Original article

Disrespect and abuse during pregnancy, labour and childbirth: A qualitative study from four primary healthcare centres of Amhara and Southern Nations Nationalities and People's Regional States, Ethiopia

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Abstract

Background: In Ethiopia, only 28% of all births occur at health facilities. Disrespect and abuse of women by health providers during pregnancy, labour and immediate postpartum is one of the main reasons that affect health care seeking from health facilities. This study explored disrespect and abuse of women using seven categories (Bowser D. and Hill K) including physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment care and detention at health facilities.

Methods: We conducted a qualitative research in four health centres of Amhara and Southern Nations Nationalities and Peoples' regional states between March and April 2014. Data were generated using in-depth interviews involving four midwives, 42 women (22 who delivered at the health facilities and another 20 who delivered at home) and eight focus group discussions involving 63 family members who accompanied labouring women to the health centres in the past three months before the study. The interview guides explored potentially abusive and disrespectful care and the perspectives of the participants towards such occurrences. Key themes were identified using phenomenological approach.

Results: This study found that most women faced disrespectful care while few were abused during labour, delivery and immediate postpartum. Women who faced disrespect and abusive care during antenatal care reported to have avoided giving birth at health facilities. However, most women and their accompanying family members were found to have normalized non-dignified care (disrespect) and abuse as indicated by a participant *"It is ok if a woman is mistreated, insulted, her consent is not asked or her privacy is violated as far as it is for the wellbeing of the delivering women and the newborn"*.

Conclusion: These findings showed that disrespect and abuse at health facilities have negatively affected women's care-seeking from health facilities for delivery. Normalization of disrespect and abuse by labouring women could be one reason for the continuation of the practice by providers. Facilitating community dialogue on respectful and compassionate care, improving client-professional relationships and ensuring functional grievance handling systems in health facilities should be given high priority to change the situation. [*Ethiop. J. Health Dev.* 2017; 31(3):129-137]

Key words: Disrespect and abuse, maternal health, pregnancy, labour, delivery, normalization, women and Ethiopia

Introduction

Despite efforts made to expand health services at a community level, there is limited decline in maternal mortality in the past 10 years in Ethiopia [1, 2]. Although current information shows promising estimates, the lifetime risk of maternal mortality is 1 in 52 which makes Ethiopia one of the ten countries contributing to 58% of global maternal deaths [3]. Proper reproductive healthcare during antenatal care (ANC), delivery and postnatal care, improves maternal survival as indicated elsewhere [4, 5]. However, use of healthcare service during ANC, delivery and postpartum remains limited in low-income countries because of unappealing attitude and mistreatment of labouring women by health workers among other things [6-8]. Disrespect and abuse can occur at any time during pregnancy, labour and delivery [9] and it was observed to have affected healthcare seeking during delivery [10]. A study from Tanzania indicated that about a third of all women faced disrespect and abuse during labour and delivery [11].

In Ethiopia, use of health service during pregnancy and delivery is very low, with only 28% of women delivering in a health facility [12]. Mistreatment by healthcare providers and discomfort at health facilities during labour and delivery were major factors contributing to limited use of health services [13-15].

However, community based studies exploring women's perceptions and experience of disrespect and abuse during pregnancy, childbirth and immediate postpartum are limited. Using the seven parameters from Bowser D, Hill K [8], this study presents the

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findings from a qualitative study that explored disrespect and abuse related to client-provider relationship during labour, delivery, post-delivery care and the reasons for disrespect and abuse in four primary healthcare units (PHCU) in Amhara Region and South Nations and Nationalities and People Regional State (SNNPR) Ethiopia.

Methods

***Study Setting and design*:** This study was conducted at project sites of the Last Ten Kilometres (L10K) Ethiopia Platform in Amhara and SNNP. L10K, is a project providing technical support to the Ministry of Health (MoH) of Ethiopia, with the aim of strengthening the links between households and health services through the Ethiopian Health Extension Program (HEP) [16] in 115 districts where 65 were in SNNP and Amhara [17].

Health centres are level one in the three-tier health system of Ethiopia catering for 15,000-25,000 population where their five satellite health posts serve 3,000-5,000 population each. These are connected to each other by a referral system [18]. At the health posts, the maternal health services provided include antenatal care (ANC) and postnatal care (PNC). The national ANC coverage (at least one ANC) was 62% where the same coverage for Amhara and SNNP regions were 67.1% and 69.3% respectively. Employing a qualitative research, this study was conducted in four purposively selected districts including Dembecha and Deneba from Amhara Regional State; and Lante and Kebet from SNNPR. The districts were selected based on ease of access. Focus group discussions and in-depth interviews were the main techniques of data generation.

***Study framework**:* The study used the seven categories developed by Bowser D. and Hill K. including physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care and detention in health facilities [8]. Using the seven categories as parent codes, child codes that express each category were entertained in the analysis. For example, physical abuse was used as a parent code while perceptions about physical abuse, slapping, pinching, pushing or shaking were treated as child codes. In the same way, the child codes for non-dignified care included insulting, blaming, mistreating and unwelcome reception. The child code for non-consented care was informed consent. The child codes for non-confidential care were visual privacy, audio privacy and non-consented information sharing. The child code for discrimination included differential treatment while child codes for abandonment of care included perceived abandoned care and being denied-of-care and services.

New ideas, which do not fall in the seven categories, were considered as emerging themes. These emerging themes included disempowerment and abrupt onset of labour as a source of home delivery, cultural norms and beliefs surrounding home delivery affect health facility delivery, perceived poor quality of clinical care as a barrier to healthcare seeking behaviors".

Study population and selection: *Four districts were selected purposively from 65 districts (30 from SNNP and 35 from Amhara) districts. One hundred ten community and health facility participants took part in this study. Community participants include 42 women (22 who delivered at health facilities and 20 who delivered at home) and sixty-three family members including mothers, sisters, children, grandmothers, friends, neighbours, and husbands (just in one FGD) who accompanied labouring women to health facilities. Four midwives (one from each district) and one maternal and child health (MCH) focal person from the Ministry of Health participated in in-depth interviews (IDIs).*

***Selection*:** To enhance recall**,** women who delivered at health facilities and at home in the past three months before the study were invited to participate in-depth interviews. Equal number of women (5 rural and 5 urban) were selected from each district to get rich information from each area.. Health extension workers (HEWs) invited women to participate in the study. In places where HEWs could not trace women, especially those who delivered at home, snowball sampling was used. Snowball sampling is a recruitment technique by which participants are asked to assist researchers in identifying other potential informants [19]. The head of the delivery ward or any midwife who was on duty the day of the visit to the health facility participated in the IDI. FGD participants were mainly women who were invited by HEWs.

Data collection: Data were collected from March to April 2014, by three researchers with public health background. Information from the community participants were collected first followed by IDIs with providers and program leads. In so doing, the information generated at a community level was used to guide the discussion with providers. Post-partum women were interviewed at a household level while FGDs with family members who had accompanied labouring women to health facilities were conducted in a quiet and convenient place (at the compound of a health center or other public facilities). A semi-structured discussion guide with 1-5 items was developed using the seven categories of disrespect and abuse. For example, five items were used to assess disrespectful care as follows: Were you insulted or yelled at by healthcare worker at any time during labour or after delivery? Were the health workers identify you by your given name? Were you accompanied by health workers to the labour ward? Were you assisted by a health worker to lie down on or get up from the examination or delivery couth? Physical abuse was assessed by using one item: Was there a time where the caretakers pinched/ slapped, hit, shacked or pushed you? Non-connected care was also assessed using one item: Were you informed of any procedure (Physical examination, injection, vacuum extraction, episiotomy, forceps delivery and so on) that was performed on to you beforehand by healthcare

workers? Confidentiality of care was assessed using three items: Were you examined and assisted to deliver in a private place where nobody can see the procedure? Were you examined and assisted to deliver in a private place where nobody can hear your conversation with the caretakers? Was any of your private information shared to other caretakers or people without your consent? Discrimination was assessed using one item: Did you receive differential treatment than women who were more educated, wealthier and older than you or from any more popular ethnic group? Abandonment of care was assessed using two items: Were you denied of any care that you deserved at any time during your labour and delivery? Can you narrate what had happened to you or your family members' from admission to discharge during delivery? Detention in health facilities was assessed using one item: Were you detained in the health facility for any reason without your will such as not settling healthcare associated bills and so on? All IDIs and FGDs were tape recorded after obtaining informed consent from the study participants.

***Data analysis*:** Recorded data were transcribed and translated into English and checked by the principal investigator for consistency. Data were then imported from word into NVIVO 10 software [20] and coded by the PI. Predetermined themes that were used to assess disrespect and abuse and emerging themes were entertained. The themes were discussed among the researchers. We followed a phenomenological approach in interpretation of the data where the analysis focused on the lived experiences of women and their families on the phenomenon under study [21, 22].

Ethical issues: The study proposal was ethically cleared by the respective regional health bureaus and informed written consent was obtained from the study participants. Confidentiality of information was maintained by removing individual identifiers. By way of following local traditions of presenting gifts when visiting postpartum women, two bar soaps were given to each postpartum woman after each interview for courtesy purposes.

Results

The findings of this study are presented using the seven categories and two emergent themes (disempowerment of women and quality of care) with the socio-demographic profiles of participants.

Socio-demographic profile of the participants: The mean age of women who delivered in the three months preceding the study was 28 years. About half of them 20(48%) were illiterate, 21 (50%) were not gainfully employed and 16 (39%) had given birth to one or two children in their lifetime. Among those who delivered at home (n=20), the majority (n=17) have never been to a health facility for delivery.

Perceptions about non-dignified care*: Participants perceptions of non-dignified care especially insulting and yelling at women during labour, delivery or immediate postpartum was found to be unacceptable by participants from Lante and Deneba while most women from Dembecha and Silte, reported that it is acceptable as far as it is for the survival and wellbeing of the mother and the newborn.*

"... As far as it is for my own benefit, it is ok ..." (IDI participant)

They also expressed the view that it is acceptable if a delivering woman is not respected when she does not follow health worker's instructions.

"... Healthcare providers usually insult a labouring woman when she does not follow their instructions, and that is ok ..." (IDI participant)

Non-dignified care: Despite differences in their perception of acceptability of non-dignified care, non-dignified care was found to be common practice by providers in all health facilities in the study areas. Some women reported that they were mistreated for not meeting the expectations and instructions of midwives:

"I was in severe pain and I got out of bed. She (the nurse) yelled at me and told me to go back to bed, but I replied that I needed help to go back to bed, ... she asked me if there is someone with me, I told her they are awaiting outside, then she called my family and they put me back to bed." (IDI with a woman delivered at health facility)

Accompanying family members also shared their own experiences about non-dignified care they have faced (as women living in the same woreda and using the same health facility). A woman indicated that non-compliance with health worker's instructions and expectation as a source of disrespect:

" …when I went there for delivery, she (the midwife) asked me if I had brought a plastic sheet to cover the delivery couch, I replied no, then she yelled at me and told me I will not be admitted to the labour ward until I brought one.. (FGD participant)

Some family members also indicated that they were mistreated while accompanying a woman in labour.

"I accompanied my neighbour to a health centre where she had antenatal follow-up ... When we reached to the facility, the on-duty midwife told us to go inside and get her a bed in an impolite way. When I asked which bed should I put her on, she yelled at me ... (FGD participant)

Non-health workers such as janitors were also reported to have mistreated delivering women. A focus group participant shared her own experience of receiving a non-dignified care by a janitor who was cleaning the delivery room floor, which was soiled by blood as follows:

"... that was the third time I had a stillbirth in the same facility ... I had the incident every year for the past three years, (she broke into tears) ... the janitor was cleaning after I gave birth and she said, 'why'? Last year the same and this year too!!! Why should I clean? You have to do it yourself, you just make me busy for nothing ...." (FGD participant) All FGD participants also broke into tears...

A midwife who took part in this study who was also the health manager acknowledged that delivering women are mistreated by health workers and emphasised the importance of disciplinary measures to protect the rights of women.

"...it is about a year ago, a nurse who was assisting a midwife insulted a woman in labour and her accompanying family members. This was unacceptable and the health centre management took a disciplinary measure ..." (IDI with a midwife who was also head of labour ward)

Health workers indicated that they are forced to react impolitely when women put their own or their children's life in danger. A midwife who faced such dilemma managing a delivery expressed her feeling as follows.

"... She (a labouring woman) jumped out of the delivery couch while the baby's head was visible and started pushing while on the floor... Yes, I yelled at her, I was so angry, I told her that she is about to suffocate her baby, I know that a mother has all the right to choose any position to give birth, but the floor is not comfortable at all to manage deliveries but she refused to deliver on a delivery couch...." (IDI participant midwife

Only a few women reported to have been escorted to the labour ward and helped to lie down on the delivery couch by health professionals. In addition, only a few women who attended health facilities for delivery reported to have been identified by their given name and had received the respect they expected. Women who were somehow identified by a proxy identification "as mother or sister" appreciated the health workers.

"The doctor who assisted me during my labour was kind and respectful...he referred to the relatively older women as "mother" and he referred to the young women as "sister" and he was calling me sister". (IDI with a woman who delivered at a health facility)

Physical abuse: In Dembecha, Silte and Deneba, physical abuse such as pushing, pinching, hitting or slapping a woman was perceived acceptable as far as it is for the wellbeing of the mother and the newborn. In these districts, there was a debate among focus group discussants on this issue, where the older women and those who lived rurally, and those who had not received formal education normalized/ accepted physical abuse.

"...Yes, because they are doing this to save my life, I don't mind ... Yes it is for my benefit and it was not meant to hurt me" (FGD participant)

Despite the acceptability of physical abuse among women and their accompanying family members, participants who delivered at health facilities indicated that they did not face any physical abuse. However, focus group discussant indicated that she had witnessed a labouring woman being physically abused by a midwife about a year ago. This was seen as positive act by most FGD participants including the one reporting the incident. They expressed their appreciation of the midwife for saving the life of the newborn as follows:

"... the labouring woman was shy as there were male nursing students in the labour ward and she clenched her legs while the baby's head was visible. The midwife instructed her to get her legs apart, but the labouring woman asked the nurse to send the students out. The nurse was upset and told the students to stand affront and follow the delivery process. At that point, the labouring woman became more shy and stiff; the midwife then slapped her face several times and hit her on the thighs until she opened her legs. Then the labouring woman opened her legs and the baby was delivered... After the baby was born, the nurse said, showing the baby to the labouring woman, 'you nearly killed this lion' (expressing the strength and size of the baby) (FGD participant).

Non-cconsented care at health facilities: Participants had mixed opinions about healthcare services provided without consent. Some reported that they needed to be asked for their consent before any procedure while others said that the health workers knew what was right for them. Actually, some participants who had delivered at health centres consistently reported that consent was not obtained before any procedures or examinations were carried out.

"... He used a metal instrument to take the baby out and told me to react when I have contractions, he did not ask my permission, or informed me of what he is doing." (Woman delivered at health centre).

However, a few other women who had delivered at health facilities reported that they were not completely in the dark about procedures. They reported that they were at least informed about some procedures such as checking on the foetal heart, foetal position or vaginal examination.

Health providers also indicated that most of the time, the condition of the delivering women did not allow them to follow such ethical procedures due to the urgent nature of labour.

"... Some mothers came to health facilities delayed; sometimes they deliver on the way to health centres. Whenever the head is visible I directly do my job, I do not have time to ask consent..." (IDI participant, Midwife)

Most health providers reported that they tried to obtain consent, especially when carrying out procedures. However, from their further explanations, it appears that what the health professionals referred to as consent was instead merely giving simple information or explanation of the procedures.

"... I will tell her what I am going to do and I take vital signs; following, I ask her to lie down on an examination bed so that I can see the foetal position, its heart beat and so on. If she has a contraction, I will proceed to vaginal examination, and when I am about to do a vaginal examination I will tell her about it". (IDI participant, Midwife).

Non-confidential care: Most participants from the four districts believed that women's privacy and confidentiality of information was very important. Having a family member around during labour was considered an added advantage. But some indicated that having non-family members around creates discomfort.

" ... I want my privacy; I do not want anybody to be in the labour ward with me while I am in labour. I have heard some women who got a chance to be with a labouring woman during her delivery talked about some private issues about the delivery process back in the village and make fun of her situation" (FGD participant.)

The presence of nursing students, who often present in large numbers, was seen as a violation of privacy by most participants. Some family member participants indicated that the midwives were not respecting the women's wishes and were letting apprentices attend the delivery. Lack of privacy was observed to deter health service use by some women, even those who had attended ANC.

" ... There were many students surrounding me, everyone was touching my abdomen. It gave me a lot of pain for the subsequent days after the examination ... I did not want to go there again even for delivery, I wanted to go to other health facilities but it was far and I did not have money ... I delivered at home" (IDI with woman who delivered at home)

Midwives indicated that they do not transfer delivering women's information to others without their consent except when there is a need to do so. However, they indicated that existing structural conditions are not good enough to maintain privacy.

"... The curtains are worn out, if we have two women delivering at the same time, we do not have any means of assuring privacy ... (IDI, Midwife)

Family members also reported that structural problems affect the privacy of delivering women in some health facilities.

" ... I was accompanying a family member, though the doctors told us to wait outside, we were able to hear and see every communication and the progress of labour peeping though an opening of the labour ward ..." (FGD participant)

Discrimination: Discrimination based on some patient attributes, such as socio-economic status or specific health conditions, was perceived to be unacceptable by participants from all districts. However, except informants from Lante, all other participants reported some sort of discrimination. Rural residents were reported to have been discriminated compared to urban dwellers.

"By the time I went there in labour, there was one woman who came from the urban area, she was there before me but I gave birth before her. They were taking care of her and treating her better than they did for me, ... they visited her more frequently, and they comfort her, and helped her back to bed after they examined her. The way they welcomed me and attended my delivery was not the same, they gave her more care "(FGD participant)

Discrimination based on economic status was mentioned by a few respondents while discrimination on the basis of friendship and family acquaintance was considered to be common.

Abandonment of care: Participants of this study indicated that abandonment of care is not acceptable. However, some indicated that it was difficult for them to know what proper care one deserved unless one has the knowledge about the standard care. To get a sense of the concurrence of abandonment of care respondents were asked to narrate their delivery history. In this narration, we captured that some women could not get sanitary pads, the necessary advice to be followed postpartum including child vaccination and necessary sanitation during and after delivery was not provided.

" ... When she was discharged, blood was gushing between her legs, she was not even provided with sanitary pad..." (FGD participant).

Most women who delivered at health facilities and their accompanying family members indicated that women or their families were requested to clean the delivery couch and dispose-off any bodily fluids or contaminated materials after delivery. Informants also reported that they did this without using any protective gloves. Though this is not clearly related to abandonment of care, women reported that they were asked to do what should have been done by a healthcare worker.

"...They told my family to throw the garbage including blood and blood stained cloths... my family collected it with their bare hands ..." (FGD participant)

Detention: Detention was reported to be uncommon and was perceived to be wrong by participants from almost all districts. A midwife from Amhara Regional State indicated that delivery care is provided free of charge, but as a procedure, the health centre should

record the service provided to women using the identification card of the husband (household head). If the husband did not bring his ID with him at time of discharge, the woman will be detained until he produces the ID or deposits some money before the woman is discharged. This was reported to have taken some hours and no woman had ever been detained overnight because of this reason. However, this was reported to have caused some discomfort among women when it happens.

Disempowerment and abrupt onset of labour as a source of home delivery: Most women who delivered at home indicated that they were interested to give birth at health facilities. However, they delivered at home because of lack of spousal support to reach to health facility, among other factors.

" ... the health center is a clean place, though I want to deliver there, I was forced to deliver at home because my husband refused to take me to health facility ..." (IDI with women who delivered at home)

" ... Though I wanted to go to health facility, I could not. My husband left me to his farm while I was in labour... I managed the delivery all alone ... my husband has five children from his previous wife and does not want any more children ..." (IDI with women who delivered at home)

Women who delivered at home despite their keen interest to deliver at a health facility reported that being a recent migrant to the area and lack of family support as barriers to health facility delivery.

I was new for this town, am not familiar with the community, my husband was working away from the town, ... I did all ANC at health center, but at the onset of labour I could not go to the health centre as I had no money. Transportation is expensive ... "(IDI with women who delivered at home)

Cultural norms and beliefs surrounding home delivery affect health facility delivery: Almost all women in Amhara reported that the most important aspect of home delivery relates to their religious belief. Most women believed that during labour, St. Mary comes to the labouring woman's home to assist the delivery. It is then customary to prepare a thick porridge, coffee, and some drinks to thank St. Mary for the help following the delivery. Failing to do so quickly is believed to hamper the help she provides for other women in labour. Upholding this cultural belief, health facilities allow women to have a coffee ceremony and porridge at the health centers post-delivery which is reported to enhance facility delivery.

"... Currently, we can make porridge and coffee at the health centre. This is very important, we can thank and send-out St. Mary while in the health centre as we do at home" (FGD participant).

Perceived poor quality of clinical care as a barrier to healthcare seeking behaviors: Most women who had accompanied family members or delivered at home questioned the proficiency of the health workers in almost all the districts. The main theme that emerged was that health workers did not have the proper knowledge and skills to handle deliveries. The following quotes indicate their concerns:

"... They admit women when they are not in labour and send them after few days. On the contrary they send back women who are already in labour and those women may deliver on the way back home or at home ..." (FGD participant).

Another focus group participant indicated the quality of care as follow:

" .... They pulled out the baby using an instrument. They misplaced the instrument and the baby's head had bulged as a plastic bag filled with water. We took the baby back to the health centre, they told us it will heal in a week time but it did not and the baby is about a month old now and he is not sucking well." (FGD participant)

Discussion

This study revealed that most women perceived disrespect and abuse acceptable as they believe it is for their own benefit. Supporting their perceptions, we found that non-dignified care/disrespect (verbal abuse and miss- treatment) was common in most health centres while physical abuse (hitting, slapping, pushing and pinching) was not. Discrimination based on social status, abandonment of care, and non-confidential care mainly lack of privacy were observed to have affected women who had delivered in most health facilities. In all health facilities, health providers did not secure informed verbal consent from the client before providing care; at most, they provided information as to what they were doing. Although detention was not common in all health centres, the practice was recognised. However, abandonment of care was not easy to assess, as women do not clearly know what appropriate care they deserved when they were in labour or immediately after they gave birth.

This study was not without limitations. Health extension workers and members of the women development army (WDA)/health development army (HDA) facilitated the selection of respondents, which could have introduced a social desirability bias. They may also have selected women who they perceived to be more positive about healthcare provided at health facilities. However, women did appear to be comfortable to express negative and positive views about delivery experiences, maximum variation sampling helped to explore the impact of D and A in service use and the interviews were conducted close in time to delivery. The role of husbands in health service use is vital, and the exclusion of this group from the study is another limitation.

***Physical abuse and Non-dignified care/disrespec*t**: Physical abuse was not common in the four areas, despite a single event reported in one of the FGDs. In this FGD, except two young women among eight participants, all considered the abuse perpetrated on a specific woman mentioned in the FGD to be appropriate behaviour motivated by good intentions. This suggests a hierarchical patient-health provider relationship where the health worker is perceived to know what is good for the patient and he/she is always right [23]. Though just one incident was reported, it was still an intrusion of a person's privacy and a crime, which had affected the dignity of a vulnerable woman who was under the guardianship of the health worker. The rural set-up of the districts, the low value given to women in the community [13] and the belief that whatever health workers are doing is for the benefit of the women could have precipitated to this brutal act by health workers. In Ethiopia, the health professional code of ethics and conduct for both midwives and physicians prohibits and criminalizes disrespect and abuse on labouring women [24, 25]. Other studies in East Africa also documented a high level of abuse [11] the universality of the problem and the normalization of abuse by both providers and women is documented elsewhere [10, 26].

Women and their accompanying family members were mistreated, insulted and yelled at them by health service providers. However, most took this mistreatment humbly, as it is for a better mother-child outcome. With this regard, one can conclude that disrespect is normalized and is an acceptable treatment package. In a country where most women are illiterate, unemployed [2], and less valued [27] women may not have a choice than accepting disrespect. Other studies in Africa also found that disrespect is common during labour, delivery and immediate postpartum[11, 14].

On the other hand, disrespect was interpreted among the participants as being insulted or yelled at. Women and their accompanying family members did not consider the abstract component of non-dignified care important. The findings from this study indicated that women who delivered at health facilities did not receive those services including being identified by their given names, receiving companionate support such as being escorted to the delivery room and helped to get up or lay back during delivery and immediate postpartum. Furthermore, women and their families did not expect such a courtesy from health workers and had normalized what they commonly faced. This might be again related to the very traditional patient-physician-relationship which gives health workers a higher position [23].

Non-consented care and confidentiality breach: The concept of consent to care was not clear either for health workers or for women who gave birth at health facilities in this study. Almost all women were aware of what was going on but consent was not inquired. On the same line, health workers also considered consent as mere information provision. Even when they used instruments to assist delivery, they never secured at least verbal consent from women before going ahead. This may be related to lack of accountability for delivery outcomes as the community associates maternal and neonatal deaths to natural selection and predetermined human destiny [13].

Confidentiality of information and privacy is considered to be very important in health service delivery as indicated in previous studies in the country [14]. However, most participants indicated that they faced some sort of lack of privacy. This was mainly due to structural items, which could be easily improved. The fact that family members are allowed to accompany delivering women is encouraging. Some studies also indicated that women do not want to be alone during labour and delivery [13, 14]. However, the delivering women themselves should cautiously choose family members that could accompany them as some women mentioned that non-family members had the opportunity to enter to the labour ward with the delivering woman and talked about the events during labour back in the villages, which has resulted in shaming the women after delivery.

Discrimination, abandonment of care and detention: Women in the four districts reported that discrimination based on certain socio-demographic and health conditions was unacceptable. However, some rurally women were not free from it. Other studies in Ethiopia also indicated that especially rural women were discriminated by health professionals [13, 27]. This may be related to the lack of transparent rules and regulations, which enable women to challenge the attitude of such health workers and ascertain their rights. This could be a major reason for low health service use by rural women in particular, as indicated elsewhere [28].

Abandonment of care was identified after a lot of probing and inquiring through detailed story telling. This is related to lack of awareness of women about what to expect from health workers during labour and delivery in general and the right to health specifically. In these facilities, family members of delivering women reported to have been instructed by health workers to take care of the biological waste (blood) disposal and cleaning the plastic sheet used by the delivering woman with their bare hands which is by no means their responsibility as far as the woman delivered in health facility. Handling biological waste in their bare hands could easily predispose family members to HIV [29]. The fact that health workers in these health facilities also reported that they request family members to dispose-off biological waste and clean the plastic sheet and delivery bed indicates not only the validity of the information but the seriousness of the situation.

Detention in health facilities was not common and only mentioned in one health centre in relation to presenting the household head's identification card for registration purposes. This was usually for a short time however; it may introduce fear and anxiety if delayed and violates

the freedom of women to leave the facility if they wish to do so.

Quality of care and home delivery: Though these findings were outside the scope of this study, we choose to present them as an emerging issue, which we believe it will contribute to service uptake. Almost all participants questioned the qualification/ ability of health workers in the health facilities. This was mostly related to admission (admitting a woman when she is not in labour), referral (delayed referral) and discharge (sending a woman in labour back home thinking it is a false labour while it is a true labour) of cases. This could be two sided: the first one could be information gap where health professionals are not describing clearly, why they have admitted and why they are referring or discharging. The second one could be lack of empathy and knowledge gap from part of the providers. Both sides needs close attention by policy makers and implementers as they affect human life.

Others also complained about the lack of proper delivery management and skill in applying instruments to assist delivery. Some women even indicated that they would not have come to these facilities if they had had any other choice. Therefore, a lot needs to be done in quality of care improvement. Studies in Ethiopia indicated that perceived poor quality of care affects health facility delivery [30-32].

Unlike other studies, home delivery in this study was found to be the least favoured choice of women. Almost every woman wanted to deliver at health facilities unless they faced some sort of problem beyond their control. This could be related to the community-based advocacy regarding the benefits of health facility delivery.

Conclusion:

Women in the study area faced disrespect and abuse during childbirth at health facilities. This was also observed to have affected healthcare seeking for delivery by some while others have normalized it thinking that health workers are doing whatever they are doing to save the lives of labouring women. Normalization of disrespect and abuse could be an indicative of the commonness of the problem and needs more work to improve client health worker communication during childbirth. Apart from disrespect and abuse, quality of care provided in health facilities including professional knowledge was a concern. However, on the other hand, some women who delivered at health facilities were appreciating the services they got from the facilities. Replicating the lessons learned from these appreciations could help to improve the services. The reasons for home delivery by those who delivered at home were reported to be beyond the control of the labouring women that could not be explained by this study and needs further investigation.

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References

1. Central Statistics Agency: Ethiopian Demographic and Health Survey 2005. Addis Ababa, Ethiopia, and Calverton, Maryland, USA Central Statistic Agency of Ethiopia; 2006.
2. Central Statistics Authority, Ethiopian Demographic and Health Survey 2011. Addis Ababa Ethiopia and Calverton Maryland USA; 2012:267-271.
3. WHO: Trends in maternal mortality: 1990 to 2013.Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Edited by Communication I. Geneva: World Health Organization; 2014:56.
4. Sibily L, Tesfaye S, Fekadu B, Hailemichaeal A, kebede A, Mohamed H and *et al.* Improving Maternal and Newborn Healthcare Delivery in Rural Amhara and Oromiya Regions of Ethiopia, through the Maternal and Newborn Health in Ethiopia Partnership. J Midwifery & Women's Health 2014:56(S6):S6-S20.
5. Zohra SL, Rehana AS, Jai KD, Zulfiqar AB: Essential interventions for maternal, newborn and child health: background and methodology. Reproductive Health 2014;11(Suppl 1).
6. Jennifer B, Robert EB, Cesar GV: Millennium Development Goals 4 and 5: progress and challenges. BMC Medicine 2013;11(255).
7. Botucatu: Humanizing childbirth care: brief theoretical framework. Interface 2008;13(supl. 1):595- 602.
8. Bowser D, Hill K: Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis. USAID-TRAction Project, Harvard School of Public Health and University Research Co., LLC; 2010.
9. WHO: The prevention and elimination of disrespect and abuse during facility-based child birth In *Human* Reproductive Program (hrp); research for impact Switzerland World Health Organization 2014.
10. d'Oliveira AF1, Diniz SG, Schraiber *LB*: Violence against women in health-care institutions: an emerging problem Lancet 2002;2002(359):1681-1685.
11. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP: Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. Health Policy and Planning 2014:1-8.
12. Central Statistical Agency: Demographic and Health Survey. Addis Ababa: Central Statistical Agency; 2016:10-17.
13. Molla M, Yirgu R, Gebremariam A, Sibley L: A Qualitative Study of Attitudes and Values

Surrounding Stillbirth and Neonatal Mortality Among Grandmothers, Mothers, and Unmarried Girls in Rural Amhara and Oromiya Regions, Ethiopia: Unheard Souls in the Backyard. J Midwifery Womens Health 2014;59(S110-S117).
14. Shiferew S, Spigt M, Godefrooij M, Melkamu T. Michael. Why do women prefer home birth in Ethiopia. BMC Pregnancy and Childbirth 2013.
15. Birmeta K, Dibaba Y, Woldeyohannes D: Determinants of maternal healthcare utilization in Holeta town, central Ethiopia. *B*MC Health Services Research 2013;13(256).
16. Federal Democratic Republic of Ethiopia Ministry of Health Ethiopia: Health Extension Program in Ethiopia, Edited by Health Extension and Education Center. Addis Ababa; 2007.
17. The Last Ten Kilometres: The last Ten Kilometres Project, Baseline Household Survey: Amhara, Oromiya, and Tigray Addis Ababa: The last 10 kilometres Ethiopia Project; 2009.
18. Federal Democratic Republic of Ethiopia MoH: Health Sector Development Programme IV 2010/11 – 2014/15. Addis Ababa: Federal Democratic of Ethiopia Ministry of Health 2010.
19. Parahoo K. Nursing Research: principles, process and issues. London: PALGRAVE MACMILLAN; 1997.
20. QSR Int: NVivo qualitative data analysis software version 10. In QSR software. 2012.
21. Palmer M, Larkin M and de Visser R. Developing an interpretative phenomenological approach to focus group data. Qualitative Research in Psychology 2010;7(2):99-121.
22. Bradbury JC, Sambrook S, Irvine F: The phenomenological focus group: An oxymoron? J Adv Nurse 2009;65(3):663-671.
23. Teutsch C: Patient -doctor communication. Med lin. North Am 2003;87(5):1115-1145.
24. Ethiopian Midwives Association: Professional Code of Ethics and Conduct for Midwives. In Midwives and their clients. Addis Ababa: Philmon Press; 2011:32.
25. Ethiopian Medical Association: Medical Ethics for Doctors in Ethiopia. Addis Ababa: Ethiopian Medical association 2010:9.
26. Freedman LP, Kruk M E: Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. The Lancet 2014;384(9948).
27. Berehane Y, Gossaye Y, Emmelin M, Hogberg U: Women's health in a rural setting in societal ransition in Ethiopia. Soc Sci Med 2001; 53(11):1525-1539.
28. Judd L: Abusive care turns women off hospitals. In Daily Trust. 2013.
29. EPHTI: Infectious Waste Management for the Ethiopian Health Center Team Addis Ababa; 2013.
30. Hailemichael F, Woldie M, Tafese: Predictors of institutional delivery in Sodo town, Southern Ethiopia. Afr J Prm Healthcare Fam Med 2013;5(1):544-549.
31. Gebrehiwot T, Sebastian SM, Edin K, Gicolea I: Health workers' perceptions of facilitators of and barriers to institutional delivery in Tigray, Northern Ethiopia. BMC Pregnancy and Childbirth 2014;14(137).
32. Sipsma H, Thompson J, Maurer L, Bradley E, Curry L: Preferences for home delivery in Ethiopia: provider perspectives. Glob Public Health 2013;8(9):1014-26 doi: 101080/174416922013835434 Epub 2013 Oct 24 2013;8(9):1014-1026.