Original Article

Factors associated with compassionate and respectful maternity care among laboring mothers during childbirth in Ethiopia

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Abstract

Context: One of the most important facilitating elements for increasing access to quality maternity care is compassionate and respectful maternity care (CRMC).

Aims: This study assessed factors associated with CRMC among laboring mothers during childbirth in Ethiopia.

Settings and Design: A cross-sectional study was employed in Adama Hospital Medical College, Ethiopia from August 01 to September 30, 2020.

Materials and Methods: Three hundred and ninety-nine postpartum mothers were selected using a systematic random sampling technique through a demographic, obstetric, and respectful maternity care questionnaire.

Statistical Analysis Used: Frequencies, percentages, means, and standard deviation were computed. Binary logistic regressions were carried out to identify factors associated with CRMC.

Results: The overall magnitude of CRMC accounts 169 (42.4%) with (95% confidence interval [CI]; 37.3–47.4). Primary and secondary level of education (adjusted odds ratio [AOR]: 5.29, 95% CI [1.92, 14.57], $P = 0.028$), discussion with health-care provider (HCP) on place of delivery during antenatal care (AOR: 9.13, 95% CI (4.85, 17.18), $P = 0.023$), multigravida (AOR: 3.75, 95% CI [1.17, 11.99], $P = 0.013$), history of previous institutional delivery (AOR: 3.306, 95% CI [1.026, 10.65], $P = 0.001$), day time (shift) of delivery (AOR: 3.52, 95% CI [1.85, 6.72], $P = 0.017$) asking for consent before the procedure (AOR: 3.49, 95% CI [1.821, 6.72], $P = 0.000$) and two or less number of health workers during labor (AOR: 4.68, 95% CI [2.495, 8.77], $P = 0.002$) were significant determinants of CRMC.

Conclusion: The proportion of CRMC was low. As a result, we recommend that HCPs who provide maternity care give friendly treatment, abuse-free care, timely care, and discrimination-free care as the pillars for improving the low rate of institutional delivery.

Keywords: Childbirth, Ethiopia, Maternity, Care, Respect

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Received: 06 August 2021; **Revised:** 16 May 2022; **Accepted:** 21 May 2022; **Published:** 05 September 2022

Access this article online	
Quick Response Code:	Website: www.jnmsjournal.org
	DOI: 10.4103/jnms.jnms_127_21

How to cite this article: Kedir FK, Gurara AM, Yami DB, Beyen TK. Factors associated with compassionate and respectful maternity care among laboring mothers during childbirth in Ethiopia. J Nurs Midwifery Sci 2022;9:230-6.

INTRODUCTION

One of the most important supporting elements for increasing access to professional maternity care is compassionate and respectful maternity care (CRMC).[1] Disrespect and abuse are violations of human rights, and they are the primary barrier to skilled birth usage, as opposed to other frequently recognized deterrents such as financial and geographical barriers.[1] Respectful maternity care is defined as care arranged for and offered to all women in a way that preserves their dignity, privacy, and confidentiality, protects them from injury and maltreatment, and allows them to make informed decisions and receive continuous support during labor and delivery.[2]

Despite significant progress, the maternal mortality ratio (MMR) in underdeveloped and developed countries is still 239 and 12/100,000 live births, respectively.[3] Despite significant improvements in maternity and child health services in Ethiopia, over three-quarters of mothers do not give birth in health facilities or with skilled birth attendants. In addition, the maternal mortality rate remains at 412/100,000 live births.[4] This result falls well short of the Sustainable Development Goal target of 70/100,000 by 2030.[5] Some of the causes that contribute to the underutilization of facility delivery include the absence of a companion during labor, poor maternity care, excessive waiting time for care, and disrespect and abuse during childbirth.[6-9]

Several studies revealed that different factors threw in the determinants of CRMC among laboring mothers from country to country as well as from place to place. The study from Bahir Dar, Ethiopia, revealed that respondent residency, mode of delivery, time of delivery, complication during delivery, family monthly income, and intention to give birth in a health facility were factors associated with CRMC.[1] The study from Northwest Amhara, Ethiopia, showed that respectful maternity care among women who gave birth was influenced by the number of antenatal care (ANC) visits, previous history of facility delivery, and delivery time.[10] Whereas a study from Mahdie Hospital in Tehran, Iran, revealed that effective communication skills of midwives have a positive effect on maternal satisfaction.[11]

Many women, particularly in low- and middle-income nations, do not have guaranteed access to excellent services.[12] Even when resources are provided, mistreatment during childbirth, such as abusive, inattentive, or disrespectful care, can jeopardize care. Women may decline to seek care when they have previously received disrespectful care, even if the caregivers are proficient in addressing difficulties. This may dissuade others from getting care as well.[12]

Even though Ethiopia's federal ministry of health devotes special emphasis to addressing gaps in the provision of compassionate and respectful health care in the health system,[13] CRMC implementation remains a problem. In addition, there have been few studies undertaken in Ethiopia to identify the factors linked to CRMC. As a result, the goal of this study was to evaluate factors linked with CRMC during childbirth in Adama hospital medical college in central Ethiopia.

MATERIALS AND METHODS

Study design, setting, and period

A cross-sectional study design was employed in Adama Hospital Medical College, Adama town, central Ethiopia from August 01 to September 30, 2020.

Participants

All postpartum mothers in Adama Hospital Medical College who were present during the data collection period were the study population. The sample size was determined using a sample size formula for estimating a single population proportion formula with a margin of error of 5%, confidence interval (CI) of 95%. It is calculated based on the proportion of CRMC which is 38.3%.[14] After adding 10% for the nonresponse rate, the final sample size was 399 individuals.

Systematic random sampling technique was used to select study participants. According to data collected from Adama Hospital Medical College, around 800 postpartum women were treated in the hospital in the previous 1 month. Considering K = 2, the first sample was taken by the lottery method from 1 and 2 and all the next participants were selected by adding sampling interval until we have reached the total sample size (399).

Inclusion and exclusion criteria

All postpartum mothers who visited and got delivery service and attending postnatal care during data collection time and who were volunteer to participate in the study was included in the study. Mothers who were health professionals or working in the study facility and gave birth during the study period, ANC visitors, and mothers who came for other services, not interested to participate in the study, not available during the data collection time and mothers who were mentally and critically ill were excluded from the study.

Data collection tools and procedures

Data were collected using face-to-face exit interviews with the study participants. A demographic, obstetric,

and respectful maternity care questionnaire were adapted from similar studies [1,6,14,15] which would initially developed in English and translated to Afan Oromo by expert of languages and then back to English to ensure consistency.

Four performance standards (friendly care, timely care, discrimination-free care, and abuse-free care) were used to assess compassionate and respectful care.[14] There were Likert scale items to measure each category in each performance standard. During analysis, the responses of "strongly agree" and "agree" were classed as "Yes" (received CRMC), while the replies of "strongly disagree," "disagree," and "neutral" were classified as "No" (disrespected and mistreated). Finally, women were considered as compassionated and respected during delivery services when the responses for the four performance standards were classified as "Yes."

To assure the quality of data, a pretest was conducted in the Asella referral and teaching hospital one week before the actual data collection time. By taking 10% of the sample size that was not included in the actual study population, corrections were made based on the results of the pretest. Every day after data collection, questionnaires were reviewed and checked for its completeness, accuracy and clarity by the supervisor and investigators. The reliability of the questionnaires was checked by Cronbach alpha reliability analysis becomes 0.791.

Data were collected from postpartum mothers using a structured questionnaire, with two Bachelor's degrees in midwifery serving as data collectors and one Master of Science in reproductive health expert serving as supervisor, both of whom were not hospital employees. Data collectors and supervisors were trained by principal investigators on the objective of the study and on the data collection instrument for one day.

Data processing and analysis

After data collection, each questionnaire was checked for its completeness and consistency. Data entry was done using Epi info version 7.1, center for disease control and prevention (CDC), USA.gov. and IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp. The data were summarized using descriptive statistics such as frequencies and percentages for categorical data and means and standard deviation for numerical data. Bivariate binary logistic regression models were used to assess the association between dependent and each independent variable and $P < 0.25$ was used to select candidate independent variables for multivariate binary logistic regression analysis. Significant association was declared using $P \leq 0.05$ and Adjusted odds ratio (AOR) with its 95% CI.

Ethical consideration

Ethical clearance was obtained from Adama General Hospital and Medical College Ethical Review Board with the ethical number of AGHMCERC/723/2020. This ethical clearance was given for Adama hospital medical college and data were collected after getting a written informed consent from every study participant. Confidentiality of information was assured by excluding names as identification in the questionnaires. Their response was kept confidential as it is only used for the study purpose.

RESULTS

Sociodemographic characteristics of the study participants

A total of 399 postpartum mothers were included in this study making a response rate of 100%. The mean age of the participants was 25 ± 5.0 years. Majority of respondents were married in their marital status and housewife in their occupational status [Table 1].

Obstetric related characteristics of postpartum mothers

Nearly half of postpartum mothers were primipara and multigravida. The majority of the study participants had

Table 1: Sociodemographic characteristics of mother's who gave birth at Adama hospital medical college, Adama, Oromia, Ethiopia, 2020 (*n*=399)

Variables	*n* (%)
Age (years)	
<25	214 (53.6)
26-34	167 (41.9)
>35	18 (4.5)
Marital status	
Married	346 (86.7)
Single	42 (10.5)
Divorced	11 (2.8)
Religion	
Orthodox	220 (55.1)
Muslim	157 (39.3)
Protestant	22 (5.5)
Ethnicity	
Oromoo	268 (67.2)
Amhara	89 (22.3)
Tigre	5 (1.3)
Gurage	37 (9.3)
Educational status	
No formal education	175 (43.9)
Primary and secondary	81 (20.3)
College and above	143 (35.8)
Occupational status	
House wife	241 (60.4)
Government employee	69 (17.3)
Private employee	39 (9.8)
Business man	38 (9.5)
Student	12 (3.0)

ANC follow-up for the current pregnancy and spontaneous vaginal delivery were their mode of delivery. Nearly half of the participants were attended by male health-care providers (HCPs) [Table 2].

Magnitude of compassionate and respectful maternal care

In this study, the overall magnitude of compassionate and respectful maternal care accounts for 169 (42.4%) with (95% CI; 37.3–47.4). The most common category of respectful maternity care identified by women in this study was providing friendly care [Table 3].

Table 2: Obstetrics characteristics of postpartum mothers at Adama hospital medical college, Adama, Oromia, Ethiopia, 2020 (*n*=399)

Variables	*n* (%)
Parity	
Primipara	209 (52.4)
2-4	173 (43.4)
≥5	17 (4.3)
Gravidity	
Primigravida	198 (49.6)
Multigravida	201 (50.4)
Abortion	
Yes	91 (22.8)
No	308 (77.2)
Antenatal care follow-up	
Yes	369 (92.5)
No	30 (7.5)
Mode of delivery	
Spontaneous vaginal delivery	313 (78.4)
Cesarean section	70 (17.5)
Instrumental delivery	16 (4.0)
Episiotomy	
Yes	228 (57.1)
No	171 (42.9)
Status of current pregnancy	
Wanted	361 (90.5)
Unwanted	38 (9.5)
Reason to deliver in the hospital	
Referred	235 (58.9)
Has Antenatal care follow-up	118 (29.6)
Interested to deliver here	46 (11.5)
Length of labor (h)	
Within 24	341 (85.5)
>24	58 (14.5)
History of previous institutional birth	
Yes	160 (40.1)
No	239 (59.9)
Sex of labor attendant	
Male	204 (51.1)
Female	195 (48.9)
Anyone other than concerned provider gets access to see you during labor	
Yes	104 (26.1)
No	295 (73.9)
Faced birth complications during your current labor	
Yes	66 (16.5)
No	333 (83.5)
Length of hospital stay (h)	
6	109 (27.3)
24	200 (50.1)
72	75 (18.8)
>72	15 (3.8)

Factors associated with compassionate and respectful maternity care

The results of multivariate logistic regression showed that seven variables: primary and secondary level education, multigravida, discussing on the place of delivery during ANC with HCP, history of previous institutional delivery, day time (shift) of delivery, asking for consent before the procedures, and two or less number of health workers during labor were significant determinants of CRMC [Table 4].

DISCUSSION

This study aimed to assess respectful maternity care and associated factors among laboring mothers during childbirth, in Ethiopia. The overall magnitude of CRMC was 42.4%. This finding is lower as compared to studies done in Nepal Medical College and Teaching Hospital 84.7%,[16]

Table 3: Categories and types of respectfully maternity care reported by mothers during childbirth, at Adama hospital medical college, Adama, Ethiopia, 2020 (*n*=399)

Categories of compassionated and respectful maternal care	Yes, *n* (%)	No, *n* (%)
Friendly care	291 (72.9)	108 (27.1)
Health-care workers cared for me with a kind approach	358 (89.7)	41 (10.3)
Health-care workers treated me in a friendly manner	319 (79.9)	80 (20.1)
The health-care providers were talking positively about pain and relief	352 (88.2)	47 (11.8)
The health worker showed his/her concern and empathy	322 (80.7)	77 (19.3)
All health-care workers treated me with respect as an individual	314 (78.7)	85 (21.3)
The health-care workers speak to me in a language that I can understand	364 (91.2)	35 (8.8)
The health-care providers called me by my name	316 (79.2)	83 (20.8)
Abusive free care	162 (40.6)	237 (59.4)
The health-care workers responded to my needs whether or not I asked	301 (75.4)	98 (24.6)
The provider gives adequate information regarding patient treatment and care	326 (81.7)	73 (18.3)
The health-care provider involve the client in treatment options	338 (84.7)	61 (15.3)
Some health-care providers slapped me during delivery for different reasons	212 (53.1)	187 (46.9)
Some health workers shouted at me because I have not done what I was told to do	219 (54.9)	180 (45.1)
Timely care	215 (53.9)	184 (46.1)
I was kept waiting for a long time before receiving services	250 (62.7)	149 (37.3)
Service provision was delayed due to the health facilities' internal problem	259 (64.9)	140 (35.1)
Discrimination-free care	189 (47.4)	210 (52.6)
Some of the health workers do not treat me well because of some personal attribute	185 (46.4)	214 (53.6)
Some health workers insulted me and my companions due to my personal attributes	165 (41.4)	234 (58.6)
I was allowed to practice cultural rituals in the facility	301 (75.4)	98 (24.6)

Table 4: Factors associated with compassionated and respectful maternity care at Adama hospital medical college, Adama, Ethiopia, 2020 (*n*=399)

Variables	Compassionated and respectful maternity care		Crude OR (95% CI)	AOR (95% CI)	*P*
	Yes	No			
Age					
<25	120	94	0.498 (0.186-1.33)		
26-34	42	125	1.894 (0.690-5.20)		
>35	7	11	Reference		
Educational status					
No formal education	90	85	0.744 (0.48-1.16)		
Primary and secondary	16	65	3.2 (1.68-6.061)	5.29 (1.92-14.57)	0.028
College and above	63	80	Reference	Reference	
Gravidity					
Primigravida	94	104	Reference	Reference	
Multigravida	75	126	1.52 (1.02-2.26)	3.75 (1.17-11.99)	0.013
Antenatal care follow-up					
Yes	152	217	1		
No	17	13	0.536 (0.25-1.135)		
Discussed on place of delivery during ANC					
Yes	137	44	18.09 (10.91-30.02)	9.13 (4.85-17.18)	0.023
No	32	186	Reference	Reference	
Status of current pregnancy					
Wanted	154	207	1.141 (0.57-2.26)		
Unwanted	15	23	Reference		
History of previous institutional birth					
Yes	119	120	2.18 (1.43-3.49)	3.306 (1.026-10.65)	0.001
No	50	110	Reference	Reference	
Sex of birth attendant					
Male	92	112	1.26 (0.85-1.87)		
Female	77	118	Reference		
Birth complications during current labor					
Yes	26	40	Reference		
No	143	190	0.864 (0.504-1.48)		
Length of hospital stay (h)					
<12	33	76	1.00		
13-24	95	105	0.48 (0.293-0.786)		
>24	41	49	0.52 (0.290-0.929)		
Time (shift) of delivery					
Day	118	49	8.547 (5.42-13.48)	3.52 (1.85-6.72)	0.017
Night	51	181	Reference	Reference	
Asked for consent before the procedure					
Asked me	132	53	11.91 (7.39-19.19)	3.49 (1.821-6.72)	0.000
Not asked me	37	177	Reference	Reference	
Number of health workers					
Two or less	134	74	8.07 (5.07-12.83)	4.68 (2.495-8.77)	0.002
Three or more	35	156	Reference	Reference	

ANC: Antenatal care, OR: Odds ratio, CI: Confidence interval, AOR: Adjusted OR

Ethiopian public health facilities 66%,[17] Referral Hospitals in Northwest Amhara 56.3%,[10] public health facilities in Bahir Dar town 57%[1] and Bale zone Public Hospitals 62.5%.[18] This lower magnitude of compassionated and respectful maternity care in this study may probably due to the variations in the health-care system, in which high workload that may burden HCP in this hospital to fully practice compassionated and respectful maternity care as expected and the imbalance between workforce and complicated cases managed in this hospital as it referral hospital for neighboring health facilities. Being teaching hospitals, the cases may not managed by the clinician those postpartum mothers were interested in. Moreover, services like the pharmacy; laboratory and pre-triage for laboring mothers were not integrated together which may lower CRMC.

The finding of this study, however, is higher than studies from southwest Nigeria 6.8%,[19]West Shewa zone in Oromia region 35.8%,[20] Yeka Sub-City Health Centers in Addis Ababa 14.7%[21] and public health facilities in Addis Ababa 22%.[6] The considerable difference may be due to differences in staff training and organization of healthcare. In addition, those studies in Addis Ababa health center they excluded those mothers who had an elective or emergency cesarean section. The finding of this study

was in line study done in Uttar Pradesh of India 43%[22] and Harar hospital 38.4%.[14]

The odds of CRMC were increased by 3-fold among postpartum mothers that had history of previous institutional delivery as compared to their counterparts. This finding is consistent with a study from referral hospitals in Amhara and a study conducted in Pakistan that where women who delivered their previous pregnancy in health facilities are 2.5 times more likely to experience respectful care than those with home delivery.[10,23] This might be due to the exposure of women from previous delivery and awareness of the women about the delivery process and HCPs might have a positive attitude toward women who had familiarity with the health-care service.

The finding of this study showed that the odds of CRMC were four times higher among postpartum mothers who gave birth during the daytime as compared to the nighttime shift. This finding is in line with a study conducted in Kenya that night shift deliveries were associated with greater verbal and physical abuse.[24] This finding is supported by the study conducted in Addis Ababa public health facilities that the odds of disrespect and abuse among mothers who delivered at night shifts were 4.42 times higher than those who delivered at day shifts.[21] The possible explanation might be due to the evidence showed that labor starts for most women at night time; on the contrary, HCPs become tired because of work overload, sleeping disturbance. In addition, there are more resources/infrastructures available and the number of health workers than at night time, in which only few health workers might be assigned for duty and also very weak supervision from senior health workers and managers during nighttime.

The current study indicates the odd of CRMC increased by 9-fold among postpartum mothers that discussed on the place of delivery during ANC with HCP as compared to those that did not. This finding is consistent with a study West Shewa zone in the Oromia region, Ethiopia as they reports women who had discussed on a place of delivery with health workers during ANC were 4.42 times more likely to receive RMC than those who did not.[20] The reason for this might be because women who had ANC and discussed on a place of delivery were more likely to be familiar with the HCPs.

In this study, the number of attending HCP was found to be significantly associated with CRMC during labor and childbirth. Accordingly, this study shows postpartum mothers who were attended to by 2 or fewer HCPs were five times more likely to receive CRMC than those who were attended by 3 or more. This finding is comparable with the study West Shewa zone in the Oromia region that mothers who were attended to by 2 or fewer providers were 2.23 times more likely to receive RMC than those who were attended by 3 or more.[20] This is may be due to mothers do not want to show their private body to more number of providers.

This study finding also shows taking consent before doing a procedure was found to affect CRMC. The odd CRMC increased by 3 fold among postpartum mothers that were asked their consent before any procedures compared to those that did not. The finding is in line with studies conducted in health facilities in Addis Ababa, Ethiopia, East and southern Africa, West Shewa zone in the Oromia region, Ethiopia.[6,12,20] This result also highlights the need for involving mothers in all types of care they receive from health facilities.

Although the problem of recall bias was minimized by conducting exit interviews for postpartum mothers immediately; the current study is not free of social desirability bias in which some mothers may report the service as positive experience while they are in the health facilities and may have fear of reporting abusive care, and it did not show cause-effect relationships since it was a cross-sectional study.

CONCLUSION

The proportion of CRMC among laboring mothers during childbirth was low. Being multigravida, discussing on the place of delivery during ANC with HCP, history of previous institutional delivery, day time (shift) of delivery, asking for consent before the procedure and two or less number of health workers during labor were significant determinants of compassionated and respectful maternity care. As a result, health-care workers and managers must focus on raising awareness among HCPs about the recommended ANC follow-up standards, encouraging women to give birth in a health facility, and developing an intervention to improve nighttime delivery services. However, additional follow-up studies could differentiate the root causes.

Conflicts of interest

There are no conflicts of interest.

Authors' contribution

All authors made substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; took part in drafting the article or revising it

critically for important intellectual content; agreed to submit to the current journal; gave final approval of the version to be published; and agree to be accountable for all aspects of the work

Financial support and sponsorship

Nil.

Acknowledgment

We would like to acknowledge Adama general hospital and medical college, data collectors and supervisor, study participants, friends and family members for their support.

REFERENCES

1. Wassihun B, Zeleke S. Compassionate and respectful maternity care during facility based child birth and women's intent to use maternity service in Bahir Dar, Ethiopia. BMC Pregnancy Childbirth 2018;18:294.
2. Moridi M, Pazandeh F, Hajian S, Potrata B. Midwives' perspectives of respectful maternity care during childbirth: A qualitative study. PLoS One 2020;15:e0229941.
3. UN IGME. United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME), "Levels & Trends in Child Mortality: Report 2017, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation", United Nations Children's Fund, New York; 2017.
4. Central Statistical Agency (CSA) [Ethiopia] and ICF. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland: CSA and ICF; 2016. p. 1-551.
5. Sachs JD. From millennium development goals to sustainable development goals. Lancet 2012;379:2206-11.
6. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reprod Health 2015;12:33.
7. Bhutta ZA, Salam RA, Lassi ZS, Austin A, Langer A. Approaches to improve quality of care (QoC) for women and newborns: Conclusions, evidence gaps and research priorities. Reprod Health 2014;11 Suppl 2:S5.
8. Dewana Z, Fikadu T, G/Mariam A, Abdulahi M. Client perspective assessment of women's satisfaction towards labour and delivery care service in public health facilities at Arba Minch town and the surrounding district, Gamo Gofa zone, south Ethiopia. Reprod Health 2016;13:11.
9. Tesfaye R, Worku A, Godana W, Lindtjorn B. Client satisfaction with delivery care service and associated factors in the public health facilities of gamo gofa zone, Southwest Ethiopia: In a resource limited setting. Obstet Gynecol Int 2016; 2016:1-7.
10. Yosef A, Kebede A, Worku N. Respectful maternity care and associated factors among women who attended delivery services in referral hospitals in Northwest Amhara, Ethiopia: A cross-sectional study. J Multidiscip Healthc 2020;13:1965-73.
11. Rezaei-Abhari F, Khorshidi S, Pourasghar M, Yazdani-Charati J, Ahmad Shirvani M. Effect of workshop training on midwives' communication skills and maternal satisfaction in maternity block. J Nurs Midwifery Sci 2019; 6:157-63.
12. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, *et al*. Direct observation of respectful maternity care in five countries: A cross-sectional study of health facilities in East and Southern Africa. BMC Pregnancy Childbirth 2015;15:306.
13. Tollera G, Girma S, Seid S, Tarekegne G, Seid K, Shkure R. Federal Democratic Republic of Ethiopia Ministry of Health. National CRC Training Participant Manual; 2017.
14. Bante A, Teji K, Seyoum B, Mersha A. Respectful maternity care and associated factors among women who delivered at Harar hospitals, eastern Ethiopia: A cross-sectional study. BMC Pregnancy Childbirth 2020;20:86.
15. Reis V, Deller B, Carr C, Smith J. Respectful Maternity Care: Country Experiences. Survey Report 2012. Washington DC: United States Agency for International Development; 2012.
16. Pathak P, Ghimire B. Perception of women regarding respectful Maternity care during facility-based childbirth. Obstet Gynecol Int 2020; 2020:1-8.
17. Sheferaw ED, Bazant E, Gibson H, Fenta HB, Ayalew F, Belay TB, *et al*. Respectful maternity care in Ethiopian public health facilities. Reprod Health 2017;14:60.
18. Mekonnen A, Fikadu G, Esmeal A. Disrespectful and abusive maternity care during childbirth in Bale zone Public Hospitals, southeast Ethiopia. ClinPract 2019;16:1273-80.
19. Ogunlaja AO, Fehintola OA, Ogunlaja IP, Popoola G, Idowu A, Awotunde OT, *et al*. Respectful maternity care or "disrespect and abuse during maternity care"; Experience of pregnant women in Ogbomoso, South West Nigeria. Rwanda Med J 2017;74:6-9.
20. Bulto GA, Demissie DB, Tulu AS. Respectful maternity care during labor and childbirth and associated factors among women who gave birth at health institutions in the West Shewa zone, Oromia region, Central Ethiopia. BMC Pregnancy Childbirth 2020;20:443.
21. Teshome G. Disrespect and abuse during facility-based child birth in Yeka sub- city health centers Addis Ababa, Ethiopia Ethiop. J. Health Dev. 2021; 35(1):1-8.
22. Sudhinaraset M, Treleaven E, Melo J, Singh K, Diamond-Smith N. Women's status and experiences of mistreatment during childbirth in Uttar Pradesh: A mixed methods study using cultural health capital theory. BMC Pregnancy Childbirth 2016;16:332.
23. Azhar Z, Oyebode O, Masud H. Disrespect and abuse during childbirth in district Gujrat, Pakistan: A quest for respectful maternity care. PLoS One 2018;13:e0200318.
24. Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N, *et al*. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. BMC Pregnancy Childbirth 2015;15:224.