**A Mixed Study to Assess the Dimension and Pattern of Disrespect and Abuse Among Women During Facility-Based Childbirth in Tamale Metropolis**

**ABSTRACT**

**Background:** Global initiatives to enhance maternal health care include plans to lower rates of maternal death, raise the proportion of competent birth attendants, and guarantee that all women have access to high-quality reproductive health services. Reducing avoidable rates of maternal and neonatal death and illness is essential to achieving the sustainable development objectives. Each woman is entitled to receive healthcare of high quality that is respectful, dignified, devoid of violence, and free from discrimination. They also have the right to be informed about procedures and any healthcare-related activities. Behaviors that involve disrespect and abuse toward women during childbirth at healthcare facilities are a public health issue, as they infringe upon women's dignity, integrity, and right to respectful care in maternity units. Healthcare providers often resort to physical violence, including actions like punching, slapping, pushing, beating, poking, and conducting forced examinations (such as abdominal and vaginal examinations without consent). As a result, women may hesitate to give birth in health facilities partly due to a fear of mistreatment by healthcare providers. The primary objective of the study is to ascertain the dimensions and patterns of disrespect and abuse experienced by women during facility-based childbirth in the Tamale Metropolis.

**Methods:** The study was conducted in Tamale Central Hospital, Tamale West Hospital, Tamale Teaching Hospital, and the SDA Hospital within the Tamale Metropolis. This hospital-based study employed a descriptive cross-sectional study design with a mixed methods approach. The study population comprised women who gave birth in the selected health facilities within northern Ghana. Participants were chosen using a systematic random sampling technique. Considering 15% of nonresponse (55), the sample size was 424. A validated survey was taken from earlier research to address the specified research objectives. The data were downloaded from the Google Form into Microsoft Excel, cleaned, coded, imported, and analysed by employing the Statistical Package for the Social Sciences (SPSS) version 24.

**Results:** Findings from the study indicated that a notable number (47.9%) of participants reported that healthcare providers did not demonstrate culturally appropriate behavior, and 70.9% noted that providers did not introduce themselves. Additionally, 58.3% reported a lack of privacy during childbirth. The type of disrespect and abuse respondents had suffered were verbal abuse, physical abuse, failure to obtain informed consent, lack of privacy and dignity, non-consented care, discrimination and stigmatization, withholding information, poor communication, restriction of movement and choices and denial of basic rights. Further analysis revealed that several factors contribute to disrespect and abuse during childbirth, including a lack of healthcare provider training in respectful maternity care, non-adherence of nurses and midwives to the patient's charter of Ghana Health Service, cultural norms that normalize disrespect and abuse during childbirth, and personal beliefs of pregnant mothers that also normalize such behavior. These findings underscore the importance of addressing these factors to enhance the quality of maternity care and foster a respectful and supportive environment for expectant mothers.

**Conclusion:** The study concluded that several factors contribute to disrespect and abuse during childbirth. These include a lack of healthcare provider training in respectful maternity care, non-adherence of nurses and midwives to the patient's charter of the Ghana Health Service, cultural norms that normalize disrespect and abuse during childbirth, and personal beliefs of pregnant mothers that also normalize such behaviour. These factors need to be addressed to improve the quality of maternity care and promote a respectful and supportive environment for expectant mothers.

**Key Words**: *Disrespect, Abuse, Maternal health, Child health, Ghana Health Service, Maternal Rights, Healthcare Provider Training*, *Cultural Competence*

**INTRODUCTION**

International efforts to enhance maternal healthcare aim to reduce maternal mortality rates, increase the proportion of births overseen by skilled professionals, and ensure universal access to top-notch reproductive health services (United Nations, 2015). Minimizing preventable instances of maternal and neonatal sickness and fatality stands as a cornerstone of the sustainable development goals (United Nations, 2015). Despite a substantial worldwide decline in maternal mortality (43%) from 1990 to 2015, 99% of maternal deaths continue to occur in developing countries (World Health Organization, 2015). Maternal health plays a crucial role in fetal programming, the process by which environmental exposures during pregnancy shape the long-term health and development of offspring. Maternal health conditions such as nutritional status, obesity, diabetes, hypertension, and mental health disorders can disrupt fetal programming and predispose offspring to a range of health problems, including metabolic disorders, cardiovascular disease, neurodevelopmental disorders, and psychiatric conditions (Thompson et al., 2024). Ghana has seen advancements in its maternal health indicators, with the maternal mortality ratio dropping from 634 in 1990 to 319 per 100,000 live births in 2015. Additionally, the rate of facility-based deliveries increased from around 42% in 1984 to approximately 73% in 2014 (World Health Organization, 2015). However, a significant portion of women, especially in northern Ghana, still lack access to healthcare facilities for childbirth services (Maya et al., 2018)

Facility-based childbirth plays a crucial role in ensuring safe and positive maternal health outcomes. However, evidence suggests that some women experience disrespect and abuse (D&A) during childbirth, which can lead to detrimental effects on their birthing experiences, emotional well-being, and overall perceptions of the healthcare system.

Behaviors that involve disrespect and abuse toward women during childbirth at healthcare facilities are a public health issue, as they infringe upon women's dignity, integrity, and right to respectful care in maternity units (World Health Organization, 2014). The mistreatment of women during childbirth at healthcare facilities has garnered international attention from advocates for maternal and child health, becoming a prominent agenda item (Sen et al., 2018). A WHO study, carried out in Ghana, Guinea, Myanmar and Nigeria showed that women were at the highest risk of experiencing physical and verbal abuse between 30 minutes before birth until 15 minutes after birth. Younger, less-educated women were most at risk, suggesting inequalities in how women are treated during childbirth. Addressing these inequalities and promoting respectful maternity care for all women is critical to improve health equity and quality (World Health Organization (WHO), 2020). The disrespect and abuse of women during childbirth at healthcare facilities constitute a violation of various rights, including women's rights to health, self-determination, privacy, bodily integrity, family life, freedom from discrimination, and spiritual freedom. Additionally, it also infringes upon the human rights of newborns and families (World Health Organization, 2015; Alliance, 2014). Each woman is entitled to receive healthcare of high quality that is respectful, dignified, devoid of violence, and free from discrimination. They also have the right to be informed about procedures and any healthcare-related activities (Sacks, 2017). Indeed, the disrespect, abuse, and neglect of women during childbirth at healthcare facilities represent serious violations of women's rights, a fact recognized across the globe (Honikman et al., 2015).

The literature highlights various forms of disrespect and abuse of women during childbirth at healthcare facilities, including non-consensual care, breaches of confidentiality, undignified treatment, physical abuse, discrimination based on specific attributes, abandonment or denial of care, and detention in health facilities due to inability to pay medical expenses (Gebremichael, 2018).

Crucially, disrespect and abuse during childbirth encompass a range of actions, including physical abuse (such as the use of force or physical restraint), sexual abuse, verbal abuse (involving harsh language, threats, and blame), stigma and discrimination (which can be based on sociodemographic characteristics or medical conditions), failure to adhere to professional standards of care (like lack of informed consent and confidentiality, inadequate physical examinations and procedures, neglect, and abandonment), strained relationships between women and healthcare providers (marked by ineffective communication, insufficient supportive care, and loss of autonomy), and limitations within health systems (like insufficient resources, absence of policies, and cultural issues within facilities) (Bohren et al., 2015).

Furthermore, healthcare providers may also resort to physical violence, including actions like punching, slapping, pushing, beating, poking, and conducting forced examinations (such as abdominal and vaginal examinations without consent). Excessive and inappropriate medical interventions, as well as procedures like episiotomy and stitching without anesthesia during childbirth, are also concerning practices that can occur (Vogel et al., 2015). Moreover, research conducted in India revealed that 9.1% of women reported experiencing disrespect and abuse themselves, while observers reported that 22.4% of women were subjected to mistreatment (Ansari & Yeravdekar, 2020). Likewise, a study carried out in India found that 71.3% of individuals experienced disrespect and abuse (Dey et al., 2017).

Women may hesitate to give birth in health facilities partly due to a fear of mistreatment by healthcare providers (Okafor et al., 2014). In 2015, a systematic review by Bohren and colleagues introduced an evidence-based categorization of mistreatment during childbirth, encompassing physical abuse (such as hitting, slapping, and pinching), verbal abuse, stigma and discrimination, and systemic issues within health facilities and systems that contribute to negative care experiences (Bohren et al., 2015). Mistreatment during childbirth not only violates the human rights and autonomy of women but also serves as a significant deterrent to seeking maternity care services at health facilities. A recent statement from the WHO on this critical public health and human rights issue emphasized the need for proactive action, dialogue, research, and advocacy to enhance maternal health worldwide (Khosla et al., 2016).

The mistreatment of women during facility-based childbirth in Ghana has been documented, although limited studies have been conducted on this issue (Rominski et al., 2016). Maya et al. (2018) presented women’s experiences of their interactions with birth attendants during facility-based childbirth in semi-urban suburbs of Accra. The findings indicated that women expressed significant concerns about the attitudes of healthcare providers and were reluctant to seek care at facilities where they felt they were not treated with kindness. Another study demonstrated that multiple forms of mistreatment are experienced by women during facility-based childbirth in Ghana. Most women reported experiencing verbal abuse in the form of shouting, yelling, insults and derogatory remarks, which had a negative impact on their self-confidence. Although mistreatment occurred throughout the birthing process in the health facilities, women reported that it was most common during the second (“pushing”) stage (Maya et al., 2018).

A study conducted among student midwives across Ghana corroborated the occurrence of mistreatment during childbirth (Rominski et al., 2016). Similarly, a study by Moyer et al. (2014) in rural northern Ghana, a study highlighted that mistreatment during facility-based childbirth was widespread and could act as a deterrent for women to seek care at health facilities in the future. These studies did not specifically evaluate the acceptability of mistreatment during childbirth or explore the perceived factors contributing to mistreatment. Previous research on disrespectful care during childbirth addressed various aspects of mistreatment in healthcare facilities without employing standardized definitions and methodologies. As a result, there are diverse descriptions and estimates of the true extent of the problem, along with varied proposals for addressing mistreatment during childbirth and advocating for respectful maternity care.

A growing body of research reports that inadequate, sometimes disrespectful, abusive or even violent care during pregnancy, childbirth or the postpartum period are specific risk factors for birth-related trauma. Many women remember childbirth as an adverse event, between 10 and 48% recall it as a traumatic event, and 1–6% go on to develop post-traumatic stress disorder with poor interactions with care providers identified as a key cause of women’s frustration and psychological distress (González-Mesa et al., 2023; Mirzania et al., 2024).

Therefore, this study seeks to determine the dimensions and pattern of disrespect and abuse of women during facility-based childbirth in the Tamale metropolis with a mixed method approach. The result from this study will contribute to advancing the understanding of the specific forms and contexts of disrespect and abuse experienced by women in this region. Ultimately, the study’s findings will guide the development of strategies to improve the quality of maternity care, enhance women’s birthing experiences, and promote respectful care practices in Tamale metropolis and beyond.

**METHODOLOGY:**

**Study design:** This hospital-based study employed a descriptive cross-sectional study design with a mixed methods approach. By employing a mixed-methods approach, this study enables both quantitative and qualitative data collection. The quantitative component quantifies the prevalence and frequency of different forms of D&A, while the qualitative component provides in-depth insights into women’s experiences, perceptions, and narratives related to D&A during childbirth. This mixed-methods approach will provide a comprehensive understanding of the issue, capturing both the breadth and depth of women’s experiences.

**Setting:** The study was conducted in Northern Regional Hospital, Tamale West Hospital and Tamale Teaching Hospital all in the Tamale Metropolis and the SDA Hospital. Tamale Metropolis is one of the 14 districts in the Northern region of Ghana. It is located almost in the central part of the region and shares boundaries with Sagnarigu District to the West and North, Mion District to the East, East Gonja District to the south and Central Gonja District to the South- West. The Metropolis has an estimated total land size of about 646.9 square kilometers (GSS-2010). There are 115 communities in the Metropolis. Geographically, the Metropolis lies between latitude 9⁰16 and 9⁰34 North and longitudes 0⁰36 and 0⁰57 West.

**Target Population:**

The study population comprised women who had given birth in the selected health facilities within northern Ghana.

Inclusion Criteria: The study included women who had given birth within a year any of the selected health facilities. Women of reproductive age (15 to 49 years). Women who consented to participate in the survey.

**Exclusion Criteria:** Women who had delivered in those facilities and developed complications and those who refused to provide informed consent were excluded.

**Sampling Technique and Size:** The four health facilities were purposefully selected due to their high patient volume and extensive utilization by the majority of the population in their respective catchment areas, catering to both specialist and general care needs. They were chosen to represent both urban and rural populations. Participants were recruited using a systematic random sampling technique, with the postnatal clinic register of each facility serving as the sampling frame. The sampling fraction was calculated using the formula (N/n), where n represents the sample size and N represents the sampling population, over a period of three months. During each postnatal clinic session at every facility, the first participant meeting the inclusion criteria was randomly selected through a simple random sampling method (by balloting) from the sampling frame. Subsequent participants were then chosen using a systematic random sampling technique. Considering 15% of nonresponse (55), the sample size was 424.

**Data Collection Instrument:** A validated survey was taken from earlier research (Bohren et al., 2015; Maya et al., 2018) to address the specified research objectives. The tool comprised three sections. The first section consisted of seven questions assessing the participants' sociodemographic characteristics. The second section, with ten questions, centered on the participants' obstetric history and experiences with maternity care. The third section included seven types of disrespect and abuse, along with 48 verification criteria to gauge experiences of disrespect and abuse. To guarantee the accuracy of the translations, the questionnaire was initially translated from English into Dagbani and then back into English by a language specialist. Before being used for the local version, the tool underwent a pretest on women in the area who were not included in the survey. Surveys were administered to participants at the medical facility. Data collection was facilitated using a computerized instrument deployed on tablets. The tool was programmed and uploaded onto tablets for the survey.

**Data Collection Procedure:** When the women were seated to receive health talk by the nurses before the postnatal clinic, the introduction of the study personnel took place. The aims and objectives of the study were explained to them. Shortly after, the description of why the questionnaire-based approach and how it works was explained to the women. The interviewers then administered the questionnaires to the participants after obtaining their written consent to participate.

**Data analysis:** The data were downloaded from the Google Form into Microsoft Excel, cleaned, coded, imported, and analysed by employing the computer software IBM Statistical Package for the Social Sciences (SPSS) version 24. Descriptive statistics were performed for continuous data, using the mean and standard deviation, and for categorical data, using percentage and frequency tables.

**Data management:** The following steps were taken to ensure the quality of data: The researcher acted as a coordinator to cross-check forms, supervise data collection, and oversee data entry. The questionnaires were transferred to Google Forms with invited links. Four (4) data collectors were trained to assist the researcher with the collection of data. Checking for completeness and accuracy of completed questionnaires was done at the end of each day of data collection. Gaps identified (such as missing gender, occupation, educational levels, age, and unanswered questions) were addressed with the respective research assistants.

**Ethical considerations:** Ethical approval was obtained from the Committee on Human Research, Publication, and Ethics from the University for Development Studies. Respondents were asked to sign a consent form before participating in the study. The purpose of the study, study procedures, potential risks and benefits of the study, as well as eligibility for the study, were explained to the participants, and they were given the opportunity to opt out at any time. All information collected was treated confidentially and used for research purposes only. Confidentiality was strictly adhered to. The study was mainly exploratory in nature and did not expose subjects to any form of risk.

**RESULTS**

**Table 1: Socio-demographic characteristics of respondents**

|  |  |  |
| --- | --- | --- |
| **Variable** | **Frequency (n)** | **Percentage (%)** |
| **Facility** |  |  |
| Tamale Teaching Hospital | 128 | 31.5 |
| Northern Regional Hospital | 98 | 24.1 |
| Tamale West Hospital | 84 | 20.7 |
| SDA Hospital | 96 | 23.6 |
| Total |  |  |
| **Age (years)** | Mean = 29.07, SD = 5.089 |  |
| <= | 18 | 4.4 |
| 21 – 30 | 221 | 54.4 |
| >=31 | 167 | 41.1 |
| Total | 406 | 100.0 |
| **Marital status** |  |  |
| Single | 86 | 21.2 |
| Married | 320 | 78.8 |
| Total | 406 | 100.0 |
| **Educational level** |  |  |
| None | 169 | 41.6 |
| Informal education | 75 | 18.5 |
| Primary | 90 | 22.2 |
| Junior High School | 26 | 6.4 |
| **Senior High School/Vocational** | 26 | 6.4 |
| Tertiary | 20 | 4.9 |
| Total | 406 | 100.0 |
| **Ethnicity** |  |  |
| Dagomba | 323 | 79.6 |
| Frafra | 22 | 5.4 |
| Mamprusi | 12 | 3.0 |
| Others\* | 49 | 12.1 |
| Total | 406 | 100.0 |
| **Partner’s education** |  |  |
| None | 124 | 30.5 |
| Informal | 112 | 27.6 |
| Primary | 45 | 11.1 |
| Junior High School | 65 | 16.0 |
| Senior High School | 42 | 10.3 |
| Tertiary | 18 | 4.4 |
| Total | 406 | 100.0 |
| **Partner’s occupation** |  |  |
| Farmer | 191 | 47.0 |
| Trader | 81 | 20.0 |
| Unemployed | 30 | 7.4 |
| Public servant | 57 | 14.0 |
| Artisan | 47 | 11.6 |
| Total | 406 | 100.0 |
| **Number of pregnancies** | Mean = 2.72, SD = 1.408 |  |
| 1 to 3 | 268 | 66.0 |
| 4 to 6 | 138 | 34.0 |
| Total | 406 | 100.0 |
| **Number of previous births** | Mean = 2.57, SD = 1.157 |  |
| 1 to 2 | 231 | 56.9 |
| 3 to 4 | 175 | 43.1 |
| Total | 406 | 100.0 |
| **Mode of birth for current or most recent pregnancy** |  |  |
| Normal vaginal delivery | 156 | 38.4 |
| Caesarean birth | 150 | 36.9 |
| Assisted vaginal delivery | 100 | 24.5 |
| Total | 406 | 100.0 |
| **Number of babies at most recent birth** |  |  |
| 1 | 318 | 78.3 |
| 2 | 88 | 21.7 |
| **Total** | 406 | 100.0 |
| **Sex of baby at most recent birth** |  |  |
| Female | 251 | 61.8 |
| Male | 155 | 38.2 |
| Total | 406 | 100.0 |
| **Registered with NHIS** |  |  |
| Yes | 379 | 93.3 |
| No | 27 | 6.7 |
| Total | 406 | 100.0 |

\*others: Akan, Ga, Ewe, Fante, and Komkomba.

**Prevalence of disrespect and abuse**

The result showed that 128(33.7%) of the respondents indicated that the provider used physical force, slapped or hit the woman. It was stated by 191(50.3%) of the respondents that the provider roughly forced legs apart, fundal pressure for normal delivery. It was stated by 90 (23.7%) of the respondents that the woman was physically restrained. Again, 63(16.6%) of the respondents that mentioned that the baby was separated without medical indication. It was indicated by 117(30.8%) of the respondents that women did not receive comfort, pain relief as necessary. It was stated by 182(47.9%) of the respondents that the provider did not demonstrate culturally appropriate ways.

Moreover, 288(70.9%) of the respondents indicated that the provider did not introduce herself/himself. It was mentioned by 287(70.7%) of the respondents that the provider did not encourage the woman to ask questions. Again, 263(64.8%) of the respondents stated that the provider did not respond politely, truthfully and promptly. It was stated by 262(64.5%) of the respondents that the provider did not explain the procedure and expectations. The result showed that 272(67.0%) of the respondents indicated that the provider did not give periodic updates on status and progress. It was stated by 279(68.7%) of the respondents that the provider did not allow the woman to move during labour. It was revealed by 240(59.1%) of the respondents that the provider did not allow the woman to assume the position of choice. It was indicated by 266(65.5%) of the respondents that the provider did not seek informed consent for procedures.

The result further showed that 235(58.3%) of the respondents reported that there was no privacy (spatial, visual or auditory). It was indicated by 147(36.5%) of the respondents that curtains and physical barriers were not used. It was stated by 121(29.8%) of the respondents that drape or body covering was not used. The result showed that 228(56.6%) of the respondents indicated that too many staff members around. It was stated by 72(17.9%) of the respondents that medical history disclosure to an unauthorized person without consent. It was indicated by 216(53.6%) of the respondents that there was humiliation by shouting, blaming or degrading. It was stated by 251(62.3%) of the respondents that the provider did not speak politely. Again, 192(47.6%) of the respondents showed that the provider made insults, threats, etc. It was stated by 160(39.7%) of the respondents that the provider used abusive language.

The result showed that 191(65.4%) of the respondents indicated that provider used language that was difficult to understand. Again, 244(56.1%) of the respondents said provider showed disrespect based on specific attributes like social class, ethnic group, age HIV status, marital status, educational level.

Furthermore, the study showed that 141(36.2%) of the respondents said that the facility closed despite being 24/7, or if open, no staff could provide care. Most (51.8%) of the respondents indicated that the provider did not encourage the woman to call if needed. The result showed that 184(47.2%) of the respondents said that the provider made women feel alone or unattended. Again, 124(31.8%) of the respondents indicated that the provider did not come quickly when needed. It was stated by 80(20.5%) of the respondents that women left unattended during the second stage of labour. Again, 83(21.3%) of the respondents showed that the provider failed to intervene when medically indicated. It was stated by 191(49.0%) of the respondents that the provider failed to grant the woman’s requests.

The result of the study showed that all the respondents indicated that provide did not release mother or baby or accompanying family member until bill is paid. Detailed information is provided in Table 2.

**Table 2: Prevalence of disrespect and abuse**

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Items (examples)** | **Frequency** | **Percentage** |
| Physical abuse | Provider used physical force, slapped or hit the woman | 128 | 33.7 |
| Provider roughly forced legs apart, fundal pressure for normal delivery | 191 | 50.3 |
| Woman was physically restrained | 90 | 23.7 |
| Baby was separated without medical indication | 63 | 16.6 |
| Women did not receive comfort, pain relief as necessary | 117 | 30.8 |
| Provider did not demonstrate culturally appropriate ways | 182 | 47.9 |
| Non-consented care | Provider did not introduce herself/himself | 288 | 70.9 |
| Provider did not encourage the woman to ask questions | 287 | 70.7 |
| Provider did not respond politely, truthfully and promptly | 263 | 64.8 |
| Provider did not explain procedure and expectations | 262 | 64.5 |
| Provider did not give periodic updates on status and progress | 272 | 67.0 |
| Provider did not allow the woman to move during labour | 279 | 68.7 |
| Provider did not allow the woman to assume position of choice | 240 | 59.1 |
| Provider did not seek informed consent for procedures | 266 | 65.5 |
| Non-confidential care | There was no privacy (spatial, visual or auditory) | 235 | 58.3 |
| Curtains and physical barriers were not used | 147 | 36.5 |
| Drape or body covering was not used | 121 | 29.8 |
| Too many staff members around | 228 | 56.6 |
| Medical history disclosure to unauthorized person without consent | 72 | 17.9 |
| Humiliation by shouting, blaming or degrading | 216 | 53.6 |
| Provider did not speak politely | 251 | 62.3 |
| Provider made insults, threats, etc. | 192 | 47.6 |
| Provider used abusive language | 160 | 39.7 |
| Discriminatory care | Provider used language difficult to understand | 191 | 65.4 |
| Provider showed disrespect based on specific attributes like social class, ethnic group, age HIV status, marital status, educational level | 244 | 56.1 |
| Abandonment or denial of care | Facility closed despite being 24/7, or if open, no staff could provide care | 141 | 36.2 |
| Provider did not encourage the woman to call if needed | 202 | 51.8 |
| Provider made woman feel alone or unattended | 184 | 47.2 |
| Provider did not come quickly when needed | 124 | 31.8 |
| Provider denied support during labour | 0 | 0.0 |
| Woman left unattended during second stage of labour | 80 | 20.5 |
| Provider failed to intervene when medically indicated | 83 | 21.3 |
| Provider failed to grant woman’s requests. | 191 | 49.0 |
| Detention in facilities | Not releasing mother or baby or accompanying family member until bill is paid | 406 | 100.0 |

**Table 3: Awareness and Experience of Disrespect and Abuse During Childbirth**

|  |  |  |
| --- | --- | --- |
| **Variable** | **Frequency (n)** | **Percentages (%)** |
| **Explanation of disrespect and abuse (multiple response)** |  |  |
| Lack of communication and information | 346 | 85.2 |
| Violation of privacy and dignity | 406 | 100.0 |
| Disregard for preferences and choices | 290 | 71.4 |
| Verbal emotional abuse | 406 | 100.0 |
| Discrimination and stigmatization | 406 | 100.0 |
| Physical mistreatment | 406 | 100.0 |
| Denial of basic rights | 406 | 100.0 |
| Failure to obtain informed consent | 280 | 69.0 |
| **Forms of disrespect and abuse known by respondents** (multiple response) |  |  |
| Verbal abuse | 406 | 100.0 |
| Physical abuse | 406 | 100.0 |
| Failure to obtain informed consent | 295 | 72.7 |
| Lack of privacy and dignity | 406 | 100.0 |
| Non-consented care | 332 | 81.8 |
| Discrimination and stigmatization | 406 | 100.0 |
| Withholding information | 247 | 60.8 |
| Poor communication | 406 | 100.0 |
| Restriction of movement and choices | 406 | 100.0 |
| Denial of basic rights | 406 | 100.0 |
| **Type of disrespect and abuse respondents had suffered (multiple response)** |  |  |
| Verbal abuse | 275 | 67.7 |
| Physical abuse | 223 | 54.9 |
| Failure to obtain informed consent | 215 | 53.0 |
| Lack of privacy and dignity | 208 | 51.2 |
| Non-consented care | 180 | 44.3 |
| Discrimination and stigmatization | 195 | 48.0 |
| Withholding information | 208 | 51.2 |
| Poor communication | 195 | 48.0 |
| Restriction of movement and choices | 186 | 45.8 |
| Denial of basic rights | 154 | 37.9 |

**Impact of Disrespect and Abuse During Childbirth on Mothers**

Table 4 contains more information on the impact of disrespect and abuse during childbirth on mothers. The result of the study showed that 288(70.9%), 300(73.9%), and 314(77.3%) of the respondents felt fear and anxiety, loss of trust, and shame and guilt respectively, when they experienced disrespect and abuse during childbirth.

Moreover, 334(82.3%), 302(74.4%), and 295(72.7%) of the respondents reported that disrespect and abuse resulted in negative self-image, fear of future healthcare experiences, and reluctance to share birth experience respectively.

The result showed that 347(85.5%), and 354(87.2%) of the respondents use listening to music or sounds, and mindfulness and meditation as coping strategies respectively (Figure 1). It was revealed by 362(91.9%) of the respondents that they received support from their partners or spouses during disrespect and abuse (Figure 2).

**Table 4: Impact of Disrespect and Abuse During Childbirth on Mothers**

|  |  |  |
| --- | --- | --- |
| **Experience of disrespect and abuse** |  |  |
| Fear and Anxiety | 288 | 70.9 |
| Loss of Trust | 300 | 73.9 |
| Trauma | 255 | 62.8 |
| Depression | 269 | 66.3 |
| Shame and Guilt | 314 | 77.3 |
| Anger and Resentment | 406 | 100.0 |
| Loss of Autonomy | 282 | 69.5 |
| Diminished Satisfaction with Childbirth | 180 | 44.3 |
| Impact on Bonding with the Baby | 153 | 37.7 |
| Reluctance to Seek Future Care | 249 | 61.3 |
| **Effects of disrespect and abuse on psychological health** |  |  |
| Negative Self-Image | 334 | 82.3 |
| Erosion of Self-Esteem | 298 | 73.4 |
| Impact on Identity as a mother | 191 | 47.0 |
| Post-Traumatic Stress Symptoms | 143 | 35.2 |
| Loss of Trust | 269 | 66.3 |
| Impact on Interpersonal Relationships | 249 | 61.3 |
| Fear of Future Healthcare Experiences | 302 | 74.4 |
| Reluctance to Share Birth Experience | 295 | 72.7 |

**Figure 1: Coping Strategies Mothers Use During Disrespect and Abuse During Childbirth**

**Figure 2: Source of support respondents received during disrespect and abuse**

**DISCUSSION**

## Prevalence of Disrespect and Abuse During Facility-Based Childbirth

The current study showed that (33.7%) of the respondents indicated that the provider used physical force, slapped or hit the woman. Inadequate training in managing challenging situations during childbirth led some midwives to resort to physical force as a way of exerting control or addressing perceived difficulties. Similar result was reported by Sando et al. (2016) who found that high levels of stress or burnout among midwives contributed to frustration and a decreased ability to handle challenging situations calmly, potentially leading to inappropriate and aggressive behaviour. Cultural or social norms that tolerate or even endorse the use of physical force in certain situations may influence midwives' behaviour, especially if these norms are deeply ingrained in their upbringing (Kujawski et al., 2015). Ineffective communication skills or a lack of training in communication techniques may result in midwives resorting to physical actions as a means of expressing frustration or attempting to control a situation. Imbalances in power dynamics within the healthcare system or between healthcare providers and patients may contribute to the use of physical force as a way for the midwife to assert dominance (Ishola et al., 2017).

It was indicated by 117(30.8%) of the respondents that women did not receive comfort, pain relief as necessary. In some cases, there may be a lack of effective communication between the woman in labour and the healthcare providers. Misunderstandings or inadequate information exchange led to unmet needs for pain relief among women in the rural northern part of Ghana (Moyer et al., 2014). This may be attributable to the fact that healthcare facilities face limitations in terms of staffing, equipment, or access to pain relief options (Maya et al., 2018). United Nations (2015) reported that their shortage of anaesthesiologists or other professionals who can administer certain pain relief interventions in Sub-Saharan Africa.

In Ghana, some hospitals may have specific protocols or policies regarding pain relief options during childbirth (Moyer et al., 2014). These policies may limit the choices available to women or create barriers to accessing certain pain management techniques. Healthcare providers may hold personal or cultural beliefs that influence their approach to pain management during childbirth. This can result in variations in the level of support and pain relief offered to women. Sometimes, healthcare providers may underestimate the level of pain a woman is experiencing during childbirth or may not recognize the need for additional pain relief. In certain situations, women may not be adequately informed about the available pain relief options or may face challenges in obtaining informed consent for specific interventions.

It was stated by (47.9%) of the respondents that the provider did not demonstrate culturally appropriate ways. Healthcare providers may not have received sufficient training in cultural competence. This training is essential for understanding and respecting the cultural backgrounds, beliefs, and practices of diverse patient populations (Dey et al., 2017). Healthcare providers have unconscious biases that influence their interactions with patients. These biases affect communication, decision-making, and the overall quality of care, including during childbirth (Sheferaw et al., 2016). Providers may not effectively communicate with patients to understand their cultural preferences, beliefs, and expectations regarding childbirth.

Ansari & Yeravdekar (2020) showed that lack of open dialogue can lead to misunderstandings and a failure to incorporate culturally appropriate practices. Again, the writers said that if the healthcare workforce lacks diversity, providers may not have firsthand experience or exposure to a wide range of cultural practices. This can contribute to a lack of awareness and understanding of culturally specific needs.

Ishola et al. (2017) found that busy healthcare environments and time constraints limit the opportunity for providers to engage in comprehensive discussions about cultural preferences with patients. This can result in a one-size-fits-all approach that may not be culturally sensitive. Healthcare institutions may not have clear policies or practices in place to support culturally competent care. The absence of guidelines or institutional emphasis on cultural competence can contribute to inconsistent implementation by individual providers.

Moreover, (70.9%) of the respondents indicated that the provider did not introduce herself/himself. If a healthcare facility does not prioritize a patient-centred approach, providers may not prioritize building rapport with patients through basic interpersonal gestures like introductions. In multicultural settings, language barriers or differences in communication styles may contribute to difficulties in effectively introducing oneself (Bekele et al., 2020). Providers may assume that language barriers prevent meaningful communication, leading to missed introductions.

Moreover, in environments where the focus is primarily on completing medical tasks efficiently, providers may prioritize the technical aspects of care over interpersonal communication (Kujawski et al., 2015). This can result in neglecting simple yet crucial gestures like introductions. Healthcare providers, especially in busy Labor and delivery settings, may face high workloads and stress. This pressure can result in oversights, and providers might forget to introduce themselves in the rush of attending to multiple patients

It was mentioned by (70.7%) of the respondents that the provider did not encourage the woman to ask questions. In busy healthcare settings, providers may face time constraints due to high patient volumes and demanding schedules. This can lead to a focus on completing necessary tasks quickly, leaving limited time for open communication (Sethi et al., 2017). Providers may assume that the woman understands the childbirth process or that she may be reluctant to ask questions. This assumption can result in a lack of proactive encouragement for questions. The nature of the provider-patient relationship can also play a role (Khosla et al., 2016). If there is a lack of trust or rapport between the provider and the woman, she may feel less comfortable asking questions. Cultural norms within healthcare settings or societal norms regarding authority figures may influence communication dynamics. Women may be hesitant to question authority, and providers may not actively promote a more collaborative approach.

Again, (64.8%) of the respondents stated that the provider did not respond politely, truthfully and promptly. Some healthcare providers may lack adequate communication skills, including the ability to respond with empathy, politeness, and clarity. Communication training gaps can lead to challenges in effectively conveying information (Diamond-Smith et al., 2016). Healthcare professionals, particularly those working in high-stress environments such as labour and delivery, may experience burnout. High workload, long hours, and emotional strain can impact a provider's ability to respond in a calm and patient manner (Gebremichael, 2018). This can result in less time for detailed explanations or polite responses, although efforts should still be made to communicate effectively. Providers may not have all the necessary information at a given moment, leading to delays in responding promptly. In such cases, providers should communicate clearly about the information gap and when they expect to provide more details. Language barriers or differences in communication styles between providers and patients can hinder effective and prompt communication.

It was stated by (64.5%) of the respondents that the provider did not explain the procedure and expectations. In Pakistan, Agha & Carton (2019)found that healthcare providers in busy labour and delivery settings faced time constraints due to high patient volumes and demanding schedules. This resulted in a focus on completing necessary tasks quickly, leaving limited time for detailed explanations. This can result in providers assuming that the woman understands the childbirth process or that she may be familiar with common procedures. This assumption can lead to a lack of proactive communication about what to expect.

The result showed that (67.0%) of the respondents indicated that the provider did not give periodic updates on status and progress. Agha & Carton (2019) reported that healthcare providers in Pakistan faced challenges in maintaining effective communication due to a high workload, multiple patients, and the demands of a busy labour and delivery environment. Busy healthcare settings may impose time constraints on providers, limiting the time available for detailed updates. The focus may be on completing necessary tasks efficiently.

The current study further showed that (58.3%) of the respondents reported that there was no privacy (spatial, visual or auditory). In busy labour and delivery settings, healthcare providers work in environments with multiple patients and high traffic (Gebremichael, 2018). This makes it challenging to ensure privacy for each individual woman. In Sub-Saharan Africa, Friberg et al. (2018) reported that some healthcare facilities lack adequate physical resources, such as private birthing rooms or partitions, to provide spatial privacy during childbirth. Limited infrastructure can impact the ability to create private spaces. A shortage of healthcare staff may result in a lack of attention to individual patients' privacy needs. Healthcare providers may be stretched thin, leading to challenges in maintaining a private and supportive environment. There may be a lack of effective communication between healthcare providers and patients regarding privacy preferences.

It was indicated by (53.6%) of the respondents that there was humiliation by shouting, blaming or degrading. In Kenya, Abuya et al. (2015) showed that midwives, experienced high levels of stress and burnout due to heavy workloads, long hours, and emotionally challenging situations. This stress can contribute to negative behaviours if not effectively managed. Some healthcare providers may not have received adequate training in communication skills, particularly in providing emotional support during childbirth. This lack of training can result in ineffective and inappropriate responses to the challenges of the birthing process. Healthcare providers who lack empathy or compassion may struggle to connect with patients emotionally. This can lead to insensitive behaviour, including humiliation or blaming (Cerón et al., 2016). Poor communication between healthcare providers and patients can lead to misunderstandings, frustration, and tension. In some cases, midwives may resort to inappropriate behaviour as a reaction to communication breakdowns.

The result showed that (65.4%) of the respondents indicated that the provider used language difficult to understand. Healthcare providers, including midwives and medical professionals, often use medical terminology or jargon as part of their communication (Ishola et al., 2017). This specialized language might be second nature to them, leading to unintentional use without considering the patient's familiarity with these terms. Providers may not always assess the patient's level of health literacy or familiarity with medical terms. Habitual use of technical language without checking for understanding can result in confusion for the patient (Sheferaw et al., 2016). Language barriers or differences in cultural background can contribute to misunderstandings. Providers might not be fully aware of the patient's language proficiency or cultural context, leading to communication challenges.

The result of the study showed that all the respondents indicated that they did not release the mother or baby or accompanying family member until the bill is paid. In Sub-Saharan Africa, the majority of healthcare institutions face financial challenges, and the practice of holding patients until bills are settled could be an attempt to secure payment promptly (Friberg et al., 2018). Again, in situations where patients do not have adequate insurance coverage or face financial constraints, healthcare providers may resort to such practices as a means to ensure payment for services rendered (Maldie et al., 2021). There may be a lack of understanding or communication breakdowns between healthcare providers and patients regarding billing processes. This can lead to misconceptions about the necessity of immediate payment before discharge.

## Women’s Perspectives on Disrespect and Abuse During Facility-Based Childbirth

The result of the study showed that all of the respondents explained disrespect and abuse as verbal emotional abuse, discrimination and stigmatization, and physical mistreatment. Moreover, all of the respondents indicated that they had experienced or witnessed verbal abuse, physical abuse, lack of privacy and dignity, and poor communication before in Ethiopia. Adinew et al. (2023) reported that failure to provide adequate information about medical procedures and interventions. Performing procedures without obtaining informed consent. Use of disrespectful language, yelling, or shouting at the mother during labour. The authors indicated that belittling or humiliating comments, undermining the mother's feelings or concerns. Rough handling or unnecessary force during examinations and procedures. Ignoring the mother's request for pain relief or assistance.

In Pakistan, Agha & Carton (2019) found that healthcare professionals experiencing high levels of stress and burnout are more likely to exhibit abusive behaviour or communication lapses. Some midwives have difficulty empathizing with the emotional and physical challenges faced by women during childbirth. Miscommunication due to language differences or cultural misunderstandings can contribute to poor communication. This may be attributable to healthcare professionals not receiving adequate training in effective communication with patients (Friberg et al., 2018).

The current study found that (82.3%), (74.4%), and (72.7%) of the respondents reported that disrespect and abuse resulted in negative self-image, fear of future healthcare experiences, and reluctance to share birth experience respectively. Kujawski et al. (2015) found among the Tanzanian women that disrespectful and abusive treatment led to a traumatic experience for mothers. Trauma triggers fear and anxiety, especially in the context of childbirth, which is already a vulnerable and challenging time. Feeling mistreated led to a loss of control over the birthing process, increasing fear and anxiety (Sethi et al., 2017). Experiencing disrespectful or abusive behaviour by healthcare professionals can be perceived as a betrayal of the trust that mothers place in their care providers. Poor communication, lack of empathy, or dismissive attitudes can erode the trust between the mother and healthcare providers (Sando et al., 2016). Meanwhile, mothers may internalize the mistreatment, blaming themselves for the perceived disrespect or abuse, even if it was not their fault. Others may fear judgment from others or feel stigmatized, particularly if they faced mistreatment due to factors such as race, socioeconomic status, or other forms of discrimination.

The result of the present study showed that (85.5%) and (87.2%) of the respondents use listening to music or sounds, and mindfulness and meditation as coping strategies respectively. Listening to calming music or sounds can serve as a distraction from the negative experiences and provide a soothing environment (Kujawski et al., 2015). The writers reported that listening to music or sounds can help create a more relaxed atmosphere, allowing mothers to focus on something positive amid challenging circumstances. Certain types of music or calming sounds have been shown to reduce stress and anxiety levels. They can have a physiological impact, such as lowering heart rate and cortisol levels, promoting a sense of calm. Choosing music or sounds that resonate with the mother can provide a sense of control and empowerment. It allows her to create a personal and positive environment in the midst of a potentially challenging situation.

In Ethiopia, Bekele et al. (2020) reported that mindfulness and meditation techniques involve focusing attention on the present moment. Engaging in mindfulness exercises can help mothers redirect their thoughts away from the distressing situation, promoting relaxation and emotional well-being. These practices are known for their stress-reducing benefits. Mindfulness and meditation encourage deep breathing and relaxation, helping mothers manage the physiological effects of stress and anxiety. Engaging in mindfulness and meditation empowers mothers by giving them a tool to control their mental and emotional state. It promotes a sense of agency and self-efficacy (Bekele et al., 2020). Another study reviewed ten articles to find prevalent interventions that might reduce disrespect and abuse of women in healthcare facilities. Most of the articles reviewed included training as a relevant part of the intervention. Every study that did so, concluded that it resulted in an improvement of the care received by the delivering women. Physical abuse was the most consistently reduced. These results suggest that provider education should include a form of RMC training, which should be encouraged by Gynecology and Obstetrics services (Mira-Catalá et al., 2024).

**CONCLUSION**

The study found that several factors contribute to disrespect and abuse during childbirth. These include a lack of healthcare provider training in respectful maternity care, non-adherence of nurses and midwives to the patient's charter of the Ghana Health Service, cultural norms that normalize disrespect and abuse during childbirth, and personal beliefs of pregnant mothers that also normalize such behaviour. The results highlight the importance of addressing these factors to improve the quality of maternity care and promote a respectful and supportive environment for expectant mothers.

**Ethical Approval and Consent:**

Ethical approval was obtained from the Committee on Human Research, Publication, and Ethics from the University for Development Studies. Respondents were asked to sign a consent form before participating in the study.

**Disclaimer (Artificial intelligence)**

Option 1:

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during the writing or editing of this manuscript.

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Details of the AI usage are given below:

1.

2.

3.

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