**Assessment of factors associated with disrespect and abuse during institutional delivery among postnatal mothers in the Tamale Metropolis**

**ABSTRACT**

**Background:** Disrespect or abuse is a mistreatment of women during pregnancy, childbirth or

postpartum period. It is one of the contributing factors of low uptake of institutional delivery. In

Ghana, there is little information about disrespect or abuse during childbirth in public health

facilities. The objective is to identify factors associated with disrespect and abuse during facility-based childbirth in Tamale metropolis.

**Methods:** The study employed a descriptive cross-sectional study design with a mixed methods approach. The study was conducted in the Northern Regional Hospital and the Tamale West Hospital, both in the Tamale Metropolis. The study population comprised women who had given birth in the selected health facilities within northern Ghana. Participants were chosen using a systematic random sampling technique. The total study participants for this study were 424 as the final sample size. Data collection was facilitated using a computerized instrument deployed on tablets. 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:** The result showed that the majority of the respondents (53%) agreed that lack of healthcare provider training in respectful maternity care can lead to disrespect and abuse. Respondents strongly agree (52.0%) that cultures that normalize disrespect and abuse during childbirth contribute to disrespect and abuse. Respondents (56.4%) were aware of any efforts or initiatives in their area to raise awareness and address disrespect and abuse during childbirth. Moreover, respondents (49.0%) agree that lack of nurses and midwives’ adherence to the patient’s charter of Ghana Health Service can lead to disrespect and abuse.

**Conclusion:** The occurrence of disrespect and abuse during facility-based childbirth is determined by an intricate interaction of elements associated with the health system, provider attitudes, training, sociocultural norms, and health regulations. To tackle these concerns, a thorough strategy is needed that encompasses enhancing health systems, training providers, and tackling societal attitudes and practices that contribute to disrespect and abuse.

**Key Words:*****Respectful maternity care, Disrespect, Abuse, Childbirth***

**INTRODUCTION**

Disrespect or maltreatment refers to the ill-treatment of women during pregnancy, childbirth in a healthcare facility, or the postpartum period. Furthermore, this action constitutes a breach of the rights of women who are capable of having children, as outlined in the Charter for Respectful Maternal Care and the 2015 declaration by the World Health Organisation (Savage & Castro, 2017). On a global scale, numerous women encounter derogatory or violent behaviour while giving birth in medical institutions (World Health Organization, 2014). There is widespread agreement that professional birthing services provided within a formal healthcare system can reduce the risk of maternal fatalities. More than 162,000 women still lose their lives in pregnancy and childbirth each year in sub-Saharan Africa (SSA). Most such fatalities occur within a day of delivery (Gebeyehu et al., 2023). The mistreatment of women not only infringes against women's rights to receive respectful care, but also poses a risk to their rights to life, health, physical well-being, and freedom from discrimination (WHO, 2015).

In 2010, Bowser and Hill proposed a conceptual framework to comprehend instances of disrespect or mistreatment towards women in the context of childbirth that takes place in healthcare facilities. The landscape review report on disrespect or abuse (D or A) proposed a classification system that categorised the manifestations of D or A into seven overlapping categories: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities (Bowser & Hill, 2010).

Respectful maternal care, as defined by the World Health Organisation (WHO) and the White Ribbon Alliance, is the provision of dignified and respectful healthcare to women during pregnancy, childbirth, and the postpartum period (White Ribbon Alliance, 2011). It ensures that every woman has the right to the highest possible standard of health and is treated with respect in all healthcare systems worldwide (WHO, 2015; Kruk, et al., 2014; Sacks & Kinney, 2015). In the same tone, the World Health Organization calls for cultural dynamic, needs preference of the recipient to be understood, recognized, anticipated and incorporated into maternity care services (Cheboi et al., 2019).

Research has shown that there is a significant occurrence of disrespect or abuse in facility-based maternal care worldwide, and various variables contribute to this issue. Bowser and Hill conducted a landscape analysis and other studies to identify and categorise the factors associated with disrespect or abuse. These factors include service delivery factors, individual and community-level factors, lack of leadership, lack of standards and accountability, and provider related factors (Bowser & Hill, 2010).

Various issues can be linked to the limited utilisation of expert delivery services in many low-income nations (Moyer et al., 2014). However, a significant and sometimes overlooked element is the presence of disrespect or harsh treatment during childbirth in healthcare facilities, which has a direct impact on the level of care provided. Several pieces of research indicate that in nations with high maternal death rates, the lack of facility-based delivery coverage is predominantly attributed to factors such as inadequate infrastructure or accessibility. Disregardful or offensive behaviours and surroundings inside health facilities diminish the quality of maternity care and result in low utilisation of professional delivery care at health facilities (Freedman & Kruk, 2014). There is ample evidence to suggest that women worldwide often encounter disrespectful or abusive treatment during childbirth in healthcare facilities (Bowser & Hill, 2010; Sando, et al., 2017; Ratcliffe, et al., 2016; Rosen, et al., 2015).

Various literary sources have reported a significant occurrence of disrespect or mistreatment in the context of maternity care provided in healthcare facilities. Over 90% of women who had no upsetting experience of disrespect and abuse rated their birth as (very) positive. The more upsetting experiences of disrespect and abuse women had, the more likely they were to rate their overall birth experience as very negative or traumatic (Leijerzapf et al., 2024). Disrespect or abuse can encompass a spectrum of behaviours, ranging from verbal mistreatment to physical violence. Various variables contribute to the occurrence of such behaviour. The various factors that can contribute to disrespect or abuse have been extensively studied and categorised in different literatures. These factors include individual and community-related aspects, national laws and policies, human rights and ethics considerations, governance and leadership factors, service delivery issues, and provider-related factors (Bowser & Hill, 2010; Ratcliffe, et al., 2016; Ishola, Owolabi & Filippi, 2017).

In 2010, Bowser and Hill proposed nine categories of interventions aimed at reducing disrespect or abuse. These categories include quality improvement interventions, interventions promoting caring behaviour, interventions focused on humanising childbirth, interventions that empower health workers to drive change, accountability mechanisms, interventions based on human rights principles, legal approaches, interventions targeting the reduction of HIV/AIDS stigma, and tools for measuring progress (Bowser & Hill, 2010; WHO, 2015). In 2015, the World Health Organisation (WHO) provided five measures to prevent and eradicate disrespect or abuse during childbirth in healthcare facilities. The strategies include: enhancing funding for research and initiatives, establishing initiatives to enhance the provision of respectful and high-quality maternal health care, formulating action plans based on human rights principles, collecting data on the occurrence of disrespectful or abusive practices and implementing interventions to address them, and engaging all relevant parties to promote women's involvement in efforts to enhance the quality of care and eradicate disrespectful or abusive practices (WHO, 2015).

In Ghana, there has been a limited amount of research undertaken on the elements that contribute to disrespect or abuse during childbirth in healthcare facilities. Furthermore, the existing studies have primarily focused on a small number of specific health facilities. Northern Ghana, as a specific region may have unique contextual factors that influence the manifestation and patterns of D&A during childbirth. Understanding the specific dimension and patterns of D&A within this region is crucial for developing targeted interventions and policy recommendations to improve the quality of maternity care and ensure respectful childbirth experiences for women.

The dimensions of disrespect and abuse during facility-based childbirth encompass various forms, including physical abuse, verbal abuse, neglect, discrimination, violation of privacy and confidentiality, non-consented care, and disrespectful communication (Ansari & Yeravdekar, 2020; Gebremichael, 2018; Maya et al., 2018). These behaviours can occur due to a range of factors, such as power imbalances, provider attitudes, cultural norms, and systemic challenges within the healthcare system (Dey et al., 2017). In order to obtain more accurate and representative results, it is advisable to conduct a study that includes a wide range of health facilities and a sample size that is representative of the population. This will allow for a comprehensive examination of the various factors associated with disrespect or abuse and facilitate the development of effective interventions (Banks, et al., 2017; Asefa, et al., 2018).

**METHODS**

**Study design:** This 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.

**Setting:** The study was conducted in Northern Regional Hospital and Tamale West Hospital, both in the Tamale Metropolis. 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 at 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.
* Women who refused to provide informed consent were excluded.

**Sampling Technique and Size:**

The two 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. The total study participants for this study were 424 as the final sample size.

**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 a 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, thus 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.

**STUDY FINDINGS**

**Socio-demographic characteristics of respondents**

The study sampled 424 mothers to respond to the questionnaire. However, 406 mothers completed the survey, achieving 97.6% response rate. The remaining 18 mothers did not finish the questionnaire due to illness. Findings revealed that 221 (54.4%) of the participants were between 21 and 30 years old. The average age of the participants was 29 years, with a standard deviation of 5.089 years. Most of the respondents (78.8%) were married, while 169 (41.6%) had not received any formal education. Additionally, the majority (79.6%) identified as Dagomba by ethnicity.

The result also showed that 124(30.5%) of the respondents’ husbands had no education. It was also revealed that 191(47.0%) of the respondents’ husbands had farming as their occupation. Majority (66.0%) of the respondents had 1 to 3 number of pregnancies. It was revealed that 231(56.9%) of the respondents had 1 to 2 previous births.

It was further revealed that 156(38.4%) of the respondents gave birth through normal vaginal delivery. Most (78.3%) of the respondents had one baby at the most recent birth. It was indicated that 251(61.8%) of the respondents had a female at the most recent birth. The result showed that 379(93.3%) of the respondents have registered with NHIS.

**Factors associated with disrespect and abuse**

The result showed that 215(53.0%) of the respondents agreed that lack of healthcare provider training in respectful maternity care can lead to disrespect and abuse. It was strongly disagreed by 176(43.3%) of the respondents that overcrowding of pregnant patients at the healthcare facilities can lead to disrespect and abuse. It was agreed by 183(45.1%) of the respondents that understaffing of midwives/doctors at the healthcare facilities can lead to disrespect and abuse.

Moreover, 116(28.6%) of the respondents strongly agreed that low socio-economic status of the client is likely to lead to disrespect and abuse. It was agreed by 168(41.4%) that lack of clients and relatives’ awareness of the patient’s rights contributes to disrespect and abuse during childbirth. It was agreed by 199(49.0%) of the respondents that lack of nurses and midwives’ adherence to the patient’s charter of Ghana Health Service can lead to disrespect and abuse.

It was strongly agreed by 167(52.0%) of the respondents that cultures that normalize disrespect and abuse during childbirth contribute to disrespect and abuse. It was strongly agreed by 130(32.0%) of the respondents that personal beliefs of pregnant mothers that normalize disrespect and abuse can lead to disrespect and abuse. It was agreed by 244(60.1%) of the respondents that communication barriers exist between healthcare providers and patients. More information is provided in Table 1.

**Table 1: Factors Associated with Disrespect and Abuse**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Statement** | **Strongly Disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly Agree** |
|  | **n (%)** | **n (%)** | **n (%)** | **n (%)** | **n (%)** |
| Lack of healthcare provider training in respectful maternity care can lead to disrespect and abuse | 16(3.9) | 24(5.9) | 24(5.9) | 215(53.0) | 127(31.3) |
| Overcrowding of pregnant patients at the healthcare facilities can lead to disrespect and abuse. | 176(43.3) | 159(39.2) | 63(15.5) | 0(0.0) | 8(2.0) |
| Understaffing of midwives/doctors at the healthcare facilities can lead to disrespect and abuse.  | 40(9.9) | 52(12.8) | 12(3.0) | 183(45.1) | 119(29.3) |
| Low socio-economic status of client is likely to lead to disrespect and abuse. | 28(6.9) | 36(8.9) | 4(1.0) | 222(54.7) | 116(28.6) |
| Lack of clients and relatives’ awareness of patient’s rights contributes to disrespect and abuse during childbirth.  | 52(12.8) | 56(13.8) | 0(0.0) | 168(41.4) | 130(32.0) |
| Lack of nurses and midwife’s adherence to the patient’s charter of Ghana Health Service can lead to disrespect and abuse.  | 0(0.0) | 8(2.0) | 32(7.9) | 199(49.0) | 167(41.1) |
| Cultures that normalize disrespect and abuse during childbirth contribute to disrespect and abuse. | 32(7.9) | 60(14.8) | 0(0.0) | 103(25.4) | 211(52.0) |
| Personal beliefs of pregnant mothers that normalize disrespect and abuse can lead to disrespect and abuse. | 4(1.0) | 24(5.9) | 0(0.0) | 248(61.1) | 130(32.0) |
| Communication barriers between healthcare providers and patients | 54(13.3) | 32(7.9) | 4(1.0) | 244(60.1) | 72(17.7) |

**Personal experience**

The result showed that 240(59.3%), and 242(59.8%) of the respondents indicated that they have experienced or observed lack of communication, and discrimination before, respectively. It was indicated by 234(57.8%) of the respondents that they have experienced or observed physical abuse.

Furthermore, 250(61.7%), 284(70.1%), and 292(72.1%) of the respondents indicated that they experienced or observed lack of privacy and dignity, informed consent violations, and cultural insensitivity before, respectively. Table 2 contains more information.

**Table 2: Personal experience**

|  |  |  |
| --- | --- | --- |
| **Type of disrespect and abuse experienced or observed** | **Frequency (n)** | **Percentage (%)** |
| Lack of communication | 240 | 59.3 |
| Discrimination | 242 | 59.8 |
| Physical abuse | 234 | 57.8 |
| Lack of privacy and dignity | 250 | 61.7 |
| Informed consent violations | 284 | 70.1 |
| Cultural insensitivity | 292 | 72.1 |

**Awareness and reporting**

The result of the study showed that most (56.4%) of the respondents were aware of any efforts or initiatives in their area to raise awareness and address disrespect and abuse during childbirth (Figure 1).

Moreover, the majority (62.63%) of the respondents who have ever experienced or observed disrespect and abuse during childbirth did not report to the healthcare facility or an external authority (Figure 2).

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**Figure 1:** **Awareness of any efforts or initiatives to address disrespect and abuse during childbirth**

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**Figure 2: Reporting of disrespect and abuse**

**DISCUSSION**

## Factors Associated with Disrespect and Abuse During Facility-Based Childbirth

The current study showed that (53.0%) of the respondents agreed that lack of healthcare provider training in respectful maternity care can lead to disrespect and abuse. In Pakistan, Agha & Carton (2019) found that some healthcare providers did not receive adequate education and training in respectful maternity care during their medical or nursing education. This deficiency resulted in a lack of awareness about the importance of treating women with dignity and respect during childbirth. Medical and nursing education often places significant emphasis on clinical skills and medical knowledge, sometimes at the expense of developing strong interpersonal skills.

Moreover, the current study showed that it was strongly disagreed by (43.3%) of the respondents that overcrowding of pregnant patients at the healthcare facilities can lead to disrespect and abuse. In Sub-Saharan Africa, healthcare providers, including doctors, nurses, and support staff, face increased stress and workload when dealing with a high volume of patients (Friberg et al., 2018). This pressure can lead to frustration and burnout, potentially resulting in disrespectful behaviour. Overcrowding can limit the amount of time healthcare providers can spend with each patient. This may result in rushed interactions, reduced empathy, and a lack of individualized care, contributing to disrespect (Ansari & Yeravdekar, 2020).

 It was agreed by (45.1%) of the respondents that understaffing of midwives/doctors at the healthcare facilities can lead to disrespect and abuse. When healthcare facilities are understaffed, midwives and doctors may face an increased workload and heightened stress levels (Asefa & Bekele, 2015). This pressure can lead to frustration, fatigue, and burnout, impacting their ability to provide respectful and patient-centered care (Wassihun & Zeleke, 2018). Understaffing often results in healthcare providers having limited time for each patient. This can lead to rushed interactions, reduced attention to individual needs, and a lack of personalized care, potentially resulting in disrespectful behaviour (Sheferaw et al., 2016). Similar studies showed that a shortage of staff led to communication challenges, both among healthcare providers and between providers and patients in Nigeria (Ishola et al., 2017). Effective communication is essential for building trust and ensuring that patients feel respected and informed about their care.

It was agreed by (49.0%) of the respondents that lack of nurses and midwives’ adherence to the patient’s charter of the Ghana Health Service can lead to disrespect and abuse. Nurses and midwives may not be sufficiently aware of the content and importance of the Patient's Charter (Dey et al., 2017). Lack of comprehensive training or awareness programs can result in a failure to understand and implement the principles outlined in the charter (Ansari & Yeravdekar, 2020). High workload and stress levels can impact healthcare providers' ability to provide patient-centered care. In environments with limited staffing and resources, nurses and midwives may struggle to prioritize adherence to the Patient's Charter (Maya et al., 2018). Effective communication is a key component of patient-centered care. If there are communication gaps between healthcare providers and patients, or among healthcare team members, it can contribute to misunderstandings and instances of disrespect.

It was strongly agreed by (52.0%) of the respondents that cultures that normalize disrespect and abuse during childbirth contribute to disrespect and abuse. In Ethiopia, Weis (2017) reported that cultural traditions and beliefs around childbirth influenced the way individuals perceive and approach the birthing process. If certain disrespectful practices are deeply ingrained in cultural norms, they may be accepted and perpetuated over time. Cultural beliefs and norms surrounding childbirth influence attitudes and behaviours towards women during labour and delivery.

Molla et al. (2017) showed that in Ethiopia, some cultures have deeply ingrained beliefs about the inferiority of women or the acceptability of mistreatment during childbirth. The authors reported that stigmatization of certain groups, such as unmarried women, adolescents, or women living with HIV, led to discriminatory treatment during childbirth. This may be due to the fact that if there is societal stigma associated with certain attributes, healthcare providers may perpetuate these attitudes in their interactions with patients. In some cultures, childbirth pain and suffering may be normalized or even valorised. This normalization can lead to a lack of empathy and understanding from healthcare providers, resulting in disrespectful treatment.

The current study found that it was agreed by (60.1%) of the respondents that communication barriers exist between healthcare providers and patients. In Tanzania, a different result was found by Kujawski et al. (2015). The authors reported that the emotional state of a woman during childbirth did not influence communication. However, in India, Ansari & Yeravdekar (2020) found that high levels of stress, anxiety, or pain may affect the ability to actively participate in conversations or comprehend information. The writers showed that varied cultural backgrounds and socioeconomic factors influenced communication styles and expectations. The nature of the provider-patient relationship can impact communication. If there is a lack of trust, rapport, or mutual understanding, it can contribute to communication barriers (Maya et al., 2018). Language barriers, where the healthcare provider and the patient do not share a common language, can hinder effective communication. Misunderstandings may occur, leading to difficulties in conveying and understanding important information.

**Socio-Demographic Related Factor**

Different studies done in different countries by using various designs showed that age, marital status, residence, education and monthly income are identified factors related to disrespect and abuse. Women under 19 years of age during labor and delivery in Kenya were more likely to abuse (Timothy A, et al; 2015). Single women experienced 100% disrespect and abuse in Nigeria (Okafor et al., 2014). Being Addis Ababan reduces disrespect and abuse by 82% as revealed work in Ethiopia (Asefa and Bekele, 2015). A paper from Tanzania found that educational background of the mother was significantly associated with their experience of disrespect and abuse (Kruk et al., 2014). Considerable high income irrespective of the seriousness of the medical condition gave an opportunity to receive care earlier in Bangladesh (E Pitchforth et al., 2014), and in Ethiopia, poor women were more likely to have been disrespected and abused (Wassihun, et al., 2018).

**Obstetric Related Factors**

**Mode of delivery:** Study in Nigeria indicated that women who gave birth by cesarean section is 7.6 times more likely to experience disrespect and abuse (D&A) than who gave birth vaginally (USAID and MCHIP, 2013).

**Gravidity:** Study conducted in Kenya to explore the prevalence of disrespect and abuse (D&A) showed that women of higher gravidity, between one and three children, were three times more likely to be detained for lack of payment or five times more likely to be requested (Abuya, et al., 2015).

**Length of stay in hospital:** A study conducted in Tanzania on disrespect and abuse treatment showed that women who had developed any complications during delivery and who stayed in the facility for delivery for less than one (1) day were more likely to report experiences of D&A (Kruk et al., 2014). Also, a study in Ethiopia showed mothers who stayed longer at a health facility after delivery were 5.14 times more likely to have been disrespected and abused than those who did not.

**ANC follow up:** Furthermore, direct observational study conducted in five counters showed that those women who received ANC were less likely to complain D&A than those who didn’t (Rosen H.E. et al., 2015). Similarly, a study done in Bahir Dar town showed respondents with a history of fewer than 4 ANC visits were 1.97 times more likely to have been disrespected and abused than respondents with a history of ≥4 ANC visits (Wassihun, et al., 2018).

**Individual related factor:** A study conducted in Ethiopia to determine the level and types of disrespect and abuse faced by women during facility-based childbirth, showed that economical back ground were only significantly associated with disrespect and abuse (89.5% among those with a monthly income of <713 birr and 70.3% among those with monthly income of ≥ 713 birr (Asefa and Bekele, 2015). In Kenya study conducted to explore the prevalence of disrespect and abuse showed that normalization, lack of autonomy and empowerment, and financial barrier are identified factors for D&A during labor and delivery (Abuya, et al., 2015).

**Service delivery related factors:** According to landscape analysis, the potential contributing factors arise from the health facility are a lack of standards infrastructure and a lack of responsibility mechanisms (Bowser and Hill, 2010). Direct observational study, which is conducted in five countries in East and Southern Africa, showed that lack of resources and staff shortage were identified factors (Rosen, et al., 2015). In Sub-Saharan Africa a systematic review study on limited electricity access in health facilities showed that 20-57% of facility lack standard infrastructure to attend delivery and in Ethiopia, Kenya, Rwanda, and Tanzania reported no electricity available in 14, 26, 18, and 50% of facilities, respectively (Adair-Rohani, et al., 2013). Another study conducted in Senegal on maternal satisfaction was mediated by the mothers' perception of compliance with care, which showed wide disparities in practice within the facilities and one of the main factors to select the place of delivery is satisfaction with the experience of institutional delivery (Oikawa, et al., 2014).

**Provider related factor:** According to landscape analysis, the factors arising from health service providers are like provider prejudice; provider distancing as a result of training; provider demoralization related to weak health systems, shortages of human resources and poor professional development opportunities; provider status and respect (Bowser and Hill, 2010). In Kenya, a study was conducted to explore the prevalence of disrespect and abuse found that the most identified factors at provider level which leads to disrespect and abuse were, poor provider attitudes, poor relationships with clients, lack of legal and ethical foundations for addressing disrespect and abuse, and provider prejudice due to lack of training (Abuya, et al., 2015).

**CONCLUSION**

It becomes apparent that disrespect and abuse during childbirth are not isolated occurrences but rather arise from an intricate interplay of multiple circumstances. These variables may encompass systemic challenges within healthcare systems, such as insufficient infrastructure, understaffing, and absence of training and accountability mechanisms for healthcare providers. Moreover, societal norms, cultural beliefs, and power dynamics play a substantial role in the occurrence of disrespect and abuse during childbirth. To tackle these difficulties, a comprehensive approach is needed, involving cooperation among healthcare professionals, legislators, community influencers, and women themselves. Efforts focused on enhancing healthcare facilities, augmenting workforce levels, and establishing thorough training programmes can contribute to the establishment of a nurturing and respectful atmosphere for birthing. Furthermore, it is essential to make deliberate attempts to question and modify established social standards that continue to promote disrespect and mistreatment. Additionally, empowering women to assert their rights and express their preferences during childbirth is a vital measure in cultivating an environment of honour and regard in maternal healthcare facilities. To effectively address disrespect and abuse during facility-based childbirth, a comprehensive approach is required. This approach should target both the underlying structural problems inside healthcare systems and the wider cultural attitudes and norms. Through collaborative efforts to enact substantive reforms and foster a climate of reverence and honour, we can guarantee that each woman is provided with the empathetic and considerate treatment she is entitled to during the process of giving birth.

Ethical approval: Ethical approval was obtained from the Committee on Human Research, Publication, and Ethics from the University for Development Studies.

Consent

As per international standards or university standards, Participants’ written consent has been collected and preserved by the author(s).

Disclaimer (Artificial intelligence)

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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.

**Reference**

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