


Women's perspectives on disrespect and abuse experiences during childbirth in a teaching hospital in Southwest Ethiopia: a qualitative study

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Abstract: *There is evidence that women in Ethiopia often face disrespect and abuse in health care facilities during childbirth. Disrespect and abuse (D&A) violate women's right to dignified, respectful health care and decrease their trust in health care facilities. There is a need for more insight into women's perspectives on D&A during childbirth in different contexts. Therefore, this study aimed to explore women's perspectives on D&A during childbirth in a teaching hospital in South-West Ethiopia. A qualitative study was conducted from November 2017 to February 2018 using in-depth interviews and focus group discussions. Postnatal women were purposively chosen and scheduled for interviews six weeks postpartum. Data saturation occurred once 32 women were interviewed, and four focus group discussions were conducted. A thematic analysis method was used to analyse the data using MAXQDA qualitative analysis software. Three main themes emerged from the data: disrespect and abuse, its contributors, and perceived consequences. The subthemes of D&A include neglected care, non-consented care, physical abuse, lack of privacy, loss of autonomy, objectification, lack of companionship, and verbal abuse. The subthemes of contributors include health care provider-related, health care system-related, and women-related contributors. The subthemes of perceived consequences include the fear of using health care facilities. Women in Ethiopia experienced D&A. Health system factors, such as the teaching environment and scarcity of supplies, contribute the most to the identified D&A. Therefore, providers, administrators, training institutions, and researchers must collaborate to address these health system factors to reduce disrespect and abuse during childbirth in teaching hospitals. DOI: 10.1080/26410397.2022.2088058*

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Introduction

One of the global sustainable development goals is to decrease the maternal mortality ratio (MMR) below 70 deaths per 100,000 live births by 2030.¹ Based on this goal, the Ethiopian

government planned to reduce the MMR from 420 in 2015 to 199 deaths per 100,000 live births by the end of 2020.² However, the recently reported MMR in Ethiopia in 2017 was 401 per 100,000 live births.³ Using health care facilities for delivery is essential for reducing maternal mortality and morbidity,^{4,5} but in Ethiopia, only 48% of women use health facilities for childbirth,

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as reported in 2019.⁶ Furthermore, 45% of women with severe maternal morbidities do not seek medical attention before complications become apparent.^{7,8}

Many studies have shown that women experience disrespect and abuse (D&A) during childbirth in health care facilities.^{9–12} Physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities are the seven types of D&A during childbirth as identified by Bowser and Hill.¹³ Based on a review of qualitative and quantitative evidence, Bohren et al.¹⁰ have developed a typology of mistreatment of women during childbirth in health facilities, including physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints.¹⁰

One of the contributors to women's lack of preference for institutional delivery is D&A during childbirth and studies have shown that women who experience D&A prefer to give birth at home for their subsequent pregnancies.^{10,12,14–16} Disrespect and abuse also contribute indirectly to maternal morbidity and mortality by deterring women from using recommended interventions in health care facilities.^{14,16–18}

Globally, there is a high prevalence of D&A in health care facilities, ranging from 15% to 99%.¹⁰ The magnitude of D&A is high in Ethiopia and varies from 21% to 99%, depending on study settings.¹² The prevalence of D&A in one tertiary teaching hospital in Ethiopia was 91.7%,¹¹ and in some rural health centres, it was 21%.¹⁹ Disrespect and abuse experienced by women at the health facility during childbirth is also considered a violation of human rights;²⁰ the Respectful Maternity Care Charter compares the seven forms of D&A with seven human rights.²¹

Disrespect and abuse have received global attention since the Bowser and Hill report.¹³ For example, the World Health Organization recommends greater attention to research and policies on D&A and has also made respectful and dignified care a component of quality of care.²⁰ Accordingly, several interventions have been implemented to reduce D&A in many settings.^{20–24} Ethiopia has also been designing respectful and compassionate care approaches and quality improvement initiatives in health care facilities.^{2,25}

This study aimed to explore women's perspectives on D&A during childbirth in a teaching hospital in southwest Ethiopia. Many quantitative studies on D&A have been published from African countries, including Ethiopia.^{9,11,19,26–30} Unlike in other African countries, where many qualitative studies on D&A have been conducted,^{31–34} there have been limited qualitative studies in Ethiopia exploring D&A during childbirth.^{35,36} Furthermore, past research has demonstrated that D&A differs based on the circumstances of the study setting.^{10,12} Studies in tertiary teaching hospitals that specifically explore experiences of D&A are limited,^{9,11} and this study, therefore, seeks to explore the impact of the teaching environment on women's perspectives on D&A.

After several years of interventions to reduce D&A, many quantitative studies conducted in Ethiopia have shown that D&A still occurs during childbirth.^{19,37} A systematic review in Ethiopia reported detention in health care facilities as a D&A experience.¹² The reason given was that the women could not pay the service fee. However, any maternal health service in Ethiopia is provided free of charge in all public health facilities. This study, conducted in a public facility, would also serve to illustrate the influence of previous efforts in Ethiopia to reduce D&A in public health facilities.

Methods and materials

Study setting and design

This study was conducted on women who gave birth at Jimma University Specialized Teaching Hospital, recently named Jimma Medical Centre. The hospital is located in Jimma, a town 352 km southwest of Addis Ababa, Ethiopia. It is a tertiary-level hospital serving a population of 15 million in the Jimma Zone. The hospital is used as a referral hospital and teaching hospital for health care workers from all disciplines.

To develop knowledge based on individual women's experiences, we used an explorative qualitative design. We conducted in-depth interviews (IDIs) and focus group discussions (FGDs) from November 2017 to the end of January 2018. Focus groups were used to gather data on women's opinions and the meanings they attributed to D&A. We conducted IDIs with individual women to gain a deeper understanding of

women's feelings and beliefs about their D&A experiences.

Study population and inclusion criteria

Post-natal women admitted to the labour ward of Jimma Medical Centre who had given birth to a live baby without severe obstetric complications, such as eclampsia or severe bleeding, were invited to participate. At the time of the women's discharge from the hospital, the first author informed them about the study and gave them the opportunity to choose whether to take part. Written informed consent was obtained from those who agreed to participate, who were scheduled for either interviews or FGDs at six weeks postpartum, which the women preferred. Thirty-two women took part in individual interviews, and 33 women took part in four focus groups of 7–9 participants each. The women represented different age groups, educational status, places of residence, and parity.

Data collection procedure and the researchers' roles

The interviews and FGDs were conducted in four Jimma town health centres and deliberately not at Jimma Hospital, to encourage the women to speak freely. The interviews and FGDs were conducted in private rooms. Semi-structured in-depth interview and focus group guides were developed based on the research questions, the literature, and the personal knowledge and experiences of the first author, who is a midwife. The in-depth interview and focus group guides were translated into two local languages (Amharic and Afaan Oromo) and translated back and forth into both languages to ensure that the meaning was preserved. The in-depth interview guide was pretested and adjusted accordingly prior to the interviews. Data from the pilot test were not included in the analysis. The in-depth interview guide included questions concerning: (1) the woman's general reception and expectations during admission; (2) labour and delivery experiences at the hospital; (3) experiences of D&A; and (4) opinions on the consequences of their poor experiences (Additional file 1). The focus group guide included the following topics: (1) the women's experiences during childbirth at the facility; (2) the women's experiences of D&A during childbirth; (2) the women's opinions on factors contributing to poor birth experiences,

and (3) the women's suggestions for improvement (Additional file 2).

The first author performed the individual interviews in a private place at the health centres. Each participant was interviewed once in their local language. Interviews lasted between 45 and 60 minutes and were audio-recorded. The FGDs were conducted by the first author and two research assistants, who made audio recordings and took notes. All three were natives of the region and had a good understanding of the local culture and language. Participants were informed that the session would be recorded and that no personal identifiers would be used during the discussions. All women were encouraged to share their experiences.

Data management and analysis

The first author transcribed the audio recordings of the interviews verbatim with the help of a research assistant. The two research assistants translated the transcripts into English. The first and third authors revised and checked the English version for consistency. Qualitative thematic analysis was used to analyse the data, following Braun and Clarke's approach.³⁸ This approach includes familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. The audio was listened to repeatedly during the transcription to gain familiarity with the data. The initial manual coding, performed by the first and third authors, was useful for familiarisation with the content of the data.

Codes were discussed between the first and third authors, who reached an agreement on codes to develop the codebook. Based on the codebook, the remaining transcripts were coded using MAXQDA, a qualitative data analysis software. In the last step, the codes were classified several times, resulting in three main themes (Additional file 3). The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to guide the reporting of this study.³⁹

Ethical considerations

Ethical approval for this study was obtained from the Regional Committee for Medical and Health Research Ethics of South-East Norway (R.E.C.), Section B (Ref 2017/1050b, 29 June 2017) and St. Paul's Hospital Millennium Medical College Institutional Review Board (reference number PM23179, 25 September 2017), Addis Ababa,

Ethiopia. Two ethical approval letters (from R.E.C. and St. Paul's Hospital Millennium Medical College Institutional Review Board, Addis Ababa, Ethiopia) and a support letter were submitted to Jimma University Institute of Health to recruit women for participation. A support letter was obtained from the hospital medical director's office to access the labour ward. All records from the interviews and focus groups were kept anonymous and confidential.

Results

Sociodemographic characteristics of participants

For a description of sociodemographic characteristics of the study participants, see [Table 1](#).

Main themes

Thematic analyses of the transcripts identified three main themes: D&A experience, perceived contributors to the experienced D&A, and perceived consequences of D&A. Each main theme consisted of multiple subthemes ([Figure 1](#)).

Experiences of disrespect and abuse

During the interviews, women described different experiences of D&A, such as neglect, non-consented care, physical abuse, lack of privacy, loss of autonomy, objectification, lack of companionship, and verbal abuse ([Figures 1 and 2](#)).

Neglected care

The “neglected care” theme has two sub-themes: neglect during admission and neglect of comfort and hygienic care after delivery. Most participants reported a lack of comfort and hygienic care after the delivery as D&A. More than half of the study participants across all levels of education and age groups reported being neglected after delivery. Most primipara women reported neglect after delivery as D&A, whereas neglect was not reported by most multipara women. Furthermore, there was no difference in reported neglect based on ethnicity. The following quote indicates neglect at admission:

“When I entered the labour room, one of the health care providers told me to lie down on a bed. Then, she left me alone without checking my labour. After some hours, she transferred me to another room, and she left me again. I asked another health care provider working in the same room to please

assist me. I cried loudly, and I was worried about what could happen to my baby and me. When she heard my cry, she came and examined me.” (FGD 1, age 26, para 3)

Most women reported that providers neglected hygienic care and comfort when they were on the delivery bed after childbirth. They reported lying down on small, unclean delivery beds for hours and that the providers lacked empathy for their experiences.

“Why would doctors leave mothers on small, uncomfortable delivery beds with their blood after delivery?” I stayed on a small delivery bed with my baby until I was discharged. At that moment, I was disappointed. I could not change my dirty clothes, and I stayed without bedding.” (IDI participant, age 28, para 2)

Non-consented care

The “non-consented care” theme had two sub-themes: lack of information and lack of consent. Most women initially reported a lack of information and, when probed, they also reported a lack of consent. The most reported non-consented care was a physical examination. However, one woman reported a coerced caesarean section.

More than half of the women reported that health care providers did not provide information about procedures during labour and delivery. All women with no schooling reported lack of information as D&A experience, whereas few women from secondary and vocational levels of education reported lack of information as D&A experience. Primipara and multipara women stated that health care providers did not provide information about the procedure.

According to the women, rather than providing information, providers asked them to follow instructions, such as adopting a position for procedures, as in the following quote:

“Why would the providers not at least tell me they were going to do procedures before examinations and treatments? When I was in the hospital for childbirth, the health care providers did not tell me anything. They only told me to open my legs, and they did the examination.” (IDI, age 26, para 2)

Lack of consent was reported among women of all education levels, age groups, parity, and ethnicity. As compared to women with college degrees, most

Table 1. Distribution of sociodemographic characteristics of participants

Characteristics	Interviews N = 32	FGD N = 33	Total N = 65
Age			
19 and less	5	7	12
20–24	5	10	15
25 and above	22	12	34
Educational status			
No schooling	3	–	3
Primary education	5	7	12
Secondary education	16	17	33
TVT (vocational training)	5	6	11
University degree	3	3	6
Number of childbirths (parity)			
Primipara	16	13	29
Multipara	16	14	30
Grand multipara (births)	–	6	6
Address			
Urban	27	33	60
Rural	5	–	5
Ethnicity			
Oromo	9	13	22
Amhara	10	9	19
Yem	5	6	11
Selete	6	4	10
Dewaro	2	1	3
Mode of delivery			
Spontaneous	24	–	24
Caesarean section	8	–	8

women with no schooling reported lack of consent as D&A.

Physical abuse

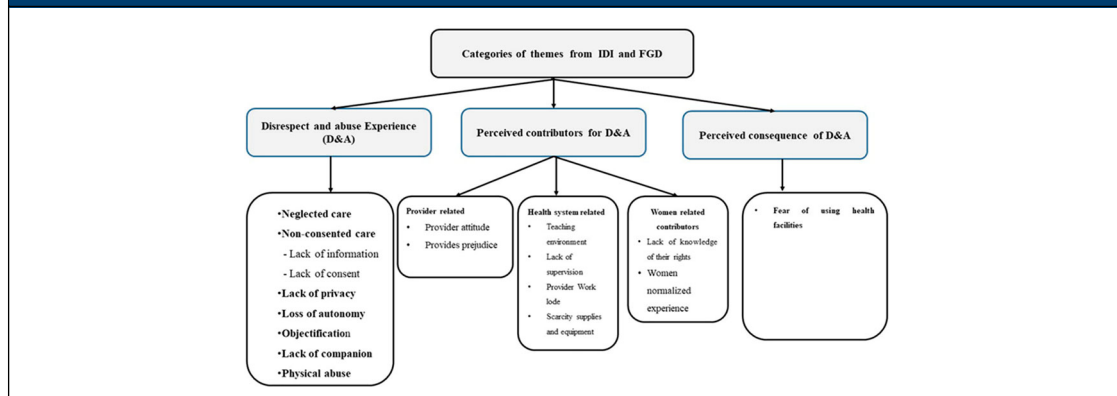
Physical abuse was the least reported form of D&A experience. However, women reported episiotomy without anaesthesia as physical abuse across all levels of education, and eight women reported physical abuse in this form, as the following quote indicates:

“My stitch was repaired without the use of painkillers. At the time, I was in so much pain; even a single accidental needle prick hurts and suturing human tissue with multiple needle pricks hurts much more”. (IDI, age 28, para 2)

Verbal abuse

Verbal abuse during labour and delivery that women experienced and reported includes unfavourable words, yelling, and blaming.

Figure 1. Themes and subthemes identified from in-depth interviews and focus group discussions on women’s experiences during childbirth a teaching hospital in Southwest Ethiopia



Women’s refusal of providers’ repeated physical examinations without privacy contributes to verbal abuse. Next to physical abuse, verbal abuse was the least commonly reported form. Further, women from all age categories, ethnicity, and secondary and vocational level education reported verbal abuse as D&A at least once. However, grand multipara women did not report verbal abuse as D&A.

The following part of the transcript shows verbal abuse in the form of blaming:

“The doctor who had been monitoring my labour left to change his cloth in another room. Another doctor came to me and wanted to check. Then I said to him, ‘No, you cannot examine me because I was checked a few minutes ago’. Then, he left me for a while, and he came back and said, ‘One of your first babies died. Do you want to kill the second baby as well?’”. (IDI, age 27, para 2)

Lack of privacy

Most of the women reported that providers examined them without curtains in the presence of students and other staff. They noted that such encounters were unexpected, humiliating, and disappointing, causing anxiety, discomfort, and additional pain. When compared to other forms of D&A, lack of privacy was the most reported form of D&A in this study. More than half of the women from all educational levels, age groups, parity, and ethnicities mentioned the lack of

privacy at least once. A participant recounted this experience as follows:

“I recall my experience as embarrassing, exhausting, and frustrating. Several students crowded around my bed, watching as another health care provider examined me. I was terrified at the time, but when providers became aware of my feelings, they all became angry”. (FGD, age 27, para 1)

A minority of women accepted the lack of privacy that others found distressing. For instance, physical examinations in the presence of their peers and service providers during labour were not a concern for some women. They believed that all women were in similar physiological and psychological states.

“I’m not worried about privacy because providers only allow women in labour in that room. As a result, the lack of privacy was not an issue, because we had been through similar experiences, including extreme labour pain. We had no time to think about privacy at that moment”. (IDI, age 28, para 1)

Loss of autonomy

Some of the women in this study felt that they had lost control of their decision-making power and the right to reject unfavourable situations. Loss of autonomy was the third least reported form of D&A, next to verbal abuse and physical abuse in this study. Women with primary-level education, women in the 20–24 year age group, and

Figure 2. Distribution of disrespect and abuse themes with their coding segments



multiparas did not report a loss of autonomy as D&A. The following quote illustrates a woman's experience with loss of autonomy:

"When I was admitted to the hospital, the beds were not cleaned well. A health care provider said to me, "Lie down on that bed". I could not refuse because I thought the provider might get upset with my suggestion, and my subsequent care might be affected". (IDI, age 25, para 1)

Objectification

Most women reported objectification as a D&A experience. Participants believed that health care providers dealt with them as if they were

objects. The views of these women were related to their experience of physical examinations conducted by multiple health care providers who wanted to learn skills.

"To learn skills, the health care provider conducted a vaginal examination on me. How can a stressed-out mother be turned into a teaching tool? How is it possible that this practice happens in a hospital where mothers are encouraged to give birth? I don't want to go through anything like that again in my life". (FGD 2, age 35, para 4)

The women claimed that the health care providers did not understand their feelings during these frequent physical examinations. They reported that

the providers lacked empathy for the unpleasant experiences of the women.

“I cried as they repeated the examinations on me with various health care providers. ‘Why are you screaming like that?’ they asked, enraged. ‘Keep your mouth shut! This is not your first time having a physical examination like this, as this is your fifth child, you told me’”. (FGD, age 27, para 4)

Lack of companionship

Most women reported lack of companionship during labour and delivery as D&A experience. The women claimed that not having a companion during labour made their hospital stay unfavourable, because they lacked support from someone with whom they could express their feelings. The women reported that birth companions could detect complications, notify medical staff, and bring essential supplies.

“After I gave birth, one of my relatives hid from the health care provider and entered my partition. She yelled and notified the health care provider of the blood that had accumulated between my two legs. As medical personnel arrived at my partition, they checked my bleeding and provided the necessary treatment to stop it. So, if my relative had not come to my aid, no one would have noticed my bleeding, and I might have died because of it. For a mother, having a companion after childbirth is crucial”. (IDI, age 25, para 1)

Some of the participants perceived not allowing birth companions in the labour ward as an acceptable practice. They perceived that companionship could affect their privacy, but also that *“having someone with you during labour may create inconveniences for health care providers”* (IDI, age 27, para 2).

“It was good in that they did not allow attendants during labour. You see, during childbirth, we cannot protect our naked bodies. If attendants were allowed in the labour ward, one woman’s attendant could see another woman’s naked body”. (IDI, age 25, para 1)

Perceived contributors to disrespect and abuse

Contributors to the D&A experience of women include health care provider-related contributors, health system-related contributors and women-related contributors (Figures 1 and 3).

Health care provider-related contributors

Two subthemes emerged under health care provider-related contributors: (1) perceived provider attitude and (2) perceived provider prejudice based on social relationships. The women reported that the providers’ attitude was a factor in their D&A experience during childbirth. They perceived that the supportive care they received during delivery depended on the good or bad attitude of the personal health care provider. Women in the same unit could have experiences of respect or disrespect.

“I remember when I arrived at the hospital with labour pain, I received good care from a good doctor. However, in the same room, I also met another doctor with bad behaviour”. (IDI, age 27, para 2)

A minority of women perceived that health care providers paid special attention to women who had social relationships with the providers. For example, women who knew the health care provider before their admission received more compassionate care than other women did.

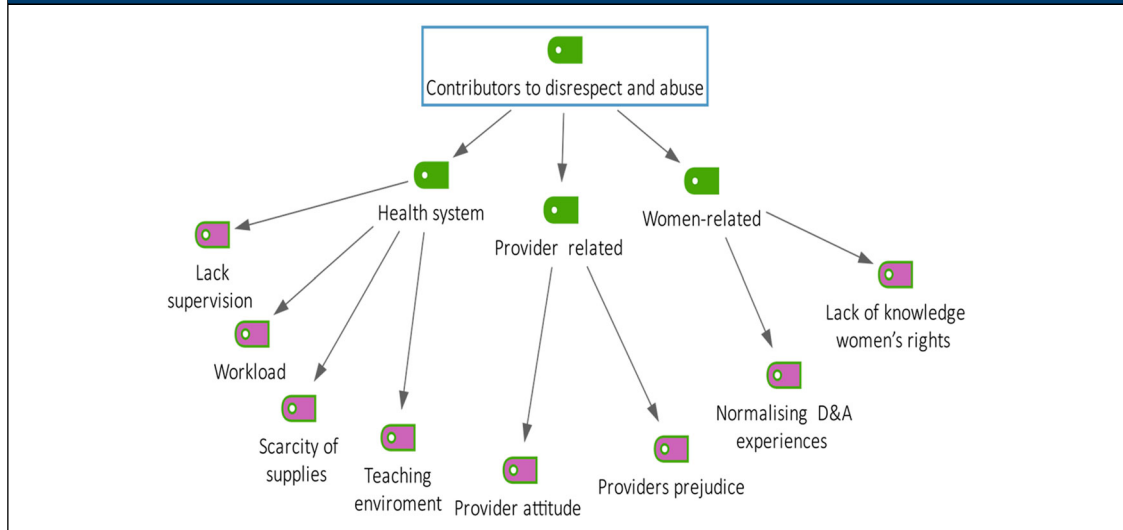
“I recognise that health care providers did their best to help all women; however, we saw some differences in supportive care based on their degree of previous social experience with the women”. (IDI, age 27, para 2)

Health system-related contributors

Health system-related factors include scarcity of equipment and supplies, workload, lack of supervision, and the teaching environment (Figures 1 and 3). Most participants perceived the teaching environment and the scarcity of supplies and equipment as contributing factors to their D&A experience. A minority of participants reported provider workload and lack of supervision as contributors. The following quote shows one woman’s perception of providers’ workload:

“I did not expect the health care providers to do anything for me after I gave birth since I’d seen a lot of women being hospitalised that day and asking for help from them”. (IDI, age 30, para 2)

Most women mentioned a lack of equipment and supplies as a contributor to health care providers’ neglect of women’s comfort and hygienic care.

Figure 3. Contributors to disrespect and abuse during childbirth a teaching hospital in Southwest Ethiopia

“The lack of bedding in such a large hospital was unexpected to me. For example, when we went to the hospital, we did not bring a bedsheet because we thought we would be able to get one there. When I got there, though, I did not get a bedsheet and had to sleep on a bed with no bedding. As a result, I didn’t sleep until I got back to my house”. (IDI, age 35, para 4)

Some women reported that sometimes they were admitted to the hospital for delivery without a specified bed. Some had to leave their beds for other women shortly after delivery:

“I arrived in the labour and delivery ward early in the morning, but I did not get a bed. At 3 pm, after eight hours of admission, without a bed in the labour room, I was given a bed. Then I gave birth in the middle of the night, and they ordered me to leave the bed to another woman right away”. (IDI, age 25, para 1)

Some women reported a lack of staff supervision as a contributor to their experience of D&A. They believed that enough medical staff were present in the delivery room, but that a lack of supervision led to health care providers neglecting women who had given birth:

“While I was in the hospital, numerous health care providers were available inside the labour ward.

However, they ignored my concerns, did not talk to me or assist me”. (IDI, age 32, para 2)

Most participants perceived the environment of the teaching hospital as the source of their experience of objectification and lack of privacy. They reported that during their stay in the labour and delivery room for childbirth, many students were present in the room to watch other health care providers perform the procedure.

Women-related contributors

Women-related contributors to D&A include a lack of knowledge of women’s rights and women’s normalising of D&A experiences (Figures 1 and 3). Some women believed that health care providers had the right to recheck them physically without asking for their permission. They also felt obligated to undergo various forms of medical examinations, even for training purposes.

“I think that health care providers were allowed to do a physical examination on us without asking our permission ... I could not refuse them when they did physical examinations on me during labour because I thought it was their right. For instance, six health care providers physically examined me while I was in labour”. (FGD, age 25, para 2)

Some women accepted physical examinations without consent.

“They did not ask our permission because we wanted to go to the hospital to get our health checked and to receive medical attention. I think the health care provider does not have an obligation to request our permission for physical examination; however, I think they must check women during labour and delivery”. (IDI, Age 23, para 1)

“I do not expect the health care providers to ask my permission for procedures and examinations that they did on me during labour and delivery. I assumed all examination and procedures were performed for my benefit at that moment, even if I want to be checked by health care workers”. (IDI, Age 26 para 1)

Perceived consequences of D&A

A significant minority of participants perceived a lack of privacy and objectification as a deterrent to institutional delivery. They assumed that the objectification and violation of privacy that they experienced during labour could make them choose home birth for future pregnancies.

“While I was in labour, a health care provider did a physical examination on me in a shared ward in an open place. We do not want to go through these humiliating encounters. Such experiences can make a woman give birth at home in subsequent pregnancies. Due to fear of such an experience, some of our friends gave birth at home, and their labour ended in serious complications. We chose the hospital because we expected to receive treatment in a private setting”. (IDI, Age 30, para 3)

The women reported that a lack of privacy in health care settings resulted in some women's preference for home delivery, resulting in related complications. Thus, they associated their current experiences of a lack of privacy with the life-threatening events experienced by their friends who had attempted home deliveries.

“Most women place their lives at risk of death due to fear of physical examinations in open spaces in health care facilities, and they decide to give birth at home rather than expose their bodies in an open space. So, women may die at home while attempting to give birth”. (FGD 4)

“At the hospital, health care providers performed physical exams on women without a curtain, in

front of many students, again and again. Such an experience is traumatic for them. Therefore, some women stopped coming to the hospital to avoid such an unpleasant encounter”. (IDI, age 27, para 2)

Discussion

This study explored women's perspectives of disrespect and abuse during childbirth in a tertiary teaching hospital in southwest Ethiopia. Three major themes were identified: D&A experiences, contributors to D&A, and perceived consequences of D&A. The identified themes were mainly interpreted based on the seven rights of childbearing women,²¹ Bowser and Hill's categories of D&A,¹³ and Bohren's mistreatment typology.¹⁰

Physical abuse in the form of slapping, pinching, and physical restraint, which was identified in prior studies,^{31,32,40} was not reported in the present study as D&A. Such variations may be due to differences in the study setting. Health care providers in teaching hospitals in Ethiopia include both staff and trainees from different professions: resident physicians, medical interns, trainee midwives, staff midwives, and obstetricians.^{2,41,42} The teaching hospital context may reduce providers' stress-related D&A of women.³¹ In some professional training programmes, students are evaluated by their senior trainees and this teaching environment may not allow the health care provider to pinch or slap the woman during labour. Detention in health care facilities, which was reported in some studies on African countries²² and in a systematic review in Ethiopia^{10,12}, was not reported as D&A in the present study. Such a difference in findings may be the effect of the government's prior interventions on improving institutional delivery in Ethiopia. In all public health care facilities, maternal health services are free from payment.²

None of the women in this study reported neglect during labour. However, in prior studies, health care providers abandoned women during delivery, leaving them to give birth alone in health care facilities.^{31,32,36} The teaching environment of the study hospital, in which trainees must support delivery and check maternal and fetal status, may have contributed to this difference. Furthermore, due to the current scenario in Ethiopia, with large numbers of students enrolled, teaching hospitals are overburdened with trainees. As a result, the chances of neglecting women during labour and delivery may be lower.

The consequences of the D&A experience reported by women in the present study included a disinclination to use health care facilities for their future pregnancies due to objectification and lack of privacy. The implication of the experience of women in this study for their rejection of institutional deliveries is consistent with prior reports in Ethiopia and other countries.^{10,12,15} In future large-scale quantitative studies, it would be important to measure the magnitude of such a perception and its contributors. This finding implies that interventions targeted at reducing objectification and the lack of privacy in teaching hospitals, are essential.

Most women cited the teaching environment and lack of resources as the primary causes of D&A. To improve women's experiences, consistent availability of supplies and equipment, an acceptable number of students per shift, and a respectful teaching environment are essential. Incorporating the content of respectful maternity care into pre-service and in-service curricula would enable service providers to understand women's feelings during examinations.

Strengths and limitations

Our study used two data collection methods (IDIs and FGDs) to allow triangulation of the findings. Interviews were conducted outside the study facilities to decrease social desirability biases, which could lead to participants not reporting unfavourable facts about D&A. However, there are some limitations of the current study that may indicate avenues for further research. Interviews and FGDs were conducted when the country was in a state of emergency. Therefore, meeting with some of the recruited participants, particularly those from rural areas, was challenging due to security issues concerning movement from place to place. The predominantly urban sample of women may have influenced the findings of the present study. We tried to decrease this challenge by including five women from rural areas as participants. We also included women with spontaneous deliveries, caesarean sections, primiparous, multiparous, and from different age categories. This approach enabled us to capture different perspectives. However, the participants included only women who had live births and did not include women with stillbirths. Therefore, the findings may not reflect the D&A associated with poor pregnancy outcomes.

Conclusions and recommendations

In the study hospital, women experienced different forms of disrespect and abuse. Contributors to D&A were provider-related factors, health system-related factors, and women-related factors. The present study shows some of the D&A not commonly reported in prior studies. Most participants reported objectification, lack of privacy, and neglect of hygienic and comfort care after delivery. The present study also identified the consequences of the D&A experience as an aversion to institutional deliveries for future pregnancies. The teaching environment and the scarcity of supplies and equipment were reported as the main contributors. Therefore, health system administrators, training institutions (universities and colleges), and teaching hospital staff need to design strategies that could improve women's experiences in teaching hospitals, such as protecting privacy, minimising the number of students assigned to the labour ward, and improving the physical structure of the labour ward. To improve women's experience of D&A including the neglect of comfort and hygienic care, supplies need to be consistently available, and training in respectful maternity care should be initiated to improve provider attitudes. Interventions to increase women's awareness of their rights and legal redress mechanisms at the facility may also improve the situation.

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and interpretation of data and reviewed the manuscript draft. All authors read and approved the final version of the manuscript.

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Data availability statement

The datasets collected and/or analysed during the current study are available from the corresponding author on reasonable request.

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Résumé

Il est avéré qu'en Éthiopie, les femmes souffrent fréquemment d'un manque de respect et de maltraitance dans les établissements de santé pendant l'accouchement. Ce manque de respect et ces abus violent le droit des femmes à des soins de santé dignes et respectueux, et diminuent la confiance qu'elles accordent aux centres de santé. Il est nécessaire de mieux comprendre les points de vue des femmes sur le manque de respect et la maltraitance pendant l'accouchement dans différents contextes. Cette étude visait à explorer les points de vue des femmes sur le manque de respect et la maltraitance pendant l'accouchement dans un hôpital universitaire du sud-ouest de l'Éthiopie. Une étude qualitative a été menée avec des entretiens approfondis et des discussions par groupe thématique. De jeunes accouchées ont été choisies par échantillonnage dirigé et convoquées pour des entretiens six semaines après la naissance. La saturation des données a été obtenue après avoir interrogé 32 femmes et mené quatre discussions de groupe. Une méthode d'analyse thématique a été employée pour traiter les données à l'aide du logiciel d'analyse qualitative MAXQDA. Les données ont permis de dégager trois thèmes principaux: manque de respect et maltraitance, facteurs qui y contribuent et conséquences perçues. Les sous-thèmes du manque de respect et de la maltraitance comprennent le manque de soins, les soins non consentis, les mauvais traitements physiques, le manque d'intimité, la perte de l'autonomie, la transformation de la femme en objet, le manque d'accompagnement et la maltraitance verbale. Les sous-thèmes des facteurs contribuant au manque de respect et à la maltraitance comprennent des facteurs liés aux prestataires des soins de santé, au système de soins de santé et aux femmes. Les sous-thèmes des conséquences perçues comprennent la crainte d'utiliser les établissements de santé. En Éthiopie, les femmes se sont heurtées au manque de respect et à la maltraitance. Les facteurs liés au système de santé, comme l'environnement de l'enseignement et la rareté des fournitures, contribuent le plus au manque de respect et aux abus identifiés. Les prestataires de soins de santé, les administrateurs, les institutions de formation et les chercheurs doivent collaborer pour s'attaquer à ces facteurs relatifs au système de santé, de façon à réduire le manque de respect et la maltraitance dont souffrent les femmes lorsqu'elles accouchent dans des hôpitaux universitaires.

Resumen

Existe evidencia de que las mujeres en Etiopía a menudo enfrentan falta de respeto y maltrato en los establecimientos de salud durante el parto. La falta de respeto y el maltrato violan el derecho de las mujeres de recibir servicios de salud dignos y respetuosos, y disminuyen su confianza en los establecimientos de salud. Se necesita más conocimiento de las perspectivas de las mujeres sobre la falta de respeto y el maltrato durante el parto en diferentes contextos. El objetivo de este estudio era explorar las perspectivas de las mujeres sobre la falta de respeto y el maltrato durante el parto en un hospital docente en el sudoeste de Etiopía. Se realizó un estudio cualitativo utilizando entrevistas a profundidad y discusiones en grupos focales. Mujeres en el período posnatal fueron elegidas intencionalmente y programadas para entrevistas a las seis semanas posparto. La saturación de datos ocurrió una vez que 32 mujeres fueron entrevistadas, y cuatro discusiones en grupos focales fueron realizadas. Se utilizó el método de análisis temático para analizar los datos utilizando el software de análisis cualitativo MAXQDA. De los datos surgieron tres temas principales: falta de respeto y maltrato, sus contribuidores y consecuencias percibidas. Los subtemas de falta de respeto y maltrato abarcan: negligencia en la atención, atención no consentida, maltrato físico, falta de privacidad, pérdida de autonomía, objetivación, falta de acompañamiento y maltrato verbal. Los subtemas de contribuidores abarcan: contribuidores relacionados con el prestador de servicios de salud, contribuidores relacionados con el sistema de salud y contribuidores relacionados con las mujeres. Los subtemas de consecuencias percibidas abarcan: el miedo a acudir a establecimientos de salud. Las mujeres en Etiopía sufrieron falta de respeto y maltrato. Los factores del sistema de salud, como el entorno docente y la escasez de suministros, fueron los que más contribuyeron a la falta de respeto y al maltrato identificados. Los prestadores de servicios, administradores, instituciones de capacitación e investigadores deben colaborar para abordar estos factores del sistema de salud con el fin de reducir la falta de respeto y el maltrato durante el parto en los hospitales docentes.