extracted data included study authors, year of publication, study country and setting, study participants, sample sizes, recruitment methods, study design, interventions, reported outcomes, measurement means, and effect measures as detailed in Table 1.

Although statistical pooling via a meta-analysis of the effects of the interventions was our preferred and planned method of synthesis per protocol, a meta-analysis of effect estimates could not be achieved due to extreme clinical and methodological heterogeneity between the included studies. The interventions in the included studies were highly varied in terms of mode of action: including various educational/training packages for health care providers, diverse community-level interventions, and policy-and health facility-level quality improvement strategies. The characteristics of the included studies are summarised in a table utilising the PICO format. This enabled the comparison of studies, including settings, population of interest, interventions being implemented, and outcomes evaluated. The outcomes of the studies were analysed for their effectiveness and then synthesised as a descriptive narrative, utilising the format of texts as recommended when there is synthesis of findings without meta-analysis [43]. The effect measures from each study were extracted and interpreted as reported by primary authors as relative or absolute risk measures— including adjusted odds ratios and relative risks for dichotomous data while mean difference between groups in studies measured outcome as continuous variables.

Assessing certainty in the findings

The Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach for systematic reviews was used to rate the certainty of the evidence for mistreatment of women, sub-categories of mistreatment of women (physical abuse, verbal abuse, non-confidential care, non-consented care, and violation of privacy), and respectful maternity care. The final grading of the certainty of the evidence was agreed by consensus of all reviewers after initially graded independently by HK and VS. A summary of the findings is presented.

Results

Search results and study selections

In the initial systematic search, 1493 studies were retrieved using electronic databases and other methods. After removing duplicates, 1265 studies were screened by examining their titles and abstracts, of which 28 were retrieved for full-text assessment. Sixteen of these studies were excluded due to incorrect or unreported outcomes ($n=9$), incorrect design ($n=6$), lack of comparison and incorrect population ($n=1$), as depicted in Fig. 1.

Characteristics of included studies

Owing to the wide range of methodological inadequacies of the studies, all selected reports were included in the analysis for pragmatic reasons, which were relevant to the aim of the review and comprised the highest available methodological rigor of all assessed studies.

Table 1 Characteristics of included studies

Lead author (citation) Country	Characteristics
Abuya et al. [23] Kenya	◇ **Design**: multicenter pre-and post-study without a control group ◇ **Participants**: Women aged 15 to 45 years were surveyed for their experiences within 24–48 h of birth at discharge ◇ **Sample**: **1,369** (641 women at baseline and 728 women at endline) ◇ **Intervention**: Multi-component intervention implemented at facility, community, and policy levels in the *Hashima* project from June 2011 – Feb 2014 ○ **Community level** - Community workshops- civic education for the community on the right to sexual and reproductive health, sensitization meetings with the community members to demand respectful care - Counseling community members who experienced disrespect and abuse by the counselors in the facility ○ **Facility level** - Providing training for health care providers (HCPs) that aimed at enhancing the protection of clients' and providers' rights through improving quality of care - Caring for carers- counselling services for HCPs to assist them cope with high workload, critical incidents, and trauma - Monitoring D&A- through facilitating incident reporting mechanisms - Mentorship- in-service role-modeling the champion provider behavior as routine continuous professional education - Maternity open day- trust-building session prepared in health facility through explaining procedures in the maternity ward for the invited members of the local communities ○ **Policy level** - Continuous policy dialogue with government, civil society, and professional knowledge networks ◇ **Outcome**: women reported and observed experiences of disrespect and abuse ◇ **Measurement:** measured as dichotomous variable, percentage of women responding to six questions asking whether they were disrespected or humiliated at least for one form of categories of D&A ◇ **Evaluation of effect:** multivariate logistic generalized linear mixed models (GLMM) were used for both observational and exit interview data and reported as both adjusted and crude odds ratios (OR) • **Observation**: lack of privacy and physical aggression were reduced from baseline while non-consented care and sharing bed were increased from the baseline level • **Survey with women**: overall D&A was reduced from baseline level 129(20.1%) to 96(13.2% (– adjusted OR: 0.55 (0.40 – 0.75) • Physical abuse, verbal abuse, violation of confidentiality and detention were also significantly declined from their baseline levels Reliability and validity of the survey tool were not shown
Afulani et al. [33] Ghana	◇ **Design**: Pre- and post-intervention study without control groups was conducted in five high volume childbirth health facilities (one hospital and 4 health centers) ◇ **Participants**: women aged 15–49 years who give birth in preceding 8 weeks in study health facilities were approached at discharge from facilities ◇ **Sample**: 215 women at baseline (March–April 2017) and 318 at endline (November 2017) ◇ **Intervention**: Two days *integrated simulation-based training* was provided for 43 health care providers including midwives, medical doctors, anesthetists, and nurses in two rounds. The content of the training includes: - Five simulation scenarios - Skills capturing session in identified seven areas of focus ◇ **Outcome:** RMC as reported by women ◇ **Measurement**: RMC measured as a continuous variable of score of person-centered maternity care scale (PCMC) structured into 4-point Likert scale from 24 items and then converted to 100 ◇ **Evaluation of the effect:** RMC, average PCMC increased by 43% from 50 (baseline score) to 72 (endline score); it was also reported as increased in linear regression coefficient (18 points than the baseline score, ($\beta = 17.6$; 95% CI = 15.6-19.6) • Dignity and respect, communication and autonomy and supportive care were subclass indictors showed increment ◇ *Used a tool validated in Kenya and India with high content, construct, and criterion validity with a good reliability*

Table 1 (continued)

Lead author (citation) Country	Characteristics
Asefa et al. [34] Ethiopia	◇ **Design**: Pre- and post-study without a control group conducted between December 2017 and September 2018 in three Hospitals in Southern Ethiopia ◇ **Participants**: women who gave birth in study facilities took part in the study at discharge ◇ **Sample**: 388 women were surveyed- 190 before intervention and 198 after intervention ◇ **Intervention**: Respectful Maternity care training- the contents and intensity of the interventions implemented include: ○ **Facility level** - Respectful maternity care training for health care providers- three-day workshops for 64 HCPs in two rounds - Five wall posters: four in English and one in Amharic posted in labor ward to be used as on job aids incorporating universal rights of childbearing women developed by White Ribbon Alliances and infographics prepared by WHO - Supportive supervisions: two round quality improvement post-training supportive supervisions were conducted through developing action plans for the standard-based identified gaps ◇ **Comparator**: usual care before the implementation of the intervention ◇ **Outcome**: women's experiences of mistreatments ◇ **Measurement**: measured as number of mistreatment categories women experienced using 25 items originating from six categories of mistreatment ◇ **Evaluation of the effect**: the effect of the intervention was evaluated using a multilevel mixed-effects Poisson regression model • Adjusted exponentiated regression coefficient = 0.82, 95% CI 0.74 to 0.91
Asefa et al. [35] Ethiopia	◇ **Design:** Pre- and post-intervention study without a control group conducted between April and May 2018 ◇ **Participants:** health care providers who provide labor and childbirth and received intervention participated in the survey ◇ **Sample:** 64 HCPs responded to pre intervention survey and all of them participated in post intervention survey ◇ **Intervention:—Facility level as described above in Asefa et al.** [34]**,** - Three days training delivered as presentations, role play, demonstrations, case studies, individual readings, videos, and a hospital visit - Contents of training- overview of maternal health in Ethiopia, human rights, and law in the context of reproductive health, RMC rights and standards, professional ethics, and continuous quality improvement ◇ **Outcome**: HCPs perceptions of RMC ◇ **Measurement**: perceptions of RMC was measured using eight domains and classified it as positive and negative perceptions ◇ **Evaluation of the effect:** an exact McNemar's test was performed to analyze pre-post differences in participants' perceptions of RMC - Proportion of perceiving RMC domains positively was 21.9% before the training, and 35.9% after the training ($p = 0.08$)
Brown et al. [36] South Africa	◇ **Design:** a pilot cluster RCT study conducted at 10 hospitals (five randomly allocated to receive educational intervention to promote childbirth companion) ◇ **Participants:** Postnatal women who received labor and birth care in study hospitals ◇ **Sample:** 2090 survey before intervention (October 1998) and 2058 exit interviews carried out after intervention (December 1999) ◇ **Intervention**: Childbirth companion promotion- a multidimensional educational intervention delivered as interactive workshop for HCPs, banners and posters at labor ward, brochures and video program promoting birth companion ◇ **Comparator**- the five control hospitals received an unrelated evidence-based intervention to promote the external cephalic version (ECV) ◇ **Outcome:** birth companion and indicators of mistreatment (described as inhuman care in study- being shouted at, being slapped, or struck, being left alone) ◇ **Measurement:** self-reported by women whether they were allowed a companion, and experiencing inhumane care mentioned ◇ **Evaluation of the effect:** Used non-parametric test (Mann Whitney U test) and did not report the effect size, only reported it as there were no significant effect

Table 1 (continued)

Lead author (citation) Country	Characteristics
Kujawski et al. [22] Tanzania	◇ **Design**: cluster RCTs ◇ **Participants**: women aged 15 and above and gave birth in study facilities were participated in exit interview ◇ **Sample**: 3068 women were included (Baseline**:** 1388 (744 from control hospital and 644 from intervention hospital) and (**Endline:** 1680 (769 from control hospital and 1001 from an intervention hospital) ◇ **Intervention**: *Staha* intervention comprising two components was implemented over two years in Korogwe District, Tanzania and compared with Muheza District as: ○ **Community level** **- Client service charter-** community and health facility stakeholders adapted client service charter. The charter was issued to the communities and posted in health facilities found within the intervention district ○ **Facility level:** **- Quality improvement program-** following the adaptation of the client service charter for six-month, quality improvement activities that activated charter content were performed to address disrespectful and abusive care ◇ **Comparator-** compared to women gave birth in health facilities without any intervention (usual care) and to the practices existing before interventions ◇ **Outcome**: women's self-reported experiences of any form of D&A ◇ **Measurement**: labeled as experienced D&A if women reported at least one of 14 questions during labor and birth based on the Bowser and Hills' categories ◇ **Evaluation of effect:** adjusted logistic regression difference in difference model between baseline and endline on a total of 2983 eligible survey results • 66% reduced odds of a woman experiencing D&A (adjusted OR: 0.34, 95% CI: 0.21–0.58, $p < 0.0001$) • The biggest reductions were for physical abuse (aOR: 0.22, 95% CI: 0.05–0.97, $p = 0.045$) and neglect (aOR: 0.36, 95% CI: 0.19–0.71, $p = 0.003$) ◇ *The validity and reliability of the survey tool was not reported*
Mihret et al. [37] Ethiopia	◇ **Design:** Pre-and-post single center without a control group interventional study from November 2018 to May 2019 ◇ **Participants:** women who received antenatal care and gave childbirth in study hospital were surveyed for their experiences before and after intervention ◇ **Sample: 738 (**369 at baseline and 369 at endline/after intervention) ◇ **Intervention:** RMC and monitoring and evaluation training for HCPs and managers, setting up waiting room, availing resources for ensuring privacy (curtains), essential, drugs written guideline and protocol, recognizing best performing staff and continuous supportive supervision by quality improvement team ◇ **Comparator-** pre intervention services ◇ **Outcome:** proportion of disrespect and abuse among pregnant women who received ANC and labor and birth in health facility ◇ **Measurement:** The D&A was identified as any form of abusive care using 24 Yes/No questions based on Bohser and Hill's categories of D&A ◇ **Evaluation of the effect:** significance of the intervention was checked using independent t- test, reported as significant ◇ Overall D&A before intervention was 71.8 and 15.9% after intervention
Montagu et al. [38] India	◇ **Design:** cluster RCT was conducted at three primary health centers and six community health centers of Unnao and Kanpur Districts of Uttar Pradesh state in India ◇ **Participants:** women aged 18–49 and gave childbirth within last seven days in participating health facilities ◇ **Sample:** 570 (285 at each group) women at baseline from September 2016 to March 2017 and 600 (300 at each group) women at endline from May to December 2018 participated in surveys ◇ **Intervention:** establishing quality improvement team and participation in Improvement Collaborative workshops to work towards the improvement of person-centred maternity care through a plan-do-study-act (PDSA) ◇ ***Comparators:*** usual care at non-interventional control health facilities ◇ **Outcome:** Person-centered maternity care (PCMC) that includes RMC domains (dignity and respect; communication and autonomy; and supportive care.) ◇ **Measurement:** measured using 23 validated survey items scaled to 100-point scale, highest score indicating better PCMC/RMC care ◇ **Evaluation of the effect:** from baseline to endline, the adjusted mean PCMC score of the intervention group increased 22.9 points (95%CI: 20.9, 25.0) ◇ **After the intervention-** PCMC mean score for intervention group was 97.13 with SD of (2.91) and in a control group mean score 63.42 with SD of (11.44)

Table 1 (continued)

Lead author (citation) Country	Characteristics
Oosthuizen et al. [39] South Africa	◇ **Design:** Pre- and post-pilot interventional study in Tshwane health district in 10 midwife-led obstetric units (MOUs) of South Africa. Five MOUs purposively selected to be part of the intervention while the remaining five were treated as a control group ◇ **Participants:** women who had given child in MOUs and returned for postnatal care from 3 days to six weeks ◇ **Sample:** 653 women at baseline from February to April 2016 and 679 at endline survey from October 2016 to March 2017 ◇ **Intervention:** CLEVER package- that includes awareness creation of women's experiences for strengthening health system with MOUs' participants, intensive behavioral change activities for 3-months and six-month support ◇ **Comparators:** usual care before intervention and care in control groups ◇ **Outcome:** RMC and satisfaction ◇ **Measurement:** validated survey tools were used to measure RMC by a question that asked to rate how women feel they were respected and the other rate their level of satisfaction ◇ **Evaluation of the effect:** the percentage of RMC changed from 38.1% at baseline to 74.5% endline, and satisfaction from 47% to 73.6% ○ RMC (aOR = 4.33) and satisfaction (aOR = 4.04) raised four times at endline as compared to baseline in the interventional groups (*P*-values < 0.0001) RMC (aOR = 1.14) and satisfaction (aOR = 1.20) raised at endline as intervention compared to control groups (*P*-values < 0.0001) ◇ As compared to the control groups, endline RMC was 71.6% for controls and 74.5% for interventional groups, while endline satisfaction was 71.1 for control groups and 73.6% for interventional groups
Ratcliffe et al. [40] Tanzania	◇ **Design:** Pre- and post-intervention study between January 2013 and December 2014 at large, urban regional referral hospital in Dar es Salaam, Tanzania ◇ **Participants:** women who gave birth at the facility during four to six weeks post-delivery in the woman's home ◇ **Sample:** 70 women at baseline and 149 women after intervention ◇ **Interventions:** two discrete interventions were implemented: ○ **Health facility level** - Open Birth Days (OBD), a birth preparedness and antenatal care education program for women while they are in third trimester pregnancy - Workshop with HCPs on respectful maternity care aimed at examining practice with respect to professional code of conduct, clients' preferences and discussion on barriers that prevent provision of RMC ◇ **Comparator:** service existing in the facility before the implementation of the intervention ◇ **Outcome:** women's experiences of respectful care and satisfaction with care ◇ **Measurement:** RMC measured as the perception of the women rating how health care providers were respectful (five Likert scale question) ◇ **Evaluation of the effect:** measured as the change in percentage of the RMC perception and very satisfied - Perception of respectful care: 22.8% of women rated the respect shown to them by providers as "excellent" compared to none at baseline - Satisfaction: 75.8% of women reported being very satisfied with their birth experience compared to only 12.9% at baseline
Ratcliffe et al. [41] Tanzania	◇ **Design through intervention-** as described above in Ratcliffe et al. [40] ◇ **Outcome:** experiences of disrespect and abuse as reported by women ◇ **Measurement:** D&A was measured using on the items developed based on the Bowser and Hills' categories of D&A ◇ **Evaluation of outcome:** evaluated as percentage difference between occurrences of individual categories of D&A and any form of abusive care as dichotomous variable: ◇ **Any form of D&A:** 70% at baseline and 18% at endline
Umbeli et al. [42] Sudan	◇ **Design:** Pre- and post-intervention study was conducted in Omdurman maternity hospital, Sudan ◇ **Participants:** women who gave childbirth in study facility were surveyed ◇ **Sample:** a total of 4469 women were surveyed (2000 before and 2469 after) training ◇ **Intervention:** training HCPs on communication skills, support during childbirth, providing information and empathy ◇ **Comparators:** usual care before intervention ◇ **Outcome: respectful care and satisfaction level** ◇ **Measurement:** RMC measured as a women's perceptions of friendly and respectful care ◇ **Evaluation of the effect:** difference between women's opinion about health care providers' behavior in labor ward ○ The proportion of HCPs who were supportive, friendly, and respectful was 1793 (89.7%) before training and 2338 (94.7%) after training ◇ Proportion of women received information on onset of labor from 76.8% to 96.8%, requested investigations from 54.9% to 94.5%, condition of the fetus from 15.3% to 92.1%, progress of labor from 9.9% to 89.9%, expected duration of labor from 8.9% to 95.0%, examination and procedure to be done from 7.5% to 57.9% from baseline level to the endline

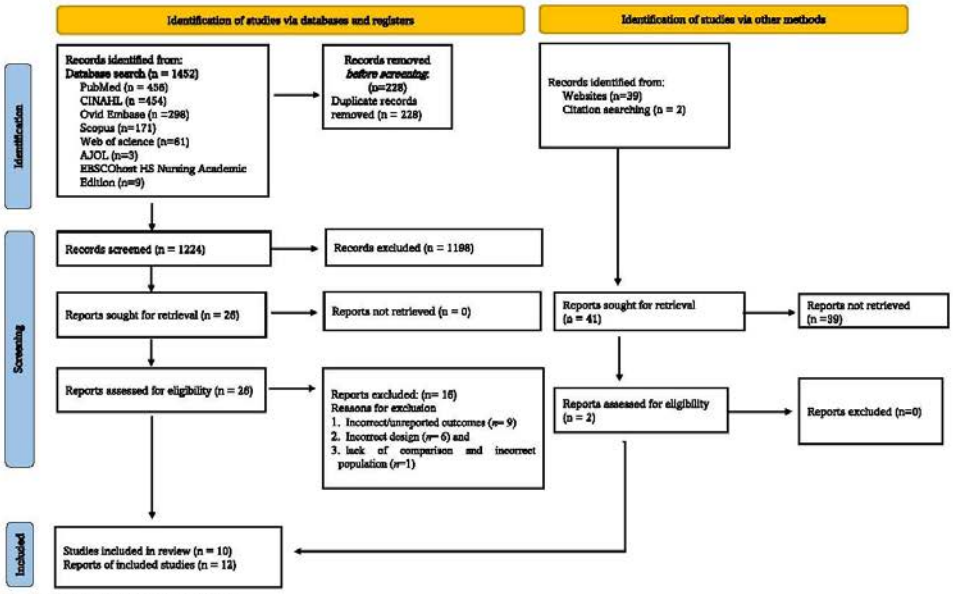

Fig. 1 Study selection flow diagram

Three of the 12 included studies were RCTs [22, 36, 38], and the remaining nine were pre-and-post/ quasi experimental studies [23, 33–35, 37, 39–42]. Out of the 12 studies included, it is worth noting that regardless of no criteria used to exclude studies based on their geographical region, eleven studies were conducted in sub-Saharan Africa (specifically, in Ethiopia, Tanzania, South Africa, Ghana, Kenya, and Sudan) and one study was conducted in India.

A total of 16,834 women and 64 health care providers participated in the studies, and the numbers in the intervention and comparison groups (control or pre-intervention) ranged from 219 to 4469 participants (mean 945, median1035) with an age of 15 years of age and above. In addition to identifying the effects of interventions during birth, Mihret et al. [37] also assessed the effects of interventions on disrespect and abuse during antenatal care. Exit interviews following childbirth or antenatal care and community follow-up surveys were the main approaches for data collection. Asefa et al. [35] identified the effects of interventions from health care providers' perspectives. The overall characteristics of the included studies are presented in Table 1.

The methodological quality of included studies

A JBI critical appraisal checklist was used to assess the methodological quality of each study. Summaries of these assessments are presented in Tables 2 and 3. All quasi-experimental studies scored positive ('Yes') for more than half of the appraisal domains, ranging from five to seven of nine quality domains. In four out of nine quasi-experimental studies [23, 33, 37, 39], the participants in the comparison groups were not similar. In contrast, all studies identified causes (interventions) and effects (mistreatment and/or respectful maternity care). Only Oosthuizen et al. [39] included a parallel control group before and after the intervention. The remaining quasi-experimental studies used the survey findings conducted before the interventions were implemented as comparison groups.

Multiple outcome measurements before and after the intervention were also identified when analysing the suitability of the included studies. If multiple surveys were conducted before and after the intervention, the authors would have ascertained whether the observed changes occurred naturally in the absence of the interventions or were due to the intervention they implemented. Because interventions were given at the cluster level (health facility level or community level) to different study participants before and after the implementation of

Table 2 Critical appraisal results for the quasi-experimental studies included in the review

Studies	Critical appraisal questions									Score
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	
Abuya et al. [23]	Y	N	Y	N	N	NA	Y	Y	Y	6
Afulani et al. [33]	Y	N	Y	N	N	NA	Y	Y	Y	6
Asefa et al. [35]	Y	Y	Y	N	N	Y	Y	N	N	5
Asefa et al. [34]	Y	Y	Y	N	N	NA	Y	Y	Y	7
Mihret et al. [37]	Y	N	Y	N	N	NA	Y	Y	N	5
Oosthuizen et al. [39]	Y	N	Y	Y	N	NA	Y	Y	Y	7
Ratcliffe et al. [40]	Y	Y	Y	N	N	NA	Y	N	N	5
Ratcliffe et al. [41]	Y	Y	Y	N	N	NA	Y	Y	N	6
Umbeli et al. [42]	Y	Y	Y	N	N	NA	Y	UC	N	5
Total % of positive scores	100	55	100	11	0	11	100	66	55	

JBI critical appraisal checklist for quasi-experimental studies (Y = Yes, N = No, UC = Unclear N/A = Not Applicable)

Q1 = is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?

Q2 = Were the participants included in any comparisons similar?

Q3 = Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?

Q4 = Was there a control group?

Q5 = Were there multiple measurements of the outcome both pre and post the intervention/exposure?

Q6 = Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?

Q7 = Were the outcomes of participants included in any comparisons measured in the same way?

Q8 = Were outcomes measured in a reliable way?

Q9 = Was appropriate statistical analysis used?

Table 3 Critical appraisal results for the quasi-experimental studies included in the review

Studies	Appraisal questions													Score
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	
Kujawski et al. [22]	Y	N	N	Y	N	UC	Y	NA	Y	Y	Y	Y	Y	9
Montagu et al. [38]	Y	N	N	UC	N	UC	Y	NA	Y	Y	Y	Y	Y	8
Brown et al. [36]	Y	N	N	UC	N	UC	N	NA	Y	Y	UC	N	N	4
Total % of positive scores	100	0	0	0	0	0	66	0	100	100	66	66	66	

JBI critical appraisal checklist for randomised controlled trials (Y = Yes, N = No, UC = Unclear N/A = Not Applicable)

Q1 = Was true randomization used for assignment of participants to treatment groups?

Q2 = Was allocation to treatment groups concealed?

Q3 = Were treatment groups similar at the baseline?

Q4 = Were participants blind to treatment assignment?

Q5 = Were those delivering treatment blind to treatment assignment?

Q6 = Were outcomes assessors blind to treatment assignment?

Q7 = Were treatments groups treated identically other than the intervention of interest?

Q8 = Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?

Q9 = Were participants analyzed in the groups to which they were randomized?

Q10 = Were outcomes measured in the same way for treatment groups?

Q11 = Were outcomes measured in a reliable way?

Q12 = Was appropriate statistical analysis used?

Q13 = Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?

interventions, participant follow-up was not achievable in all studies, except for the [35] study in which data were collected from the same participants before and after the intervention. All quasi-experimental studies which measured both before and after the intervention utilised the same measurement tools; however, the reliability and

validity of the tools used to measure the outcome were not reported in three of the nine studies [35, 40, 42]. Although all studies performed analyses aimed to investigate specific effects of the interventions, the influences of other confounding factors were not controlled for in the statistical analyses of six of the nine quasi-experimental studies [35, 37, 39–42].

All three cluster RCT studies randomly assigned the intervention to the clusters, as shown in Table 3. As the interventions in these studies were held at the cluster level, it is less likely to expect concealment of the intervention assignment to the groups, and all of them were scored as not concealed [22, 36, 38]. Even though the groups were recruited by matching samples, significant socio-demographic variation between the survey respondents existed before and after the interventions in each group of all three studies.

Information regarding blinding in the studies was considered inadequate. Therefore, biases in both the performance of the intervention and detection of the outcome by the personnel (health care providers) and outcome assessors (data collectors in this instance) have the potential to be present. Only Kujawski et al. [22] described and acknowledged the possibility of information contamination among women before recruiting them to participate in the study (initial awareness regarding the presence of intervention at a specific health facility). Prior information regarding the presence of intervention may have influenced self-selection to the interventional facility. In the remaining two cluster RCTs [36, 38], there was no clear information regarding the level of bias introduced by knowledge of the intervention by participants (women) and outcome assessors. As the recruitment of women was performed after the intervention was implemented in all three studies, concealment of the participant groups to the personnel who delivered the intervention was not possible. Both the control and intervention groups were treated identically in Kujawski's [22] and Montagu's [38] trials, while additional unrelated interventions occurred in the control groups in Brown's [36] trial. While participants in all these studies were analysed in the groups in which they were initially randomised and the outcomes were measured similarly in both groups, the tools used to measure the outcome were not replicable, and no appropriate statistical analysis was conducted in one cluster trial [36].

Interventions

Interventions varied between studies, ranging from health care provider RMC training to community engagement strategies for reducing mistreatment and policy amendments. This section describes the types of interventions by classifying them as multi-component, training-based, quality improvement, and companion of birth.

Multi-component interventions

Three pre- and post-studies [23, 40, 41] and one cluster RCT [22] study evaluated multi-component interventions targeting health care providers and/or women and community members. Abuya et al.'s [23] before and after study in Kenya evaluated the interventions designed to lower the rate of disrespectful and abusive behaviours under the Hashima project at the policy, community, health facility (13 facilities), and individual levels. They evaluated the effects of the interventions by surveying 1,369 women at discharge from the facility (641 women before and 728 women after intervention). In this study, RMC training was provided to health care providers and policymakers to enhance their understanding of the existence of disrespect and abusive care. Workshops on women's reproductive rights were also examined. The workshops were led by community members to enhance the relationships between community agencies and health facilities. Through technical meetings, the researchers also conducted continued policy dialogues with government representatives, professional associations, and civil society.

Similar to the results reported by Abuya et al.'s [23] study, Kujawski et al.'s. [22] cluster RCTs evaluated a two-stage intervention at the community and health facility levels. They designed a client service charter to create standards for mutual respect enacted by community and health-facility providers. The content of these community-level charters was then adapted by health facilities and incorporated into quality improvement activities. These quality improvement activities include ensuring privacy during admission and examinations, transparency of processes and care, trust-building mechanisms, and anonymous exit surveys to measure women's satisfaction. The effectiveness of the quality improvement activities developed from the client service charter was evaluated by surveys involving 1680 women (769 women in the control group and 1001 women in the intervention group) compared to the baseline surveys of 1388 women (744 women in the control group and 644 women in the intervention group) in the control and intervention groups.

In a pre- and post-study (70 woman at baseline and 149 women after intervention) conducted in Tanzania [40, 41], the authors evaluated two facility-based interventions which aimed to mitigate the mistreatment of women and enhance delivery of RMC. The intervention included an antenatal care education program for women in the third-trimester of pregnancy, drawing attention to the low information level among women as identified

in a survey performed before designing the intervention [44]. They also implemented workshops with health care providers after examining the barriers and enablers to RMC. The evaluation assessed whether the workshops impacted women's experiences of disrespect and abuse by examining whether the survey results varied between the populations sampled before and after the interventions were introduced.

Training based intervention at facility levels

The common method of implementing change toward RMC at the health facility level is health care provider training/simulation and using pre- and post-intervention data for evaluation purposes. Three studies in Ethiopia [34, 35, 37] evaluated the effects of health care provider RMC training, followed by infrastructure improvements such as resource availability, visual prompts (posters), recognition of providers who adhere to RMC, and post-training health care provider supportive supervisions.

Other health care providers' training focusing on RMC incorporates information about creating awareness about women's experiences [39], ways of treating women with dignity and respect, communication, respecting women's autonomy, birth choices and preferences, and encouraging birth companions [33, 42]. Further health facility interventions in the included studies were a quality improvement workshop aimed at improving health providers' ability to deliver RMC through a plan-do-study-act cycle [38].

Birth companion

Another means of augmenting RMC included the presence of a birth companion for labouring women. A cluster RCT study from South Africa [36] evaluated the benefits of promotive strategies toward the availability of birth companions. They encouraged the uptake of birth companions by providing educational intervention to promote childbirth companions in interventional hospitals compared to usual care in control hospitals [36].

Effectiveness of interventions

The effect measures of the outcomes of the studies are described in the summary of findings table (Table 4). We synthesised the effectiveness of interventions by grouping studies in the outcomes the programs' focused on achieving and the categories of interventions implemented. We reviewed the reduction of mistreatment during maternity care and a change in respectful maternity care, women's satisfaction, health care provider perceptions of RMC, and the employment of birth companions for women during labour and birth. Changes in these outcomes are presented in the following sub-sections.

Mistreatment of women in health facilities

Moderate certainty evidence emerged from two cluster RCTs [22, 36] and four pre- and post-studies [23, 34, 37, 41] assessed the effects of multi-component interventions in diminishing mistreatment of women as reported by women in health facilities.

Kujawski et al. [22] projected implementing client service charters at the community and health facility level was associated with reduced odds of a woman experiencing mistreatment of women by two-thirds (aOR = 0.34, 95% CI: 0.21–0.58, 2983 participants) as compared to control groups. Other pre-post interventional studies [23, 41] also reported the possibility of reducing the odds of mistreatment of women through multi-component interventions. Abuya et al. [23] revealed that multi-component interventions were associated with a reduction in the odds of women experiencing humiliation and disrespect by 42 per cent (aOR = 0.58, 95% CI: 0.43–0.79, absolute risk reduction = 7%, 1369 participants). Ratcliffe et al. [41] also revealed the benefits of implementing interventions on health care providers and women. They reported that the prevalence of disrespect and abuse experienced by women was reduced from 70 per cent at baseline to 18 per cent after intervention (absolute risk reduction = 52%, 219 participants).

Other pre- and post-intervention studies have also shown a declining trend in women experiencing mistreatment in maternity care after implementation of interventions [34, 37]. Asefa et al. [34] reported the number of mistreatment categories that women experienced was declined by 18 per cent after implementation of RMC promotive interventions through training and supportive supervision (adjusted exponent of $\beta = 0.82$, 95% CI: 0.74–0.91, 388 participants). Mihret et al. [37] study, implementing health care provider training, concluded that the prevalence of any mistreatment that women experienced was reduced from 71.8 per cent in the pre-intervention group to 15.9 per cent in the post-intervention group (absolute risk reduction = 56%, 738 participants).

One cluster RCT [36], with significant methodological weaknesses, evaluated the effects of an intervention to promote the importance of a birth companion being present. Consistent with methodologically flawed research, their findings were insignificant. While the authors did not perform appropriate statistical analysis to estimate an intervention's effect size, physical abuse was reported to be reduced from 2 per cent to 1 per cent in the intervention arm. In comparison, it increased from 3 per cent to 4 per cent in the control group. Although the difference was not statistically significant, the risks associated with other types of mistreatments, such as verbal abuse and abandonment of care, increased in both arms of the

Table 4 Summary of findings table

Multi-component RMC intervention compared to usual care for reduction of mistreatment of women and/or enhancing RMC

Population: Healthy women during maternal health care utilisations
Setting: Maternity care units (antenatal, labour and postnatal wards) in Ethiopia, Sudan, Kenya, Tanzania, South Africa, Ghana & India
Intervention: Multi-component RMC intervention
Comparison: usual care
Data sources: all data sources were from women self-report in primary studies— some effect measures were calculated based on summary findings by reviewers if not given in primary articles

Outcomes	Anticipated absolute effects Single effect size was not pooled, and narrative synthesis of each studies effect measures were given	Nº of participants (studies)	Certainty of the evidence (GRADE)
Any form of mistreatment of women	The effect measure from one cluster RCT [22] — aOR = 0.34, 95% CI: (0.21–0.58) (3.2% in intervention groups vs 15.76% in control groups). Observation studies: four pre- and post-studies showed reduction in any forms of mistreatment; aOR = 0.58, 95% CI: (0.43, 0.79) (20% before vs 13.2% after intervention) [23], 18% risk reduction— aIRR = 0.82(95% CI 0.74, 0.91) [34]. Other two pre-post studies showed absolute risk reduction from crude OR of 0.07(95% CI 0.05—0.1) (71.8% vs 15.9%) [37] and OR = 0.08, 95% CI: 0.043—0.17) (18% after intervention vs 70% before intervention) [41]	8680 (5 studies—1 RCT [22] and 4 pre-and-post observational studies [23, 34, 37, 41])	⊕⊕⊕◯ Moderate[a,b]
Physical abuse	Effect measures from two cluster RCTs: [22] — (OR: 0.22, 95% CI: 0.05–0.97) (1.8% control vs 0.3% intervention), while the other cluster RCT did not report summary statics but identified it as significant [36]. Pre-and-post studies also showed reduction of physical abuse— (OR 0.5; 95% CI: 0.3–0.9) (4.2% before vs 2.1% after intervention) [23], absolute risk reduction from 16.7% before to 8.9% after intervention [34], 61% at baseline to 15.4% at the postintervention [37] and from 52 to 1% [41]	7830 (6 studies— 2 cluster RCTs [22, 36] and 4 pre-and-post observational studies [23, 34, 37, 41])	⊕⊕◯◯ Low[a]
Verbal abuse	Verbal abuses were decreased with effect measures from pre-and-post studies— (OR 0.6; 95% CI: 0.4–0.8) (18.0% before vs 11.3% after intervention) [23], decreased from 78% to 24.4% [37], 54% to 5% [41]. Even though not significant, non-dignified care was also decreased in one cluster RCT [22] 2.2% vs 11.2% (aOR = 0.58, 95%CI: 0.3–1.1) and in another pre-and-post study by [34]— from 8.6% to 5.8%	5772 (5 studies— 4 pre-and-post observational studies [23, 37, 41] [34] & 1 cluster RCT [22])	⊕⊕⊕◯ Moderate[a]
Non-confidential care	Effect measures for decrement of non-confidential care— (OR 0.5; 95% CI: 0.2–0.9) (3.9% before vs 1.8% after intervention) [23], 69% reduced risk, RR = 0.31, 95% CI: (0.26—0.37) (79.5% vs 24.7%) [37] and 98% reduced risk, RR = 0.02 95% CI: (0.01—0.10) (54% vs 1%) [41]	2326 (3 pre-and-post observational studies [23, 37, 41])	⊕⊕◯◯ Low[c]
Non-consented care	Effect measures —18% absolute risk reduction (83.3% vs 65.3%, RR = 0.78, 595% CI: (0.70—0.90) [34]. Similarly, Mihret et al. [37] showed 52.9% risk reduction (69.9% vs 17.1%, RR = 0.24, 95% CI: (0.19—0.31) while [41] showed 4% risk reduction from 5 to 1%. Unlike these three studies, Abuya's [23] pre-and-post study highlighted increment of the risk after intervention by 20% (61% vs 81%; aOR = 3.4, 95%CI: 2.5–4.7)	2545 (4 pre-and-post observational studies [23, 34, 37, 41])	⊕⊕◯◯ Low[c]

Table 4 (continued)

Multi-component RMC intervention compared to usual care for reduction of mistreatment of women and/or enhancing RMC			
Privacy violated	From pre-and-post study- effect measures showed decrement of privacy violation—52.5% reduction (79.7% to 27.1%; RR = 0.34, 95%CI: (0.28—0.41) [37] and [41]—50.4% reduction (53.1% vs 2.7%; RR = 0.05, 95%CI: (0.02—0.13). Although not significant additional two pre-and-post study also showed reduction in privacy violation—from 7.4% to 5.7%; aOR = 0.69, 95% CI: (0.44 – 1.08) [23] and from 81.8% to 77.4%, RR = 0.95, 95%CI: (0.85 —1.05) [35]	2708 (4 pre-and-post observational studies [23, 35, 37, 41])	⨁◯◯◯ Low[c]
Respectful maternity care	Two cluster RCTs showed an increment of RMC—person-centred maternity care score raised by 22.9 points (95%CI: 20.9—25.0) [38] and — aRR 3.44 (2.45—4.84) [22]. Similarly, four pre-and-post studies also showed improvement of RMC related to intervention—18 points increment in RMC ((β = 17.6, 95%CI: (15.6—19.6), a relative increase of 43% from 50 to 72 [33]; increased by 36.4% (38.1% to 74.5%) [39]; respectful care increased from none at baseline to 22.8% at the time of evaluation [40] and 5% increment in RMC (89.7% vs 94.7%) [42]	13,119 (6 studies— 2 cluster RCTs [22, 38] and 4 pre-and-post observational studies [33, 39, 40, 42])	⨁⨁⨁◯ Moderate[a]

High certainty: we are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect

Very low certainty: we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect

aOR adjusted odds ratios, *CI* confidence interval, *RR* incidence risk ratio, *RMC* respectful maternity care, *RCT* randomised controlled trial

Explanations

[a] The cluster RCT was assessed as having a serious risk of bias due to lack of allocation concealment, blinding and variation in patient characteristics and patient-reported outcomes. All observational studies were also assessed as having a serious risk of bias because of lack of allocation concealment, blinding, randomization, patient-reported outcome, failure to adequately control for potential confounders in two studies, and lack of repeated measurement both before and after the intervention

[b] The inconsistency between the studies could be due to the observed variations in the implemented intervention and outcome measurements

[c] The findings were based only on observational studies that had a serious risk of bias because of lack of allocation concealment, blinding, randomization, patient-reported outcome, failure to adequately control for potential confounders in two studies, and lack of repeated measurement both before and after the intervention in all studies. Additionally, the data were based on patient/women/ reports

RCT, as opposed to physical abuse. Verbal abuse (being shouted at) and abandonment (being left alone) increased from 14 per cent and 12 per cent before intervention levels to 15 per cent and 16 per cent after intervention in interventional groups (4148 participants).

Respectful maternity care

Moderate certainty evidence from two cluster RCTs [22, 38] and four pre- and post-interventional studies [33, 35, 39, 40, 42] suggests an enhancement of respectful maternity care secondary to various interventions in the community, health system, and facility levels (overall 13,119 study participants). Following the implementation of health care provider team-based quality improvement activities through plan-do-act-study cycles, Montagu et al. [38] reported an improvement in RMC scores (expressed as person-centred maternity care) by 22.9 points (95% CI: 20.9–25.0) in intervention groups compared to control group (1170 samples). Furthermore, Kujawski et al. [22] identified that implementation of community and health facility-based interventions was associated with increased respectful care from health care providers to women during their stay at the birth facility (RR: 3.44, 95% CI: 2.45–4.84, p-values < 0.0001, 2983 participants).

Similarly, a pre- and post-study by Afulani et al. [33] reported a relative increment of mean RMC (person-centred maternity care) score by 43 per cent from 50 per cent at baseline to 72 per cent after intervention implementation. While controlling for potential confounders, the RMC score after the intervention was 18 times higher than the baseline score ($\beta = 17.6$; 95% CI: 15.6-19.6, 538 participants). Such increments were also observed in individual subscales for dignity and respect, communication and autonomy, and supportive care, with risk differences of 15, 87, and 55 per cent, respectively.

Based on a pre- and post-study, Oosthuizenez et al. [39] reported positive childbirth experiences (RMC) increased from 38.1 per cent at baseline to 74.5 per cent during follow-up in intervention groups (aOR = 4.33, p-value < 0.0001, 1332 participants). Umbeli et al. [42] evaluated the effects of training health care providers on communication skills to improve specific aspects of RMC. The proportion of women reporting perceived supportive, friendly, and respectful care from health care providers increased by 5 per cent (89.7% before training to 94.7 per cent after training, 4469 participants). Another pre- and post-study evaluated the effects of educating women on birth preparedness and complication readiness and training health care providers to mitigate mistreatment of women reported an increment of perceived respectful care to 22.8per cent compared to none at baseline (219 participants) [40].

Asefa et al. [35] assessed the positive outcomes of training health care providers on respectful maternity care. They concluded that training alone could only result in a minimum resolution of the mistreatment of women (i.e., lack of RMC). Nevertheless, they did report the proportion of health care providers who positively perceived RMC domains increased from 21.9 per cent before the training to 35.9 per cent after the training (p-value = 0.08, 64 participants).

Maternal satisfaction

Three pre- and post-studies [39, 40, 42] and one cluster RCT [22] evaluated whether interventions increased women's satisfaction with maternity care. These studies reported improved satisfaction after implementing interventions to address mistreatment during maternity care, however, there were limitations in the measurement of women's satisfaction.. One of these studies, conducted by Ratcliffe et al. [40], reported a significant increase in maternal satisfaction from 12.9 per cent before the intervention to 75.8per cent after training health care providers, suggesting that effective interventions can lead to improved satisfaction despite the limitations in measurement (219 participants). Umbeli et al. [42] and Oosthuizen et al. [39] also suggested an improvement in maternal satisfaction by 5.9 per cent (89.8% at baseline to 95.7% after the intervention, 4469 participants) and 26.6 per cent (47.0% at baseline to 73.6% post-intervention, 1332 sample), respectively. However, Kujawski et al.'s [22] cluster RCT showed little or no difference (aOR = 0.98, CI:0.91–1.06, p-value = 0.67, 2983 participants) between the intervention and control groups related to the proportion of women reporting being satisfied with the care provided.

Discussion

This systematic review illustrates how community-, policy-, health system-, and health facility-level interventions can influence women's perceived experiences of mistreatment and/or respectful care during their maternal care encounters in health facilities. All papers included in the review implemented and evaluated various interventions which extended from quality improvement activities in health facilities to the community- and policy-inclusive strategic activities. Even though their effect sizes varied from study to study, most of the wide-ranging interventions were reported to have had made a positive effect in reducing the mistreatment of women and/or enhancing respectful maternity care in health facilities.

Downe et al. [24] published a systematic review that explored the roles of RMC policies in changing the intrapartum experiences of women, suggesting that such interventions could reduce non-respectful behaviours and practices in maternity care. In addition, Dhakal et al. [25] explored low-level evidence highlighting educational interventions and their effectiveness in promoting respectful maternity care. As such, this review builds on this evidence, focusing on multi-component interventions during the continuum of maternity care rather than focusing on specific components of interventions, thus highlighting the complexity of the phenomenon of mistreatment.

Given the complex nature of mistreatment of women, the reviewed studies suggest that interventions targeting all system approaches (health facilities, communities, health systems, and policies) are required to be executed in order to bring about sustained and transformational change for women. This could be achieved by improving interpersonal relationships between HCPs and women, addressing health facility and health system constraints such as shortage of skilled staff inadequate medical supplies, and implementing policies that empower community engagement in health care decisions. Even though such interventions echo the complexity of the issue and are therefore heterogeneous, and it is difficult to quantitatively ascertain their cumulative effects, the clinical significance of such interventions are indispensable in addressing the complex drivers of the mistreatment of women. The importance of initiating a multi-factorial response to the phenomenon of mistreatment and the varied characteristics of maternity care settings across the globe has been established in the *Bangkok Charter for health promotion* and *WHO intrapartum recommendations* [29, 45].

Our review identified that the overall experience of mistreatment of women was reduced by at least half when related to multi-component interventions in pre-post and cluster RCT studies [22, 23, 41]. Individual interventions enable a shift in knowledge and attitudes that allow behavioural change and mutual respect between HCPs and clients. Changing individual HCPs' and clients' behaviours cannot be sustained without improving both health facilities and the overall health system by enacting decisive policy actions by engaging with communities and users of the service. Designing and implementing impactful strategies aimed at reducing mistreatment and enhancing RMC for women must address the unique and hierarchical levels of health facilities, including cultural and institutional change. Including higher-level interventions would not only sustain positive interaction between health care providers and women but would also address the higher-level drivers of mistreatment of women beyond individual behaviours. Although the benefits of interventions that engage communities in health care interventions were well established and frequently advocated in previous studies [46–48], only four of the studies reviewed engaged community members in the development of their interventions. This may reflect the challenges women and families face when receiving disrespectful maternity care and the obstacles they face as a result of diminished agency when advocating for the delivery of RMC in an inhospitable health setting. However, engaging communities in future interventions still remains necessary to achieve a sustainable reduction in the mistreatment of women and to reduce the normalisation of women's mistreatment during maternity care.

Multi-component interventions implemented at various levels within an organisation did not clearly inform which set of interventions successfully addressed the intended goal for quality and respectful care. Specific interventions that either targeted enhancing health care providers' awareness of respectful care or quality improvement activities were seen to reduce the mistreatment of women [34, 37]. Staff attitude and value transformation training were also found to reduce mistreatment of women; however, the overall success in minimising abusive care appeared to be more significant when the interventions were directed at changing the health facility's circumstances by providing the facility and staff with essential supplies, drugs, and equipment. Recognising health care providers' efforts to provide respectful care is also crucial. Although an impossibility for many health settings, this could be realised through motivational strategies and counselling services for health providers, the provision of greater staffing and equipment resources, supporting them in managing high workloads, critical incidents, and trauma, as identified in Mihret et al. [37] and Abuya et al. [23]. Recognising the daily struggles of health care providers in health facilities, including coping with resource limitations, underpayment, and high patient load, can enhance their sense of value and respect in their role.

The presence of a birth companion has been shown to be crucial in addressing inequalities, improving emotional support, and maternal and newborn health outcomes [49]. It is also highlighted as a critical component of respectful maternity care by the World Health Organization [50]. This review's findings further support the significance of having a birth companion; while there is no consistency of effect in reducing all forms of mistreatment of women, Brown et al. [36] showed a reduction in physical abuse when a birth companion was present. The authors indicated that the implementation of birth companions was more challenging than expected, especially in health care systems with limited resources and

frequent turnover of staff [36]. To better advocate and implement interventions to routinely incorporate birth companionship, it is essential to address all factors that may hinder the positive outcome of having a birth companion [51]. This includes a health facility-level commitment to enacting the policy and facilitating the physical space required for a birth companion to be present without compromising a woman's privacy.

Mistreatment and RMC are not necessarily two direct sides of the same coin. Reducing or eliminating women's mistreatment does not necessarily mean that respectful maternity care is present within a facility. Any effort to improve the quality of care should uphold the safety and dignity of women by situating respectful maternity care at the core of its service [21]. Accordingly, research which focused on quality improvement activities were included in the review. Quality improvement activities based on local health facilities' attempts to manage the number of women accessing the service and strategies to avoid or manage the busyness of the facility were included. Such interventions enable health facilities to assess adaptable changes through continuous plan-do-study-acts (PDSA) [38]. Likewise, scenario-based integrated simulation training for health care providers was highlighted as an intervention that enhanced woman-centred maternity care through the change of behaviours in practice [33]. Such training can allow health care providers to learn, practice, and reflect on stressful situations and minimise spontaneous reactions which can be abusive to women. If such interventions also include efforts to change infrastructure limitations and motivational strategies for HCPs, they could bring about sustainable changes in respectful maternity care.

The importance of good rapport between a health care provider and a woman is vital in building mutual respect and understanding [52, 53]. However, most of the studies included in this review overlooked the importance of this factor. Only Umbeli et al. [42] explored this concept, revealing that improved communication skills with HCPs can increase women's respectful care in a supportive and friendly manner. However, equal attention should be given to reducing and eliminating all forms of mistreatment, enhancing communication, and achieving respectful care is difficult to realise in a facility where mistreatment is normalised.

It must be noted that this review has some limitations that we have considered. First, it includes studies that differed in study design and methods and studies that measured both the mistreatment of women and respectful maternity care. This reflects the complexity of the phenomenon across each health care setting, but in this review contributed to the heterogeneity of the studies and prevented pooling of intervention effect sizes in the meta-analysis. The lack of a meta-analysis does not limit the quality of this review. We performed the synthesis without meta-analysis by categorising intervention effects based on the types of studies, interventions implemented, and quality of the studies, as recommended by Campbell et al. [43]. Second, we only included studies and papers written in English. Therefore, there is a possibility that we may have missed some important reviews written in other languages; however, we believe the study selection bias due to this inclusion criteria are minimal, as most major high-quality peer-reviewed journals are published in English, reflecting the research community's desire to reach a wide audience [54].

Conclusions

Interventions aimed at reducing women's mistreatment and enhancing respectful maternity care should simultaneously incorporate multiple and varied approaches in order to positively affect women's clinical experiences during childbearing. Low to moderate certainty evidence suggests that multi-component interventions were effective in reducing the mistreatment of women and/or enhancing respectful maternity care in health facilities. Interventions that motivate health care providers through various recognition strategies were found to be more successful in bringing change than interventions that only focused on training at an individual level. Future interventions should consider incorporating individuals, health facilities, health systems, policy-level drivers, and community/consumer engagement in the mistreatment of women and the determinants of respectful care.

Abbreviations

AOR	Adjusted odds ratio
CI	Confidence interval
GRADE	The Grading of Recommendations, Assessment, Development, and Evaluation
HCP	Health care providers
IRR	Incidence risk ratio
JBI SUMARI	JBI System for the Unified Management, Assessment, and Review of Information
PDSA	Plan-do-study-acts
PICO	Population, Intervention, Comparator and Outcomes
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
PROSPERO	Prospective Register of Systematic Reviews
RCT	Randomized controlled trials
RMC	Respectful maternity care
SSA	Sub-Saharan African
WHO	World Health Organization

Supplementary Information

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Additional file 1.

Additional file 2.

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Authors' contributions
HK, KB, AS and Vs conceptualized the review. HK designed the search strategy, performed the search and KB, AS and VS revised the databases search strategies. HK and VS screened records for eligibility, while KB and AS involved in final record selection after screening has made. AS and HK independently assessed the retrieved studies for methodological quality, and KB and VS were involved to reach on consensus. HK extracted the data from primary articles and KB, AS and VS revised it, HK performed the narrative synthesis, wrote the first draft of the manuscript, KB, AS and VS critically reviewed the manuscript, provided the feedbacks and edits to the drafts. All authors read and approved the final manuscript.

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Declarations

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Not applicable.

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Not applicable.

Competing interests
The authors declare that they have no competing interests.

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Publisher's Note

Appendix 13: Paper2: Survey Women's Perspectives

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RESEARCH Open Access

The mistreatment of women during maternity care and its association with the maternal continuum of care in health facilities

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Abstract

Background Mistreatment of childbearing women continues despite global attention to respectful care. In Ethiopia, although there have been reports of mistreatment of women during maternity care, the influence of this mistreatment on the continuum of maternity care remains unclear. In this paper, we report the prevalence of mistreatment of women from various dimensions, factors related to mistreatment and also its association to the continuum of maternity care in health facilities.

Methods We conducted an institution-based cross-sectional survey among women who gave birth within three months before the data collection period in Western Ethiopia. A total of 760 women participated in a survey conducted face-to-face at five health facilities during child immunization visits. Using a validated survey tool, we assessed mistreatment in four categories and employed a mixed-effects logistic regression model to identify its predictors and its association with the continuum of maternity care, presenting results as adjusted odds ratios (AORs) with their 95% confidence intervals (CIs).

Results Over a third of women (37.4%) experienced interpersonal abuse, 29.9% received substandard care, 50.9% had poor interactions with healthcare providers, and 6.2% faced health system constraints. The odds of mistreatment were higher among women from the lowest economic status, gave birth vaginally and those who encountered complications during pregnancy or birth, while having a companion of choice during maternity care was associated to reduced odds of mistreatment by 42% (AOR = 0.58, 95% CI: [0.42–0.81]). Women who experienced physical abuse, verbal abuse, stigma, or discrimination during maternity care had a significantly reduced likelihood of completing the continuum of care, with their odds decreased by half compared to those who did not face such interpersonal abuse (AOR = 0.49, 95% CI: [0.29–0.83]).

Conclusions Mistreatment of women was found to be a pervasive problem that extends beyond labour and birth, it negatively affects upon maternal continuum of care. Addressing this issue requires an effort to prevent mistreatment through attitude and value transformation trainings. Such interventions should align with a system level actions, including enforcing respectful care as a competency, enhancing health centre functionality, improving the referral system, and influencing communities to demand respectful care.

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Keywords Mistreatment of women, Maternity care, Health care facilities, Respectful maternity care, Continuum of maternity care

Introduction

The continuum of maternal, neonatal, and childcare is widely recognised as a critical intervention to reduce maternal, neonatal, and child mortality [1]. The provision of quality care plays a pivotal role in ensuring the continuity of these essential services. A woman's humiliating interaction with her health care provider (HCP) or other staff members, as well as the state of the health infrastructure and systems, are all considered detrimental to the quality of maternity care [2]. Various terminologies have been used to describe such experiences of women, including disrespect and abuse [3], maltreatment [4], and obstetric violence [5], underscoring the importance of ensuring terminological clarity. To focus on woman's experience and minimise individual blame [6], in this study, we refer to the mistreatment of women during maternal health care as defined in the methods section.

Despite the World Health Organization's (WHO) declaration affirming every woman's right to receive the highest standard of care with dignity and respect [7], mistreatment of childbearing women remains a pervasive global public health issue reported across all nations and cultures [7]. In Sub-Saharan Africa (SSA), the pooled prevalence of mistreatment was reported to affect up to 44% of women [8]. Mistreatment of childbearing women is not only confined to low- and middle-income countries; it is also reported in high-income countries with resilient health care resources. One out of every five women in Europe [9], one-sixth of women in the United States of America [10], two out of every five women in Latin America [11], and one in every ten women in Australia [12] have experienced mistreatment.

In Ethiopia, various forms of disrespect and abuse categories discussed by Bowser and Hill [3] were reported from different regions [9]. The prevalence of these mistreatment forms ranges from 14.5% when reported by healthcare providers [10] to almost all women self-reporting (98.9%) [13] experiencing at least one form of mistreatment. Most studies conducted in Ethiopia have focused on the mistreatment of women, as reported by women. However, these studies often conflate various categories of mistreatment without considering their dimensionality [13–22]. While such aggregation of various categories of mistreatment is important for understanding the issue, addressing them separately is crucial for effective and focused interventions in the actual context.

When women experience mistreatment in health care facilities during their pregnancy or birth, it continues to have a negative impact on their lives. It can decrease women's confidence in health facilities which can lead to an increased likelihood of maternal complications due to a lack of engagement in services [23–25]. Furthermore, it can be a deterrent to service utilisation, even more than sociocultural beliefs and practice [26]. Due to a history of mistreatment, it is alleged women in low-income countries regardless of pregnancy risk factors would prefer to give birth at home with dignity, alone or with a family member, than face mistreatment in a health facility [2, 27].

Such challenge becomes even more significant when these mistreatments occur in countries where maternal continuum of care dropouts are common, as is the case in Ethiopia. This is particularly pertinent in Ethiopia, where maternal care discontinuation is a pressing concern. The 2019 Ethiopian Mini Demographic and Health Survey revealed a significant gap in continuum of maternal care. While 74% of women started antenatal care, only 48% gave birth in health care facilities, and merely 34% received postnatal checks within two days of the birth [28]. This signals significant problem with service discontinuation and calls for an investigation into the underlying factors.

Previous studies have identified various socio-demographic and contextual factors associated with the completion of continuum of maternity care [29, 30]. However, there is limited evidence linking experiences of mistreatment and its impact on the extent of continuity of care. To fully understand the link between mistreatment and continuum of care, it is essential to measure mistreatment of women using a validated tools focusing on specific concepts at a time. Therefore, the aim of this study was to determine the prevalence of mistreatment of women in various dimensions, identify the factors associated with mistreatment, and identify its association with the continuum of maternity care in health facilities.

Methods

Study design and setting

A cross-sectional survey-based study was conducted from February to June 2022, adhering to the STROBE reporting guideline. This paper is part of larger mixed method study conducted in western part of Ethiopia, East Wollega Zone Oromia regional state. Ethiopia is administratively divided into twelve regions and two

city administrations. These regions have been further subdivided into zones, woredas or districts, and kebeles (the lowest tier of government administrative units). Based on the 2007 Ethiopian population and housing census projections, the average projected population of Ethiopia in 2022 was 105.17 million, and about 78% of the population lived in rural areas [31].

Ethiopian health service delivery is structured in a three-tier system of primary, secondary, and tertiary levels. The primary level, or primary health care (PHC) unit, comprises health posts, health centres, and a primary hospital that provides services for about 100,000 people. It provides blood transfusion and emergency surgical services, including caesarean sections. The secondary level is a general hospital, which serves as a centre of health care for an average of one million people and is a referral centre for primary hospitals. A referral centre for the general hospital is the tertiary level, a specialised hospital providing care for an average of five million people [32, 33].

East Wollega zone, where this study was conducted, is one of administrative zones of Oromia Regional State whose capital city is Nekemte and contains one special-city woreda (Nekemte), 17 woredas, 43 towns and 287 rural kebeles. The East Wollega zone's total population was 1.806 million in 2022. The number of women of reproductive age accounts for 18% of the total population with a total fertility rate of 4.07. East Wollega zone has two tertiary hospitals, both found in Nekemte town, three district hospitals and 67 health centres [31–33].

Study participants

The study population includes women who received at least one component of the continuum of maternity care services (antenatal care, labour and birth or postnatal care) and gave birth within three months before the data collection period. Hence, study participants were women who had given birth within the past three months after accessing maternal health care services from health facilities. They were approached between six weeks and three months after giving birth to capture their experiences related to mistreatment and service utilization throughout the continuum of care, covering the antenatal period, childbirth, and the postnatal period.

To minimise bias, women were excluded from the study if they had a personal relationship with any person employed at any of the health care facilities where recruitment occurred. Women who were unable to provide consent, had experienced a recent stillbirth, or were at risk of psychological trauma were also excluded from the study.

Sampling and recruitment

The total sample of women included in the survey was calculated using a single population proportion formula in which the proportion (prevalence) of the mistreatment of women was 67.1% (from study conducted in Northern Ethiopia by Wassihun et al. [21]), and a 95% confidence level, with a 5% margin of error, and the cluster effect of 2, the desired sample size was 679. After adjusting the desired sample size for a 10% non-response rate, the total sample size for women participants was determined to be 755. To enhance the robustness of the findings, 760 participants which gives the power 90% were approached in the study.

For logistical and safety reasons related to the civil conflict in Ethiopia, participants were purposively selected from four woredas: Diga, Nekemte, Guto gidda and Sasiga. Two hospitals, three health centres and one health post were selected to invite women to participate in the study. The women were approached to participate when they visited the health facilities to have their child vaccinated. This opportunity for recruitment into the study was chosen as 97% of all mothers visit a health facility to have their children vaccinated [33]. Utilising the vaccination clinics also reduced any accessibility difficulties the researcher may have encountered due to some of the geographical locations which are widespread and difficult access especially during a time of civil unrest. All the women who came to the vaccination clinic with their newborn baby and who met the inclusion criteria were approached to participate in the study between February and June 2022.

Measurements

Outcome variables

In this study, we focused not only on mistreatment of women during childbirth but also during antenatal care and postnatal checkups and their link with continuum of care. Hence, under the aims assessing magnitude of mistreatment of women and associated factors, mistreatment of women is outcome variable and then it is the exposure variable for the model that assessed its association with continuum of care. To achieve these, various categories of mistreatments of women were measured under two broader dimensions—the overt and covert as discussed by Bohren et al. [34]. The overt mistreatment results from outright intentional abuse against women (physical abuse, verbal abuse, stigmatisation and discrimination) that parallels with a broader violence against women framework [35]. We categorised the mistreatment arising

from such intentional abuses under the latent construct of interpersonal abuse. In other hand, the latent construct underlying covert mistreatment includes failure to maintain professional standards of care, the poor rapport between a woman and the health care provider, as well as any constraints related to health facilities and system limitations which occurs during the process of the care and are related to the broader quality of care framework [36].

The maternal continuum of care encompasses the care provided to women during pregnancy, birth, and the postnatal period. Although completion of continuum of care should include all components of these three stages, for the purpose of analysing the association between mistreatment and the continuum of care, a woman was considered to have completed the continuum of care if she received four or more episodes of antenatal care, a skilled health care provider attended the birth of the baby and, she received at least two episodes of postnatal care. The first episode of postnatal care was expected to be provided within 24 h of birth, and the next between 48- and 72-h following birth.

Primary exposure variable

Various forms of mistreatment including interpersonal abuse, failure to maintain professional standards of care, poor rapport between a woman and the health care provider, and health system conditions and constraints were exposure variables for the analysis conducted to assess the association between mistreatment and maternal continuum of care.

Independent variables

- Sociodemographic characteristics: woman's age, residence (urban–rural), educational status, average monthly income- measured as a factor variable (lowest, low, middle, and highest) based on the income quintile.
- Pregnancy and birth: parity, mode of birth, support from a partner or household members, complication during pregnancy or childbirth.
- The quality of antenatal care: was based on the proportions of components of care received as recommended by WHO [37] including: recording of blood pressure, received tetanus toxoid immunisation, iron folate, advice on complications readiness (advice on danger signs like occurrences of severe headache, convulsion, blurring of vision, vaginal bleeding, upper abdominal pain, sudden gush of fluid per vagina, decreased fetal movement, lower abdominal tenderness and foul smelling vaginal discharge), birth preparedness, nutrition counselling, blood sample for basic investigations such as blood group and Rh factor, haemoglobin, screening test for syphilis, Hepatitis B virus surface antigen test and HIV testing, urine testing and drugs for intestinal parasites. For each of these care components, a code of 1 was assigned if the women reported receiving the specific component and 0 if not. The total sum score of these ten items was then calculated to represent the quality of antenatal care received.
- Health service-related factors: type of the health facility, primary care providers, presence of companion, date, and time of birth.

Data collection instruments and process

A validated community-based survey tool developed by a WHO-led study [6] was adapted and translated in to Afaan Oromo to measure the level of mistreatment of women during maternity care. This tool was developed based on a mixed-method and iterative approach. A total of 32 items were used to measure the level of mistreatment of women based on seven typologies as identified by Bohren et al. [34].

Two data collectors were recruited for the data collection. The data collectors did not have an employment background in health sciences; they were engaged only to assist women with low literacy levels to complete the survey. Before they were able to assist with survey data collection, training regarding the objective of the study, data collection instrument, data collection techniques and methods was provided by the researcher to minimise their influence on participant responses. Survey data was collected through a paper-based interviewer administered questionnaire. Each woman was asked individually about their sociodemographic, pregnancy and birth related characteristics, and the care received and experiences during their recent childbirth in the health facilities where they received maternity care (antenatal care to postnatal care).

Data analysis

Survey data were checked for completeness and entered Epi-info version 7.1 software for data entry based on a predesigned data entry template. The data entered to Epi-info were exported to Stata version 17 for cleaning and analysis [38]. Descriptive analysis of sociodemographic, pregnancy, birth and postnatal characteristics were performed. These descriptive statistics were calculated and presented using tables, figures, and text: median and interquartile range for the variables which were continuous but not normally distributed, and frequencies and percentages for categorical variables were reported.

Thirteen indicators of mistreatment were included under interpersonal abuse. Six of these indicators focused

on physical abuse which included being hit, slapped, or pinched, gagged, tied to the bed, forcefully held down, denial of pain relief, and forceful abdominal/fundal pressure. On the other hand, verbal abuse included being shouted, screamed, insulted, scolded, mocked, hissed at, receiving negative comments related to the woman's status, being threatened and blamed. Discriminatory comments related to woman's educational status, age, language, or economic status, feeling discriminated against in any way and held back from asking concerns were indicators included under stigma and discrimination category. Women who experienced at least one category of physical abuse, verbal abuse or stigma and discrimination was coded as 'Yes = 1', while those who did not experience were coded as 'No = 0'.

A mixed-effect logistic regression model was fitted to identify factors associated to interpersonal abuse. The model was specified using the generalized linear mixed effects regression (*glmer*) function of *lme4* package [39] using R Statistical Software [40]. Variables significantly associated to outcome variable at *p*-value less than 0.2 in multilevel bivariable analysis were taken as candidates in multi-variable analysis. To obtain the best fitted model, three models were constructed: the first model being intercept-only model with five health facilities being a random effect variable; the second model with fixed effects for individual factors related to sociodemographic, pregnancy and birth related characteristics of the women and random effect for health facilities; and the third model containing contextual variables in addition to variables included in model two as fixed effects and health facilities for random effect variable.

To model the association between mistreatment of women and completion of continuum of care, three multilevel mixed-effects models were employed using same function and package discussed above. The first model served as a null model with only an intercept, the second model included random intercepts for health facilities, and the fixed effects consisted of interpersonal abuses and experiences of poor rapport between women and healthcare providers. The final model, which is a better fitted model, incorporated additional socio-demographic, pregnancy, and childbirth-related variables to assess the independent association between mistreatment and the continuum of care. Here, the outcome variable was completion of continuum of maternity care, i.e., having at least four antenatal care check-ups, birth attended by skilled care providers and at least two postnatal check-ups within first week of birth.

Setting health facilities as a random-effect variable in all models allowed us to account for the correlation between individuals who received care from the same health facility. By this approach we were able to obtain more precise estimates of the fixed effects of predictors and effectively control for the clustering effect, as recommended by Faraway [41]. The Akaike information criterion (AIC) and Bayesian information criterion (BIC) was used to assess the model fit. Predictor variables having multi-collinearity (correlation) to each other were checked by variance inflation factors (VIF) and removed from the final model. Each model's effect sizes were reported as adjusted odds ratios (AOR) with their 95% confidence intervals (CI).

Results

Sociodemographic characteristics of the participants

Overall, 760 women completed the survey, and all received their maternity care from health facilities. The participants ages ranged from 18 – 39 years with a median age of 25 years and interquartile range (IQR) of 5. The majority ($n=735$; 96.7%) were married. Three out of four women ($n=576$; 75.79%) were of a Protestant religion and most participants ($n=743$; 97.76%) identified themselves as Oromo in ethnicity. One in every five women were unemployed. Most of the participants resided in urban and semiurban areas ($n=662$; 87.11%). Three hundred thirty-eight (44.47%) women were educated to college diploma or university degree level, while nearly half ($n=392$; 51.58%) of their husbands/partners were educated to college and above level. The median average monthly income of the women's household was 3000 Ethiopian birr (ETB) with an IQR of 3000 ETB, and three-fourths of them earned less than 5000 ETB. The median travel time to the nearest health facility was reported to be five minutes by car (median 5 ± 7.5) (Table 1).

Pregnancy, birth, and postpartum related characteristics of the participants

Most of the participants' pregnancies were planned ($n=673$; 88.5%) and the majority of women were supported during their pregnancy and birth ($n=744$; 97.9%) by the woman's partner and other relatives. Two out of every five women were primiparous ($n=310$; 40.8%), and the typical number of previous births among women were two.

Fifty-one women (6.7%) reported having an earlier stillbirth, while 10.0% ($n=76$) reported experiencing complications during their last pregnancy. Of these women, 31.6% ($n=24$) experienced a hypertensive disorder of pregnancy, while others reported antepartum haemorrhage (13.2%), premature rupture of membranes (19.7%), and postpartum haemorrhage (6.6%) among other complications included anaemia, hyperemesis gravidarum, oligohydramnios and Rh- isoimmunisation (Table 2).

Figure 1 depicts the services women received from health facilities during their antenatal care. Most women

Table 1 Sociodemographic characteristics of women participated in survey, East Wollega Zone, Western Ethiopia, 2022 ($n=760$)

Characteristics	Categories	Frequency	Percentage
Age (years)	18–19	37	4.9
	20–24	339	44.6
	25–29	279	36.7
	30–34	80	10.5
	35 +	25	3.3
Marital status	Married	735	96.7
	Others[a]	25	3.3
Religion	Protestant	576	75.8
	Orthodox	142	18.7
	Muslim	40	5.3
	Others	6	0.8
Ethnicity	Oromo	743	97.8
	Amhara	13	1.7
	Others	4	0.5
Occupation	Government employee	171	22.5
	Housewife	165	21.7
	Private business	154	20.3
	Agriculture	83	10.9
	Unemployed	158	20.8
	Student	29	3.8
Residence	Rural	98	12.9
	Urban	662	87.1
Educational status	No formal education	35	4.6
	Primary school	159	20.9
	Secondary school	228	30.0
	College and above	338	44.5
Husband educational status	No formal education	27	3.5
	Primary school	121	15.9
	Secondary school	220	28.9
	College and above	392	51.6
Income (Median and IQR = 3000)	Lowest (< 2000 ETB)	186	24.5
	Low (2000-3000ETB)	163	21.5
	Middle (3000–5000)	228	30.0
	Highest (> 5000)	183	24.1
Travel distance to the health facility by vehicle Median 5 and IQR = 7.5	< 2.5 min	243	32.0
	2.5-5min	181	23.8
	5-10min	165	21.7
	10 and above	171	22.5

[a] Others-includes single, divorced, widowed, cohabit and separated individuals

received eight of ten routine components of care, however less than one-sixth ($n=110$; 14.5%) were given drugs for intestinal parasite.

Continuum of maternity care

Almost all women ($n=759$; 99.9%) attended at least one antenatal care visit at health facilities. Of these, 380 (50.1%) received prenatal care at public hospitals while 359 (47.3%) received it at health centres. Only two out of five women ($n=305$; 40.1%) began to receive antenatal care during the first trimester of pregnancy as recommended by the WHO (2016) antenatal care guideline most of the women received their first antenatal care visit at 16 weeks gestation.

Among the women who received antenatal care, two-thirds ($n=499$; 65.7%) received four or more antenatal

Table 2 Pregnancy, birth, postpartum care related characteristics of women, East Wollega Zone, Western Ethiopia, 2022 ($n=760$)

Characteristics	Categories	Frequency	Percentage
Pregnancy plan	Yes	673	88.5
Pregnancy was supported	Yes	744	97.9
Number of births (parity) Median 2±2	Primiparous	310	40.8
	Multiparous	409	53.8
	Grand multiparous	41	5.4
Previous history of stillbirth	Yes	51	6.7
Pregnancy complication	Yes	76	10.0
Causes of pregnancy complications ($n=76$)	Hypertensive disorder	24	31.6
	Antepartum haemorrhage	10	13.2
	Premature rupture of membrane	15	19.7
	Others antepartum complications[a]	22	28.9
	Postpartum haemorrhage	5	6.6
Received antenatal care	Yes	759	99.9
Health facility where antenatal care received ($n=759$)	Health centre	359	47.3
	Hospital	380	50.1
	Private clinic	17	2.2
	Health post	3	0.4
Gestational age at first ANC (weeks) ($n=759$) Median 16±8	First trimester	305	40.2
	Second trimester	438	57.7
	Third trimester	16	2.1
Number of antenatal cares received ($n=759$)	One-three	260	34.3
	Four above	499	65.7
Place of birth	Health centre	116	15.3
	Hospital	596	78.4
	Private clinic	13	1.7
	Home	34	4.5
	On the way to health centre	1	
Skilled assistance at birth (SAB)	Yes	725	95.4
	Four + ANC and SAB	484	63.7
Mode of birth	Spontaneous vaginal birth	564	74.2
	Operative vaginal birth	92	12.1
	Caesarean section	104	13.7
Time of birth	Day	478	62.9
	Night	282	37.1
Day of birth	Weekday	477	62.8
	Weekend	283	37.2
Postnatal care (PNC)	PNC within 24 h of birth	719	94.6
	PNC on the third day of birth to seven days	136	17.9
	PNC between 7–14 days of birth	27	3.5
	PNC on six weeks of birth	5	0.7

[a] Anaemia, hyperemesis gravidarum, oligohydramnios, Rh- isoimmunisation

care episodes while 97.0% of these women and 63.7% ($n=484$) of women all women received four and above antenatal care check-ups and their birth were also attended by skilled providers. From which 136, 17.9% of all women completed continuum of care up until second post-natal check-ups within first week of birth. Only three women received all components of continuum of maternity care, including four or more antenatal care visits, skilled health provider attendance during birth, and postnatal care up to six weeks after birth.

Skilled health care providers including midwives, nurses and medical doctors assisted with 725 (95.4%)

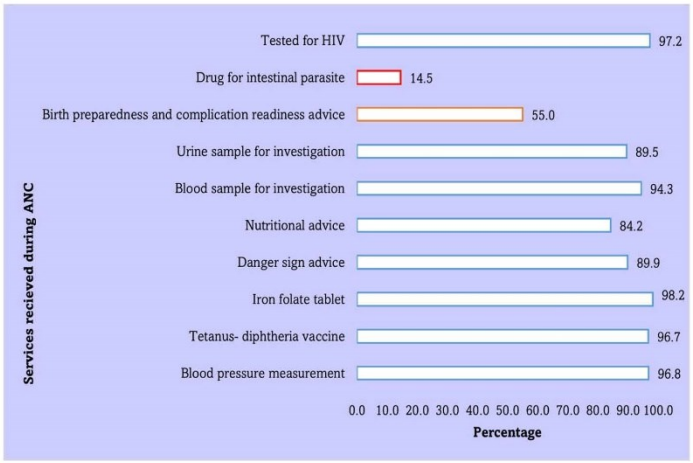

Fig. 1 Bar chart showing the percentage of services given to women attending antenatal care from health facilities of East Wollega Zone, Western Ethiopia, 2022 ($n=759$)

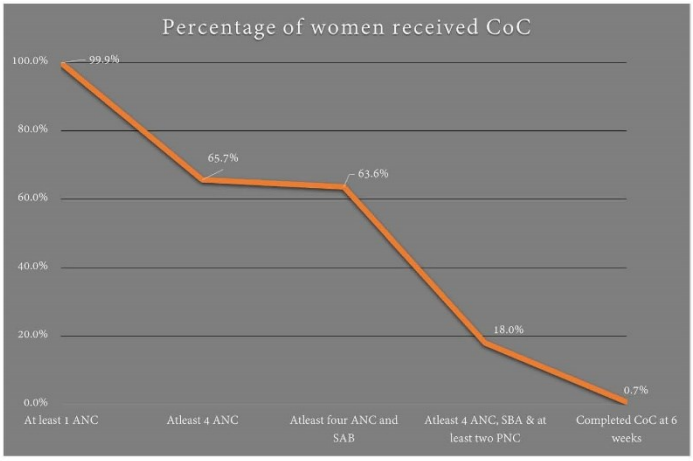

Fig. 2 Percentage of women received continuum of maternity care from health facilities (initial ANC to six week postnatal) of East Wollega Zone, Western Ethiopia, 2022 ($n=759$)

births. Most of the births ($n=596$; 78.4%) occurred in public hospitals, while 34 (4.5%) women gave birth at home. Almost three-quarters of births ($n=564$; 74.2%) were a spontaneous vaginal birth (Table 2 and Fig. 2).

Mistreatment of women

Interpersonal abuse

This category of mistreatment occurred during direct interactions between the woman and health care providers and includes any form of physical and /or verbal abuse, or stigma or discrimination. A total of 284 (37.4%, 95% CI: [34.32–41.23]) women reported experiencing at

Table 3 Mistreatment that women experienced during maternity care in health facilities of East Wollega Zone, Ethiopia, 2022 ($n=753$)

Categories of mistreatment	Sub-categories	Frequency (%)
Interpersonal abuse	**Any physical abuse, verbal abuse, stigma, or discrimination**	**284(37.4%)**
Physical abuse	**Any physical abuse**	207(27.2%)
	Denial of pain relief while in health facility	142(18.7%)
	Forceful abdominal downward pressure (fundal pressure)	77(10.1%)
	Hit or slapped or pinching or pinched by materials	70(9.2%)
	Gagged	20(2.6%)
	Forcefully held down to the bed	12(1.6%)
	Tied to the bed	3(0.4%)
Verbal abuse	Any verbal abuse	158(20.8%)
	Shouted, screamed, insulted, scolded, mocked, hissed at	150(19.7%)
	Negative comments	28(3.7%)
	Threatened	15(2.0%)
	Blamed	14(1.8%)
Stigma and discrimination	Any discrimination	36(4.7%)
	Negative comments (educational status, age, tribe, language, or economic status…)	19(2.5%)
	Felt discriminated	22(2.9%)
	Held back from asking concerns	5(0.7%)
Failure to meet professional standard	Overall failure of professional standard of care	227(29.9%)
	Lack of consented care	190(25.0%)
	Lack of information	185(24.3%)
	Lack privacy	31(4.1%)
	Ignored or neglected	21(2.8%)
	Non-confidential care	15(2.0%)
	Felt nuisance	8(1.0%)
Poor rapport with health care providers	Overall poor rapport b/n health care providers and women	387(50.9%)
	Lack of birth companion	329(43.3%)
	Not allowed to move during labour	48(6.5)
	Emotionally unsupported	29(3.8%)
	Did not receive response for concerns /questions	17(2.2%)
	My concerns were not heard	14(1.8%)
	Not allowed to eat	6(0.8%)
Health system conditions and constrains	Overall health systems constrain	47(6.2%)
	Lack of bed during PNC	39(5.3%)
	Lack of bed during labour & birth	11(1.5%)
	Bribe/asked for informal payment or gift	4(0.5%)
	Ordered to clean up after oneself	1

least one form of interpersonal abuse. Most of the abuse ($n=248$; 87.3%) occurred during woman's labour and birth, while some women also experienced mistreatment during their antenatal or postnatal care check-ups. Fourteen (4.9%) women reported experiencing mistreatment in more than two care units, including antenatal care, during birth, and postnatal care (Table 3).

Physical abuse was the most common form of interpersonal abuse overall, with 207 (27.2%) women reporting experiencing some form of physical abuse. The most reported types of physical abuse included denial of pain relief during procedures such as episiotomy and after caesarean section, which could also be considered emotional abuse ($n=142$; 18.7%) followed by forceful abdominal pressure, known as fundal pressure ($n=77$; 10.1%). Other types of physical abuse reported included slapping, punching, or pinching by either a finger or an object ($n=70$; 9.2%) among others.

One hundred fifty-eight (20.8%) women reported experiencing verbal abuse, which included being shouted and screamed at, insulted, scolded, mocked, or hissed at. Verbal abuse included negative comments, blaming, and threats. Additionally, women reported experiencing provider prejudice based on their social status. Thirty-six (4.7%) women shared that they encountered negative comments from healthcare providers, which made them feel discriminated against or inferior. These negative experiences hindered their ability to express their concerns about themselves and/or their baby.

Failure to meet professional standard of care

Two hundred twenty-seven (29.9%) received substandard care, with healthcare providers failing to obtain their consent for certain procedures or exams and frequently withholding crucial information. One hundred-ninety (25.0%) women reported that they were not asked for consent nor were they offered an explanation or rationale for the health care provider performing certain procedures such as an abdominal or vaginal examination during labour and birth. Women also reported a lack of privacy ($n=31$; 4.1%) when in the health facility and reported being neglected or ignored ($n=21$; 2.8%) (see Table 3).

Poor rapport between women and health care providers and health systems constrains

Half of the women ($n=387$; 50.9%) reported having an unsatisfactory interaction with health care providers. Three hundred twenty-nine (43.3%) women were not allowed to have companion of their choice present with them during antenatal care, labour, and birth or during immediate postpartum period in health facilities, leaving them feeling emotionally unsupported due to being ordered to remain still or a lack of response from healthcare providers.

Forty-seven (6.2%) women reported facing health system-related constrains regarding resources at the heath care facility, ranging from unavailability of a bed during a woman's birth or immediate postnatal period. Indeed, 39 (5.3%) women reported having no access to a bed during their birth, and 11(1.5%) were unable to access a bed after birth, as presented in Table 3.

Factors associated with mistreatment of women

When comparing the standard logistic regression to the null multilevel mixed-effect binary logistic regression model, we found evidence of variation in women's mistreatment experiences across healthcare facilities (likelihood ratio test: $\chi2=68.5$, df$=14$, $p<0.001$). This suggests that the multilevel mixed-effects model is a better fit. The null model yielded an Intraclass Correlation Coefficient (ICC) of 6.4%, indicating that approximately 6.4% of mistreatment variability in can be attributed to differences between the health facilities (Table 4).

In the final multivariable multilevel mixed-effects model, several factors were found to be significantly associated with interpersonal abuses experienced by women in health facilities. These factors include the economic status of the women, the occurrence pregnancy or birth complications, previous history of stillbirth, mode of birth, and the presence of a companion during maternity care (Table 4).

Women from different economic statuses experienced mistreatment to different extents. Specifically, women from the lowest economic status had 80% higher odds of experiencing mistreatment compared to those from higher economic backgrounds (AOR = 1.80, 95% CI: [1.06 – 3.04], p-value = 0.029). Among the pregnancy and birth related factors, the presence of any complications during a woman's pregnancy or birth was associated with increased odds of mistreatment. Women who faced complications were 78% more likely to experience mistreatment compared to those who did not encounter any complications (AOR = 1.78, 95%CI: [1.05 – 3.01], p–value = 0.031).

Previous history of stillbirth, mode of birth, and presence of a companion were associated with reduced occurrence of interpersonal abuses. Women with a prior stillbirth were 51% less likely to experience mistreatment (AOR = 0.49, 95%CI: [0.24 – 0.97]; p-value = 0.041). Similarly, women who had a caesarean section were 41% less likely to experience mistreatment compared to women who gave birth vaginally (AOR = 0.59, 95% CI: [0.36 – 0.98], p-value = 0.042). Furthermore, women who were allowed to have a companion of their choice during maternity care had 42% decreased odds of experiencing mistreatment compared to women who were not permitted (AOR = 0.58, 95%CI: [0.42 – 0.81]; p–value = 0.001) (Table 4).

Association between mistreatment of women and the maternal continuum of care

The association of mistreatment of women with the completion of maternal continuum of care was assessed while controlling for other variables, as presented in Table 5. In this context, completion of the continuum of care involves to meeting specific criteria specified in the methods section, including a minimum of four antenatal care check-ups, childbirth attended by skilled providers, and at least two postnatal care check-ups within the first week after birth. The final model yielded ICC of 25.4%, indicating that 25% of the variability in completing the continuum of care was attributed to the variation in health facilities.

Table 4 Factors associated with mistreatment of women during maternity care in East Wollega Zone, Western Ethiopia, 2022 ($n=752$)—results from Mixed-Effects Logistic Regression Models

Variables	Model I AOR [95%CI]	Model II AOR [95%CI]	Model III	
			AOR [95%CI]	*P*-values
A. Fixed effects				
(Intercept)	**0.40[0.25 – 0.65]**	**0.15 [0.04 – 0.53]**	**0.14 [0.04 – 0.52]**	**0.003**
Woman's age (years)		1.03 [0.99 – 1.07]	1.03 [0.99 – 1.07]	0.140
Educational status				
Highschool and below		*Reference*	*Reference*	
College and above		0.88 [0.59 – 1.30]	0.86 [0.58 – 1.27]	0.440
Socio-economic status				
Lowest		1.84 [1.09 – 3.09]	1.80 [1.06 – 3.04]	0.029
Low		0.61 [0.35 – 1.05]	0.62 [0.36 – 1.06]	0.081
Middle		0.94 [0.60 – 1.49]	0.93 [0.58 – 1.47]	0.746
High		*Reference*	*Reference*	
History of stillbirth				
No		*Reference*	*Reference*	
Yes		0.50 [0.25 – 0.99]	0.49 [0.24 – 0.97]	0.041
Presence of complication				
No		Reference	*Reference*	
Yes		1.80 [1.06 – 3.04]	1.78 [1.05 – 3.01]	0.031
Mode of birth				
Vaginal birth		*Reference*	*Reference*	
Instrumental		1.41 [0.87 – 2.29]	1.54 [0.94 – 2.50]	0.085
Caesarean section		0.55 [0.34 – 0.90]	0.59 [0.36 – 0.98]	0.042
Birth companion				
No			*Reference*	
Yes			0.58 [0.42 – 0.81]	<0.001
Hospital versus health centre				
Health centre			*Reference*	
Hospital			2.20 [0.87 – 5.56]	0.096
B. Random effects				
Health facilities				
Variance	0.223	0.31	0.197	-
Intraclass correlation (ICC)	0.064	0.087	0.057	-
C. Model fitness				
AIC	966	935	926	-
BIC	975	999	999	-
Log-Likelihood	-481	-453	-447	-
Deviance	962	907	894	-
***P*-value**	-	<0.001	<0.001	-

Women who encountered physical abuse, verbal abuse, stigma, or discrimination during maternity care were found to have a significantly decreased likelihood of completing the continuum of care, with their odds reduced by half compared to those who did not experience such interpersonal abuse (AOR = 0.49, 95% CI: [0.29 – 0.83], *p*-value = 0.008). Although not statistically significant, the presence of poor rapport was also observed to be associated with reduced odds of completing the maternal continuum of care.

Among the social determinants of health, higher education attainment, specifically attending college and above, was found to significantly enhance the likelihood of completing continuum of maternity care. Women with a college education or higher were 77% more likely to complete the continuum of care compared to those with

Table 5 Association between mistreatment of women and continuum of maternity care in East Wollega Zone, Western Ethiopia, 2022: A mixed-effects binary logistic regression analysis ($n=752$)

Variables	Null model AOR [95%CI]	Model II AOR [95%CI]	Model III	
			AOR [95%CI]	*P*-values
A. Fixed effects				
(Intercept)	0.04[0.01 – 0.19]	0.05[0.01 – 0.27]	0.00[0.00 – 0.04]	<0.001
Any interpersonal abuse				
Not experienced		*Reference*	*Reference*	
Experienced		0.49[0.30 – 0.80]	0.49[0.29 – 0.83]	0.008
Poor rapport between woman and healthcare providers				
Not experienced	-	*Reference*	*Reference*	
Experienced	-	0.70[0.44 – 1.10]	0.67[0.42 – 1.08]	0.101
Woman's age (years)	-	-	1.05[0.99 – 1.11]	0.098
Educational status				
Secondary school and below	-	-	*Reference*	
College and above		-	1.77[1.01 – 3.10]	0.046
Income				
Lowest	-	-	*Reference*	
Low	-	-	0.60[0.27 – 1.35]	0.220
Middle	-	-	1.01[0.50 – 2.03]	0.991
High	-	-	1.36[0.64 – 2.86]	0.425
Presence of complication				
No	-	-	*Reference*	
Yes	-	-	3.20[1.73– 5.94]	<0.001
Quality of antenatal care	-	-	1.25[1.03 – 1.51]	0.023
B. Random effects				
Health facilities				
Variance	1.94	2.31	1.12	-
Intraclass correlation (ICC)	0.370	0.412	0.254	-
C. Model fitness				
AIC	557	547	521	-
BIC	566	566	572	-
Log-Likelihood	-276	-269	-250	-
Deviance	553	539	499	-
P-value	-	0.002	<0.001	-

an educational status below college level (AOR = 1.77, 95% CI: [1.01 – 3.10], *p*-value = 0.046). Additionally, the presence of complications during pregnancy or birth also emerged as another factor associated with completing the continuum of maternity care. Women who experienced pregnancy complications were three times more likely to complete the continuum of care than those without complications (AOR = 3.20, 95% CI: [1.73 – 5.94], *p*-value < 0.001). Additionally, receiving a better-quality antenatal care during pregnancy was associated with a 25% increased odds of completing the continuum of maternity care (AOR = 1.25, 95% CI: [1.03 – 1.51], *p*-value = 0.023).

Discussion

In this study, we report on the prevalence of mistreatment of women during maternity care, factors associated with interpersonal abuse and also the relationship between mistreatment of women and continuum of maternity care. More than a third of women encountered at least one instance of physical abuse, verbal abuse, stigma, or discrimination, with several factors associated with its occurrences. Nearly one-third of women did not receive care that met professional standards, and every other woman reported poor rapport with health care providers. Our study also suggests women were less likely to attend and finish the continuum of care if they

endured mistreatment in their initial period of antenatal care or thereafter.

Previous studies have highlighted significant variation in the prevalence of mistreatment experienced by women during maternity care worldwide, ranging from low rates in some countries [12] to nearly universal experiences in others [13]. This study also demonstrates the significant problem of mistreatment, with varying magnitudes observed for different types of mistreatments. Ensuring care meets professional standards and upholds dignity, respect, confidentiality, and involving clients in the decision-making process are crucial for improving the quality of care, as outlined in WHO's *standards for improving quality of maternal and newborn care in health facilities* [42]. However, the findings from this study reveals a substantial proportion of women experienced care that failed to meet these standards, along with experiencing nuanced interpersonal abuses, poor rapport with healthcare providers and health system related constrains. Identification of these varied categories of mistreatment in current study signifies the need to understand mistreatment of women as a product of complex personal, structural and system issues that need system-wide solutions [42–44].

The occurrence of mistreatment during maternity care was associated with various characteristics of women, such as social status, education, and socioeconomic background, which have been documented to play a significant role [22, 45]. Our study confirms those findings and also identified that women from the lowest income group had higher odds of experiencing interpersonal abuses. This highlights the inequality in care provision for marginalised and impoverished women [46], perpetuating mistreatment as both health care providers and women themselves normalise it. Constraints within the health care system and unequal power dynamics among providers hinder addressing these issues across the continuum of care [47].

Furthermore, women with complications during pregnancy or birth faced intensified interpersonal abuse, emphasising the greater vulnerability of those in need of additional physical and emotional care. Women who had a vaginal birth also faced higher odds of mistreatment compared to women who required a caesarean section, likely due to the increased pain and challenges of spontaneous labour, as reported elsewhere [48]. Conversely, women who had a companion present had a lower risk of experiencing interpersonal abuse, underscoring the positive influence of having a supportive companion present during childbirth [49]. These factors become more pressing in hospitals with higher patient ratios compared to health centres [22, 47], as women tend to bypass health centres, contributing to hospital congestion for various reasons, including perceptions of poor quality of care and infrastructure issues [47].

The occurrence of mistreatment in healthcare facilities undermines service utilisation, contributing to the discontinuation of completing continuum of care [29, 30]. In our study, we found that half of the women who experienced physical abuse, verbal abuse, stigma, or discrimination discontinued maternity care. Women who have experienced mistreatment in any form during pregnancy may be more likely to discontinue prenatal care, even if they had initially intended to give birth at that facility. They prioritise giving birth in a dignified manner and prefer to avoid such mistreatment, despite recognising the potential impact of choosing a home birth. Demonstrating that women are reluctant to seek evaluation and assistance from health care providers who disrespect and abuse them, leading to mistrust, dissatisfaction and even depression [50]. This reluctance contributes to complications and hampers efforts to reduce maternal and neonatal mortalities, thereby impacting on the global sustainable development goals (SDG) target of maternal health [51]. The negative associations between mistreatment and the continuity of care highlight the need for comprehensive, system-wide interventions that go beyond educational measures, such as training, which have been found to be inadequate on their own [51].

Our study presents significant ongoing occurrences of mistreatment of women during maternity care requiring urgent change within the health care system. We acknowledge there are some limitations and strengths in our study. The limitation of this study is that the findings were based on participants only from four districts near the zonal capital city, this was due to challenges in accessing women from remote areas affected by ongoing unrest during data collection in the area. However, efforts were made to include women from rural areas who sought care in nearest health centre and hospital. We believe the occurrence of mistreatment and its effect would not differ significantly in the remaining district and primary hospitals from what observed in current study.

Another important limitation to consider in this study is that we recruited women during immunization due to community unrest in the area. Current study participants may exhibit a higher health-seeking behaviour than those who did not come for vaccination, which could lead to an underestimation of the influence of mistreatment on the continuity of care. A community-based study could have offered a more accurate depiction of the relationship between mistreatment of women and continuity of care. Although over 97% of women in Ethiopia visit health facilities to have their children vaccinated [33], potential participants may have been lost, and therefore, the

findings from this study might not be generalisable to the broader population.

Additionally, the cross-sectional nature of our study design limits our ability to establish a causal association between mistreatment and continuity of care, as we were unable to determine whether experiences of mistreatment during previous pregnancies and births also contributed to the discontinuation of continuity of care or if it was solely influenced by the experiences during the current pregnancy and birth.

A notable strength of our study is the exploration of a previously unexplored aspect, the influences of mistreatment on the continuum of maternity care in Ethiopia. Additionally, we measured mistreatment in various categories, considering its multidimensionality and utilising validated survey tools, instead of reporting the magnitude as a single combined measure.

Conclusions

Mistreatment of women in maternity care is a pervasive issue that extends beyond labour and birth, encompassing antenatal and postnatal care as well. This mistreatment has significant negative consequences, hindering women's engagement and completion of the continuum of care and resulting in reduced utilisation of maternal healthcare services. Such trends have detrimental effects on overall maternal well-being. It is crucial to identify and address these gaps by avoiding interpersonal abuse, enhancing rapport through attitude and value transformation trainings. Such interventions should align with a system level actions, including enforcing respectful care as a competency of every provider, enhancing health centre functionality, improving the referral system, and influencing communities to demand respectful care. Such changes could promote positive maternal and neonatal health outcomes while fostering trust and respect between women and healthcare providers. Collaborative efforts involving healthcare providers, facilities, communities, and policymakers are necessary to ensure equitable and respectful care for all women, irrespective of their social or medical circumstances.

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Authors' contributions

HK, KB, VS, and AS conceptualized the study and designed the protocol. HK oversaw data collection, analysed the data, and drafted the manuscript. KB, AS, and VS supervised the study's conduct, data analysis, and also critically revised the manuscript. All authors have read and approved the final manuscript.

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Availability of data and materials

The dataset used in this study is available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki's ethical principles and guidelines by ensuring that all potential participants were fully informed about the study and given enough time to decide about participating. Written informed consent was obtained from all participants, and for non-literate women, informed consent was obtained from next of kin. The study obtained ethical approval from Institutional Review Committee of Wollega University, Ethiopia (Ref No. WU/RD/469/2021) and the Human Research Ethics Committee at the University of Technology Sydney (Ref. No: UTS HREC ETH21-6587).

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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Publisher's Note

Appendix 14: Paper 3: Survey HCPs' Perspectives

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Health care providers' perspectives on the mistreatment towards women during maternity care: Do perceptions of the working environment and empathy level matter?

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ABSTRACT

Background: Mistreatment of women in maternity care violates human rights, erodes trust and disrupts the continuity of maternal healthcare services. Investigating Health Care Providers' (HCPs) perspectives is indispensable in uncovering drivers and designing targeted interventions.
Aim: To identify the roles of HCPs' perceptions of the working environment and levels of empathy on the mistreatment of women during maternity care.
Methods: We conducted a self-administered survey among 148 maternal HCPs practising in ten health centres and four hospitals in the East Wollega Zone, Western Ethiopia, from June to September 2022.
Findings: Most providers reported seeing other HCPs mistreating women (93.2%), while three-fourths (75.7%) admitted it as their actions. Violation of privacy and confidentiality was the most frequently reported category of mistreatment (44.6%), followed by physical abuse (37.1%) and verbal abuse (35.8%). The likelihood of mistreating women was reduced by 65% (AOR=0.35, 95% CI: [0.14, 0.86]) among individuals with positive perceptions of their working environment compared to those with negative perceptions. A unit increase in providers' empathy also led to a five per cent decrease in mistreatment (AOR=0.95, 95% CI: [0.91, 0.98].
Conclusions: HCPs' perceptions of their working environment and enhanced empathy levels were associated with the reduction of the odds of mistreatment of women. While empathic care should be cultivated as a component of HCPs' competencies, efforts should be made to improve the conditions of the demanding health system to realise a resilient, motivated, competent, and compassionate workforce. The interplay between gender, profession, and mistreatment level requires further investigation.

Statement of the significance

Problem

Mistreatment of women during maternity care in health facilities.

What is already known

Mistreatment of women during maternity care is identified as a global issue, with particularly high occurrence rates in low- and middle-income countries where health-related challenges are prevalent. Various individual-level factors related to the mistreatment of women have been reported, with a significant impact on the health care-seeking behaviours of the community.

What this paper adds

HCPs acknowledged the presence of mistreatment of women during maternity care, both as witnessed by other providers and as their actions, occurring at least a few times. The perceptions of HCPs regarding their working environment and their levels of empathy were found to be related to the reduction of the mistreatment of women in health facilities.

Introduction

Annually, nearly 140 million births occur in a world where significant disparities in equity and quality of care exist [1]. These gaps in equity and quality of care persist globally despite recognising evidence-based, equitable, respectful, and compassionate care for all

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women and their babies in maternity care policies [2]. Unnecessary and excessive interventions are commonly practiced in middle-income and high-income countries. In contrast, many women and babies die because of limited access to essential interventions in resource-limited countries [3]. Considering these widened gaps in service provisions, there has been a shift in the maternal, newborn, and child health care agenda, moving away from merely striving to improve survival with a focus on addressing drivers of thriving and transformation [4]. One driver of inequality affecting this envisioned transformation and thriving is the prevailing mistreatment of women during maternity care [5].

Mistreating women during maternity care violates human rights and influences women and their families to mistrust maternal health care services and drop from the continuum of care, even though they recognise its significance in their care [6,7]. Several studies document that women do not want to seek care from HCPs who mistreat and abuse their dignity [8–11]. A qualitative study found that women who were mistreated during antenatal care avoided health facility births because of confidence and trust issues [8], which was also linked to a heightened risk of postpartum depression [10,11]. Eliminating such impactful incidences in the continuum of care requires system-wide interventions based on first-hand evidence that incorporates the views of health care providers [12].

Most of the previous studies on mistreatment during maternity care were based on women's perspectives; however, some studies from various countries, including Ethiopia, have also reported that HCPs themselves have acknowledged the presence of mistreatment of women during maternity care, mostly reporting instances as unintentional [13–15]. In a study where most service providers reported witnessing disrespectful care, Asefa et al. found that most HCPs believed that the absence of respectful care discourages women from seeking childbirth at health facilities [16]. While HCPs recognise such negative impacts of mistreatment of women during maternity care, they find themselves unable to effectively prevent it [16].

The health system and HCPs benefit from upholding the belief that there should be no justification for treating women with disrespect during maternity care. However, apprehension about being blamed for poor outcomes in maternal and neonatal health, coupled with the fragility of health systems characterised by limited infrastructure and resources in low-income countries, have frequently been cited as a driving factor behind the mistreatment of women [17–19]. The presence of inadequate infrastructure, such as a limited number of skilled providers, can lead some women to feel neglected, even when the behaviour of providers is respectful. Such scenarios starkly contrast with instances of interpersonal abuse, such as verbal or physical mistreatment, which often appear to be deliberate acts [19].

In addition to considering contextual factors within the health care system, it is also important to examine how HCPs' views on their working environment play a role in the mistreatment of women. The available evidence regarding how HCPs' overall perceptions of the actual working environment, their profession, and their relationship with other HCPs influence the mistreatment of women is limited. Generating such empirical evidence is crucial to understanding how the health system can be equipped with motivated, competent and compassionate health work forces, as envisioned by the Ethiopian Ministry of Health [20]. Hence, in this study, we aim to determine the extent of mistreatment as reported by HCPs—from their own actions or what they have witnessed from their colleagues. Furthermore, we sought the roles of positive perceptions of the working environment and increased levels of empathy in the mistreatment of women during maternity care, as self-reported by HCPs, while controlling for the effects of other variables.

Methods

Study setting and population

This study was part of a larger study conducted in the East Wollega Zone, Oromia Regional State, Western Ethiopia, from June to September 2022. With an estimated 123 million people in 2022, Ethiopia is the second most populous country in Africa, with low economic, infrastructure, development, and health indices, including high maternal and child morbidity and mortality [1]. Maternal and child health care services are provided by midwives, nurses, and medical doctors, among others. The health care delivery system in the country is structured into three tiers, including primary-, secondary- and tertiary-level health care, through which preventive, curative and rehabilitative services are provided at health posts, health centres, primary hospitals, general hospitals, and specialised hospitals [20].

Despite efforts being made to increase the availability and skill mix of the health workforce, Ethiopia has a health worker density estimated to be 1.0 per 1000 population (midwives, nurses, medical doctors and health officers) [21], which is considerably lower than the 4.45 per 1000 population standard proposed by the World Health Organisation (WHO) [22]. There is an inadequate skill mix of professionals, where there is a relatively higher number of nurses, while there is a high shortage of physicians (one GP to ten thousand people) and midwives (one to six thousand people) [21,22].

To investigate the mistreatment of women by HCPs within health facilities, we conducted a cross-sectional survey involving maternal HCPs from six districts working in ten health centres and four hospitals. The survey was conducted among providers from these six districts with the aim of obtaining diverse participants from urban and semi-urban hospitals, as well as health centres given low number of the HCPs in each facility as discussed earlier. This approach allowed us to include HCPs from various professions. Although including HCPs from additional health facilities and districts could have been beneficial, we were unable to do so due to community unrest in the study area during data collection. The survey participants were midwives, nurses, medical doctors, health officers, and integrated emergency surgical officers. All maternal HCPs who were actively providing antenatal, birth and postnatal care were approached to participate in the study, while those who were not providing these cares but rather holding the duties of the office work at the district (Wereda office) and Zonal Health office, were excluded. Hence, a total of 170 survey questionnaires were distributed. Data were collected through self-administered surveys, taking into account the sensitivity of the research topic. Participants received surveys along with envelopes, and after completion, they returned the sealed surveys to a designated coordinator.

Measurements

Outcome variable: mistreatment of women

The primary outcome variable of this study was the mistreatment of women in facilities, as reported by HCPs, either as they witnessed or admitted themselves as their own actions. To identify various forms of mistreatment towards women, participants were asked to evaluate the first-order encounters of mistreatment under seven constructs. The constructs encompassed various aspects: disrespectful and unfriendly care; verbal and physical abuses; discrimination based on social status; lack of privacy and confidentiality; neglect and abandonment; and loss of autonomy. These constructs align with the WHO's vision for the quality of maternal and newborn care under the categories of experiences of care [23]. The crucial components of quality maternal and newborn care involve effective communication and supportive emotional care that upholds respect and dignity. The absence of these elements indicates mistreatment in the care process, which is the response variable in this study.

Thirty questionnaire items were adapted from the Person Centred

Maternity Care scale, which was previously validated in a study conducted in Kenya [24]. The items were tailored to capture HCPs' perspectives. Participants were asked to rate each item on a scale ranging from 0 to 3 (0 - No never, 1 - Yes, a few times, 2 - Yes, most of the time, 3 - Yes, all the time), representing the frequency of the observed mistreatment. The questionnaire was administered in English and Afan Oromo through a self-administered survey. To assess the construct validity of the items, a factor analysis was conducted, resulting in four factors with eigenvalues above 1. All items were loaded on the first factor with a factor loading greater than 0.30 after the promax rotation of the factors. The internal consistency of the items was evaluated using Cronbach's alpha, resulting in an alpha value of 0.90, indicating good reliability.

In alignment with the World Health Organisation's stance to eradicate all forms of disrespect and abuse within health care facilities [25], we classified any instance of mistreatment in at least one form as mistreatment, regardless of its frequency. Accordingly, to determine the proportion of self-reported mistreatment actions conceded by HCPs, we computed a binary indicator variable labelled *'Yes'* or *'No.'* If participants' responses indicated *'0–no, never'* concerning verbal abuse, physical abuse, breach of privacy or confidentiality, discrimination, neglect, and infringement upon autonomy, they were classified as *'No'* and coded 0. Conversely, if any of these forms of mistreatment were indicated as *'1–Yes, a few times, 2–Yes, most of the time,* or *'3–Yes, all the time,* the variable was categorised as *'Yes.'* We adopted this approach based on the belief that the presence of any of these forms of mistreatment, even if they occur infrequently, still implies a deficiency in providing respectful care.

Independent variables

Perceptions of the working environment. Perceptions of the working environment among individual HCPs were measured using a set of 16 items. These items were rated on a five-point Likert scale adapted from a Delphi study aimed at defining a positive working environment for health care professionals [26]. The 16 items covered various aspects of the working environment, such as workload, patient-to-health care provider ratio, autonomy, professional development opportunities, relationships among professionals, teamwork, perceptions of their profession, and level of satisfaction with the service they were providing, among others. Participants were asked to rate each of the 16 items on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

The internal consistency of these items was good, with a Cronbach's alpha value of 0.8370. To assess the overall perception of the working environment, the scores of all the items were summed after missing values (one to three observations) were replaced with the mean of that specific variable, resulting in a possible total score ranging from five to 80. A lower sum score indicated a less positive perception of the work environment, whereas higher scores indicated a more positive perception. Perception of the working environment was dichotomised as negative if the sum score was less than the mean value and positive if the sum score was above the mean value. This binary variable was used in the final model that associates this variable with the odds of HCPs mistreating women.

Health care providers' level of empathy

The empathy levels of health care providers were evaluated using a 20-item self-reported Likert scale consisting of seven response options based on health professionals' Jefferson Empathy Scale [27]. The reliability and validity of the empathy scale for HCPs have been established in previous studies. Out of the 20 items, ten were positively formulated, while the remaining ten were negatively formulated. This approach aimed to minimise the potential influence of participants' monotonous responses. Each item was rated on 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) for positively constructed items and the reverse for negatively constructed items. The internal consistency of these items was deemed acceptable, with a Cronbach's alpha coefficient of 0.73. Missing values for each item were replaced with the mean value of that specific item, following the recommendation of Hojat et al. [28]. The overall empathy level was then calculated as the sum of the scores across all the items, resulting in possible values ranging from 20 to 140. A higher score indicates a greater level of empathy, while a lower score indicates a lower level.

Other variables

Individual demographic characteristics of the providers, such as age in years, sex, marital status, profession, monthly salary, years of experience, average number of births attended per day, and history of respectful maternity care training, were included in the analysis. Furthermore, contextual factors such as the types of facility they practice (hospital vs. health centre), presence and implementation of specific respectful maternity care policy in health facilities, and the presence of a redress system in health facilities were also evaluated and controlled in the regression model.

Statistical analysis

The responses of each participant were entered into Epi-info data entry software, Windows version 7 [29], and then exported to Stata 17 for data cleaning and analysis [30]. Descriptive statistical summaries, including frequency and tabulations for factor variables and mean/-median and standard deviations for continuous variables, were generated and presented in tables and graphs.

To predict the level of self-reported mistreatment of women from HCPs' positive perception of the working environment, empathy level, gender, profession, experiences, the average number of childbirths attended per day and health facility type, a binary logistic regression model was used. The need for a mixed-effect model was checked for the clustering effects of being from the same health facilities or districts, and there was no evidence of correlation. There was no significant difference between the standard logistic regression model and the mixed effect model, where health facilities were treated as an intercept variable (P-value = 0.333), and there was an avoidable intraclass correlation coefficient of approximately nil. Consequently, binary logistic regression was used to model factors associated with the proportion of mistreatment of women, as self-reported by HCPs. Model fitness was assessed using the Hosmer and Lemeshow goodness-of-fit test, and the model assumptions were assessed, and no violations were detected. Sensitivity analysis was conducted and the final results of the model of the associations between the outcome variable and independent variables were reported in the AOR with 95% confidence intervals, statistical significance level being 0.05 p value.

Findings

Demographic description of the participants

Overall, 148 HCPs responses were analysed in this study out of the 170 distributed survey questionnaires. Almost two-fifths of the participants worked in a hospital (*n=63, 42.6%*). The gender distribution of the participating HCPs showed a slightly higher number of males (*n= 82, 55.4%*). The median age of the participants was 28 years, indicating that half of the individuals were younger than 28 years with an interquartile range (IQR) of 3 years (27–30 years), representing the age range between the 25th percentile (27 years) and the 75th percentile (30 years).

Two-thirds of the study participants were midwives by profession (*n= 99, 66.9%*), while nearly three out of five of the study participants had work experience of more than five years (*n= 87, 58.8%*). There was high variation among individuals in the number of births attended per day by the health professionals, with an average of three births attended by HCPs daily, ranging from one to 12 births. One-third of the

participants' primary work units were labour and birth (*n= 48, 32.4%*).

Almost half of the participants (*n=72, 48.6%)* did not receive any respectful maternity care-related awareness creation training, while two out of three participants reported that their health facility had respectful maternity care standards of care. Even though more than half of the participants reported that their health facilities have a legal redress system for complaints (*n= 77, 52.0%*), nearly half of the participants believe that women do not know about the presence of this redress system (*n= 37, 48.0%) (*Table 1).

Health care providers' perceptions of the working environment

Participants were asked to express their perception of a working environment, which could either be a health centre or a hospital. In response, 38% of participants strongly disagreed with the notion that the workload is not heavy. Approximately two-thirds of the participants (67%) were also strongly disagreed with the notion describing the adequacy of payment they receive relative to their workload. Another issue that reflects the perception providers have of their working conditions is the suitability of the working environment. More than one-third (37%) strongly disagreed regarding the appropriate structuring of the working environment, while another third (30%) of participants strongly disagreed with the availability of continuous professional development opportunities in the health system and the facility.

Furthermore, nearly one-third of participants strongly disagreed with the adequacy of the number of health care providers, the quality of health facilities' management support, the suitability of the unit where they work, the proportional size of the clients visiting the HF, the availability of continuous professional development opportunities and recognition and respect given for HCPs by managers. The overall mean score for perception of the working environment was 46.5, which ranged from 19 to 75, with a maximum possible score of 80 (Table 2).

Table 1
Description of participants by demographics and service delivery characteristics, Western Ethiopia, 2022 (N 148).

Characteristics	Frequency (%)
Health facility that they work	
Hospital	63 (42.6)
Health Centre	85 (57.4)
HCP's age (years): Median (IQR)	28 (27–30)
HCP's gender	
Male	82 (55.4)
Female	65 (43.9)
Missing	1
Marital status	
Married	106 (71.6)
Single/separated/widowed	41 (27.7)
Missing	1
Religion of HCPs	
Protestant	108 (74.0)
Orthodox	26 (17.8)
Others (Muslim, Adventist, Wakeffata)	12(8.1)
Missing	2(1.3)
Ever had child	
Yes	101 (68.2)
No	47 (31.8)
Profession	
Midwife	99 (66. 9)
Clinical Nurse	25 (16. 9)
Obstetrician and Gynaecologist	10 (6.8)
Health officers	6 (4.0)
General practitioner	5 (3.4)
IESOs[a]	3 (2.0)
Work experiences	
Five years and less	61(41.2)
Above five years	87 (58.8)
Primary working unit	
Antenatal care (ANC)	51 (34.5)
Labour, birth (LB) and postnatal unit (PNC)	48 (32.4)
ANC, LB & PNC	49 (33.1)
Received RMC training	
Yes	76 (51.4)
No	72 (48.7)
Do health facility have specific RMC related policy	
Yes	95 (64.2)
No	53 (35.8)
Implementation of RMC standard in the facility	
Yes	82 (55.4)
No	66 (44.6)
Presence of redress system in the facility	
Yes	77 (52.0)
No	71 (48.0)
Women are aware of the presence of the redress (N= 77)	
Yes	40 (52.0)
No	37 (48.0)
Number of childbirths attended by HCPs/day: Mean (SD)	3 (±2)

[a] IESOs: Integrated Emergency Surgical Officers

Health care providers' level of empathy

The overall sum score of the empathy level ranged from 68 to 138, with a mean empathy score of 105.66 (SD= 16.50). The mean item scores ranged from 3.66 for item number 18, "*I do not allow myself to be influenced by strong personal bonds between my patient and their family members*", to 6.00 for item number 5, "*I have a good sense of humour that I think contributes to better clinical outcome*". The remaining indicators of empathy levels fell between these two extremes. The HCPs demonstrated relatively encouraging levels in understanding patients' feelings, paying attention to patients' emotions, imagining themselves in their patients' shoes, and acknowledging the importance of empathy in patient treatment, as presented in Table 3.

Level of mistreatment of women reported by health care providers

Health care providers acknowledged the occurrence of mistreatment towards women in their health facilities. When asked about the treatment of women in a disrespectful manner in their facilities, 84% of the participants stated that women were treated this way '*a few times*'. Additionally, 72% reported witnessing women being treated in an unfriendly manner '*a few times*'. Specific forms of mistreatment have also been reported as either witnessing other providers mistreating women or as self-committed, including verbal and physical abuse, provider prejudice, neglect, and abandonment.

For instance, half of the participants reported witnessing instances where other HCPs verbally abused women during maternity care. Furthermore, 49% of the participants reported observing at least one form of physical abuse, such as women being hit, pushed, or physically restrained. More than half (56%) of the HCPs reported witnessing differential care being practiced by others based on women's social attributes, 'a few times' or 'most of the time'. Neglect and abandonment were also reported, with 38 and 8% of participants stating that they had seen women being left alone or unattended 'a few times' and 'most of the time', respectively, as presented in Table 4.

Health care providers themselves admitted that they had mistreated women at some point in their care. Of the surveyed providers, 31% reported instances of verbally abusing women a few times during care provision, whereas the majority (64%) stated that they had never engaged in verbal abuse against women. Similarly, one-third of the providers (32%) reported that they had physically abused women during care provision. Additionally, 30% of the providers felt that they had treated women differentially on a few occasions without being aware of their bias.

Regarding the lack of privacy and confidentiality during care provision, more than half (55%) of the providers reported that they had never breached the privacy and confidentiality of women. However, providers reported feeling that they had breached privacy and confidentiality 'a few times' (30%), 'most of the time' (6%), and 'all the time' (9%). Health care providers also reported feeling that they violated women's autonomy, such as restricting their mobility without

Table 2
Health care providers' perceptions of the work environment.

Items	Strongly disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly agree n (%)
Workload is not heavy	56(37.8)	33(22.3)	21(14.2)	22 (14.9)	16 (10.8)
Number of HCPs are adequate	45(30.4)	47(31.8)	18(12.2)	19(12.8)	19(12.8)
Number of clients that visit HF is not large	39(26.3)	37(25.0)	32(21.6)	24(16.2)	16(10.8)
HFs' management support is very good	47(31.8)	26(17.6)	30(20.3)	27(18.2)	18(12.2)
The unit where I work is structured in a suitable manner	56(37.8)	34(23.0)	27(18.2)	23(15.5)	8(5.4)
I am autonomous in accomplishing tasks and making decisions by myself	20(13.5)	24(16.2)	25(17.0)	41(27.7)	38(25.7)
The relation among HCPs is encouraging and welcoming	31(20.9)	23(15.5)	18(12.2)	45(30.4)	31(21.0)
The CPD opportunities are very good	45(30.4)	36(24.3)	27(18.2)	22 (14.9)	18(12.2)
There are equal and open (blame-free) communication and feedback	39(26.3)	35(23.6)	35(23.6)	23(15.5)	16(10.8)
The HCPs work in team respectfully for common goals	15(10.1)	16(10.8)	23(15.5)	55(37.2)	39(26.3)
Senior staffs (including physicians) respect junior staffs	18(12.2)	29(19.6)	21(14.2)	42(28.4)	38(25.7)
Women or attendants who come with clients treat HCPs with a respect	23(15.5)	22(14.9)	26(17.6)	45(30.4)	32(21.6)
The HF managers recognise staff's heavy duty, and they respect HCPs	42(28.4)	25(16.9)	31(20.9)	28(18.9)	22(14.9)
I am very happy with my profession	19(12.8)	13(8.8)	11(7.4)	39(26.3)	66(44.6)
I am very satisfied in providing maternal health care	19(12.8)	10(6. 8)	22(14.9)	44(29.7)	53(35.8)
The salary I receive is commensurate with the workload	100(67.6)	15(10.1)	15(10.1)	7(4.7)	11(7.4)
Overall perceptions of working environment (Mean= 46.06, SD=11.8)					
Negative perception (frequency (%))					71 (48.0)
Positive perception (frequency (%))					77 (52.0)

Table 3
Mean and standard deviation of health care provider empathy score, East Wollega Zone, Western Ethiopia, 2022 (N 148).

Items	Mean	Std. dev.
My understanding of how my patients and their families feel does not influence treatment/care outcomes.	4.30	2.45
My patients feel better when I understand their feelings.	5.82	1.89
It is difficult for me to view things from my patients' perspectives.	4.84	2.20
I consider understanding my patients' body language as important as verbal communication in caregiver-patient relationships.	5.15	2.15
I have a good sense of humour that I think contributes to better clinical outcome.	6.02	1.63
Because people are different, it is difficult for me to see things from my patients' perspectives.	4.92	2.14
I try not to pay attention to my patients' emotions in history taking or in asking about their physical health.	5.82	2.06
Attentiveness to my patients' personal experiences doesn't influence treatment outcomes.	4.56	2.46
I try to imagine myself in my patients' shoes when providing care to them.	5.74	1.91
My patients value my understanding of their feelings which is therapeutic in its own right.	5.71	1.80
Patients' illnesses can be cured only by targeted treatment; therefore, my emotional ties to my patients do not have a significant influence in treatment outcomes.	5.16	2.38
Asking patients about what is happening in their lives is not helpful in understanding their physical complaints.	5.70	2.05
I try to understand what is going on in my patients' minds by paying attention to their nonverbal cues and body language.	5.26	2.11
I believe that emotion has no place in the treatment of medical illness.	5.94	1.85
Empathy is a therapeutic skill without which success in treatment/care is limited.	4.20	2.51
An important component of the relationship with my patient is my understanding of their emotional status, as well as that of their families.	5.70	1.88
I try to think like my patients in order to render better care.	5.49	2.07
I do not allow myself to be influenced by strong personal bonds between my patients and their family members.	3.57	2.32
I do not enjoy reading nonmedical literature or the arts.	5.41	2.10
I believe that empathy is an important factor in patients' treatment.	5.89	1.90
Overall Empathy score: Mean (SD)	105.66	16.50

significant clinical indication and forcing them to stay in a health facility against their will. Overall, three out of four health care providers (n=112, 75.7%, 95% CI: [68.05 – 81.96]) reported mistreating women at least in one way or the other, including verbally, physically, discriminating against, violating their privacy and confidentiality, neglecting/abandoning, or restricting their autonomy, at least 'a few times' in their health facilities, as shown in Fig. 1 and Table 4

Factors associated with self-reported mistreatment of women

The effects of HCPs' empathy levels and perceptions of the working environment were assessed using a multivariable logistic regression model. This assessment controlled for the effects of other variables, such as HCPs' age, gender, profession, years of experience, average number of childbirth attendances per day, and the type of health facility where they work. As presented in Table 5, health HCPs of their working environments, empathy score, and the interaction between gender and profession were statistically significantly associated with self-reported mistreatment of women.

The results of the multivariable logistic regression analysis showed that the likelihood of HCPs mistreating women during maternity care decreases based on the HCPs' positive perception of their working environment and their level of empathy. The odds of mistreating women decreased by 65% among providers who reported a positive perception of their working environment compared to those who viewed their working environment negatively (AOR= 0.35, 95% CI: [0.14, 0.86]). Similarly, a one-unit increase in HCPs' empathy score was associated with a 5% decrease in the odds of mistreatment of women during maternity care (AOR= 0.95, 95% CI: [0.91, 0.98]). Another factor found to be associated with self-reported mistreatment was the interaction of gender and the profession of the providers. The likelihood of mistreating women was found to be almost four times higher among male midwives than among female midwives (AOR= 3.73, 95% CI: [1.25, 11.20]) (Table 5).

Discussion

In this paper, we report on the mistreatment towards women by HCPs, encompassing instances of witnessing colleagues' mistreatment and self-admitted mistreatment towards women. A significant portion of providers, approximately three out of four, acknowledge engaging in mistreatment of women during care provision. Notably, our findings highlight an association between positive perceptions of the working environment, higher empathy levels, and a reduced likelihood of mistreatment towards women. Furthermore, we identified the presence of disparities in the reported mistreatment toward women based on the interaction between profession and gender, with male midwives exhibiting higher odds of mistreatment than female midwives. These findings collectively contribute to a comprehensive understanding of the

Table 4
Health care providers' perspectives on the extent of mistreatment of women in their respective health facilities, East Wollega Zone, Western Ethiopia, 2022 (N 148)[a].

Construct	Questions	No, never, N (%)	Yes, a few times, N (%)	Yes, most of the time, N (%)	Yes, all the time, N (%)
Distespectful and unfriendly care	*In your experience in your health facility, do HCPs treat women disrespectfully?*	*6 (4.1)*	*124 (83.8)*	*18(12.2)*	*0*
	Do HCPs at your health facility treat women in unfriendly manner?	*23 (15.5)*	*106 (71.6)*	*19 (12.8)*	*0*
Verbal abuse	*In your experience in this facility, do HCPs shout at, scold, insult, threaten or talk to women rudely?*	*72(48.6)*	*60 (40.5)*	*14 (9.5)*	*2 (1.4)*
	Do HCPs give negative comments about patients' or their baby's physical appearance (such as weight, private parts, sexual activity, cleanliness other aspects)?	*96 (64.9)*	*44 (29.7)*	*7 (4.7)*	*1 (0.7)*
	Do HCPs threaten women with any aspects (forcing to accept treatment they did not want, physical violence, withhold care, poor treatment outcome)?	*115 (77.7)*	*28 (18.9)*	*2 (1.4)*	*3 (2.0)*
	Do HCPs blame women for something that happened to them or their baby during their stay in the facility?	*74 (50.0)*	*50 (33.8)*	*11 (7.4)*	*13 (8.8)*
	In your experience at this facility, have you seen these happen?	*46 (31.1)*	*74 (50.0)*	*19 (12.8)*	*9 (6.0)*
	In your experience at this facility, have you ever verbally abused women?	*95 (64.2)*	*46 (31.1)*	*4 (2.7)*	*3 (2.0)*
Physical abuse	*Are women treated roughly like pushed, beaten, slapped, pinched, physically restrained, gagged, tied to bed when they are getting care in the health facility's team you serve?*	*109 (73.6)*	*33 (22.3*	*2 (1.3)*	*4 (2.7)*
	Are women denied pain relief for any reason?	*89 60.1)*	*38 (25.7)*	*14 (9.5)*	*7 (4.7)*
	Do HCP in your facility practice fundal pressure during second stage of labour?	*71 (48.0)*	*64 (43.2)*	*9 (6.1)*	*4 (2.7)*
	In your experience at this facility, have you seen these happen?	*61 (41.2)*	*72 (48.6)*	*13 (8.8)*	*2 (1.3)*
	In your experience at this facility, have you ever done these physical abuses?	*93 (62.8)*	*48 (32.4)*	*6 (4.0)*	*1 (0.7)*
Stigma and Discrimination	*Will you say women are treated differently because of their personal attributes, like their age, marital status, number of children, education, wealth, ethnicity, their connections with the facility or things like that?*	*78 (52.7)*	*45 (30.4)*	*20 (13.5)*	*5 (3.4)*
	In your experience at this facility, have you seen when women are treated differently because of any their attributes listed above in your facility by other HCPs?	*53 (35.8)*	*68 (45.9)*	*15 (10.1)*	*12 (8.1)*
	Do you think you treat women differently based on some attributes like their education, wealth, ethnicity, age, marital status, their connections with the facility or things like that without being aware of it?	*91 (61.5)*	*44 (29.7)*	*8 (5.4)*	*5 (3.4)*
Violations of privacy, consented care and confidentiality	*During examinations in the health facility team you work, women are not covered up with a cloth or blanket or screened with a curtain so that they do not feel exposed?*	*80 (54.0)*	*40 (27.0)*	*12 (8.1)*	*16 (10.8)*
	HCPs do not ask women's permission before performing any examination? (eg. Abdominal or vaginal exam)	*59 (39.9)*	*40 (27.0)*	*21 (14.2)*	*28 (18.9)*
	HCPs do not explain to women why a procedure is done (eg. Abdominal or vaginal examination)?	*61 (41.2)*	*58 (39.2)*	*13 (8.8)*	*16 (10.8)*
	Do HCPs speak to women as load as other people not involved in their care can hear what they are discussing?	*78 (52.7)*	*50 (33.8)*	*15 (10.0)*	*5 (3.4)*
	Do you feel like women's health information is not kept confidential at this facility by other HCPs?	*65 (43.9)*	*59 (39.9)*	*20 (13.5)*	*4 (2.7)*
	In your experience at this facility, have you ever felt that you did not keep privacy and confidentiality of the client?	*82 (55.4)*	*44 (29.7)*	*9 (6.1)*	*13 (8.8)*
Neglect and abandonment	*Do HCPs ignore women, refuse their request of help, or fail to respond to requests of help in a reasonable amount of time?*	*80 (54.0)*	*58 (39.2)*	*9 (6.1)*	*1 (0.7)*
	Do HCPs discourage a mother's companion to remain with her, whenever possible?	*85 (57.4)*	*45 (30.4)*	*13 (8.8)*	*5 (3.4)*
	In your experience at this facility, have you seen when women have been left alone or unattended by other HCPs?	*78 (52.7)*	*57 (38.5)*	*12 (8.1)*	*1 (0.7)*
	Do you feel you personally ignored women and left them unattended?	*112 (75.7)*	*27 (18.2)*	*7 (4.7)*	*2 (1.3)*
Loss of autonomy (detention)	*Do women instructed not to walk or move around during labour, not to eat without any clinical significance?*	*103 (69.6)*	*35 (23.6)*	*7 (4.7)*	*3 (2.0)*
	Are women forced to stay at the health facility against their will because they cannot pay?	*130 (87.8)*	*13 (8.8)*	*5 (3.4)*	*0*
	In your experience at this facility, have you seen when women's autonomy is violated by other HCPs as mentioned above?	*111 (75.0)*	*32 (21.6)*	*3 (2.0)*	*2 (1.3)*
	In your experience at this facility, have you ever felt that you violated women's autonomy that mentioned above?	*113 (76.3)*	*30 (20.9)*	*2 (1.3)*	*2 (1.3)*

[a] The decimal place is rounded to the precise zero decimal place in the description.

factors that contribute to the reduction of mistreatment in women within health care settings.

In this study, HCPs reported witnessing a higher proportion of mistreatment from other providers towards women than that they have self-reported. A significant majority of providers (93.2%) reported that they had observed other providers mistreating women, including verbal or physical abuse, privacy or confidentiality breaches, discrimination, neglect, and autonomy violations. However, fewer HCPs admitted to mistreating women themselves (75.7%), possibly attributed to a social desirability bias arising from a motivation to maintain a positive self-concept or to avoid potential embarrassment and repercussions linked to revealing their own involvement in disrespectful care [31]. Nonetheless, the extent of self-reported mistreatment toward women in this study was still higher compared to that reported in another study conducted in Ethiopia, despite differences in the tools and measurement methods used [16]. Self-reported physical abuse toward women (35.8%) was relatively lower than that reported in Kenya by Afulani et al. [32] (45%) and comparable to self-reported verbal abuse in the same study and a study from Ghana [33]. Acknowledging the presence of such self-reported mistreatment towards women and recognising its detrimental impact imply that there is an opportunity to enhance the behaviours of service providers for the better.

A positive working environment is crucial for achieving organisational goals by enhancing employee commitment and their drive to achieve [34]. In this study, HCPs with positive perceptions towards their working environment conditions, including workload, adequacy of

provider numbers, trust, teamwork, and supportive relationships with leaders, among other indicators of perception, were found to be associated with a two-thirds (65%) reduction in the likelihood of mistreatment occurrence compared to those with negative perceptions. Such an influence of a positive working environment was also highlighted in a previous qualitative study that focused on complex adaptive maternity care [12]. The absence of a positive working environment was found to contribute to disrespectful care, impacting HCPs' motivation to implement respectful care. Similarly, instances where HCPs feel overlooked, lack support from the system, and work in a poor organisational climate marked by blame-shifting and the normalisation of mistreatment are identified as challenges to achieving respectful working environments [35]. It is valuable to recognise the significance of establishing a positive working environment to foster health facilities where a culture of respect and quality is ingrained.

Similar to a positive working environment, the empathy level of HCPs was also found to be correlated with mistreatment toward women. This study demonstrated that even a unit increase in HCPs' empathy leads to a five per cent decrease in the likelihood of mistreatment. Despite the challenge of nurturing empathy in a fragile workplace, it remains well established that higher empathy among HCPs enhances efficiency and is linked to more respectful care [36]. The origins of low empathy, whether inherent before joining the profession or as a result of a demanding environment, are uncertain. However, solutions such as early-career empathy training [37] or in-service programmes [38] were reported to elevate empathy levels. Notably, countries such as Germany recommend selecting students based on empathy to embed this competency [39]. Overall, promoting enhanced empathy holds undeniable importance in the ongoing effort to reduce mistreatment of women during maternity care.

The disparity in empathy levels among HCPs based on gender has been documented in previous studies, with females exhibiting higher levels of empathy [40]. In the current study, we did not find an interaction effect between empathy levels and gender on the mistreatment of women. Nevertheless, there was a noticeable difference in self-reported mistreatment toward women between male and female midwives: the likelihood of mistreating women was found to be four times higher among male midwives than among female midwives. It is worth noting that there are relatively comparable numbers of male and female midwives in Ethiopia, unlike in other parts of the world.

Health care providers in low resource countries, including Ethiopia to the context of this study, face challenges originating from country's income status, administrative issues, and broader health system commitment [41]. On top of such resource related chronic issues, maternity service provision documented to be filled with dilemmas and stress-inducing environment related to individual, interpersonal and institutional factors [42]. In current study HCPs reported issues such as heavy workloads, reduced professional development opportunities, inadequate compensation, and dissatisfaction, leading providers to acquire negative perceptions and impacted empathy levels. This underscores the need for a comprehensive examination of factors affecting smooth working conditions. Thus, we recommend Ethiopian Ministry of Health and Oromia Regional Health Bureau to commit itself towards implementing planned in Health Sector Transformation Plan II [43] where job fairness, emotional well beings of providers and collaborative team sprit for common goals maintained through continuous monitoring

Table 5
Factors associated with self-reported mistreatment of women by HCPs in Western Ethiopia and binary logistic regression model (N 146).

Variables	COR [95% CI]	AOR [95% CI]	P values
Perceptions of working environment			
Negative	Reference	Reference	-
Positive	0.47 [0.21, 0.98]	0.35[0.14, 0.86]	0.023
Empathy score	0.96[0.93, 0.99]	0.95[0.91, 0.98]	0.008
Health facility type			
Hospital	Reference	Reference	-
Health centre	1.06 [0.49–2.28]	1.49[0.58, 3.86]	0.406
Age in years			
23–29	Reference	Reference	
30 and above	1.15 [0.53, 2.52]	1.83[0.74, 4.51]	0.188
Experience in years			
Five years and less	Reference	Reference	
Above five years	0.80 [0.37, 1.76]	0.65[0.25, 1.74]	0.398
Profession and gender*			
Female midwives	Reference	Reference	-
Male midwives	3.01[1.12, 8.14]	3.73[1.25, 11.20]	0.019
Female other profs	2.06[0.51, 8.31]	2.67[0.60, 11.98]	0.198
	1.60[0.60, 4.32]	2.26[0.73, 6.98]	0.158
Average number of childbirths attended per day	0.98 [0.82, 1.17	0.98 [0.80, 1.22]	0.919

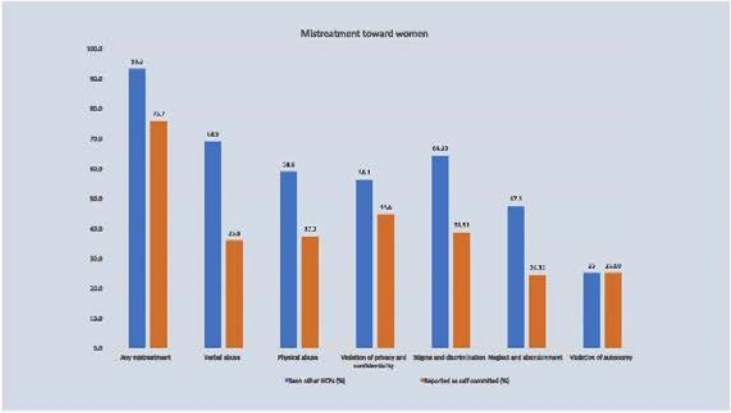

Fig. 1. Mistreatment toward women during maternity care: percentage of witnessed other HCPs mistreating women and self-committed at least few times (N 148).

and non-tolerance to negative instances counting to mistreatment. In addition to addressing resource-related constraints, it is essential not to overlook the importance of transforming HCPs' values and attitudes towards respectful maternity care through continuous professional development learning opportunities. Alternative measures like recruiting pre-motivated and empathic individuals toward training institution and also building empathy levels through in-service capacity building could be also practiced [44].

It is important to acknowledge the limitations in this study, where a high sample of participants could have enhanced the power of the study. Despite the efforts to increase the number of participants, some potential participants did not return completed surveys, and regional unrest hindered the inclusion of further HCPs from certain districts in the zone. Nevertheless, this study serves as driving evidence for the necessity of a detailed nationwide study on the impact of negative workplaces and reduced empathy in normalising mistreatment of women in health care facilities. The self-administered data collection method may have led to reporting bias due to social desirability, impacting completed survey rates. Still, the results are encouraging, with a significant number of providers acknowledging the presence of mistreatment towards women both from their personal perspective and based on what they have observed among their colleagues.

Conclusions

A substantial proportion of HCPs, comprising three-quarters of participants, acknowledged that they have engaged in mistreatment of women at least a few times in various ways during their practice. Recognising the importance of cultivating a positive working environment within health facilities, where a culture of respect and quality is deeply rooted, holds great value to reduce the occurrences of mistreatment of women in health facilities during maternity care. Efforts of enhancing positive workplace, the promotion of heightened empathy remains crucial in the ongoing endeavour to mitigate mistreatment of women during maternity care. Further investigation is warranted to delve deeper into the underlying drivers that contribute to the observed connections between gender, profession, and the probability of mistreatment towards women in the study area.

Ethics statement

We obtained ethical approval from the Institutional Review Committee of Wollega University, Ethiopia, on September 15, 2021 (Ref No. WU/RD/469/2021) and from the Human Research Ethics Committee at the University of Technology Sydney on December 16, 2021, with the reference number of UTS HREC ETH21-6587.

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CRediT authorship contribution statement

Conceptualization: [HK, KB]; Methodology: [HK, VS]; Software: [HK]; Validation: [VS, KB]; Formal analysis: [HK, AS, KB, VS]; Investigation: [HK, VS, KB, VS]; Writing – original draft: [HK]; Writing – review & editing: [VS, KB, AS]; Visualization: [HK, VS]; Supervision and Project administration: [KB, VS, AS].

Conflict of interest

We declare that we have no conflict of interests.

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Appendix 15: Paper 4: Qualitative Findings—Women's Perspectives

PLOS ONE

RESEARCH ARTICLE

Women's narratives of experiences, drivers and consequences of mistreatment during maternity care in western Ethiopia

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Abstract

Background

The mistreatment of women during maternity care hinders quality care globally and deter women from seeking health services. To implement necessary actions, it is essential to explore instances of mistreatment, their factors and negative outcomes. This study explores the narratives of mistreatment experienced by women, its drivers, as well as the consequences of mistreatment.

Methods

We conducted a descriptive qualitative study among women who had received maternity care at East Wollega Zone, Ethiopia. Data were obtained through in-depth interviews with purposively selected participants in Afan Oromo, each lasting, on average, 30 to 60 minutes. Interviews were conducted within three months of childbirth and discontinued upon reaching data saturation at seventeen interviews. All interviews were audio recorded, transcribed, translated into English, coded using NVivo 12 and analysed through thematic and framework analysis.

Result

Three main themes were identified in this study: experiences, drivers, and consequences of mistreatment of women during maternity care. The narratives of mistreatment fell into two sub-themes: interpersonal abuse and mistreatment in the process of care. Women described experiencing physical and verbal abuse, stigma, and discrimination, as well as neglect and abandonment, violations of privacy and confidentiality, and health facility failures related to resource limitations. These forms of mistreatment were perceived to arise from a complex interaction of factors at an individual, interpersonal, and facility level, as well as broader health system and societal norms, such as gender inequality. The identified consequences of mistreatment included fear of future childbirth, negative perceptions towards health facilities and healthcare providers, switching to home birth, and psychological stress.

Conclusions

This qualitative study presents women's first-hand experiences of mistreatment in health facilities, highlighting various forms stemming from interpersonal interactions and systemic deficiencies in care quality. These experiences lead to significant negative consequences and implications on service delivery. The findings underscore the importance of understanding the complex factors driving mistreatment, extending beyond individual healthcare providers' behaviours to macro-level health system issues and general violence against women in society. This emphasises the importance of applying a systems-thinking approach to address the abuse and suffering women experience during maternity care in health facilities.

Introduction

In recent decades, a significant shift has transpired in the discourse regarding the mistreatment of women and the quality of maternal health services instigated by pivotal research and international initiatives. Bowser and Hill's [1] global investigation, the establishment of the Respectful Maternity Care (RMC) Charter by the White Ribbon Alliance [2], and the World Health Organization's (WHO) condemnation of disrespect and abuse [3], all signal a marked focus on systemic drivers of mistreatment of women experienced in childbearing and integration of RMC in WHO guidelines for positive childbirth experiences [4]. Despite these activisms against the mistreatment of women during maternity care in health facilities, it remains a pervasive global issue for women [5].

Any childbearing woman can experience mistreatment when using health services [3], and has been reported to affect up to 44% of women in Sub-Saharan Africa [6], two out of every five women in Latin America [7], every five women in Europe [8], every six women in the United States of America [9], and every ten women in Australia [10]. The widespread mistreatment of women highlights the urgent need for targeted interventions at individual and systemic levels. Focusing exclusively on system-level improvements risks overlooking the essential role of personal accountability in ensuring respectful care [11]. Addressing and eliminating the mistreatment of women in maternity services requires a multifaceted approach involving systemic changes, policy interventions, and a cultural shift [12]. Indeed, this underscores the requirement for individual health services to examine the unique contextual factors influencing instances of mistreatment within their respective settings. This paper focuses on the issue of mistreatment of women during maternity care, with a specific emphasis on its occurrence and consequences in Ethiopia.

In Ethiopia, the prevalent mistreatment of women during maternity care, which ranges from 2.0% to 79.0% [13], undermines the national commitment to reducing maternal mortality [14] by impeding the quality of essential, safe and respectful maternity care and potentially deterring women from seeking health services [15, 16]. Prior research in this domain has primarily concentrated on gaining insight through quantifying women's subjective experiences [17]. To understand its nature, origins, and consequences comprehensively, it is crucial to consider how women describe their experiences throughout the entire continuum of maternity care rather than focusing solely on childbirth. Despite the essentiality and significance of women's perspectives, there needs to be an adequate exploration of the drivers of mistreatment beyond the level of the individual and the consequences of the mistreatment of women.

Given the nuanced and multifaceted nature of mistreatment, comprehensive research must now encompass all relevant stakeholders, including women, healthcare providers, senior management of healthcare facilities and the community at large [18]. To present this comprehensive perspective in a manner that centres women's experience without attributing blame to any specific group [19], we adopted the term 'mistreatment of women' as well as in other publications that explore different facets of the mistreatment of women [15, 20]. Employing a qualitative design, this paper presents the findings of women's expectations of healthcare facilities, experiences of mistreatment, the underlying drivers, and perceived consequences. These insights were analysed using thematic analysis and deductively by integrating the Socioecological Framework for violence against women [21] and WHO quality of care frameworks [22].

Methods

Study context, design and frameworks

This paper presents the qualitative segment of a broader research inquiry that investigated the mistreatment of childbearing women in Ethiopia. As part of a nested convergent mixed-method approach, a qualitative study was conducted in East Wollega Zone, Oromia Regional State, Western Ethiopia, from September 2022 to December 2022. This region in Ethiopia is characterised by diverse Agro-ecological zones and geographically challenging topography, impacting the availability and access to health infrastructure, particularly for rural people, where nearly 83% of the population is projected to live in rural areas in 2022 [23], with an estimated 1.80 million people in East Wollega Zone in 2022, representing 4.5% of the regional and 1.7% of the national population [23, 24].

Oromia region has shown subpar performance in maternal and child health, as evidenced by statistics indicating that only 71% of pregnant women receiving antenatal, 44% of births were attended by skilled attendants, which mainly comprised of midwives both at health centres and hospitals, and 56% of women giving birth without the assistance of midwives or other trained birth attendants. Although zonal-level data was not publicly available, regional data shows that the area has the third-highest total fertility rate in the country, with 5.4 births per woman and an average household size of 5.2 people. In 2022, an estimated 3.9 million live births occur in the country, with approximately 54,000 occurring in the East Wollega Zone [25, 26]. Of these, around 23,760 births took place in health facilities, with an annual average of 3,264 at Nekemte Specialized Hospital and 3,072 at Wollega University Referral Hospital, while the rest occurred at three district hospitals and 68 health centres [27]. In our study, the majority of births (78.4%) occurred in a hospital, with 15.3% taking place in health centres and 1.7% in private clinics [15].

Mistreatment during childbirth is conceptualised in this study as it parallels the violence against women in the community, emphasising the seriousness of the issue, particularly within the context of a critical period in a woman's life—pregnancy and birth [11]. This framing positions mistreatment as actions or behaviours that inflict physical, emotional, or psychological harm and violations of the dignity and rights of women [3]. Woman-centred principles underpin the examination of the mistreatment of women and mandate that maternity care provision is both respectful and safe [4]. To explore how mistreatment arises from both abusive actions by healthcare providers and systemic failures in maternity care, we drew upon two conceptual frameworks: The Integrated Socioecological Framework for Violence Against Women and the WHO Quality of Care Framework [22]. Both tools were used to understand the complex interplay of individual, interpersonal, community, and societal factors of the mistreatment of women in health facilities, and the rationale for selecting these frameworks are discussed in further detail below.

Socioecological framework of violence against women

Mistreatment of women within the context of childbearing is challenging to investigate because of the numerous external factors beyond an individual woman's immediate context that indirectly influence an individual's experiences of pregnancy, birth and early mothering [18]. Investigating a complex phenomenon using a concept that involves an interplay of various levels allows for a comprehensive understanding of the multifaceted factors contributing to the phenomenon and recognises the interconnectedness and mutual influence among the different levels [28].

The Socioecological Framework of Violence Against Women conceptualises violence against women as an interplay of various levels of influence, these being personal history, microsystem/interpersonal, mesosystem (health facilities), exo-system/health system, and macrosystem/societal domains [21]. Fig 1 presents a pictorial representation of the framework. Adopting the Socioecological Framework enables a holistic perspective that recognises the multifaceted nature of mistreatment across health system, community, health facility, interpersonal, and individual levels. This framework facilitates the identification of drivers of mistreatment, contributing to the development of multifaceted interventions at various levels.

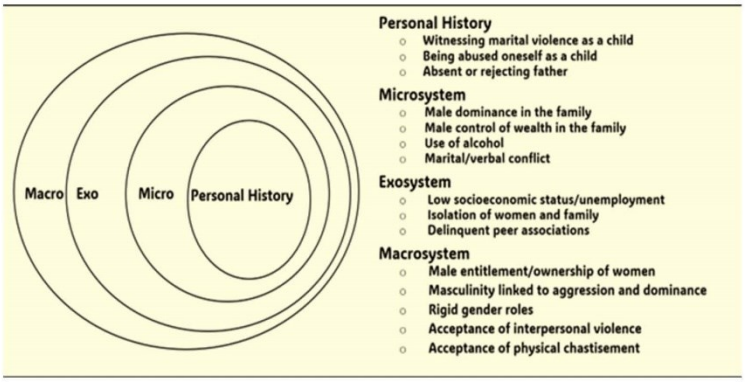

Fig 1. Socioecological framework for the violence against women.

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WHO's Quality of Care Framework

The WHO Quality of Care Framework conceptualises that the quality of healthcare for women and their babies emanates from structural and content conditions of the health system [22]. This framework (see Fig 2) allows for evaluating the quality of women's and newborn healthcare services by emphasising safe and evidence-based woman-centred practices. Its relevance to mistreatment lies in its direct linkage of a woman's care experience to the care provided, positioning mistreatment as a potential outcome of engaging with health services [22].

The Socioecological Framework provides a broader societal context for understanding violence, presenting how social structures, institutions, and interactions contribute to violent behaviour. In contrast, yet complementing the Socioecological Framework, the WHO Quality of Care Framework focuses more specifically on the organisational and structural aspects of healthcare, such as the process of care and desired health outcomes, ensuring a focus on

evidence-based practices, safety, woman-centred care, timely access, and equitable delivery. The framework we developed by integrating these two frameworks is visually presented in the results section (Fig 3), with the corresponding findings detailed in each part.

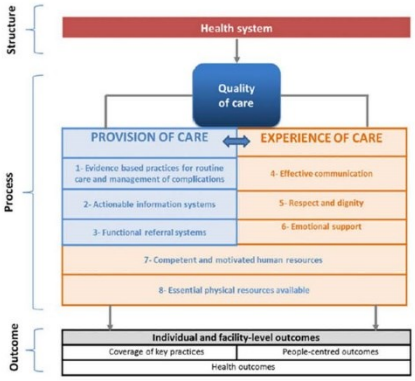

Fig 2. WHO Quality of Care Framework for maternal and newborn health.

https://doi.org/10.1371/journal.pone.0313217.g002

Recruitment and sampling

The qualitative data collection involved purposively selected participants from the quantitative phase of the larger study, conducted within three months of birth [15]. The participants had received at least one component of the continuum of care—antenatal, birth, or postnatal care. Healthcare providers were also interviewed; however, their results have been compiled in a separate report and are included in this manuscript. Participants included women from diverse backgrounds (rural and urban settings, younger and older, multiparous and primiparous) who were recruited and interviewed to provide a thorough understanding of the phenomenon. Telephone interviews were conducted at mutually agreeable times and were chosen due to the large geographical area and the ongoing civil conflict in Ethiopia. Data collection ceased after seventeen interviews when data saturation was reached, as no new insights emerged from adding further participants.

Data collection instruments

A semi-structured interview guide, aligned with the research aims, was formulated to elicit detailed insights from participants concerning the mistreatment of women, its drivers, and the consequences of mistreatment. The interview guide for both the women and healthcare professionals comprised four domains focusing on (1) expectations from healthcare facilities during maternity care; (2) experiences and perceptions of mistreatment from healthcare providers in recent maternity care; (3) perceived factors influencing mistreatment; and (4) potential impacts of mistreatment on service utilisation.

Data collection procedures

Interview participants were informed of the voluntary nature of their participation, provided with a participant information sheet, and requested to complete consent forms if they wished to participate. Assurances of confidentiality were given, emphasising their ability to terminate

the interview at any point without repercussions. Participants were also informed that the study's researchers were independent of healthcare facilities, and their participation would not impact their healthcare utilisation. HK conducted in-depth interviews with women; all interviews were conducted in the Afan Oromo language. HK speaks the same language as participants, is part of their ethnic group, and deeply understands the local service delivery system and the sociocultural context. HK was a PhD student at the time of data collection, trained in qualitative research under the supervision of experienced qualitative researchers (KB, VS and AS). Following data collection, the audio-recorded data were transcribed and translated into English to analyse and report the findings in collaboration with English-speaking authors (KB, VS, and AS). On average, each interview lasted between 30 and 60 minutes.

Analysis

This study was analysed thematically using the Braun and Clarke data analysis framework [29]. Thematic analysis is an inherently flexible method and helps identify key themes, richly describing large bodies of qualitative data and highlighting similarities and differences in experience [29, 30]. The themes were then guided by the frameworks mentioned above.

The interviews were transcribed verbatim into Afan Oromo and then translated into English for further analysis. The transcripts were read in their entirety whilst listening to the audio recordings to check for accuracy and begin comprehending and understanding this large data set. Line-by-line coding of the transcripts was conducted on sub-samples exported to the qualitative data management program NVivo (Version 12.) for coding. Descriptive coding, in-vivo and process coding of the participants' data were performed to the development of initial coding as recommended by Saldaña [31]. The inductive themes identified from the data and deductive analytic approaches from the interview guide were employed. Hence, the parts related to the mistreatment experiences employed descriptive analysis, while the Socioecological Framework for Violence Against Women [21] was used to explore the perceived drivers of mistreatment in health facilities.

Reflexivity

The primary researcher (HK) is a midwifery lecturer at the public university within the study area, with over a decade of midwifery experience. The supervisors are also academic supervisors in midwifery but are outsiders to the study context, having no prior exposure to the study area or its participants. The primary author conducted this research as part of his PhD studies in Midwifery. None of the participants had a prior relationship with the interviewer, the primary author. Participants were made aware of the purpose of the research and that their responses would be kept confidential before the interviews commenced.

The study took place during a period of civil unrest in the area, significantly impacting the conditions for research. The security situation posed serious challenges, making it difficult to move freely between districts and execute the study as initially planned, especially in engaging participants from rural areas. This contributed to the decision to perform the interviews over the phone for safety reasons, and this methodological adaptation raises awareness of potential limitations, such as the reduced capacity to capture non-verbal cues. This shift prompts reflection on the balance between accessibility and nuanced data collection in challenging contexts.

While conducting this study, even though the researcher perceives the presence of contributing health system and individual factors in the area as an insider, the primary author and the rest of the research team firmly believe there should be no justification for instances of mistreatment. It is not something we should tolerate; instead, it requires collaborative efforts from all local and international actors.

Ethics approval and consent to participants

All participants were provided with information regarding the study in their preferred language to enable understanding. Participants were given sufficient time to ask questions and reflect on the information provided. Written informed consent was received from each participant, and they were informed that they were free to discontinue or withdraw from the study without any negative consequences. Ethical approval was granted from the local Institutional Review Committee in Ethiopia, Wollega University, and the Human Research Ethics Committee at the University of Technology Sydney, with the approval number of UTS HREC REF NO. ETH21-6587.

This study was reported in accordance with the consolidated criteria for reporting qualitative research (COREQ) [32].

Results

Overview

Overall, seventeen interviews were conducted with women. The women's ages ranged from 20 to 33 years, including primiparous and multiparous women (2 to 4 births) and were from three districts (Nekemte, Diga and Wayyu Tuka) (Table 1).

Data analysis resulted in three broad themes: experiences of mistreatment, perceived drivers, and consequences of mistreatment in health facilities. Codes under experiences of mistreatment were organised into categories aligned with the WHO's typology of mistreatment [33], such as verbal and physical abuse, stigma, and discrimination–classified as interpersonal abuse within the Socioecological Framework [21]. Other categories, including privacy violations, poor rapport, neglect and abandonment, and system constraints were grouped under mistreatment in the care process, aligning with the broader Quality of Care Framework [22]. The drivers and the consequences of mistreatment were similarly developed, with drivers analysed across individual, interpersonal, health facility, health system, and societal levels. Overall findings are presented within an integrated conceptual framework combining the Socioecological and the WHO's Quality of Care Frameworks, as illustrated in Fig 3.

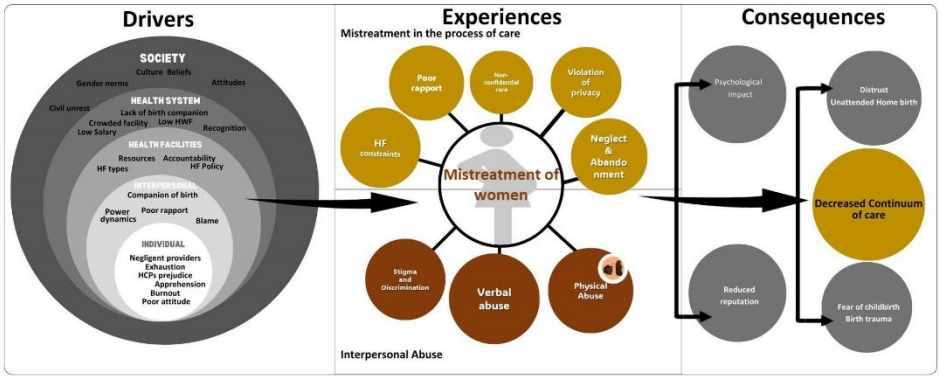

Fig 3. Framework illustrating the mistreatment of women during maternity care, synthesised by integrating components from the Socioecological and WHO Quality of Care Frameworks.

https://doi.org/10.1371/journal.pone.0313217.g003

Table 1. Demographic characteristics of the women who participated in the in-depth interview (n = 17).

	Categories	Frequency (%)
Age	18–24	4(23.5)
	25–29	7(41.2)
	30 and older	6(35.3)
Educational status	Primary	4(23.5)
	Secondary	6(35.3)
	College and higher	7(41.2)
Parity	Primiparous	8(47.1)
	Multiparous	9(52.9)

https://doi.org/10.1371/journal.pone.0313217.t001

Narratives of mistreatment experienced

To understand women's experiences in health facilities, women were asked about their initial expectations from health facilities and what they found during their maternity care. Participants disclosed that all they required from both health facilities and healthcare providers was to obtain quality services that consider their psychological well-being aligning with health facilities' mission—"*initial promises*", as they expressed. For instance, while describing the services that women or the community as a whole require from health institutions and professionals, the following interview participant said:

> "*. . .What I mean is, irrespective of a person's circumstances, it would be nice if they greeted people with a friendly demeanour. It would be ideal if health care providers understood what patients are going through and treated them with the same warmth and empathy, in support of their mental wellness.*" [IDI-WP-09]

The participants also emphasised the importance of receiving quality care, care that maintained professional, solid ethics. The experiences during antenatal care and private clinics were described as '*respectful*' and '*caring*.' While describing the behaviours of health care providers, a 20-year-old primiparous woman referred to antenatal care service providers as "*courteous*" and mentioned them as an example of polite, well-mannered providers:

> "*. . .Um, I think . . . if they assist people in a good way instead of treating people disrespectfully, the women who come there are like their mothers and sisters, and they should be treated with kindness. . . yea, like the place where we received antenatal care, they were very helpful. We are very grateful to them; they were very courteous.*" [IDI-WP-08]

One woman who switched from a public hospital to private care due to her past negative experiences described her experience at the private clinic as excellent. She expressed it as follows:

> "*I opted for private care for birth because of the bad history I had previously. In the private facility, they have taken excellent care of me, provided medication, and ensured a smooth birth. After giving birth, they continued to care for my baby.*" [IDI-WP-06]

Categories of mistreatment experienced by women. As participants shared their expectations and positive experiences with healthcare providers and facilities, the topic of mistreatment emerged spontaneously. Participants described the negative experiences they had

encountered, witnessed, or heard about, either secondary to interpersonal abuse or as a lack of quality of care during the care process, as presented accordingly in the following sections.

Interpersonal abuses. *Physical abuse.* Women participants raised concerns about physical abuse, describing instances where they had observed healthcare providers resorted to hitting women during childbirth due to perceived non-compliance. Participants also highlighted encountering painful procedures as a result of receiving pain-relieving analgesics or anaesthesia, as well as forceful shoving. While sharing her negative experience, a 20-year-old woman described the behaviour of a healthcare provider who assisted in her birth, stating, *"She hit my thighs"* and "*tossed me back and forth.".*

> *"When she assisted with my birth, she hit my thighs with her hands and tossed me back and forth on the bed. She had the practice students take turns watching me. She told me that my baby was distressed and cut my body [episiotomy]. But she got up and moved away from me; she didn't seem to be trying to save my distressed baby. . . . she stepped away from me and said, 'Finish screaming first!'."* [IDI-WP-08]

Furthermore, instances of forceful pushing, hitting, or pinching with forceps during the second stage of labour were reported, either from personal experience or witnessing another woman being hit. One participant stated, *"They hit you with scissors"* and *"pinch you,"* and mentioned that she had personally experienced being struck by a healthcare provider [IDI-WP-06].

Even when it might not be intended to cause harm, forceful pushing and aggressively placing a woman's legs apart have been reported in situations where a woman did not comply with the orders given by health care providers. When asked if she had experienced anger or any physical aggression from healthcare providers, one participant described the situation as follows:

> *"If you scream or try to lift your legs from where they have positioned them, they will forcefully push your legs back down. This was clearly obvious."* [IDI-WP-02]

Lack of provision of local anaesthetic during perineal incision for episiotomy, as well as the omission of other forms of pain-relieving agents during instrumental birth and uterine wiping, were reported to cause excruciating pain and discomfort for the women undergoing these procedures. Women who experienced such incidents suggested providers justified carrying out these painful procedures as a means to prevent the complications and fear of being responsible for poor outcomes, as witnessed in the underneath quote:

> *"The experience of restitching after the birth was very painful. . .She tried to clean me up, going in and out with her hands. This is what I still find troubling. The pain was intense when she reached into my sensitive womb."* [IDI-WP-03]

In addition to their personal experiences, some women also witnessed other women being physically abused. One woman described observing another woman being hit because she was tired and was unable to find the energy to push during childbirth:

> *"I witnessed them hitting another labouring woman at my side, but not me. . . . I saw her being beaten because she could not progress."* [IDI-WP-02]

Verbal abuse. Women detailed experiencing various forms of verbal abuse, including scolding, threatening, mockery, blame, disavowals, and other insulting remarks from health care

providers and other supportive staff in the facility. They described enduring such verbal abuses throughout their stay in the healthcare facility, beginning from their initial visit for antenatal care for some women and often during labour at the time of birth. For instance, one woman reported being scolded, "*You are not even showing*!" when she first visited the hospital and then mentioned having to leave the hospital in a disappointed mood.

Participants frequently also mentioned being yelled at in derogatory terms, which they described as making them feel unwelcome. One mother described the unsympathetic and insensitive behaviour of a healthcare provider during labour, stating:

> *"My labour pain gets severe, and my husband came and held me up. . . 'What! Why are you hanging on to her? Let her go. Is she the only one experiencing labour pain!' said one provider to my husband as he supported me while I was in labour pain. Because it was my first time, I did not know how to handle the pain. After that, they became four [providers], and they said, 'Her labour is not that severe; she does not require a bed,' as they stood beside me, adding, 'Is she superior to the rest? Why did the doctor assign her a bed?' "* [IDI-WP-01]

Another primiparous mother shared her experience of being scolded mockingly throughout her birthing process, including targeted personal comments related to her appearance. She also talked about how her childbirth experience lacked informative support. Instead of receiving gentle and professional guidance, the healthcare providers were aggressive, and their communication style felt like yelling, which only added to the woman's distress during labour, making the situation *"quite worrisome."*

> *"Right from the beginning, you approach the situation[labour] with a sense of anxiety. When the person working there shows anger, it becomes quite worrisome. Uhm. . .they express their scolds loudly, telling you not to shout and to push quietly. Throughout my birth, I heard her saying, "The baby is small, that's all she was struggling for."* [IDI-WP-02]

Health facilities, particularly hospitals, are sometimes overcrowded, and there may be insufficient resources to accommodate them. In these situations, women have reported experiencing being yelled at, feeling ignored, and receiving negative verbal responses when requesting post-natal beds. One woman recalled staying on the birthing couch throughout the night after giving birth and only being able to get up in the morning. When they asked for a bed, the healthcare providers responded saying:

> *'There are no beds; Should I give birth to it for you?'."* [IDI-WP-10]

Another form of verbal abuse reported by women includes being threatened and blamed for any negative outcomes that have occurred or were feared to be possible. These incidents were observed when women failed to cooperate with healthcare providers, indicating a lack of responsibility for any potential complications and depicting the provider's attitude as 'passing the buck'. For instance, one woman mentioned that she was told that if anything happened to her, they would not be liable. So, she needed to endure the pain and follow the provider's instructions:

> *". When I pleaded, 'Please, it is painful," she responded, 'Then sign a release so I won't be held responsible if you face any issues.'. . . I just watched. I wanted it to be over."* [IDI-WP-03]

Another woman also described such experience as follows:

"There are times when they say, 'Spread your legs,' and they purposely scold you even when you ask the right thing . . .and I take these all as serious problems." [IDI-WP-04]

A mother who had lost her previous baby a few hours after birth described the situation, recalling her experience. She recounted how healthcare providers blamed her for her baby's feeding issues and discharged her without properly assessing the newborn's condition. While describing the situation she faced during the loss of her previous baby, she recounted it as follows:

". . . when we informed them about the baby's difficulty in sucking, one of the healthcare providers there came and inserted her finger into the baby's mouth and said, 'The baby is healthy, but it is you who refused to breastfeed.' Afterwards, they asked us to leave. . . they discharged us even though we informed them that the baby was not breastfeeding. They said, 'Unless you have refused to give her, the baby is healthy and can latch.' She never had a proper latch and never breastfed." [IDI-WP-06]

Stigma and discrimination. Several women reported feeling discriminated against or receiving a lower level of attention compared to others. One woman reported perceiving discrimination when an attendant provided unequal care, favouring a non-labouring woman over those in distressing labour. She expressed frustration and concern over this unequal treatment, suggesting the reason for the preferential care might be related to personal connection or the role played by woman's notability. This differential treatment left the participant feeling disappointed and frustrated:

"I wanted to raise the issue of treating people unequally. . . I saw a nurse sitting next to a woman . . . cared well. I wished for such care. I know that person, maybe she is a famous person. While another mother was screaming in labour, the nurse was sitting and chatting with that woman without enquiring what was happening with the other woman screaming.." [IDI-WP-02]

In relation to overcrowding in the facility, women reported that healthcare providers controlled and restricted birth companions in the labour and birthing ward but that this rule was applied inconsistently. Partiality in enforcing rules, possibly due to familiarity between clients and staff or other factors, left some women feeling neglected, helpless, unsupported, and confused during childbirth. One woman felt isolated and believed she was treated differently when it came to having a birth companion and described that the health care provider did not consistently enforce the same rule for everyone; they allow birth companions for some while they send other birth companions away.

"While sending out my companion, she did not do this for all. . . She would go and help the other woman in labour, saying, 'Cheer up, be strong.' I don't know if they knew each other or not. She even called someone for her, her companions, to help her, and they would reach out to her, offering encouragement. She was very helpful for her, but for me.... puu, nope." [IDI-WP-08]

Mistreatment in the process of care. The mistreatment experienced by women in this category is not solely attributed to the individual behaviours of healthcare providers. Instead, these instances have emerged within the care process, stemming from compounded issues

involving healthcare providers and the facility—in the lack of quality care perspective. These issues include violations of privacy, non-consented care, lack of confidentiality, neglect, abandonment, and poor communication. Delays in receiving midwifery care, lack of attention and breaches of professional standards of care led to some women enduring life-threatening situations, as depicted below:

> *"They discharged me while I was still bleeding, before my condition had stabilised, and before I had changed my clothes. I gave birth at 8 o'clock, and I was discharged at 12 o'clock. They mentioned they would provide the necessary items like vaccination for the baby immediately after birth. However, later, as they saw me still lying there, they asked, "What are you doing here for so long?" So, I just left at that point."* [IDI-WP-05]

Violation of privacy, confidentiality, and preferences. Another set of issues related to the structural arrangements of the labour and birthing unit, as well as the attitude of the health care providers, pertained to the failure to meet professional standards of care. This included the violation of privacy, confidentiality and the inability of women to participate in the decisions being made about their care. One woman, despite describing the service she received as 'good,' highlighted the lack of privacy and consented care during examinations:

> *"At the time they examined me, there were no curtains or screens. The way they accommodate you is good, but there was no privacy. When they examine my cervix, they remain silent, and no one asks you for your consent or preferences."* [IDI-WP-04]

This lack of consent was not an isolated incident and was often accompanied by practices that violated the privacy of women during labour or childbirth. Associated with the uncomfortable setup of the health care facility, such as the absence of curtains or screens and private rooms, there were reports of multiple people being present in a single small labour attendance unit. When a woman was asked if healthcare providers obtained her consent or provided an explanation before performing an episiotomy, she described that it was not the case and mentioned hearing the sound of cutting her body without explanation:

> *"...when I was giving birth ... I recall being instructed to 'push ... push.' I believe I was able to push the baby out, but while I was following their directions, they made an incision in my body, I just heard the 'snip' sound while they cut my body without saying anything to me. ...They did not ask me anything of the sort. Around seven or eight apprenticeship students were standing around me, observing. She did not say anything to me–no explanation, no mention of doing stitches, and no pain relief medication."* [IDI-WP-03]

Besides the violation of privacy and confidentiality, women also reported unnecessary repeated examinations along with poor communication. One woman, while explaining that she had never experienced such mistreatment in her previous births, stated that several students repeatedly performed vaginal examinations on her without offering any explanations, all in front of the people present in the room.

> *"They repeatedly examined me without saying anything. Even many of the students who were practising there have also seen me right in front of the people, in front of everyone who came to visit other birthing women. There were many people present, and many women were lying; in front of everybody, they performed examination [vaginal examination]."* [IDI-WP-05]

Neglect and abandonment. Feeling neglected and abandoned was identified as additional forms of mistreatment described by women during their care, attributed either to individual healthcare providers' attitudes or facility conditions. Some women emphasised that certain providers would occasionally ignore them, potentially worsening the women's conditions, which they reported as *'feeling left alone'*, *'ignored'*, *'neglected'* and *'abandoned'*, not only when they were alone but also when healthcare providers were present, expressing a sense of inattentive observation or using the woman's unborn baby as a tool to gain compliance. One woman shared her experience:

> *". . . She turned to me and said, 'Your baby is dying, be strong.' But she moved away and started sitting. She told me that my fetus was distressed and cut my body [episiotomy]. But she got up and moved away from me, she did not seem to be trying to save my distressed baby."* [IDI-WP-08]

When the provider who initially admitted the mother left her alone, other providers often claimed that it was not their responsibility. This abandonment or lack of attention during labour led to women giving birth by themselves in the same place where they were labouring:

> *"I gave birth on the same bed I was lying on when I first arrived, and they did not even notice when I gave birth. I gave birth to my baby on my own pyjamas. . . It was not until the people in the room shouted, 'Please, she's giving birth here,' that the healthcare providers rushed in. When they arrived, I had already given birth right there. My child had water [amniotic fluid] in his nose. He even still struggles to breathe."* [IDI-WP-05]

The participants also reported instances where labouring mothers were intentionally abandoned, ignored, or neglected by the providers. One woman recounted an experience where she felt abandoned by a group of providers due to hierarchical issues among them. She mentioned that one provider prevented others from examining her during labour, insisting that she wanted to be examined only by a specialist doctor, contrary to her actual desire. She recalled it as:

> *"When another doctor came to examine me, one of them said, 'Leave her alone; there is no one other than the specialist doctor who checks her status.' She did this at least to two, and then they left me. . .while they came and assessed other labouring women repeatedly, they just ignored me."* [IDI-WP-01]

Exposed to unfair fees. Maternal and child health services in public facilities in Ethiopia are generally exempt from charges. However, some women have reported being unexpectedly subjected to outsourced fees. One woman complained that she was asked to purchase medications but did not receive them.

> *"Initially, they sent my husband to buy medication. After he made the purchase, they took it away and never returned it. We bought medication for 500 Ethiopian Birr and left without receiving it. They repeatedly asked him to bring medicine."* [IDI-WP-05]

Perceived drivers of mistreatment

As participating women discussed their experiences during service utilisation, they also shared their perceptions of the drivers of these mistreatments. These perceived drivers within this theme were categorised based on their nature, ranging from individual to system and

community-level drivers based on the Socioecological Framework and the WHO quality of care frameworks as presented in the following sections.

Ontogenic: Individual-level factors. Issues at the individual level that the women thought to be influential in the occurrence of mistreatment include *exhaustion*, *burnout*, *negligence*, *negative attitudes*, and *fear of poor outcomes*, among others. One participant, reflecting on her own experiences during childbirth, mentioned that a "*lack of empathy*" and "*attitude*" might have contributed to those behaviours rather than increased workloads. She also recognised that there were respectful providers among them when asked about the aspects contributing to these negative behaviours.

> *"I am not sure why they would behave like that. They might mention being busy, . . .umm. . .but you see only a few patients in the hospital when they themselves are being crowded. If it were really crowded, you would understand . . .I think it is a lack of empathy. . .Yes, their attitude is somewhat lacking. However, there are some who genuinely care for people and provide dedicated service. There are individuals who have strong desire among them."* [IDI-WP-05]

On top of the impacted empathy and lacking attitude, exhaustion leading to despair was also perceived as one of the underlying reasons for mistreatment by other women. Participants brought up the issue of exhaustion, which may affect the confidence and satisfaction that providers have in their service provision and their professional outlook when dealing with individuals of various personalities:

> *"I think it is because they work there every day, and it makes them exhausted. They, the workers, seem desperate. I do not think they find satisfaction in performing their skilled tasks. Uhm . . . it looks like they lose their way and end up there in despair due to the intense experiences they go through. I wonder if these experiences with women could affect them and lead to improper behaviours. Maybe these lead them to be careless."* [IDI-WP-03]

Negligence arising from carelessness was also mentioned as a reason behind the behaviour of some providers and leading to mistreatment. Such behaviours overall are described as a loss of responsibility and accountability.

> *"I would say the problem lies in the lack of accountability. It is not just the health care professionals but everyone working in the system who needs to take responsibility. I think they have forgotten their responsibilities. .... Even those who are passionate about their job and understand the excitement of a new life coming into the world seem to have forgotten this."* [IDI-WP-06]

Microsystem: Interpersonal. Interpersonal issues, whether between women and healthcare providers or among professionals themselves, were identified as contributing to negative experiences for women in healthcare facilities. One of these interpersonal issues contributing to mistreatment was poor communication during interactions. For instance, a woman who felt impatiently treated by a midwife [the women mostly call/see midwives as nurses] during a labour examination reported that misunderstandings between her attendants and healthcare providers resulted in her being ignored by the care team. She recounted the midwife's nervousness as:

> *"It was my mother who accompanied me to the labour ward initially; after we arrived there, I was sitting, and my mother was standing. Then they asked us. . .'what was your case?' my*

mother did not hear what they asked and replied, 'uhh, what did you say?' to the nurse who asked us because she didn't hear what the nurse asked as she was facing toward me, and then the nurse said 'what does it mean to say 'uhh', just leave the room and stay outside', while getting nervous [laughter. . .]." [IDI-WP-01]

Mesosystem: Health facility-related issues. Various issues related to health facility conditions, ranging from health facility types, lack of conducive environment, facility-specific policies, crowdedness, delay and resource-related issues, were perceived by participants to act as a conduit for the occurrence of mistreatment. Some women raised concerns related to health facility policy, including a lack of an adequate number of providers during holidays, poor regulation and control from the leaders, and lack of a redress system, which all result in mistreatment. When recounting the way providers hand over cases, one woman said she was left alone because the one who was caring for her left without reporting to others:

"I got tired of asking for help. Those who were supposed to assist me just disappeared, abandoning me, let alone helping me without my consent. Others would say, 'She's not mine; she belongs to Sister 'X', did she go off?' by calling her name. They did come after many requests for help. . . I believe they swapped shifts, maybe she left during that time." [IDI-WP-02]

A woman who believed that addressing women's complaints could enhance the health facility's shortcomings noticed a lack of initiatives aimed at assessing these weaknesses and striving for improvement. She observed a deficiency in feedback mechanisms from both health centres and the hospitals' leadership, which could have been used to address facility weaknesses in providing care.

"The organisation should address community complaints. I think that covers it. Unfortunately, in many places, there seems to be a lack of follow-up, and it appears that the leadership has forgotten its responsibilities. I haven't come across that. I've never seen any inquiries about whether we were receiving proper service or not, neither in the health centre nor in the hospital." [IDI-WP-06]

Lack of readiness of health centres in terms of resources was also cited to enhance occurrences of mistreatment by leading women to undermine services provided in health centres and leading them to opt for hospitals, resulting in the crowdedness of the hospital.

"There are some differences between the conditions at the health centre and the hospital. . .It is difficult to say there is follow-up at the health centre; the hospital is more equipped. It was only iron that you get from the health centre." [IDI-WP-04]

Exosystem: Health system. Several issues stemming from different levels of the health system influence the services offered to women by healthcare providers and facilities. These concerns are connected to the foundational aspects of quality care within the healthcare system, encompassing both organisational and physical elements that shape the care process. Overcrowding in health facilities, conflict arising because of hierarchy among providers, fear of blame, disabled functionality of the referral system, culture of blame, and lack of accountability among providers were highlighted to drive mistreatment.

Power dynamics among providers marked by poor coordination, a lack of teamwork and respect often leave women feeling isolated and abandoned. These issues reflect deep-rooted

problems in interdisciplinary collaboration, shaped by professional training norms and hierarchical positions, such as those between doctors and midwives:

"... the providers became four, and they said, 'Her labour is not that much, and it does not necessitate a bed.' As they stood beside me, they added, 'Is she superior to the rest? Why did the doctor assign her a bed?'" [IDI-WP-01]

The fear of being held responsible for any negative outcomes that women and newborn babies might experience is found to influence how healthcare providers behave. Some women reported being threatened by professionals, who warned they would not be held responsible if anything went wrong with them or their babies. This behaviour reflects broader systemic issues, where the focus is placed on avoiding adverse outcomes, potentially at the expense of the quality of care provided. This issue is highlighted in a quote from a woman who underwent a painful procedure:

"... *There's a saying from providers, "If something happens to the child, it's not on me."* [IDI-WP-04]

Macrosystem: Society level. This category presents how societal factors, such as gender norms, beliefs, and community attitudes, influence how health facilities and healthcare providers deliver services. Structural gender inequality in society leads to the tolerance of violence against women. Consequently, mistreatment of women becomes normalised within health facilities, stemming from the belief that 'health care providers have the right to chastise women' during childbirth to ensure compliance with the birthing process. These circumstances render women in a passive role, disempowered from speaking out against abusive behaviours during service reception. Such normalisation and disempowerment of women could be seen when one woman recounted an incident where another woman was bitten and expressed the futility of lodging complaints by stating, 'no one hears you':

"...may be the hospitals are different, but in another hospital, I saw two midwives beating a woman who was bleeding while a tube was in her body, I saw it with my own eyes... when I witnessed those two midwives beating that woman, I wanted to retaliate physically if I could ... if I were in that situation, I do not think I would stay quiet...What else can you do? No one hears you." [IDI-WP-05]

Insecurity within the community due to ongoing unrest was another contextual issue found to have a substantial impact on the services tailored for women. This included restricted access and the reluctance of service providers, ultimately disrupting the referral system linking lower-tier facilities with higher ones. Reflecting on the challenges amplifying the constraints of rural health centres and health posts, a woman highlighted the scarcity of ambulances and instances where health facilities remained inaccessible despite undertaking lengthy journeys to reach semi-urban district facilities.

"In our village? ... [yes ...], the problem is the one I mentioned to you now. If a pregnant woman goes into labour and if one calls for an ambulance, they'll tell you, 'The ambulance was burned.' Even for the labouring woman herself, if they find a private car, they pay and take her to the facilities." [IDI-WP-07]

Consequences of mistreatment of women

In response to inquiries about the repercussions of mistreatment within health facilities, participants expressed a spectrum of outcomes. These included psychological impacts, discontinuation of care, and a heightened fear of childbirth, all influencing their decisions regarding ongoing service utilisations.

". . .Some opt to deliver at home, saying, 'It is better to stay at home than going hospital and get incised and sutured.' Why do you go to the health facility? Isn't it for better care, both for yourself and the baby? . . . If there is no better care at facilities; those with money go for private birth, while those without may choose to give birth at home, and I know someone who refused to go and gave birth at home." [IDI-WP-06]

Another woman highlighted the impact of mistreatment on both the fear surrounding childbirth and the reputation of the health facility within the community, expressing her determination not to revisit the facility.

"We talk about it at home, 'maybe they were busy.' Even if they were busy, it shouldn't be like this. I have made up my mind not to go there again. It has completely turned me away from seeking their services, as to me." [IDI-WP-02]

Some mentioned that mistreatment prompted them to choose private clinics, affecting the reputation of public health facilities and affecting. For those women who could not afford a private clinic or hospital, their alternative option to birthing in a public hospital was to give birth at home alone. One mother vividly described how having experienced mistreatment at one health facility, she contemplated avoiding giving birth at a health facility, stating:

". . .on the first day, I went home because of the scolds. I mean, I made up my mind and decided home birth. My family objected and called for an ambulance. I think it might be the same for other people." [IDI-WP-09]

In addition to driving women away from public health facilities, it was also reported to be related to the unfortunate death of newborns. A woman who experienced mistreatment in her previous birth mentioned that the outcome of her baby could have been different if the providers had responded to their requests:

". . .I lost my child due to mishandling issues like this. If they had provided proper care during birth and had assisted us when we said the baby wasn't breastfeeding, the outcome might have been different." [IDI-WP-06]

Discussion

This study explored the narratives of women's experiences, perceived drivers and consequences of mistreatment of women during maternity care in line with the Socioecological and WHO Quality of Care Frameworks, following the initial development of themes from the women's in-depth interviews in East Wollega Zone, Western Ethiopia. The findings show the persistence of the mistreatment of women despite the attention given to eliminating it both globally and nationally [4, 14].

The narratives of mistreatment reported by women, whether from their own experiences or observations of other women, include interpersonal abuse and mistreatment during the care process. Among these forms of mistreatment, the first three—physical abuse, verbal abuse or stigma and discrimination can be considered as intentional interpersonal abuse occurring between women and healthcare professionals and should be viewed as a subset of the violence against women in the community [21]. The consideration that mistreatment of women during maternity care aligns with violence against women in society is supported by previous work by Jewkes et al. [11]. Physical abuse, as reported by women in this study, includes acts of hitting, slapping, forceful pushing, and denial of pain-relieving agents. These are intentional actions, even if the motives of healthcare providers may stem from preventing bad outcomes rather than inflicting harm [34]. Similarly, verbal abuse, which encompasses negative comments, insults, mockery, and derogatory words, was also reported along with stigma and discrimination, which often arise from providers' prejudices. These prejudices were perceived by women to originate from various factors such as favouritism toward individuals of higher social status (e.g., education and economic status), familiarity between the woman and healthcare providers, and partiality in implementing health facility policies (e.g., those related to birth companions). Such factors were identified as reasons predisposing women to discriminatory actions, consistent with previous studies [17, 35, 36]. These experiences of women have also been reported previously in earlier qualitative studies [36–40], highlighting the sustained suffering of women during pregnancy and birth from interpersonal abuse.

The remaining forms of mistreatment align with health system failures and issues encountered during the processes of caregiving, which are closely related to the failure of overall quality of care [22]. Women reported being ignored or abandoned when requesting help, even when expressing concerns about complications. Some of these forms of mistreatment stemmed from deliberate malevolence, such as the collective abandonment of women by groups of professionals after labelling them as non-cooperative or non-respectful behaviour towards an individual midwife. Likewise, examining a woman in front of others without visual and auditory privacy, including confidentiality violation and failing to obtain informed consent before procedures, were also reported. Structural issues, such as the absence of curtains and the use of shared rooms, may have contributed to such mistreatment in the care process, as also mentioned in previous studies [33, 41]. In most Ethiopian health facilities, it is common for many students from various disciplines to attend to a single birthing mother in non-emergency situations, exacerbating overcrowding and repeatedly violating women's rights to dignified care and autonomy. These practices reinforce a lack of respect for privacy and informed consent, which should be recognised as breaches of women's autonomy, impacted professionalism and a challenge to the quality of care.

While there should be no justifications for mistreatment, multiple underlying factors were perceived as contributing to its occurrence. These driving factors manifest from various levels, including personal history and characteristics, interpersonal issues, concerns within healthcare facilities, broader health system factors, and societal influences, mirroring the pattern seen in general violence against women in the community [21]. Personal history or the individual characteristics of healthcare providers, such as exhaustion, demotivation, and burnout, can lead to negligence and reduced empathy, directly ending with mistreatment. Such behaviours from healthcare providers may stem from high workloads and limited staffing [38]. This implies that personal issues, when compounded with chronic health facility and system-related issues, worsen the mistreatment of women in health facilities. Women's perception of poor-quality care at health centres, accompanied by the lack of resources and limited staff, leads them to bypass these centres and opt for hospitals, resulting in overcrowding and increasing the risk of mistreatment or neglect in emergencies [28]. As expressed by study participants,

health centres often remain empty due to these perceptions, with women fearing inadequate care and the unavailability of essential resources. Consequently, women prefer hospitals, exacerbating overcrowding and contributing to mistreatment.

In addition to personal and health facility-level factors, mistreatment can result from the interaction of drivers at macro-level factors—originating from societal norms and health system cultures [11]. In Ethiopia, a significant proportion of women experience various forms of violence, including early unconsented marriage, multiple forms of domestic and intimate partner violence, and poor societal perception of women's education and work rights [26]. These societal factors influence the healthcare providers' perceptions of women, compounded by health system issues such as inadequate recognition and unfair treatment from the leaders towards providers. When healthcare providers themselves feel disrespected by health system administrators and facility leaders, power dynamics strain relationships [42, 43]. This can lead providers at lower levels to exert control over women through mistreatment actions, including verbal or physical abuse, as also witnessed in a previous study [44].

During pregnancy and childbirth, women are vulnerable and often unable to defend and protect themselves from mistreatment. This mistreatment does not leave them unaffected; it can result in serious consequences for both the mother and the child [3]. In this study, women reported various forms of consequences of mistreatment, including fear of childbirth in health facilities and switching to giving birth at home while knowing the consequences of unattended birth at home in the hands of unskilled relatives traditionally, failures of the reputations they have for health facilities and healthcare providers, and even neonatal loss. The findings also suggest that mistreatment led to psychological distress, with women reporting the effects of interpersonal abuse as well as feelings of being ignored and abandoned. Such instances of mistreatment signify a lack of psychological support during labour and birth and have been linked to postpartum depression in previous studies [45, 46]. Neglect or abandonment during labour and birth can result in devastating outcomes, including stillbirth, neonatal death, and maternal death if unanticipated obstetric emergencies, such as fetal distress or severe bleeding encounter. These devastating consequences of mistreatment highlight the urgency of prioritising this issue and necessitate policy intervention to ensure respectful and dignified care for all, regardless of circumstances.

The interviews conducted with women have provided valuable insights from diverse perspectives. However, despite efforts to engage participants from various community groups within the Zone, our initial targets were not fully met due to civil unrest in certain areas during data collection. We endeavoured to include rural participants through mobile phone interviews to address this challenge. However, conducting interviews via telephone limited our ability to grasp the nuanced nonverbal cues that often enrich communication and understanding. The benefits of conducting face-to-face interviews would have included an observation of nonverbal cues throughout the interviews, which could have led to further discussion in understanding the depth of negative consequences of mistreatment of women.

Conclusions

This qualitative study presents women's first-hand experiences of mistreatment in health facilities, where three main themes were explored: the experiences of mistreatment, the drivers of mistreatment, and the consequences of mistreatment in East Wollega Zone, western Ethiopia among women who received maternity care from health facilities. These experiences lead to significant negative consequences and implications on service delivery. The findings highlight the need to understand the complex factors contributing to mistreatment, which go beyond individual healthcare providers' behaviours to macro–level health systems issues and an

acceptance of societal violence against women. This emphasises the importance of applying a systems-thinking approach to address the abuse and suffering women experience when receiving maternity care in health facilities.

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