HAWASSA UNIVERSITY

COLLEGE OF MEDICINE AND HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

DISRESPECTFUL AND ABUSIVE MATERNITY CARE DURING CHILDBIRTH AND ASSOCIATED FACTORS AT PUBLIC HEALTH FACILITIES IN SHASHEMENE TOWN, SOUTHERN ETHIOPIA

MPH THESIS

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DISRESPECTFUL AND ABUSIVE MATERNITY CARE DURING CHILDBIRTH AND ASSOCIATED FACTORS AT PUBLIC HEALTH FACILITIES IN SHASHEMENE TOWN, SOUTHERN ETHIOPIA

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A THESIS SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH, COLLEGE OF MEDICINE AND HEALTH SCIENCES, SCHOOL OF GRADUATE STUDIES, HAWASSA UNIVERSITY

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APPROVAL SHEET

WE,THE UNDERSIGNED,MEMBERS OF THE Board of examiners of the final open defense by **MITIKU DEJENU** Have read and evaluated his thesis entitled " DISRESPECTFUL AND ABUSIVE MATERNITY CARE DURING CHILDBIRTH AND ASSOCIATED FACTORS AT PUBLIC HEALTH FACILITIES IN SHASHEMENE TOWN, SOUTHERN ETHIOPIA" and examined the candidate ,this is therefore ,to certify that the thesis has been accepted IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN GENERAL PUBLIC HEALTH.

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ACRONYMS

ANC	Antenatal Care
AOR	Adjusted Odds Ratio
CI	Confidence Interval
CRC	Compassionate and Respectful Care
CSA	Central Statistical Agency
D&A	Disrespect and Abuse
EPHI	Ethiopian Public Health Institute
IRB	Institutional Review Board
MMR	Maternal Mortality Ratio
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Science
VIF	Variance Inflation Factor
WHO	World Health Organization

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ABSTRACT

Background: Disrespect and abuse during childbirth in healthcare facilities is a global public health issue that negatively impacts the utilization of skilled birth services. In Ethiopia, despite policies promoting equitable maternal care, there is a high prevalence of disrespect and abuse, which deters women from accessing healthcare facilities. There is a notable research gap, with limited mixed-method studies providing a comprehensive understanding of the issue.

Objective: To assess the magnitude and associated factors of disrespectful and abusive maternity care during childbirth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

Methods: A facility-based cross-sectional study using both quantitative and qualitative methods was conducted. The study included 383 mothers, selected through systematic sampling, who gave birth at selected public facilities. Quantitative data were collected using structured questionnaires administered via interviews, while qualitative data were gathered through in-depth and key informant interviews with mothers and healthcare providers. Quantitative data were analyzed using SPSS, with descriptive statistics determining the extent of disrespect and abuse. Bivariable and multivariable logistic regression identified associated factors, with a p-value less than 0.05 considered significant. Thematic analysis was used for qualitative data.

Result: The study found that 68.1% of mothers experienced disrespectful and abusive maternity care. Common forms included non-consented care (68.1%), non-dignified care (63.2%), non-confidential care (55.9%), and physical abuse (32.6%). Factors significantly associated with increased odds of experiencing disrespect and abuse included having no formal education [AOR=3.73, 95% CI: 1.93-12.79], primary education [AOR=2.28, 95% CI: 1.08-4.81], residing in rural areas [AOR=2.20, 95% CI: 1.20-4.02], nighttime delivery [AOR=2.89, 95% CI: 1.75-4.76], prolonged facility stays [AOR=2.21, 95% CI: 1.34-3.66], and poor knowledge of mothers [AOR=2.03, 95% CI: 1.20-3.45]. Qualitative findings indicated that lack of resources, high workloads and inadequate training contributed to such behaviors by healthcare providers.

Conclusion: Disrespectful and abusive maternity care is highly prevalent in Shashemene Town, with various forms of mistreatment experienced by women during childbirth. Addressing systemic issues through resource allocation, training, and enhanced support mechanisms for healthcare workers and mothers is essential for promoting respectful and high-quality maternity care services.

1. INTRODUCTION

1.1 Background

Globally, pregnancy and childbirth are pivotal events in the lives of women and their families. These periods are often marked by intense vulnerability, necessitating heightened attention and care. The process of bringing new life into the world is a complex and delicate journey, that can significantly impact the physical, emotional, and psychological well-being of the mother (1).

The United Nations international human rights framework identified mistreatment of women during childbirth as a key human rights issue, and highlights the importance of a human rights–based approach to birthing care (2). The World Health Organizations (WHO) defines respectful maternitycare as care organized for and provided to all women in a manner that ensures their dignity,privacy and confidentiality, maintains freedom from harm and exploitation, and enables informed choice and continuous support throughout maternity care (3).

Disrespect and abuse (D&A) in maternity care refers to interactions or facility conditions that local consensus deem “humiliating or undignified” and those interactions or conditions that are “threatening or violent” (4). There are a range of categorical abuses that fall under the overarching theme of D&A, including physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities (5).

Globally, disrespect and abuse (D&A) during childbirth is prevalent, with studies indicating that up to one in three women experience some form of mistreatment during childbirth (6). In Ethiopia, the prevalence of D&A varies widely, with studies reporting rates from 21.1% to as high as 98.9%, with an average prevalence of 49%(7). Common forms of D&A include non-consented care (68.1%), non-dignified care (63.2%), non-confidential care (55.9%), and physical abuse (32.6%)(8).

The Sustainable Development Goals (SDGs) aim to reduce maternal mortality globally, with a specific target under SDG-3 to lower the maternal mortality ratio to less than 70 per 100,000 live births and end preventable deaths of newborns and children under 5 years of age (9). In 2020, there were approximately 287,000 maternal deaths worldwide with a Maternal Mortality Ratio (MMR) of 223 per 100,000 live births(10). In Ethiopia, this issue is particularly acute, with a maternal mortality rate of 412 deaths per 100,000 live births and a high perinatal mortality rate

(11). Despite efforts to increase facility-based deliveries, experiences of disrespect and abuse could hinder progress and discourage vulnerable groups from seeking care (12).

The Ethiopian Federal Ministry of Health has expanded health facilities and enhanced community connectivity to improve access to maternity services(13). However, recent studies indicate that improving access alone does not necessarily increase usage. Perceived poor quality of care and substandard interpersonal care deter women from seeking delivery services(14). In resource-limited settings, personal interactions between clients and providers are crucial in shaping women's experiences and perceptions of maternity care, contributing to reducing maternal mortality and morbidity(5).

Advancing maternal health is a critical global health priority. The absence of compassionate and respectful maternity care during labor and delivery results in low uptake of services, contributing to maternal mortality and morbidity(10, 12, 15). Providing a safe environment for laboring mothers, where they receive emotional and physical support from families and healthcare professionals, is essential. Understanding the extent and causes of D&A is vital for increasing the use of maternal health services and reducing maternal mortality, thus implementing effective strategies.

1.2 Statement of problem

Respectful maternity care during childbirth is a basic human right, yet research globally has shown that disrespectful and abusive treatment during this vulnerable period is unacceptably common across many health systems (16, 17). In Ethiopia, efforts to expand facility-based births have been hampered by persistently high maternal mortality and low skilled birth attendance, at rates of 412 deaths per 100,000 live births and 48% nationally, respectively (11, 18). Though policies prioritizing access to equitable, quality maternal health services are in place, abundant evidence demonstrates that the majority of Ethiopian women endure disrespectful care during labor and delivery which may deter them from delivering at health facilities in the future (12, 19).

Over the past decade, research has emerged from Ethiopia highlighting the issue of disrespectful maternity care in healthcare facilities, leading to further exploration of this obstacle to skilled birth attendance and safe motherhood(20). Evidence indicates that the prevalence of disrespect and abuse during childbirth varies widely, from 21.1% to 98.9%, with an average prevalence of 49%, a figure that is alarmingly high(7, 8).Physical abuse, non-confidential care, abandonment care, and detention were the commonest type of D&A reported(7).Furthermore, a number of qualitative studies have revealed that women often experience severe violations of their human rights, including verbal and physical abuse, lack of informed consent, breaches of privacy, and denial of preferred birthing positions during delivery in various regions(21).

Disrespectful and abusive maternity care during childbirth can have severe negative health, social, and economic impacts(22). Health-wise, such care can lead to stress and fear, which can result in poor birth outcomes and delayed lactation(23). Socially, it can lead to a loss of trust in health care providers and the health system, further exacerbating health disparities(21). Economically, it can decrease the utilization of maternal health services, thereby increasing the risk of complications during childbirth and postnatal periods, which can lead to increased healthcare costs(12, 24).

The problem of disrespectful and abusive maternity care during childbirth is multifaceted, with contributing factors spanning across health system, provider, and personal levels.Key factors associated with an increased likelihood of such care in Ethiopia include lower maternal education levels, being unmarried, residing in rural areas, lack of birth preparedness,

complications during delivery, poor communication between provider and patient, and staffing shortages due to high patient load(25). Furthermore, evidence suggests that mothers who experience mistreatment during childbirth are often reluctant to formally report these incidents, primarily due to systemic barriers and fear of retaliation(26).

The recognition of compassionate and respectful maternity care during labour and delivery as a crucial aspect of global health care provider quality assurance programs underscores the importance of this issue. Maternity care is intrinsically linked to issues of gender equity and gender violence, given its specificity to women(3). The Ethiopian Federal Ministry of Health, recognizing these concerns, has expressed its commitment to providing compassionate and respectful maternity care (CRC). This commitment is aimed at addressing the high prevalence of disrespect and abuse during labour and delivery in health facilities(27).

Despite the wealth of evidence indicating a high prevalence of disrespectful maternity care in Ethiopia, which is socially-patterned and significantly underreported, most of the studies have been derived from large hospitals and urban areas, with a focus on quantitative studies, while rural primary health centers and health posts with qualitative triangulation remain less explored(28). Moreover, previous studies overlooked potentially relevant factors like normalization of D&A and women's autonomy.Ethiopia is a vast and culturally heterogeneous nation, with significant variations in socio-cultural norms, healthcare infrastructure, and resource availability across different regions and localities(21). Consequently, the manifestations and underlying factors contributing to disrespectful and abusive maternity care may vary depending on the specific context. Yet there remain considerable research gaps on context-specific manifestations and drivers in many localities, like West Arsi zone.

By conducting a mixed-methods study in Shashemene, both quantitative data on prevalence and associated factors, as well as qualitative insights into lived experiences and perceptions can be captured. This comprehensive approach will provide a deeper understanding of the contextual nuances shaping disrespectful and abusive care within this town and surrounding communities. The localized knowledge generated can inform tailored interventions and strategies within the cultural and resource context of Shashemene and similar settings. Ultimately, shedding light on the unique challenges in this area has the potential to guide efforts enhancing respectful

maternity care and improving maternal health outcomes in Shashemene, West Arsi Zone and the broader Oromia region.

1.3 Significance of the study

This study holds significant importance in several ways. Firstly, it brings to the forefront the critical issue of disrespectful and abusive maternity care during childbirth, a topic that is often overlooked but has profound implications for maternal and child health. By focusing on public health facilities in Shashemene Town, Southern Ethiopia, the study provides valuable insights into the local context, which can help in designing culturally appropriate and effective interventions.

Secondly, the study aims to identify factors associated with disrespectful and abusive maternity care within the specific setting of Shashemene. Understanding these context-specific factors is crucial for developing tailored strategies to address them, thereby improving the quality of maternity care in the town and similar localities.

Thirdly, the findings of this study can inform program design and practice at the local level, guiding the development of measures to ensure respectful maternity care, which is a fundamental human right. By shedding light on the unique challenges faced in Shashemene, the study can contribute to the implementation of targeted efforts to enhance respectful care and improve maternal health outcomes in the town, as well as in the broader West Arsi Zone and Oromia region.

Furthermore, this study contributes to the existing body of literature on maternity care in Ethiopia and globally, enriching our understanding of the challenges and potential solutions across diverse settings. It addresses the research gap on context-specific manifestations and drivers of disrespectful care in smaller towns and rural areas, where access to healthcare and cultural dynamics may differ from larger urban centers.

2. LITERATURE REVIEW

2.1 Magnitude of disrespectful and abusive maternity care during childbirth

Disrespectful and abusive maternity care during labor and delivery has been recognized as a major global health system challenge over the past decade (17). Research worldwide has revealed unacceptably high prevalence rates, significantly impacting maternal morbidity and mortality by serving as a barrier to skilled birth attendance(15).

A 2015 systematic review by Bohren et al. reported that across 34 studies in 24 countries, 15-98% of women experienced some form of mistreatment during childbirth. Common specific experiences included “non-dignified care,” “shouting or scolding,” “neglect,” and “physical abuse”(5). A global survey conducted by WHO found that about 41.6% of observed women and 35.4% of surveyed women experienced physical or verbal abuse, stigma, or discrimination. Physical and verbal abuse peaked 30 minutes before birth until 15 minutes after birth(29).

In the US, approximately 17.3% of women reported experiencing at least one form of mistreatment during childbirth. Verbal mistreatment was reported by 8.5%, neglect by 7.8%, violations of physical privacy by 5.5%, and instances where healthcare providers either threatened to withhold treatment or forced unwanted treatment by 4.5% (30). Another finding from a Listening to Mothers survey in the US found that 17% of women felt pressured into having interventions against their will (31).

Within developing Asian countries, research indicates a high burden as well.A review of studies conducted in India revealed that disrespectful maternity care, ranges from 20.9% to a staggering 100%. The pooled prevalence was found to be 71.31%. Interestingly, the prevalence was higher in community-based studies at 77.32%, compared to 65.38% in facility studies. The most frequently reported form of mistreatment was non-consensual care, with a prevalence of 49.84%. This was followed by verbal abuse (25.75%), threats (23.25%), physical abuse (16.96%), and discrimination (14.79%)(32).In Pakistan, an almost universal prevalence of D&A during childbirth was observed, with 99.7% of women experiencing such treatment according to objective assessments. However, it is noteworthy that only 27.2% of women reported a subjective experience of D&A(33). Similarly, in Bangladesh, a concerning 78% of women reported experiencing physical abuse during childbirth(34).

In sub-Saharan Africa, abundant evidence has revealed that disrespectful and abusive care during facility-based childbirth is unacceptably pervasive.A meta-analysis revealed that in Sub-Saharan Africa, the combined prevalence of disrespect and abuse (D&A) experienced by women during childbirth at health facilities was 44.09%. The study further broke down this figure to show the prevalence of specific types of D&A: physical abuse (15.77%), non-confidential care (16.87%), abandonment (16.86%), and detention (4.81%)(35).In Nigeria, a significant majority of women (98.0%) experienced at least one form of disrespect and abuse (D&A) during their most recent childbirth. The most prevalent forms of D&A were non-consented services and physical abuse, reported by 54.5% and 35.7% of women, respectively. Other forms of D&A included non-dignified care (29.6%), abandonment or neglect during childbirth (29.1%), non-confidential care (26.0%), detention in the health facility (22.0%), and discrimination (20.0%)(24).Additionally, prevalence was measured at 19.5% In Tanzania (36). And in Malawi, 74% of observed births involved some form of disrespectful care (16).

In Ethiopia specifically, disrespect and abuse during facility-based childbirth have become a growing focus due to persistently high maternal mortality and low uptake of skilled birth attendance (12). A systematic review and meta-analysis conducted in Ethiopia revealed a high prevalence of mistreatment during childbirth, with a combined reported prevalence of 49%. The study detailed the prevalence of specific types of abuse: physical abuse (13.6%), non-confidential care (14.1%), abandonment (16.4%), and detention (3.2%)(7). However, another estimate of mistreatment varies widely, ranging from 21.1% to as high as 98.9%. The most frequently violated right during facility-based childbirth in Ethiopia was non-dignified care, while the least commonly reported form of abuse was detention in health facilities(8).

A study conducted in Addis Ababa found that one in seven women (15%) experienced some form of D&A during childbirth. Furthermore, only 46% of women reported effective communication, and a mere 9.6% received emotional support during childbirth (20). Another study in Gondar town found a higher prevalence of disrespect and abuse, with 49.6% of mothers reporting such experiences during care. The most common forms of disrespect and abuse were non-confidential care (49.9%), unconsented care (35.8%), and delayed care (28.7%)(37).

Few studies conducted in the Oromia region of Ethiopia have highlighted the prevalence and types of disrespect and abuse (D&A) during childbirth. In North Showa Zone, every participant

reported experiencing at least one form of D&A, with physical abuse (100%), non-consented care (97.2%), and non-confidential care (66.2%) being the most common. Other forms included abandonment/neglect (34.7%), non-dignified care (29%), discriminatory care (22.8%), and detention (5.5%)(38).A separate study in Shambu town, also in the Oromia region, found an overall D&A prevalence of 78.2%. The most frequently encountered forms were unconsented care (86.1%), non-dignified care (37.3%), lack of privacy (33.9%), physical abuse (21.5%), and neglectful care (13.3%)(39).Furthermore, a cross-sectional study in public hospitals in the Bale zone reported a D&A prevalence of 37.5%(40).

2.2 Factors associated with disrespectful and abusive maternity care

Disrespect and abuse during facility-based childbirth is a complex phenomenon driven by an interconnected web of factors operating at the health system, provider, and personal levels (41). Research over the past decade has aimed to delineate key associated factors in order to inform targeted interventions.

2.2.1 Socio-demographic factors

Younger age has been linked to increased experiences of disrespectful maternity care in some studies. A Tanzanian study found that women under 20 years old had 2.6 times higher odds of experiencing D&A compared to those over 35 years (42). Similarly, a study in Kenya revealed that teenagers were more likely to endure non-dignified care and neglect (26). However, other studies in Nigeria and Ethiopia did not find any association between age and disrespectful care (12, 24).

Unmarried women appear to be more vulnerable to disrespectful care in some contexts. Qualitative research in Tanzania demonstrated that unmarried women were more likely to be neglected, receive non-confidential care, and be detained in facilities (41). Studies in Ethiopia also showed increased odds of experiencing D&A among unmarried women (38, 40). However, a study in Nigeria did not reveal significant differences based on marital status (24).

Evidence linking lower maternal education to mistreatment is inconsistent. A study in Ethiopia found that women with no education had increased odds of experiencing non-consented care, non-confidential care, non-dignified care, and neglect (12). However, other studies in Tanzania and Nigeria did not demonstrate this association (24, 42).

Some research from Ethiopia has revealed that women who identified as housewives had higher odds of experiencing disrespectful care compared to employed women or students (38). However, studies in other contexts like Tanzania and Nigeria did not find any significant link (24, 42). Furthermore, there is limited evidence on the linkage between income status and disrespectful care. A study in Tanzania did not find any association (42). However, an Ethiopian study showed some evidence that lower income increased odds of experiencing physical abuse, non-consented care, and neglect (38, 43).

Rural residence appears to be a risk factor for disrespectful care in some settings. Qualitative study in Tanzania showed rural women was more likely to experience discrimination and abandonment (41). A study in public health facilities in Ethiopia also revealed higher odds of physical abuse, non-consented care, non-confidential care and neglect among rural residents compared to urban residents (38).

2.2.2 Obstetric related factors

There is conflicting evidence on the role of ANC attendance in exposure to disrespectful care. Several studies in Ethiopia have demonstrated increased odds of experiencing D&A among women who did not attend any ANC visits (40, 44). However, other studies in Ethiopia, Nigeria and Tanzania did not show significant differences based on ANC attendance (45).

A few studies have linked multiparty to increased odds of enduring disrespectful care. Studies from India and Kenya found that women who had three or more pregnancies had higher odds of experiencing physical abuse, non-consented care, non-confidential care and neglect compared to primiparous mothers (46). However, other studies conducted in Ethiopia have not found significant gravidity or parity-based differences (47).

Some research demonstrates that caesarean deliveries and night-time deliveries are associated with increased odds of disrespectful care. A study in Tanzania showed that women with caesarean deliveries had 2.9 times higher odds of experiencing D&A compared to spontaneous vaginal deliveries (42). An Ethiopian study also revealed increased odds of overall mistreatment linked to cesarean section and instrumental deliveries (48, 49). Furthermore, some evidence links night deliveries between 6pm-6am to higher odds of enduring any form of D&A (5). However, one study in Nigeria and Ethiopia did not show mode or delivery time differences (50). Furthermore, prolonged duration in facilities has been linked to experiences of mistreatment in

some studies. Studies from Tanzania, Kenya and Ethiopia revealed increased odds of enduring non-dignified care, neglect, or physical abuse when facility stays exceeded five or more hours compared to less than one hour stays (51). However, other facility-based studies have not demonstrated this linkage (44, 48).

Previous place of delivery may be associated with increased vulnerability to disrespectful care. Mothers who had a previous history of home delivery were three times more likely to be disrespected and abused when compared to their counterparts(52).Delivery complications appear to elevate the risk of enduring disrespectful care in some contexts. Studies in Tanzania and Ethiopia also demonstrated increased odds of overall mistreatment linked to delivery complications (44, 52). However, another Ethiopian study did not show significant differences (38).

2.2.3 Individual-level factors

The high overall prevalence of disrespect and abuse during facility-based childbirth across many countries has resulted in the normalization and resignation towards enduring mistreatment among some women (8, 41). Qualitative research in Tanzania revealed that mothers often consider D&A to be a normal experience during childbirth (41). Similarly, interviews with Nigerian women showed that they tend to tolerate and rationalize experiences of violation, expressing reluctance to challenge normative hierarchies in maternal health (53). Moreover, Ethiopian studies also showed in their finding as the widespread observation and experience of disrespect and abuse indicates, it is normalized, culture and attitudinal among women and caregivers in health institutions (54).

Women's restricted autonomy and decision-making ability regarding location of delivery contributes to vulnerability towards enduring disrespectful facility conditions in some cultural contexts. A mixed methods study in Ethiopia demonstrated that women with lower autonomy scores were more likely to deliver at facilities endure poor conditions like lack of beds, experience physical abuse, and lack continuous labor support (8, 20). Qualitative analyses revealed how gender and socio-cultural dynamics disempower women, perpetuating normalized notions that they should tolerate poor care (21).

2.2.4 Provider and service related factors

Provider gender may play a contributory role to experiences of disrespectful care in select contexts, although evidence remains limited. Some qualitative analyses have indicated that female patients are often more uncomfortable with delivery assistance from male providers (26). Relatedly, interviews with nurses in Ethiopia revealed that they believe female patients prefer and are more cooperative with female nurses (55). However, a quantitative study from eastern Ethiopia revealed the odds of RMC were two times higher among women attended by male providers as compared to women whose labor attended by female providers (44). Oppositely, Women who were attended by male health care providers were over three times more likely to experience D&A than women who were attended by female health care providers (56).

The involvement of multiple staff during labor and delivery seems to elevate odds of enduring mistreatment. Having multiple providers was also linked to increased overall likelihood of D&A in one Ethiopian study (56). Provider professional categories may contribute to differential care practices. In Tanzania, women reported higher satisfaction with nurse-midwife care compared to general nurse care or medical assistant care (17). However, a study conducted in central Ethiopia revealed that women who were attended by midwives/nurses were more likely to experience disrespect or abuse compared to those who were attended by doctors(38).

Provider dissatisfaction linked to health system weaknesses such as under-staffing and resource shortages appears to perpetuate normalized disrespectful care. A review of studies demonstrated increased likelihood of D&A when providers perceivedpoor support from facility management to the unreserved effort of provider, inconvenient working environment (8). Moreover, an assessment of respectful maternity care standards in Ethiopia showed that facilities with low scores had inadequate supervision structures compared to those that scored highly (12).

2.3 Conceptual framework

A conceptual framework showing the association between disrespectful maternity care and various factors including socio-demographic, obstetric-related, individual-related, and provider and service-related components. The framework aims to provide a comprehensive understanding of how these diverse factors may influence the quality of maternity care.

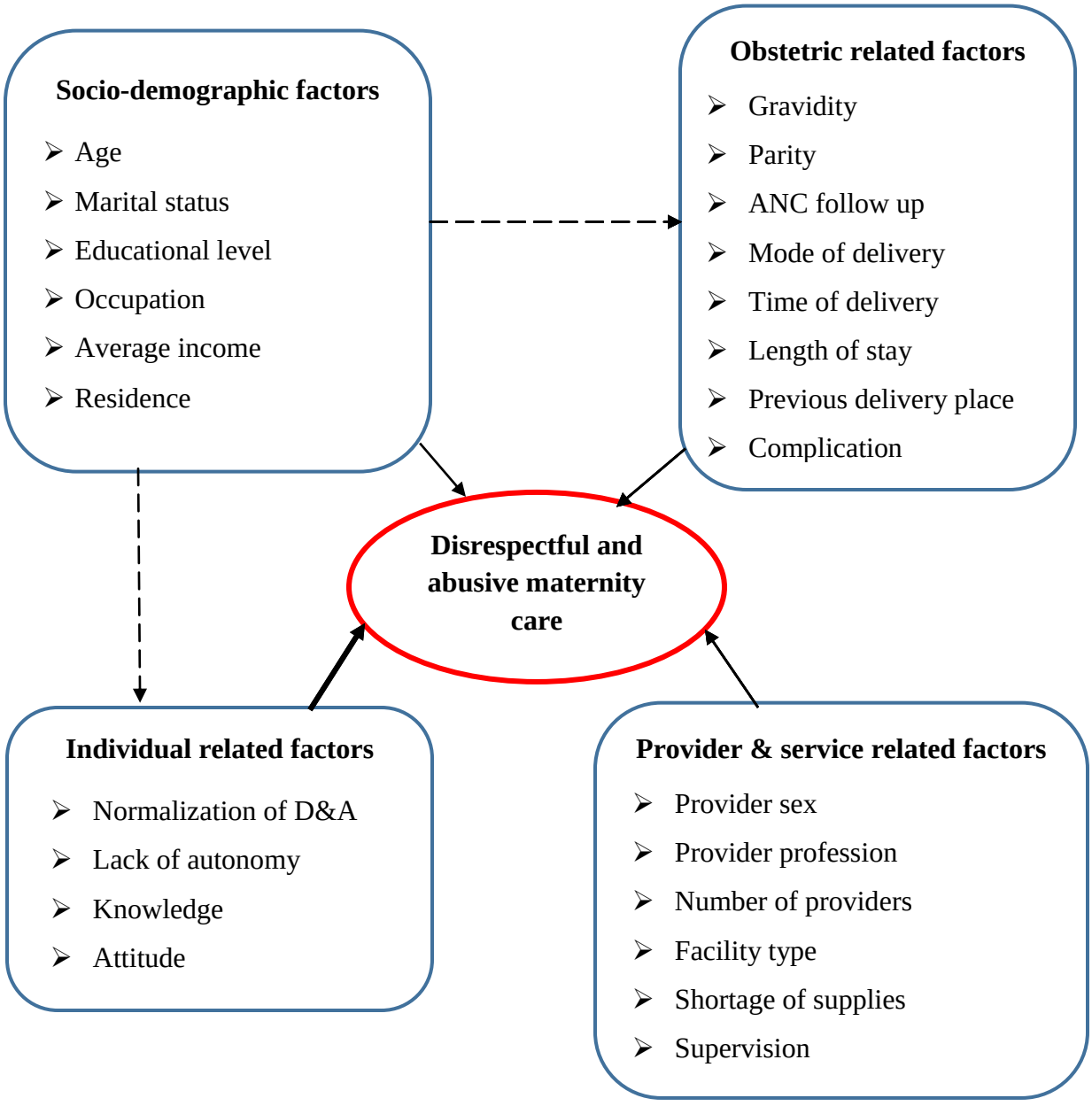

Figure 1: Conceptual framework factors associated with disrespect and abuse during child birth adapted from literature(57).

3. OBJECTIVES

3.1 General objective

- ✓ To assess the magnitude and associated factors of disrespectful and abusive maternity care during childbirth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

3.2 Specific objectives

- ✓ To determine the magnitude of disrespectful and abusive maternity care during childbirth.
- ✓ To identify the factors associated with disrespectful and abusive care during childbirth.
- ✓ To explore perception and experiences of disrespectful and abusive care during childbirth.

4. METHODS AND MATERIALS

4.1 Study area

The study was carried out in selected public health facilities situated in Shashemene, a town located in the West Arsi Zone of the Oromia region, approximately 250 km south of Ethiopia's capital, Addis Ababa. As per the 2023 report from the Shashemene health office, the town boasts a population of 393,035, with an estimated 43,234 women of reproductive age. Shashemene town's economy is primarily driven by both agricultural and non-agricultural activities, reflecting its hinterland characteristics. Trade and agriculture are the mainstays of the town's economy. Historically, trade has been a significant economic activity, and it continues to play a crucial role today. The town has long been recognized as a central hub for long-distance trade routes, which have historically traversed its center. Additionally, Shashemene's strategic position on an international highway linking Ethiopia with Kenya enhances its economic importance.The town is equipped with two public hospitals and five health centers, all of which provide a range of maternity services. These services encompass Basic Emergency Obstetrics care, newborn care, as well as antenatal, delivery, and postnatal care.

4.2 Study design and period

A concurrent mixed study design was employed, with both quantitative and qualitativesimultaneously collected. The study was conducted from April 10 – May 10, 2024.

4.3 Source and study population

4.3.1 Source population

All mothers who gave birth at public health facilities in Shashemene town.

4.3.2 Study population

For the quantitative phase, all mothers who gave birth in selected public health facilities in Shashemene town during the data collection period.

For the qualitative phase, mothers who gave birth, service providers and heads of maternity care units of the selected health facilities for in-depth and key informant interviews.

4.4 Inclusion and exclusion criteria

4.4.1 Inclusion criteria

All mothers who gave birth at the selected health facilities and lived in Shashemene town for at least six months during data collection period were included.

For in-depth interviews, health service providers who were working in the selected health facilities for at least for six months preceding the study were included.

4.4.2 Exclusion criteria

Mothers who were critically ill and unable to communicate at the time of data collection were excluded.

4.5 Sample size determination

4.5.1 Sample size for objective one

Sample size for first objective was calculated by using single population proportion formula with the following assumptions:95% level of confidence (Z= 1.96), 5% margin of error (d=0.05) and 37.5% prevalence of disrespectful and abusive maternity care from a study done in Bale zone, Ethiopia (40).

$$n = (Z_{1-\alpha/2})^2 P * (1-P)/d^2$$

$$n = \frac{(1.96)^2 * 0.375 * 0.625}{(0.05)^2} = 358$$

The sample size determined was 358, after adding 10% non-response rate the sample size for first specific objective will be 394.

4.5.2 Sample size for objective two

The sample size was also calculated for second specific objective by using Epi Info version 7.2StatCalc program based on the findings from different studies done in Ethiopia, considering 95% confidence level, power of 80% and 1:1 ratio.

Table 1: Sample size determination for factors associated with disrespectful and abusive maternity care during childbirth.

Factors	Assumptions	Percent in unexposed	ARR	Sample size	10% NRR	Final sample size	Ref.
Marital status	Power=80% CI= 95% Ratio= 1:1	45.7%	2.6	162	16	178	(49)
ANC visit	Power=80% CI= 95% Ratio= 1:1	61.3%	1.97	352	35	387	(58)
Sex of provider	Power=80% CI= 95% Ratio= 1:1	63%	3.3	142	14	156	(56)

Upon comparing the sample sizes calculated for the first and second specific objectives, it was observed that the former (394) exceeds the latter (387). Consequently, the larger figure, 394, was adopted as the final sample size for the quantitative study.

4.5.3 Sample size for qualitative study

For the qualitative component of the study, eight in-depth and eight key informant interviews were carried out. These involved eight delivery attendants and maternity unit heads for key informant interviews, as well as eight mothers who gave birth at the chosen facilities for in-depth interviews.

The objective of the qualitative study was to reach saturation, a point where no new information emerges, signaling that the data collection has achieved a state of informational redundancy. This approach prioritizes the depth and richness of data over statistical representativeness.

4.6 Sampling technique and procedure

There are two public hospitals and five health centers in Shashemene town, one hospital and two health centers selected using a simple random sampling method: MelkaOda General Hospital, Abosto Health Center, and Awasho Health Center. The total sample size was proportionally divided based on the client volume at each health facility.The sampling fraction was determined by the size of the delivery at each selected health facility. On a monthly average, MelkaOda General Hospital sees 365 births, AbostoHealth Center sees 131, and AwashoHealth Center sees 143. Using the proportional allocation method, the study included 225 mothers' from MelkaOda General Hospital, 81 mothers from AbostoHealth Center, and 88 mothers from Awasho Health Center.

The study employed a systematic random sampling technique to select each participant. This was based on the assumption that the average number of mothers giving birth during the data collection period in the selected health institutions was 958, and the required minimum sample size was 394. Therefore, the sampling interval (K) wasapproximately 3 ($K = N/n \Rightarrow 958/394 = 2.4 \approx 2$). As a result, every other mother was included in the study (Figure 2).

For the qualitative study, in-depth and key informant interviews participants were selected using purposive sampling techniques.Healthcare providers selected expert purposive technique based on their unique roles and experiences in the field of maternity care. These individuals were identified for their potential to provide in-depth, insightful, and knowledgeable responses to the research questions. In the case mothers hetrogenous purposive technique was used, those who can provide rich, relevant, and diverse perspectives were selected.

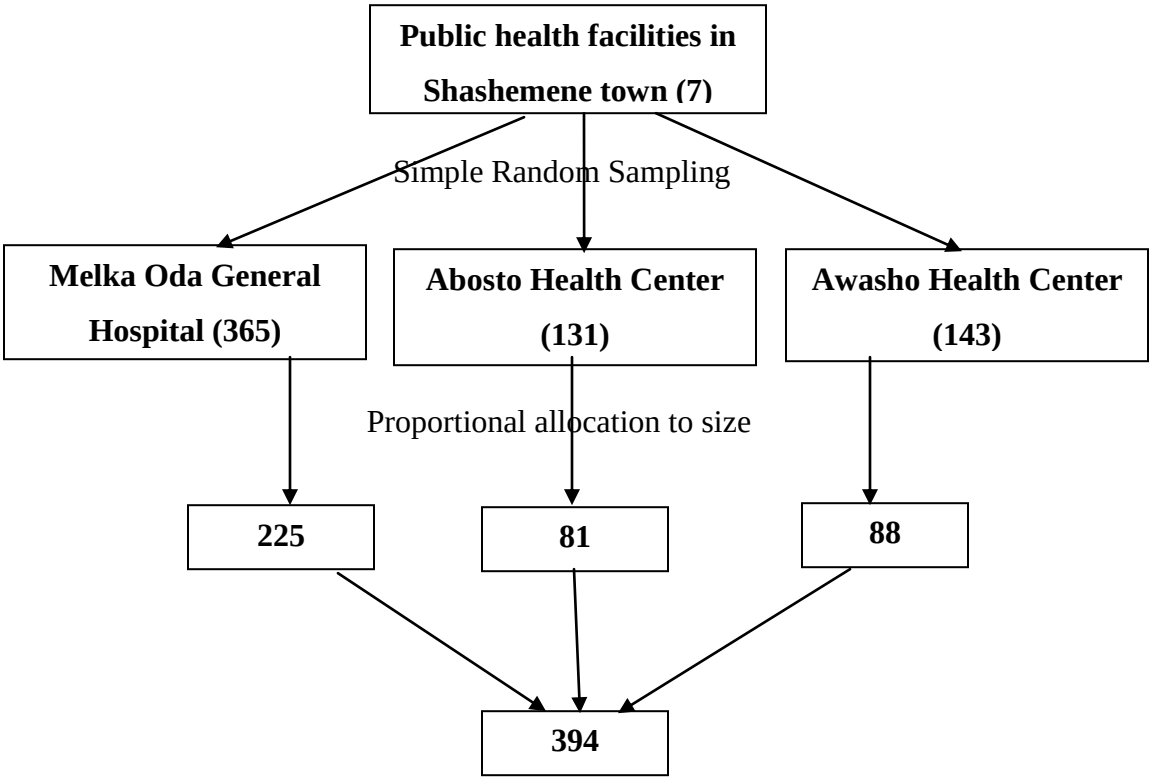

Figure 2: Schematic presentation of sampling procedure and participant selection.

4.7 Study variables

4.7.1 Dependent variable

- Disrespectful and abusive care

4.7.2 Independent variable

Socio-demographic factors: Age, marital status, educational level, occupation, average income and residence.

Obstetric related factors: Gravidity, parity, ANC follow up, mode of delivery, time of delivery, length of stay, previous place of delivery and delivery complication.

Individual related factors: Normalization of Disrespectiful&Abusive, lack of autonomy, knowledge and attitude

Provider and service related factors: Provider sex, provider profession, number of providers, facility type,, supervision,and shortage of supplies.

4.8 Operational definitions

Disrespect or abuse: encompasses seven overlapping categories: physical abuse, non-confidential care, non-consented care, non-dignified care, discrimination based on specific client attributes, abandonment or denial of care, and detention in the facility (48).

In this study, D&A was measured using 26 verification criteria. A mother was considered to have experienced D&A in a particular category if she has encountered at least one of the verification criteria under that category. Furthermore, a mother was regarded as having been disrespected or abused if she has experienced at least one of the seven categories of D&A (48).

Physical abuse: it was assessed using six specific criteria, including: the denial of necessary pain relief, the infliction of physical harm during childbirth (forceful actions, slapping, hitting, beating, or pinching), physically restraining the woman, touching or demonstrating the woman in a culturally inappropriate manner, separating the woman from her baby without a medical indication, and denying food or fluid to the mother without a medical indication.

Non-confidential care: defined by two criteria: the absence of drapes or covers during examinations to protect the mother's privacy, and the lack of a screen separating the couch or bed during examination or childbirth.

Non-consented care: it was assessed using nine criteria: lack of self-introduction or greeting, discouragement of a companion's presence, discouragement of the woman's questions, delayed or impolite responses to questions, failure to explain procedures and expectations, failure to provide periodic updates on labor status and progress, restriction of movement during labor, denial of the woman's preferred birth position, and failure to obtain consent prior to any procedure.

Non-dignified care (including verbal abuse): it was measured by using three criteria; not speaking politely, insulting the woman, and not permitting to practice cultural practices.

Discrimination: it was measured by using two criteria; the use of language or language level that the woman cannot comprehend, and discrimination based on race, ethnicity, education, or economic status.

Abandonment or denial of care: it was measured using three items: not encouraging the mother to call theprovider if needed, not coming quickly when the woman call, and leaving the mother alone.

Detention in the facilities: it was assessed by using one criterion: detaining the mother in a health facility against her will.

Normalization of D&A: refers to the perception ofaccepting D&A as standard or typical during childbirth (19).

Knowledge: It was evaluated through a set of eight questions related to respectful maternity care, maternal rights, and the recognition of disrespectful and abusive practices during childbirth. Mothers who scored above or equal to the mean was considered to have "good knowledge," while those who scored below the mean was considered to have "poor knowledge (44).

Attitude: It was assessed using a set of ten questions, with responses captured on a five-point Likert scale ranging from ‘strongly agree’ to ‘strongly disagree’.Mothers who scored above or equal to the mean was considered as having a "positive attitude," while those who scored below the mean was considered as having a "negative attitude (44, 59).

Supervision: in this study refers to the direct oversight and guidance provided by managers or heads to the healthcare providers during the delivery process, encompassing activities such as monitoring, providing feedback, and ensuring adherence to established protocols.

4.9 Data collection tools and procedures

4.9.1 Quantitative data collection

Data for the quantitative study were gathered using a structured questionnaire, administered by an interviewer, and adapted from previous studies (48, 49). The questionnaire was divided into five sections: socio-demographic characteristics, obstetric-related factors, individual-related factors, provider and service-related factors, and items for assessing disrespect and abusive care. To assess disrespect and abuse during childbirth, we employed a standardized and structured questionnaire from the Maternal and Child Health Integrated Program (48, 59).The questionnaire was initially developed in English, then translated into Afan Oromo and Amharic, and subsequently back-translated into English to ensure consistency. The questionnaire digitized

using the KoBo Collect mobile application for efficient data collection.Data collection was conducted using the Afan Oromo/Amharic versions of the questionnaire.

The data collection was conducted by four experienced midwives and one supervisor, all who were proficient in the local language and have prior experience with the KoBo Collect application. Data was collected using smartphones.A two-days training session was provided to ensure they are well-versed in the study's objectives, data collection instrument, KoBo application utilization, respect for individual rights, informed consent procedures, and interviewing techniques.

Interviews with mothers took place in the postnatal room shortly after delivery, just before they are ready to leave. To minimize bias, these interviews were conducted in a convenient and private area, without the involvement of any health care provider working in the study facility.

4.9.2 Qualitative data collection

In-depth interview guides, adapted from previous studies was utilized to focus on the experiences and perceptions of disrespect and abusive maternity care (20, 21). These guides were translated into Afan Oromo and Amharic languages to ensure clear communication.

The key informant interview involved eight healthcare providers and the indepth interviews involved eight mothers who gave birth at the facilities. The mothers were purposively selected based on their identification as having experienced disrespect and abuse during the quantitative data collection phase. These interviews were tape-recorded, and notes were also taken for comprehensive data collection. The principal investigator and a midwife nurse conducted the interviews, ensuring professional and empathetic approach in gathering sensitive information.

4.10 Data quality assurance

Prior to data collection, a two-day training session was conducted for both data collectors and supervisors. The training encompassed key areas such as study objectives, data collection instruments, KoBo application utilization, ethical considerations, interview techniques, and data quality assurance. Supervisor also trained on evaluating the consistency and quality of questionnaires.

A pretest was conducted one week before the actual data collection, involving 5% of the sample size (20 mothers). This pretest aims to identify and rectify any potential limitations or

shortcomings in the data collection instruments and process.Based on the pretest results, the questionnaire and interview guide revised to ensure clarity, understandability, uniformity, and completeness. The ultimate goal was to have a final questionnaire that is clear, easy to understand, uniformly interpreted, and comprehensive in capturing the necessary data for the study.

During the data collection continuous monitoring and supervision was conducted by the supervisor and principal investigator to ensure data quality.Furthermore, the questionnaire was properly coded and categorized to streamlined data management, enhance accuracy and consistency, facilitate data analysis, improve data interpretation, and maintain data quality throughout the research process.

Qualitative data quality assurance was meticulously maintained through comprehensive training, iterative refinement of interview guides based on pretest feedback, continuous monitoring by supervisors and principal investigators, and meticulous translation and transcription processes carried out by expert linguists to ensure accuracy and consistency.

4.11 Data entry and analysis

The data collected via the KoBo Collect application were exported to the Statistical Package for Social Sciences (SPSS) version 27 for data cleaning and analysis.Descriptive statistics, including frequency, mean, median, standard deviation, and percentage, were employed to provide a detailed description of the participants' characteristics and to ascertain the magnitude of disrespectful and abusive maternity care.

Both bivariable and multivariable logistic regression analyses were conducted to identify factors significantly associated with disrespectful and abusive maternity care. Variables with a P-value of 0.25 or less in the bivariable analysis were included in the multivariable logistic regression models to control for confounding.The fitness of the logistic regression model was evaluated using the Hosmer and Lemeshow test *($p = 0.307$)*, and the Variance Inflation Factor (VIF) was used to check for multicollinearity among the independent variables *($VIF<10$)*.Adjusted Odds Ratios (AOR) with 95% Confidence Intervals (CI) was reported. A P-value of less than 0.05 was considered statistically significant.

For the qualitative component of this study, data from in-depth and key informant interviews were meticulously transcribed and subsequently translated into English. It provides tools for coding, which was the process of categorizing and tagging data with labels that represent their content..

Finally, the data was summarized in a manner that aligns with the specific objectives of the study. The results from the quantitative survey were complemented by the findings from the qualitative analysis.

4.12 Ethical consideration

The study involved human participants, and ethical considerations were paramount. Ethical approval was secured from the Institutional Review Board (IRB) at Hawassa University's College of Medicine and Health Sciences. An official letter was submitted to the Shashemene Town Administration Health Department to initiate the study. Data collection was commenced upon receipt of permission and cooperation letters from the selected health facilities.

Participants provided informed written consent after receiving a clear explanation of the study's purpose, procedures, duration, potential risks, and benefits in their local language. Assurance of confidentialitywas given, with the understanding that the information provided will be used solely for research purposes. Confidentiality was maintained by using unique code numbers instead of respondent names on the questionnaires. The study linked mothers who reported experiencing disrespect and abuse to counseling and support services available at the healthcare facility.

5. RESULT

5.1 Socio-demographic characteristics

A total of 383 mothers were participated in this study with a response rate of 97.2%. The mean age of the participants was 26.7 years with a standard deviation of 5.6 years. About one third (33.9%) of the mothers were aged ≤24 years. A significant majority were married (89.8%). Regarding educational status of the participants, 152 (39.7%) had secondary education followed by 120 (31.3%) college or above educational status. The most common occupations were housewives (30.8%) and employees (27.4%). Two hundrend sevety three (71.3%) of the respondents reside in urban areas. With regard to income distribution 47.8% earns less than 5000 and 52.2% earns 5000 or more. The median monthly income of the participants was 5000 birr with interquartile range of 4500 birr and 160 (41.8%) of the respondents earn between >birrETB (Table 2).

Table 2: Socio-demographic characteristics of women who givebirth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

Variable	Category	Frequency	Percent
Age	≤ 24	130	33.9
	25-29	132	34.5
	30-34	79	20.6
	≥35	42	11.0
Marital status	Single	7	1.8
	Married	344	89.8
	Divorced	18	4.7
	Widowed	14	3.7
Educational status	No formal education	37	9.7
	Primary education	74	19.3
	Secondary education	152	39.7
	College or above	120	31.3
Occupation	Housewife	118	30.8
	Farmer	46	12.0
	Employee	105	27.4

	Daily laborer	41	10.7
	Merchant	73	19.1
Residence	Urban	273	71.3
	Rural	110	28.7
Income	≤ 2500	109	28.9
	2501 – 5000	114	29.8
	≥5000	160	41.8

5.2 Obstetric related factors

The study involved participants with varying maternal and delivery characteristics. More than half (61.9%) of the women had 2-4 pregnancies, while 19.3% had five or more. Antenatal care (ANC) visits were high, with 92.7% attending at least one visit during their current pregnancy. Regarding the birth place for previous deliveries, nearly half (48.0%) delivered at health centers, followed by hospitals (28.7%). The most common mode of current delivery was vaginal delivery (60.3%), with cesarean sections (6.5%) and instrumental deliveries (17.5%) being less frequent. More than half of deliveries (55.4%) were nighttime. About three fourth (74.2%) did not experience complications during delivery. The time spent at the facility prior to birth was almost evenly distributed, 198(51.7%) staying less than 8 hours and 48.3% staying 8 hours or more (Table 3).

Table 3: Obstetric characteristics of women who givebirth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

Variable	Category	Frequency	Percent
Gravidity	**1**	**72**	**18.8**
	2-4	**237**	**61.9**
	≥ 5	**74**	**19.3**
ANC visits for the current pregnancy	**Yes**	**355**	**92.7**
	No	**28**	**7.3**
Birth place for previous delivery	**Hospital**	**110**	**28.7**
	Health center	**184**	**48.0**
	Health post	**7**	**1.8**
	Home	**22**	**5.7**
Mode of current delivery	**Vaginal delivery**	**231**	**60.3**
	Cesarean section	**25**	**6.5**
	Instrumental delivery	**67**	**17.5**

Time of delivery	**Daytime**	**171**	**44.6**
	Nighttime	**212**	**55.4**
Complications during delivery	**Yes**	**99**	**25.8**
	No	**284**	**74.2**
Time stayed at facility prior to birth	**< 8 hours**	**198**	**51.7**
	≥ 8 hours	**185**	**48.3**

5.3 Individual related factors

More than half (61.9%) of participants possess good knowledge on disrespectful and abusive maternity care, while just less than half (49.3%) exhibiting a positive attitude. A large majority, 76.5%, do not consider disrespectful or abusive behavior during childbirth as normal or acceptable, whereas 23.5% do. Regarding decision-making during pregnancy and delivery, 170 (44.4%) of participants' report having complete autonomy. A substantial (70.0%) of participants received information about respectful maternity care during their ANC visits. Care received during maternity aligned with the expectations for 70.5% of participants. In terms of support and involvement from family members, 58.0% reported strong support, 37.6% moderate support, 2.1% limited support, and 2.3% no support (Table 4).

Table 4: Individual related factors among women who givebirth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

Variable	Category	Frequency	Percentage
Knowledge	Good	237	61.9
	Poor	146	38.1
Attitude	Positive	189	49.3
	Negative	194	50.7
Normality of D&A	Yes	90	23.5
	No	293	76.5
Autonomy in decision making	Complete autonomy	170	44.4
	Some autonomy	153	39.9
	Limited autonomy	47	12.3
	No autonomy	13	3.4
Information on D&A	Yes	268	70.0
	No	115	30.0

Care meets expectations	Meet expectations	270	70.5
	Not meet expectations	113	29.5
Support during pregnancy	Strong support	222	58.0
	Moderate support	144	37.6
	Limited support	8	2.1
	No support	9	2.3

5.4 Provider and service related factors

Among the respondents, 204 (53.3%) reported that their main provider during delivery was female. The majority (89.3%) were assisted by a nurse or midwife, with 6.3% assisted by a doctor and 4.4% by a health officer. The majority of deliveries occurred in hospitals (61.4%), while 38.6% occurred in health centers. Regarding supervision, 44.1% experienced supervision by managers or heads, 13.3% did not, and 42.6% were unsure. During the delivery process, 36.8% experienced shortages of supplies, 36.3% did not, and 26.9% were unsure. Additionally, 68.7% had two or fewer attendants during delivery, while 31.3% had more than two (Table 5).

Table 5: Provider and service related factors among women who givebirth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

Variable	**Category**	**Frequency**	**Percentage**
Sex of main provider	Male	179	46.7
	Female	204	53.3
Profession of main provider	Doctor	24	6.3
	Health officer	17	4.4
	Nurse/midwife	342	89.3
Type of facility	Hospital	235	61.4
	Health center	148	38.6
Supervision by managers/heads	Yes	169	44.1
	No	51	13.3
	Don’t know	163	42.6
Shortages of supplies	Yes	141	36.8
	No	139	36.3
	Don’t know	103	26.9

Number of attendants	≤2	263	68.7
	>2	120	31.3

5.5 The magnitude of disrespectful and abusive maternity care

Among the total 383 study participants, 261experienced disrespectful and abusive care during child birth with overall magnitude of disrespectful and abusive care was 68.1% [95% CI: (62.2, 72.4)] (Figure 3).

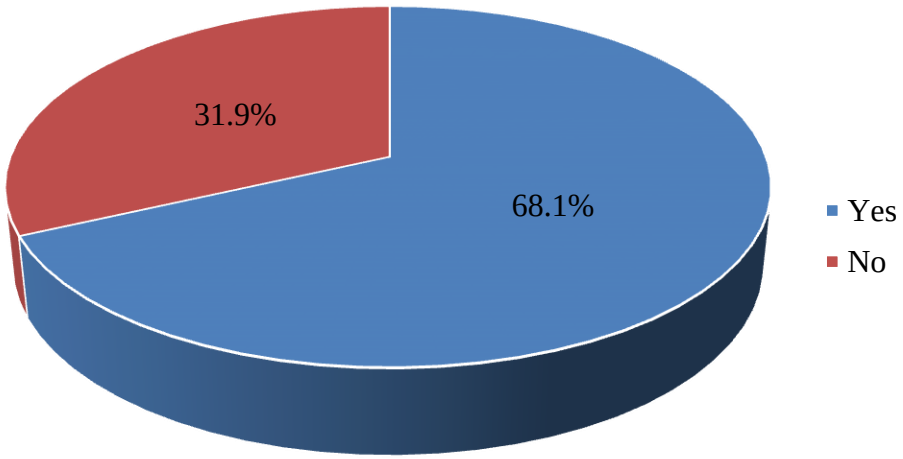

Figure 3: The magnitude of disrespectful and abusive maternity care among women who give birth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

Type of disrespectful and abusive maternity care

In the context of disrespectful and abusive care experienced by women, various forms of mistreatment were identified: non-consented care (68.1%), non-dignified care (63.2%), non-confidential care (55.9%), physical abuse (32.6%), discrimination based on specific patient attributes (13.3%), abandonment of care (13.3%), and detention in health facilities (5.5%) (Figure 4).

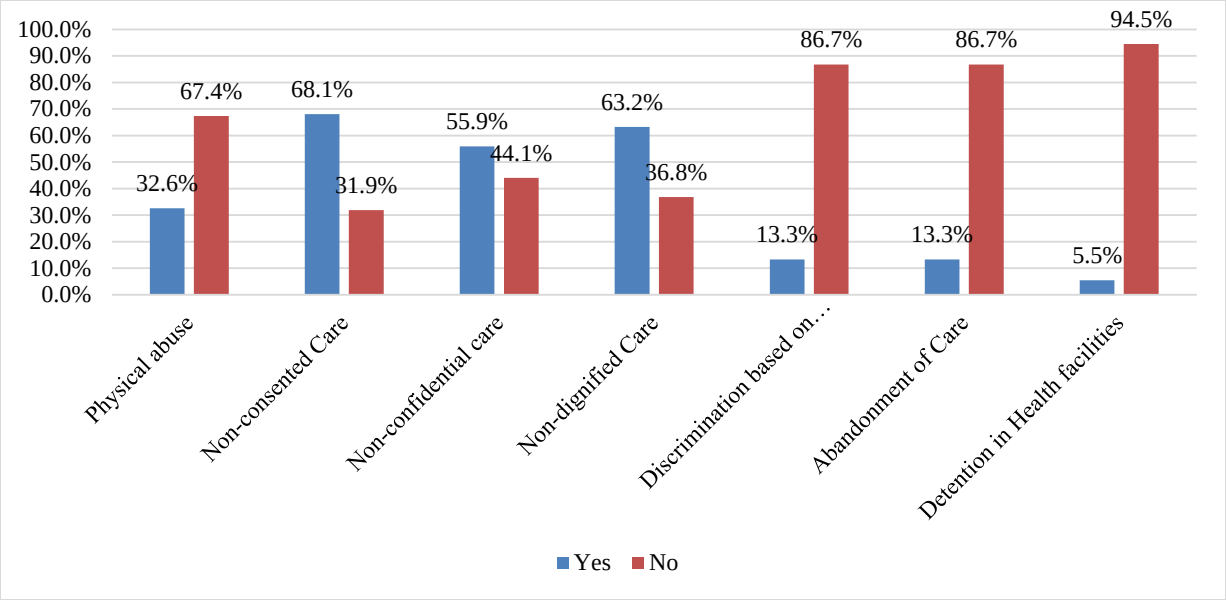

Figure 4: The types of disrespectful and abusive maternity care among women who givebirth at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

5.6 Factors associated with disrespectful and abusive care during childbirth

During bivariable logistic regression analysis educational status, residence, ANC follow up, time of delivery, duration of stay at facility, knowledge, and sex of the main delivery attendant were significantly associated with disrespectful and abusive care.

After adjusting for potential confounding variables in multivariable logistic regression educational status, residence, time of delivery, duration of stay at facilityand knowledge were found to be independent predictors of disrespectful and abusive care. Women with no formal education had 3.73 times higher odds of disrespectful and abusive care compared to those with college or above education [AOR = 3.73, 95% CI: (1.93, 12.79)]. Similarly, women with primary education also had 2.28 times higher odds of disrespectful and abusive care compared to those with college or above education [AOR= 2.28, 95% CI: (1.08, 4.81)]. The odds of disrespectful and abusive care were 2.20 times higher among women residing in rural areas as compared to those in urban areas [AOR = 2.20, 95% CI: (1.20, 4.02)].The odds of disrespectful and abusive care were 2.89 times higher among women who delivered at night time compared to those who delivered at day time [AOR= 2.89, 95% CI: (1.75, 4.76)]. Additionally, women who stayed at the facility for ≥8 hours had 2.21 times higher odds of disrespectful and abusive care as compared to those whose who stayed for <8 hours [AOR= 2.21, 95% CI: (1.34, 3.66)].Women

who had poor knowledge had 2.03 times higher odds of disrespectful and abusive care compared to those womenwho had good knowledge [AOR = 2.03, 95% CI: (1.20, 3.45)].

Table 6: Bivariable and multivariable regression of factors associated with disrespectful and abusive maternity care at public health facilities in Shashemene Town, Southern Ethiopia, 2024.

	D & A			
Variable	**Yes (%)**	**No (%)**	**COR (95% CI)**	**AOR (95% CI)**
Age (Years)				
≤ 24	85 (65.4)	45 (34.6)	1.16 (0.57-2.39)	0.77 (0.29-2.02)
25-29	99 (75.0)	33 (25.0)	1.85 (0.88-3.86)	1.71 (0.71-4.11)
30-34	51 (64.6)	28 (35.4)	1.12 (0.52-2.43)	1.16 (0.48-2.79)
≥ 35	26 (61.9)	16 (38.1)	1	1
Educational status				
No formal education	31 (81.6)	7 (18.4)	2.95 (1.20-7.25)	**3.73 (1.34-10.35)**
Primary education	57 (78.1)	16 (21.9)	2.38 (1.22-4.61)	**2.28 (1.08-4.81)**
Secondary education	101 (66.4)	51 (33.6)	1.32 (0.80-2.17)	1.71 (0.98-2.99)
College or above	72 (60.0)	48 (40.0)	1	1
Residence				
Urban	172 (63.0)	101 (37.0)	1	1
Rural	89 (80.9)	21 (19.1)	2.49 (1.46-4.25)	**2.20 (1.20-4.02)**
Gravidity				
Primigravida	46 (63.9)	26 (36.1)	1.14 (0.58-2.23)	1.73 (0.62-4.83)
Multigravida (2 – 4)	170 (71.7)	67 (28.3)	1.64 (0.95-2.82)	1.90 (0.92-3.93)
Grandmultigravida (≥ 5)	45 (60.8)	29 (39.2)	1	1
ANC follow up				
Yes	245 (69.0)	110 (31.0)	1.67 (0.77-3.65)	1.94 (0.74-5.07)
No	16 (57.1)	12 (42.9)	1	1
Time of delivery				
Daytime	98 (57.3)	73 (42.7)	1	1
Nighttime	163 (76.9)	49 (23.1)	2.48 (1.60-3.85)	**2.89 (1.75-4.76)**
Complications during delivery				
Yes	67 (67.7)	32 (32.3)	0.97 (0.60-1.59)	0.98 (0.55-1.75)
No	194 (68.3)	90 (31.7)	1	1
Duration of stay				

< 8	123 (62.1)	75 (37.9)	1	1
≥ 8	138 (74.6)	47 (25.4)	1.79 (1.15-2.78)	**2.21 (1.34-3.66)**
Knowledge				
Good knowledge	148 (62.4)	89 (37.6)	1	1
Poor knowledge	113 (77.4)	33 (22.6)	2.06 (1.29-3.29)	**2.03 (1.20-3.45)**
Sex of main healthcare provider				
Male	111 (62.0)	68 (38.0)	0.74 (0.46-1.19)	0.67 (0.39-1.14)
Female	150 (73.5)	54 (26.5)	1	1
Number of attendants				
≤ 2	174 (66.2)	89 (33.8)	0.59 (0.38-0.91)	0.70 (0.43-1.14)
>2	87 (72.5)	33 (27.5)	1	1

5.7 Qualitative findings

5.7.1 Disrespectful and abusive care experience from both mothers and healthcare providers' perspectives

Eight indepth interviews were conducted among mothers, the age ranging between 21-34 years. Educational levels varied, with several mothers having only primary education (4, 50%) and few have no formal education (2, 25%) and secondary education and a significant number were from rural kebeles. Almost all of the mothers participanted IDI were housewifes. Eight key informant interviews we conducted among healthcare providers. The participants'profession included midwives and nurses, most were working in labor ward (62.5%) and heads of the delivery ward (37.5%). The professional experiences of the key informant healthcare providers range from two to eight years.

The in-depth interviews with mothers reveal a wide range of experiences, with some reporting positive interactions and respectful care, while many others faced neglect, verbal abuse, and lack of support. Mothers' perceptions of care varied from feeling respected and well-supported to feeling neglected and mistreated.

A 22-year-old mother shared:

"While I was laboring, the health workers left me alone, and I gave birth to my baby by myself without their attendance… their communication is poor, and one healthcare worker even shouted at me when I asked for help."

Similarly, interviewed healthcare workers acknowledged instances of disrespectful and abusive care, often attributing these to high workloads and lack of resources. While some healthcare workers reported no encounters with such issues, others recognized their occurrence. They generally aimed to provide respectful and compassionate care but acknowledged that systemic issues could lead to lapses. Healthcare workers perceived their role as crucial in ensuring informed consent and providing emotional support.

A midwife commented:

"Yes, sometimes mothers experience disrespect or abuse. For example, a healthcare worker might shout at the mother, insult her, or slap her on the thigh."

Another midwife added:

"Sometimes health workers may shout at the mother and attendants… sometimes we might miss obtaining consent in emergency cases."

5.7.2 Reasons for disrespect or abusive carefrom mothers and healthcare providers' perspectives

Both mothers and healthcare providers identified several reasons for disrespectful and abusive care. From the mothers' perspectives, factors included healthcare workers' stress, high patient volume, insufficient resources, and the personal attitudes of healthcare staff.

A mother shared:

"The healthcare worker was so busy; they had to take care of many mothers at once. They seemed stressed and one healthcare worker shouted at me when I asked for help."

Healthcare providers also cited similar reasons, emphasizing the impact of high workloads, resource constraints, and individual behavior. They highlighted that lack of training and support significantly contributed to the problem.

A healthcare worker explained:

"Due to the high number of patients, sometimes we cannot provide the care we want to. It becomes overwhelming, and unfortunately, some colleagues might take out their frustration on patients."

Another healthcare worker noted:

"There is a shortage of beds and essential supplies. When we are under-resourced, it is challenging to maintain a high standard of care, and this sometimes leads to disrespectful behavior."

Additionally, healthcare workers mentioned that systemic issues, such as inadequate governance and infrastructure, exacerbated the problem. These factors often led to stress and burnout among staff, contributing to disrespectful and abusive care.

A midwife stated:

"The main reasons for disrespect or abuse are the heavy workload and lack of resources. We are understaffed and overworked, which can sometimes cause us to behave poorly towards patients."

Both perspectives highlight that the primary reasons for disrespect and abuse are systemic issues within the healthcare system, including high workloads, insufficient resources, and lack of proper training and support for healthcare workers. These factors create a stressful environment that can lead to negative behaviors and interactions with patients.

5.7.3 Recommendations for improvement

Both mothers and healthcare providers offered several recommendations for improving maternity care.

Mothers suggested significant improvements in infrastructure and resource availability. They emphasized the need for more beds, better facilities, and ensuring the availability of essential supplies and medications. Additionally, mothers advocated for allowing family members to provide support during labor, which they believed would enhance their overall experience and well-being.

A mother recommended:

"The hospital should have more beds and better facilities. It would also be helpful if a family member could stay with us during labor for support."

Mothers also stressed the importance of improving the behavior and attitude of healthcare workers. They felt that better training and fostering a culture of respect and empathy among staff would significantly enhance the quality of care.

Another mother mentioned:

"Healthcare workers need to be more compassionate. Good communication would make a big difference."

Healthcare workers echoed the need for infrastructural improvements and additional resources. They highlighted the critical need for more beds, better facilities, and the consistent availability of necessary medications and supplies to ensure they can provide high-quality care.

A healthcare worker suggested:

"We need more beds and better facilities. Ensuring that we have all the necessary supplies and medications is crucial for providing good care."

Healthcare workers also recommended enhancing training focused on compassionate and respectful care. They believed that such training would help improve interactions with mothers and ensure that care is delivered in a respectful and empathetic manner.

A midwife commented:

"Training on respectful and compassionate care is essential. It would help us provide better support to mothers and improve our interactions with them."

In addition to training, healthcare workers proposed better incentive mechanisms to motivate staff and reduce burnout. They also emphasized the importance of improving communication with patients, ensuring that mothers are well-informed and involved in decision-making processes.

Another healthcare worker added:

"Providing incentives and support for healthcare workers can help reduce burnout and improve the quality of care. Better communication with patients is also vital to ensure they feel respected and informed."

6. DISCUSSION

In this study, the magnitude of disrespectful and abusive maternity care was 68.1%. Non-consented care (68.1%), non-dignified care (63.2%), non-confidential care (55.9%), and physical abuse (32.6%) were the most common types of disrespectful and abusive care. Educational status, residence, delivery time, duration of stay prior to delivery and knowledge were determinants of disrespectful and abusive maternity care.In IDI, experiences were mixed, with some mothers reporting respectful and supportive care while others faced neglect and lack of support. High workload, negligence, individual behavior, lack of resources and governance issues were mentioned as factors contributing to disrespect and abusive care by mothers and healthcare providers in qualitative interview.

Our study found the prevalence of disrespectful and abusive maternity care during childbirth to be 68.1%. the finding is comparable prevalence reported from studies conducted at Bahir Dar, Northwest Ethiopia (67.1%)(58) and a review of studies from India (71.31%) (32).However, the result found from the current study was higher than the prevalence report of studies conducted in Sidama Region (46.9%)(49), Bale Zone, Oromia Region(37.5%)(40), Gondar town (49.6%)(37), Tanzania (19.5%)(36) and a systematic review in Ethiopia(49%)(7).The variation in the reported prevalence can be attributed to the measurement tools used to assess disrespectful and abusive care may differ across studies, leading to divergent estimates. Additionally, differences in the quality of maternal health services and the broader health system context across regions and facilities can contribute to varying levels of disrespectful care.

On the other hand, this finding was lower compared to the prevalence reported by a studies conducted Addis Ababa (75.4%)(20), Asosa (82.4%)(52), East Hararghe (77%)(43), Arba Minch (98.9%)(48), Shambu town, Oromia region(78.2%)(39) and North Showa Zone, Oromia region (100%)(38).The discrepancies could be attributed to variations in study settings, methodologies, and contextual factors. Differences in the level of provider training, facility policies, and overall quality of maternal health services across these regions may contribute to higher instances of mistreatment. Additionally, the study designs, sampling strategies, and data collection approaches employed in these studies could have influenced the reported prevalence rates.

Furthermore, variations in socio-cultural norms, attitudes, and awareness levels regarding disrespectful care among women in these specific contexts may have impacted the recognition and reporting of such experiences.

Our study found non-consented care (68.1%), non-dignified care (63.2%), non-confidential care (55.9%), and physical abuse (32.6%) as the most common types of disrespectful and abusive care. The qualitative data supported these findings, with mothers reporting various forms of disrespect and abuse, including neglect, verbal abuse, and lack of support. Additionally, a study in Gondar town found a prevalence of 49.9% for non-confidential care and 35.8% for non-consented care (37). However, a systematic review in Ethiopia revealed a prevalence of 13.6% for physical abuse, which is lower than the 32.6% reported in our study (7). The variations in reported prevalence rates for different types of disrespectful and abusive care can be attributed to cultural norms and attitudes towards specific forms of mistreatment may influence the recognition and reporting of such experiences by women.

The qualitative data supported the above findings, with mothers reporting various forms of disrespect and abuse, including neglect, verbal abuse, and lack of support. A 22-year-old mother shared, “While I was laboring, the health workers left me alone, and I gave birth to my baby by myself without their attendance… their communication is poor, and one healthcare worker even shouted at me when I asked for help.” Healthcare workers acknowledged the occurrence of disrespectful and abusive care, attributing it to high workload and resource constraints. One midwife mentioned, “Yes, sometimes mothers experience disrespect or abuse. For example, a healthcare worker might shout at the mother, insult her, or slap her on the thigh.”

The current study revealed that the odds of disrespectful and abusive care were four and two times higher among women with no formal education and primary education, respectively, compared to those with a college or above educational status. This finding is consistent with previous research Arba Minch, Southern Ethiopia(48), Assossa Zone, Northwest Ethiopia(52), and Jimma, Southwest Ethiopia (60). The association between lower educational levels and higher vulnerability to disrespectful care could be attributed to reduced awareness and knowledge about respectful maternity care standards, as well as limited decision-making autonomy and agency in demanding better treatment.

The finding that the odds of disrespectful and abusive care were two times higher among women from rural areas compared to those from urban areas is supported by qualitative research in Tanzania, which showed that rural women were more likely to experience discrimination and abandonment during childbirth (41). Additionally, a study in public health facilities in Ethiopia revealed higher odds of physical abuse, non-consented care, non-confidential care, and neglect among rural residents compared to urban residents (38, 48). This discrepancy in residence could be attributed to various factors, including disparities in educational status and resource availability between rural and urban, as well as socio-cultural norms and attitudes towards disrespectful care that may be more deeply entrenched in certain rural communities.

Our finding that the odds of disrespectful and abusive care were three times higher among women who delivered at nighttime compared to those who delivered during the day is consistent with previous literature. Both mothers and healthcare providers cited high workload, and lack of resources as the factors for disrespectful and abusive care.This finding was supported by those in studies conducted in Central Ethiopia (61), Northwest Ethiopia (62), and East Hararge (43), which indicated that women who delivered during the day were more likely to receive respectful maternity care than those who delivered during the night. A global study by Bohren et al. (2015) found that physical and verbal abuse peaked 30 minutes before birth until 15 minutes after birth, which often coincides with nighttime deliveries(5). This association could be explained by factors such as staff fatigue, resource constraints, and reduced supervision during night shifts, which may contribute to increased instances of disrespectful care.

The finding that women who stayed at the facility for ≥8 hours prior to delivery had about two times higher odds of disrespectful and abusive care compared to those who stayed for less than 8 hours is supported by studies from Tanzania, Kenya, and Ethiopia. These studies revealed increased odds of enduring non-dignified care, neglect, or physical abuse when facility stays exceeded five or more hours compared to less than one hour stays (63). This might be due to the prolonged durations in facilities may contribute to provider frustration, fatigue, and resource constraints, potentially leading to increased instances of disrespectful care.

Our study found that women who had poor knowledge had approximately two times higher odds of disrespectful and abusive care compared to those with good knowledge. The qualitative findingsalso show that lack of training and individual behavours contribute to increased instances

of disrespectful care.This finding aligns with qualitative research from Ethiopia, which demonstrated that women's restricted autonomy and decision-making ability regarding location of delivery contributes to vulnerability towards enduring disrespectful facility conditions (8, 20). Limited knowledge and awareness about respectful maternity care standards and women's rights during childbirth may perpetuate the normalization of mistreatment and reduce the likelihood of challenging or reporting such experiences.

Limitation of the study

The study’s findings should be interpreted with consideration of certain limitations. The research methodology relied on interview data regarding women’s childbirth experiences, rather than direct clinical observation, which may have reduced the objectivity of the measurements. Furthermore, due to the sensitive subject matter of the study, there is a potential for social desirability bias, which could lead to respondents intentionally underreporting or overreporting the prevalence and influencing factors

7. CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

Disrespectful and abusive maternity care during childbirth is a significant issue in public health facilities in the study area. The magnitude of disrespectful and abusive care was found to be 68.1%, with non-consented care, non-dignified care, non-confidential care, and physical abuse being the most common types. The study identified several factors associated with an increased risk of disrespectful and abusive care, including lower educational status, residing in rural areas, delivering at nighttime, prolonged stay at the facility, and poor knowledge about respectful maternity care. mothers reveal a wide range of experiences, with some reporting positive interactions and respectful care, while many others faced neglect, verbal abuse, and lack of support.Healthcare workers acknowledged instances of disrespectful and abusive care. Both mothers and healthcare providers cited systemic issues such as high workloads, resource constraints, and lack of training as contributing factors.

7.2 Recommendations

Based on the study findings, the following recommendations were made to address disrespectful and abusive maternity care during childbirth:

- Implement comprehensive training programs for healthcare providers on respectful and compassionate maternity care, emphasizing informed consent, dignified care, confidentiality, and prevention of physical abuse.
- Strengthen efforts to improve access to education and awareness-raising campaigns for women, particularly in rural areas, to increase their knowledge about respectful maternity care standards and their rights during childbirth.
- Enhance the availability and allocation of resources, including adequate staffing, infrastructure, and essential supplies, to alleviate the workload and stress on healthcare providers, particularly during nighttime deliveries and prolonged facility stays.
- Develop and enforce policies and guidelines that promote respectful maternity care practices, ensuring accountability for instances of disrespectful and abusive care.
- Encourage the involvement of family members or birth companions during labor and delivery to provide emotional support and advocate for respectful care.

- Implement incentive and support mechanisms for healthcare providers to reduce burnout and improve job satisfaction, which can positively impact the quality of care provided.
- Conduct further research with clinical observation and explore the underlying systemic factors contributing to disrespectful and abusive care.

7. REFERENCES

1. World Health Organizations. Maternal Health Geneva, Switzerland2023 [Available from: https://www.who.int/health-topics/maternal-health#tab=tab_1.
2. Pillay N. Maternal mortality and morbidity: a human rights imperative. The Lancet. 2013;381(9873):1159-60.
3. World Health Organizations. Respectful maternity care: the universal rights of childbearing women. In: Alliance WR, editor. Washington DC,2011. p. 1-6.
4. Bradley S, McCourt C, Rayment J, Parmar D. Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: a qualitative systematic review and thematic synthesis of women's perceptions and experiences. Social science & medicine. 2016;169:157-70.
5. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS medicine. 2015;12(6):e1001847.
6. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth Geneva, Switzerland: World Health Organization; 2023 [Available from: http://www.who.int/entity/reproductivehealth/topics/maternal_perinatal/endorsers.pdf.
7. Kassa ZY, Husen S. Disrespectful and abusive behavior during childbirth and maternity care in Ethiopia: a systematic review and meta-analysis. BMC research notes. 2019;12(1):1-6.
8. Mengesha MB, Desta AG, Maeruf H, Hidru HD. Disrespect and abuse during childbirth in Ethiopia: a systematic review. BioMed Research International. 2020;2020.
9. FUND S. Sustainable development goals. Available at this link: https://www un org/sustainabledevelopment/inequality. 2015.
10. World Health Organization. Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division: executive summary. 2023.
11. Central Statistical Agency (CSA) [Ethiopia], ICF. Ethiopia Demographic and Health Survey 2016. In: CSA, ICF, editors. Addis Ababa, Ethiopia, and Rockville, Maryland, USA2016.
12. Sheferaw ED, Bazant E, Gibson H, Fenta HB, Ayalew F, Belay TB, et al. Respectful maternity care in Ethiopian public health facilities. Reproductive health. 2017;14(1):1-12.

13. Federal Ministry of Health. Annual Health Sector Performance Report, 2019/20. 2021.
14. Andargie AA, Abebe M. Factors associated with utilization of institutional delivery care and postnatal care services in Ethiopia. Journal of Public Health and Epidemiology. 2018;10(4):108-22.
15. Minckas N, Gram L, Smith C, Mannell J. Disrespect and abuse as a predictor of postnatal care utilisation and maternal-newborn well-being: a mixed-methods systematic review. BMJ global health. 2021;6(4):e004698.
16. Sethi R, Gupta S, Oseni L, Mtimuni A, Rashidi T, Kachale F. The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery. Reproductive health. 2017;14:1-10.
17. Sando D, Abuya T, Asefa A, Banks KP, Freedman LP, Kujawski S, et al. Methods used in prevalence studies of disrespect and abuse during facility based childbirth: lessons learned. Reproductive health. 2017;14:1-18.
18. Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. Ethiopia Mini Demographic and Health Survey 2019: Final Report. In: EPHI and ICF, editor. Rockville, Maryland, USA2021.
19. 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. Reproductive health. 2015;12:1-9.
20. Abebe AH, Mmusi-Phetoe R. Respectful maternity care in health centers of Addis Ababa city: a mixed method study. BMC Pregnancy and Childbirth. 2022;22(1):792.
21. Molla M, Muleta M, Betemariam W, Fesseha N, Karim A. Disrespect and abuse during pregnancy, labour and childbirth: a qualitative study from four primary healthcare centres of Amhara and Southern Nations Nationalities and People's Regional States, Ethiopia. Ethiopian Journal of Health Development. 2017;31(3):129-37.
22. Smith J, Banay R, Zimmerman E, Caetano V, Musheke M, Kamanga A. Barriers to provision of respectful maternity care in Zambia: results from a qualitative study through the lens of behavioral science. BMC Pregnancy and Childbirth. 2020;20(1):26.
23. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. International Journal of Gynecology & Obstetrics. 2015;128(2):110-3.

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 and childbirth. 2015;15(1):1-14.

25. Edmealem A, Tsegaye D, Andualem A, Ademe S, Gedamu S. Implementation of compassionate and respectful health care service at Northeast Ethiopia: patients' perspective. International Journal of Caring Sciences. 2020;13(2):991-1003.

26 Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. The Lancet. 2019;394(10210):1750-63.

27 Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reproductive Health. 2019;16(1):77.

28. Sakala C, Declercq E, Joynt J, Turon J. Listening to mothers in California: Results from a population based survey of women's childbearing experiences. California Health Care Foundation: Data Snapshot. 2018.

29 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(7):e0200318.

30. National Institute of Population Research and Training, International Centre for Diarrhoeal Disease Research B, MEASURE Evaluation. Bangladesh maternal mortality and health care survey 2016: preliminary report. Bangladesh Maternal Mortality Health Care Survey. 2017.

31. Kassa ZY, Tsegaye B, Abeje A. Disrespect and abuse of women during the process of childbirth at health facilities in sub-Saharan Africa: a systematic review and meta-analysis. BMC International Health and Human Rights. 2020;20(1):23.

32. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP. Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. Health policy and planning. 2018;33(1):e26-e33.

33. Zeleke AM, Bayeh GM. Maternal disrespect and abuse among mothers who gave childbirth at public health facilities and associated factors in Gondar town, Northwest, Ethiopia. Journal of Midwifery and Reproductive Health. 2022;10(1):3165-74.

34. Adinew YM, Hall H, Marshall A, Kelly J. Disrespect and abuse during facility-based childbirth in central Ethiopia. Global health action. 2021;14(1):1923327.

35. Bekele W, Bayou NB, Garedew MG. Magnitude of disrespectful and abusive care among women during facility-based childbirth in Shambu town, Horro Guduru Wollega zone, Ethiopia. Midwifery. 2020;83:102629.

36. Mekonnen A, Fikadu G, Esmeal A. Disrespectful and abusive maternity care during childbirth in Bale zone Public Hospitals, southeast Ethiopia: cross-sectional study. Clin Pract. 2019;16(5):1273-80.

37 McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RN, Winch PJ. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. BMC pregnancy and childbirth. 2014;14(1):1-13.

38. Sando D, Ratcliffe H, McDonald K, Spiegelman D, Lyatuu G, Mwanyika-Sando M, et al. The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. BMC pregnancy and childbirth. 2016;16:1-10.

39. Usso A, Adem H, Alemu A, Mohammed A. Disrespect and Abuse during Childbirth in Public Health Facilities in Eastern Ethiopia: a cross-sectional study2022.

40. 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 and childbirth. 2020;20:1-9.

41. Ukke GG, Gurara MK, Boynito WG. Disrespect and abuse of women during childbirth in public health facilities in Arba Minch town, south Ethiopia – a cross-sectional study. PLOS ONE. 2019;14(4):e0205545.

42. Negash BT, Yoseph A. Status of Disrespectful and Abusive Maternity Care Among Women who Delivered in Hospitals of Sidama zone, South Ethiopia, in 2019. 2020.

43. Abamila N, Agago T, Garedew M. Disrespect and abusive maternity care and associated factors in the labor and delivery wards of public health facilities in Assosa Zone, Ethiopia. Ethiopian Journal of Reproductive Health. 2022;14(01):9-.

44 Orpin J, Puthussery S, Davidson R, Burden B. Women's experiences of disrespect and abuse in maternity care facilities in Benue State, Nigeria. BMC Pregnancy and Childbirth. 2018;18(1):213.

45 Amsalu B, Aragaw A, Sintayehu Y, Sema A, Belay Y, Tadese G, et al. Respectful maternity care among laboring women in public hospitals of Benishangul Gumuz Region, Ethiopia: A mixed cross-sectional study with direct observations. SAGE Open Medicine. 2022;10:20503121221076995.

46 Gebregziabher S, Hawulte B, Abera L, Goshu AT. Disrespect and abuse experienced by women giving birth in public health facilities of Eastern Ethiopia: a multicenter cross-sectional study. Journal of International Medical Research. 2022;50(10):03000605221130015.

47. Wassihun B, Deribe L, Worede N, Gultie T. Prevalence of disrespect and abuse of women during child birth and associated factors in Bahir Dar town, Ethiopia. Epidemiology and health. 2018;40.

48 Sheferaw ED, Mengesha TZ, Wase SB. Development of a tool to measure women's perception of respectful maternity care in public health facilities. BMC pregnancy and childbirth. 2016;16:1-8.

49. Siraj A, Teka W, Hebo H. Prevalence of disrespect and abuse during facility based child birth and associated factors, Jimma University Medical Center, Southwest Ethiopia. BMC pregnancy and childbirth. 2019;19:1-9.

50 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 and childbirth. 2020;20:1-12.

.51 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. Journal of Multidisciplinary Healthcare. 2020:1965-73.

ANNEXES

Annex I: Information sheet and consent form (English version)

Title: Disrespectful and abusive maternity care during childbirth and associated factors at public health facilities in Shashemene Town, Southern Ethiopia: A mixed cross-sectional study

Principal Investigator: Dr. MitIku Dejenu

Introduction: You are being invited to participate in a research study conducted by Dr. Mitiku Dejenu from Hawassa University. The purpose of this study is to assess the magnitude and associated factors of disrespectful and abusive maternity care during childbirth at public health facilities in Shashemene Town, Southern Ethiopia.

Study Procedures: If you agree to participate in this study, you will be asked questions related to your socio-demographic factors, obstetric history, individual factors, provider and service factors, and your experiences related to disrespectful and abusive care during your recent childbirth at this facility. The interview will take approximately 30 minutes of your time.

Risks and Discomforts: There are no known risks associated with participating in this study. However, you may feel uncomfortable answering some questions about personal birthing experiences.

Benefits: There are no direct benefits to you for participating in this study. However, your participation may help improve understanding of respectful maternity care practices and inform efforts to enhance the quality of care for women during childbirth.

Confidentiality: Your responses will remain confidential, and no identifying information will be included in reports. Data will be kept securely in password-protected files.

Voluntary participation: Your participation in this study is completely voluntary. You can decline to answer any questions you do not wish to answer, and you may withdraw from the study at any time without losing any benefits you are entitled to.**Contact information:** If you have any questions about the study, you may contact the researcher, Dr. Mitiku Dejenu, at 0913896621.

Ethical approval: This study has been approved by the Institutional Review Board (IRB) at Hawassa University's College of Medicine and Health Sciences.

Consent Form

I confirm that I have understand the information sheet regarding the study on assessing disrespectful and abusive maternity care during childbirth and associated factors at public health facilities in Shashemene town. I have had the opportunity to ask any questions related to this study.

I understand that my participation is voluntary and I am free to withdraw participation at any time without giving reasons and without losing any benefits I am entitled to.

I agree for the information provided to be used for the purposes of this study. I understand that the information collected will remain confidential.

By signing this form, I agree to participate in this study. I confirm that I have received a signed copy of this consent form.

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Signature of Participant Date

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Name of Data Collector Signature Date

Annex II: Questionnaire for quantitative data (English version)

Questionnaire code: _____

Health Facility code: _____

Part I. Socio-demographic characteristics			
Code	***Questions***	***Possible responses***	***Skip***
Q101	What is your current age?	_____ years	
Q102	What is your current marital status?	1. Single 2. Married 3. Divorced 4. Windowed	
Q103	What is the highest level of education you have completed?	1. No formal education 2. Primary education 3. Secondary education 4. College or above	
Q104	What is your current occupation?	1. Housewife 2. Farmer 3. Employee 4. Daily laborer 5. Merchant 6. Others(specify)_____	
Q105	Do you currently reside in an urban or rural area?	1. Urban 2. Rural	
Q106	What is the average monthly income for your household?	_____ Birr	

PART II. Obstetric related factors			
Code	**Questions**	**Possible responses**	**Skip**
Q201	How many times have you been pregnant, including the current pregnancy?	_____ in number	If '1' go to Q205
Q202	How many live births have you had previously?	_____ in number	
Q203	Have you ever had stillbirth?	1. Yes 2. No	
Q204	Where did you give birth to your previous children?	1. Hospital 2. Health center 3. Health post 4. Home	
Q205	Have you attended ANCvisits for the current pregnancy?	1. Yes 2. No	If 'No' go to Q208
Q206	Where did you attend ANC for this pregnancy?	1. Government hospital 2. Government HC 3. Health post 4. Private facility 5. Other (specify)_____	
Q207	How many ANC visits did you attend during your most recent pregnancy?	1. Once 2. Twice 3. Three times 4. Four or above	
Q208	How was your most recent delivery conducted?	1. Vaginal delivery 2. Cesarean section 3. Instrumental delivery	
Q209	During what time of day did you give birth?	1. Daytime (6:00 AM - 6:00 PM)	

		2. Nighttime (6:00 PM - 6:00 AM)	
Q210	How long did you stay at the health facility before giving birth?	_____ hours	
Q211	Did you experience any complications during your delivery?	1. Yes 2. No	

PART III: Individual related factors			
Code	**Questions**	**Possible responses**	**Skip**
Q301	Have you received information about respectful maternity care during your ANC visits or any other educational sessions?	1. Yes 2. No	
Q302	In your community, do you feel that disrespectful or abusive behavior during childbirth is considered normal or acceptable?	1. Yes 2. No	
Q304	If you witness or experience disrespectful or abusive care, will you report it to the healthcare facility or any relevant authority?	1. Yes 2. No 3. I don't know	
Q305	Did the care you received align with your expectations for respectful maternity care, or were there notable discrepancies?	1. Aligned with expectations 2. Not aligned with expectations	
Q306	When it comes to decisions related to your childbirth experience, how much support and involvement do you feel you have from your family members?	1. Strong support 2. Moderate support 3. Limited support 4. No support	
Q307	In the pregnancy and delivery period, how	1. Complete autonomy	

	much involvement or autonomy do you have in making decisions?	2. Some autonomy 3. Limited autonomy 4. No autonomy	
Knowledge on disrespectful and abusive maternity care			
Q309	What does "respectful maternity care" mean?	1. Giving birth at home 2. Receiving care with dignity and respect 3. Quick delivery process	
Q310	Does every woman have the right to respectful maternity care during childbirth?	1. Yes 2. No 3. I don't know	
Q311	Which of the following is a right a mother has during childbirth?	1. Only following medical advice without consent 2. The right to be treated with respect and dignity 3. Healthcare providers making all decisions	
Q312	Which of the following is an example of disrespectful maternity care?	1. Providing clear information about the procedures 2. Ignoring the mother's preferences without explanation 3. Giving compassionate care during labor	
Q314	What is "informed consent" in maternity care?	1. Making decisions for the mother without her knowledge 2. Respecting the mother's right to choose and explaining procedures 3. Not involving the mother in	

		any decision-making process	
Q315	Is it true that detention in health facilities due to inability to pay is a form of disrespectful and abusive maternity care?	1. Yes 2. No 3. I don't know	
Q316	Is abandonment or denial of care considered a form of disrespectful and abusive maternity care?	1. Yes 2. No 3. I don't know	
Q317	If you experience disrespectful or abusive care during childbirth, what should you do?	1. Keep quiet and do nothing. 2. Report the incident to the relevant health authorities. 3. Take revenge on the healthcare provider.	
Attitude towards disrespectful and abusive maternity care			
Q318	I believe that respectful maternity care during childbirth is a fundamental right for every woman.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
Q319	It is crucial for healthcare providers to obtain my informed consent before conducting any medical procedures during childbirth.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
Q320	I believe that disrespect in maternity care, such as ignoring my preferences without explanation, is a serious issue in public health facilities.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
Q321	I feel comfortable reporting instances of disrespectful or abusive maternity care if I	1. Strongly disagree 2. Disagree	

	were to experience it.	3. Neutral 4. Agree 5. Strongly agree	
Q322	Maintaining my privacy and dignity during childbirth is important to me, and I expect healthcare providers to respect these aspects.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
Q323	Experiencing disrespectful or abusive maternity care can negatively impact a mother's overall well-being.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
Q324	I am aware that every woman has the right to receive continuous support during labor and childbirth.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	
Q325	I believe that there are adequate support systems in place for mothers who have experienced disrespectful or abusive maternity care.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree	

PART IV. Provider and service related factors			
Code	**Questions**	**Possible responses**	**Skip**
Q401	What was the sex of the main provider conducting your delivery?	1. Male 2. Female	
Q402	Who assisted you during this delivery?	1. Doctor 2. Health officer	

		3. Nurse/midwife 4. Other (specify)_____	
Q403	How many health professionals attended your delivery?	_____ in number	
Q404	Type of facility?	1. Hospital 2. Health center	
Q405	Did you have any reasons for choosing the facility? (more than one answer is possible)	1. Referred from other health facilities 2. Have adequate drugs and equipment 3. Good health providers 4. Facility where the respondent usually goes 5. Other (specify)_____	
Q406	Was there any supervision of the providers by managers/heads during your delivery?	1. Yes 2. No 3. I don't know	
Q407	During your delivery process, have you experienced any shortages of supplies that necessitated ordering drugs or other supplies from different facilities?	1. Yes 2. No 3. I don't know	

Part V: Disrespect or abuse during childbirth			
Physical abuse			
Code	**Question**	**Response**	**Remarks**
Q501	Did the birth attendants/the care providers use physical forces (**slapping, pinching, beating /hitting**) against you while you were in a labor pain?	1. Yes 2. No	
Q502	Were you physically restrained during childbirth against your will or without clear medical necessity?	1. Yes 2. No	
Q503	Did you encounter any situations where you felt that necessary	1. Yes	

	pain relief was intentionally denied? (Explain: during suturing perineum tear, episiotomy)	2. No	
Q504	Were you separated from your baby without a clear medical reason during or after childbirth?	1. No 2. Yes	
Q505	Did you feel that healthcare providers touched you or demonstrated procedures in inappropriate manner?	1. Yes 2. No	
Q506	Were you restricted from drinking any fluid throughout the labor course?	1. Yes 2. No	
Non-consented Care			
Q507	Did the care provider introduce him/herself to you and your companion?	1. Yes 2. No	
Q508	Were you discouraged or prevented from having a companion (such as a family member or friend) present during your childbirth?	1. Yes 2. No	
Q509	Did the care providers encourage you to ask questions?	1. Yes 2. No	
Q510	Did you encounter situations where your questions were met with delays or impolite responses from healthcare providers?	1. Yes 2. No	
Q511	Were healthcare providers clear in explaining procedures and what to expect during your childbirth experience?	1. No 2. Yes	
Q512	Were you regularly updated on the progress of your labor, and were healthcare providers transparent about any changes?	1. No 2. Yes	
Q513	Were you asked for your consent before any medical procedures were performed during your childbirth?	1. No 2. Yes	
Q514	Were there instances where your consent for procedures was obtained under duress or without adequate time for consideration?	1. No 2. Yes	
Q515	Did you feel pressured or coerced into agreeing to medical interventions without fully understanding the implications?	1. Yes 2. No	
Non-confidential care			
Q516	Did the health care providers use curtains or other physical barriers so that your privacy was kept during the labor and delivery processes?	1. No 2. Yes	

Q517	Did the birth attendants share your secret information with other non-concerned persons? Or don't you trust them that your secret is likely to be shared with others?	1. Yes 2. No 3. I don't know	
Non-dignified Care			
Q518	Did the care provider speak to you politely throughout the course of the labor?	1. No 2. Yes	
Q519	Did you experience any situations where healthcare providers insulted you or used offensive language during your childbirth?	1. Yes 2. No	
Q520	Were you allowed to practice your cultural customs or preferences, such as adopting a specific birthing position that holds cultural significance for you?	1. Yes 2. No	
Discrimination based on specific patient attributes			
Q521	During your childbirth experience, did healthcare providers use language or terminology that you found difficult to understand?	1. Yes 2. No	
Q522	Did you experience any discrimination or differential treatment based on your race, ethnicity, education, or economic status during your childbirth?	1. Yes 2. No	
Abandonment of Care			
Q523	Have you ever left alone without the care provider nearby you while you were in labor and needed help?	1. Yes 2. No	
Q524	Did you give birth in the health institution by yourself because the care providers were not around you?	1. Yes 2. No	
Q525	Have you encountered a life-threatening condition for which you have shouted for help but could not get anyone reached you in time?	1. Yes 2. No	
Detention in Health facilities			
Q526	Did the health care providers detain you in the health facility because of payment of because you have pose damage to the property of the health institution?	1. Yes 2. No	

Annex III: In-depth interview guide for mothers

Introduction: You are being invited to participate in a study conducted by Dr. Miteku Dejenu from Hawassa University. This study aims to explore women's experiences and perspectives related to respectful maternity care practices during childbirth in Shashemene town.

If you decide to participate, you will be asked to take part in an in-depth interview where you will be asked questions about your recent delivery experience. The interview will take approximately 60-90 minutes. With your permission, the interview will be audio recorded to ensure accuracy. Your participation is completely voluntary.There are no known risks associated with participating in this study. However, you may feel uncomfortable answering some questions about personal birthing experiences. You can decline to answer any questions you do not wish to answer. Your responses will remain confidential and no identifying information will be included in reports. Data will be kept securely in password protected files.

If you have any questions about the study, you may contact the researcher at [0913896621].

Your participation in this study may help improve understanding of respectful maternity care practices and inform efforts to enhance quality of care for women during childbirth. There is no compensation provided for participating in this study. However, your contribution is greatly appreciated.

Consent Form

I have read the information sheet and understand the purpose of this study. I have had an opportunity to ask questions which have been answered to my satisfaction.

I agree to participate in this in-depth interview and allow it to be audio recorded.

I understand that:

- My participation is voluntary and I can withdraw at any time.
- My responses will be kept confidential and I will not be identifiable in study reports.
- I can decline to answer any questions I prefer not to answer.

Name: _____ Signature: _____ Date: _____

Demographic background: Name, age, gender, education, and occupation.

Interview points:

1. Could you share your overall experiences at the healthcare facility during your recent delivery and postpartum period?
2. How would you describe your interactions with the medical staff, including doctors and nurses, during your delivery and postpartum care?
3. Did you feel that your dignity was respected throughout the labor and delivery process? Could you provide specific examples?
4. Can you describe the level of physical and emotional support you received during delivery?
5. How much involvement did you have in the decision-making process regarding your delivery experience and the care provided to you and your baby?
6. How did you respond when you encountered unethical practices or disrespectful and abusive behavior from healthcare professionals?
7. In your opinion, what could be the potential reasons for this disrespect or abuse?
8. Do you have any recommendations for enhancing respectful maternity care practices at this facility?
9. Is there anything else you would like to share about your delivery experience?

Annex IV: Key informant interview guide for healthcare providers

Introduction: Thank you for participating in this Key Informant Interview focused on disrespectful and abusive maternity care during delivery and associated factors in Shashemene town. Your expertise and insights as key maternity care provider are crucial for a comprehensive understanding of the factors influencing disrespectful and abusive maternity care in our region. The information gathered will contribute significantly to the study's objectives, and we appreciate your time and valuable contributions.

Instructions: Your insights are highly valued, and we encourage you to express your thoughts openly. During the interview, please feel free to elaborate on your experiences and observations. All information shared will be treated with the utmost confidentiality, and your input is

instrumental in shaping effective strategies for preventing disrespectful and abusive maternity care. There are no right or wrong answers – we are interested in your perspectives, experiences, and recommendations. Thank you for your commitment to this important dialogue.

Demographic background: Name, age, profession, position, and work experience.

1. Could you describe your role and experiences in caring for mothers during labor, delivery, and the immediate postpartum period?
2. What policies or protocols are in place at this facility regarding respectful maternity care? Have you received any training on compassionate, patient-centered care approaches?
3. How do you ensure mothers understand procedures, provide fully informed consent, and feel respected? Can you share examples of communication approaches you employ?
4. Based on your observations, do mothers endure mistreatment or disrespect during facility-based childbirth? If so, what are the most common examples?
5. Why do you think some medical staff engages in behaviors perceived as disrespectful?
6. How informed consent for procedures obtained is and how much autonomy do mothers have in decision-making?
7. Can you describe the level of emotional support and reassurance provided throughout labor and immediately post-delivery?
8. What barriers exist to providing optimal patient-centered, respectful, compassionate care during childbirth? What resources or interventions could help promote respectful care?
9. Do you have any other suggestions to improve respectful maternity care at your facility or system-wide? Is there anything else you would like to add?

አባሪ V ፡የመረጃእናየስምምነትቅጽ (የአማርኛቅጂ)

ርዕስ፡- በወሊድ ወቅት አክብሮት የጎደለው እና አስነዋሪ የእናቶች እንክብካቤ እና ተያያዥ ጉዳዮች በደቡብ ኢትዮጵያ በሻሸመኔ ከተማ በህዝብ ጤና ተቋማት ላይ የተደረገ ቅይጥ ጥናት

ዋና መርማሪ፡- ዶ/ ር ምትኩ ደጀኑ

በሻሸመኔ ከተማ በሻሸመኔ ከተማ በሚገኙ የህዝብ ጤና ተቋማት በወሊድ ወቅት አክብሮት የጎደለው እና አስነዋሪ የወሊድ እንክብካቤን ለመገምገም በተደረገው የምርምር ጥናት ላይ እንድትሳተፉ ተጋብዘዋል ።

የዚህ ጥናት ግኝቶች ልጅ በሚወልዱበት ጊዜ አክብሮት የጎደለው እና የሚንገላታ እንክብካቤ ምን ያህል እንደሆነ እና በአካባቢው ሁኔታ ውስጥ ተያያዥነት ያላቸውን ነገሮች ለመረዳት ይረዳል.

ለመሳተፍ ከተስማሙ፣ ከማህበራዊ-ስነ-ህዝብ ሁኔታዎች፣ ከማህፀን ህክምና ጉዳዮች፣ ከግለሰባዊ ሁኔታዎች፣ ከአገልግሎት ሰጪ እና ከአገልግሎት ሁኔታዎች፣ እና በቅርብ ጊዜ በዚህ ተቋም ውስጥ በወሊድዎ ወቅት ከአክብሮት እና አላግባብ እንክብካቤ ጋር በተያያዘ ያጋጠሙዎት ጥያቄዎች ይጠየቃሉ። ጥያቄዎቹ በጊዜዎ 30 ደቂቃ ያህል ይወስዳሉ።

በዚህ ጥናት ውስጥ ያለዎት ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ነው። ምንም አይነት ጥቅማጥቅሞችን ሳያጡ ተሳትፎን አለመቀበል ወይም በማንኛውም ጊዜ ተሳትፎን ለማቋረጥ የመምረጥ መብት አለዎት።

ያቀረቡት መረጃ በጥብቅ በሚስጥር ይጠበቃል። በመተንተን እና በውጤቶች ሪፖርት ወቅት መረጃው ይጣመራል እና መለያ መረጃ ይወገዳል. ግኝቶች በሳይንሳዊ መጽሔቶች ላይ ሊታተሙ ይችላሉ ነገር ግን የተሳታፊዎች ማንነት አይገለጽም።

ስለ ጥናቱ ማንኛውም አይነት ጥያቄ ካሎት ወይም ከጥናቱ ጋር የተያያዙ ማናቸውንም ችግሮች ሪፖርት ማድረግ ከፈለጉ፣ እባክዎን ከላይ የቀረቡትን ዝርዝሮች በመጠቀም ዋና መርማሪውን ያግኙ። በስነምግባር ዙሪያ ለሚነሱ ጥያቄዎች በሀዋሳ ዩኒቨርሲቲ ህክምና እና ጤና ሳይንስ ኮሌጅ የስነ ምግባር ገምጋሚ ኮሚቴን ማግኘት ይችላሉ።

ማንኛውም አይነት ጥያቄ ካሎት፣ ማነጋገር ይችላሉ፡-

ስም ፡ ምትኩ ደጀኑ

ስልክ፡ +251913896621

በጣም አመሰግናለሁ!

የስምምነት ቅጽ

በሻሸመኔ ከተማ በሚገኙ የመንግስት ጤና ተቋማት በወሊድ ጊዜ እና ተያያዥ ጉዳዮች ላይ አክብሮት የጎደለው እና አስነዋሪ የእናቶች እንክብካቤን በመገምገም ላይ የተደረገውን ጥናት አስመልክቶ የቀረበውን መረጃ እንዳነበብኩ አረጋግጣለሁ። ከዚህ ጥናት ጋር የተያያዙ ጥያቄዎችን ለመጠየቅ እድሉን አግኝቻለሁ.

የእኔ ተሳትፎ በፈቃደኝነት እንደሆነ ተረድቻለሁ እናም በማንኛውም ጊዜ ምክንያት ሳልሰጥ እና ምንም አይነት ጥቅማጥቅሞችን ሳላጠፋ ተሳትፎዬን ለማቆም ነፃ ነኝ።

የቀረበው መረጃ ለዚህ ጥናት ዓላማዎች እንዲውል ተስማምቻለሁ። የሚሰበሰበው መረጃ ሚስጥራዊ ሆኖ እንደሚቆይ ተረድቻለሁ።

ይህን ቅጽ በመፈረም በዚህ ጥናት ለመሳተፍ ተስማምቻለሁ። የዚህ የስምምነት ቅጽ የተፈረመ ቅጂ እንደደረሰኝ አረጋግጣለሁ።

የተሳታፊ ቀን ፊርማ

የመረጃ ሰብሳቢ ፊርማ ቀን ስም

አባሪ VI፡መጠየቂያመረጃመጠይቅ (የአማርኛቅጂ)

መጠይቅ ኮድ፡ _____

የጤና ተቋም ኮድ፡ _____

ክፍል I. ማህበረ-ሕዝብ ባህሪያት			
ኮድ	***ጥያቄዎች***	***ሊሆኑ የሚችሉ ምላሾች***	***ዝለል***
Q101	የአሁኑ ዕድሜዎ ስንት ነው?	_____ ዓመታት	
Q102	አሁን ያለሽበት የትዳር ሁኔታ ምንድነው?	5. ያገባች 6. ያገባች 7. የተፋታች 8. ባል የሞተባት	
ጥ 103	ያጠናቀቁት ከፍተኛ የትምህርት ደረጃ ምንድነው?	5. መደበኛ ትምህርት የለም 6. የመጀመሪያ ደረጃ ትምህርት 7. የሁለተኛ ደረጃ ትምህርት 8. ኮሌጅ ወይም ከዚያ በላይ	
Q104	አሁን ያለሽበት ሙያ ምንድን ነው?	7. የቤት እመቤት 8. ገበሬ	

		9. ሰራተኛ 10.የቀን ሰራተኛ 11.ነጋዴ 12.ሌሎች (ይግለጹ)_____	
Q105	በአሁኑ ጊዜ በከተማ ወይም በገጠር ውስጥ ይኖራሉ?	3. ከተማ 4. ገጠር	
ጥ 106	የቤተሰብዎ አማካይ ወርሃዊ ገቢ ስንት ነው?	_____ ብር	

ክፍል II. ከማህፀን ጋር የተያያዙ ምክንያቶች			
ኮድ	**ጥያቄዎች**	**ሊሆኑ የሚችሉ ምላሾች**	**ዝለል**
Q201	የአሁኑን እርግዝና ጨምሮ ስንት ጊዜ አርግዛችኋል?	_____ በቁጥር	'1' ከሆነ ወደ Q205 ይሂዱ
ጥ202	ከዚህ በፊት ስንት ህያው ልደቶች ነበሩዎት?	_____ በቁጥር	
Q203	ሟች ልደት አጋጥሞህ ያውቃል?	3. አዎ 4. አይ	
Q204	የቀድሞ ልጆችህን የት ነው የወለድከው?	5. አዎ 6. አይ	
Q205	ለአሁኑ እርግዝና በANC ጉብኝቶች ላይ ተሳትፈዋል?	3. አዎ 4. አይ	'አይ' ከሆነ ወደ Q208 ይሂዱ
Q206	ለዚህ እርግዝና በኤኤንሲ የት ነበር የተከታተሉት?	6. የመንግስት ሆስፒታል 7. የመንግስት ኤች.ሲ 8. የጤና ፖስታ	

		9. የግል ተቋም 10. ሌላ (ይግለጹ)_____	
Q207	በቅርብ እርግዝናዎ ወቅት ስንት የኤኤንሲ ጉብኝቶች ተገኝተዋል?	5. አንድ ጊዜ 6. ሁለት ግዜ 7. ሦስት ጊዜ 8. አራት ወይም ከዚያ በላይ	
ጥ208	በጣም የቅርብ ጊዜ ማድረስዎ እንዴት ተካሄደ?	4. በምጥ 5. በቀዶ ጥገና 6. በመሳሪያ የታገዘ	
Q209	በየትኛው ቀን ውስጥ ነው የወለድከው?	3. ቀን (6:00 AM - 6:00 PM) 4. ምሽት (6:00 PM - 6:00 AM)	
Q210	ከመውለዳችሁ በፊት በጤና ተቋም ለምን ያህል ጊዜ ቆዩ?	_____ ሰዓታት	
Q211	በወሊድዎ ወቅት ምንም አይነት ችግር አጋጥሞዎታል?	3. አዎ 4. አይ	

ክፍል III: ከግለሰብ ጋር የተያያዙ ምክንያቶች			
ኮድ	**ጥያቄዎች**	**ሊሆኑ የሚችሉ ምላሾች**	**ዝለል**
Q301	በANC ጉብኝቶችዎ ወቅት ወይም በሌላ የትምህርት ክፍለ ጊዜ ስለ አክባሪ የወሊድ እንክብካቤ መረጃ ደርሶዎታል?	3. አዎ 4. አይ	
Q302	በአካባቢያችሁ፣ በወሊድ ጊዜ አክብሮት የጎደለው ወይም የሚሳደብ ድርጊት እንደ መደበኛ ወይም ተቀባይነት ያለው እንደሆነ ይሰማዎታል?	3. አዎ 4. አይ	
Q304	ክብር የጎደለው ወይም አስነዋሪ እንክብካቤ ካዩ ወይም ካጋጠሙዎት ለጤና አጠባበቅ ተቋሙ ወይም ለሚመለከተው አካል ሪፖርት	4. አዎ 5. አይ 6. አላውቅም	

	ያደርጋሉ?		
Q305	የተቀበሉት እንክብካቤ ለአክብሮት የወሊድ እንክብካቤ ከምትጠብቁት ነገር ጋር ይስማማል ወይስ ጉልህ ልዩነቶች ነበሩ?	3. ከተጠበቀው ጋር የተጣጣመ 4. ከተጠበቀው ጋር አልተጣጣመም።	
Q306	ከወሊድ ልምድዎ ጋር የተያያዙ ውሳኔዎችን በተመለከተ፣ ከቤተሰብዎ አባላት ምን ያህል ድጋፍ እና ተሳትፎ እንዳለዎት ይሰማዎታል?	5. ጠንካራ ድጋፍ 6. መጠነኛ ድጋፍ 7. የተወሰነ ድጋፍ 8. ምንም ድጋፍ የለም።	
Q307	በእርግዝና እና በወሊድ ጊዜ፣ ውሳኔ ለማድረግ ምን ያህል ተሳትፎ ወይም ራስን በራስ የማስተዳደር መብት አለህ?	5. ሙሉ ራስን በራስ ማስተዳደር 6. አንዳንድ ራስን በራስ የማስተዳደር 7. የተገደበ ራስን በራስ የማስተዳደር 8. የራስ ገዝ አስተዳደር የለም።	
አክብሮት የጎደለው እና አስነዋሪ የወሊድ እንክብካቤ ላይ እውቀት			
Q309	"የተከበረ የወሊድ እንክብካቤ" ማለት ምን ማለት ነው?	4. ቤት ውስጥ መውለድ 5. በአክብሮት እና በአክብሮት እንክብካቤን መቀበል 6. ፈጣን የማድረስ ሂደት	
Q310	እያንዳንዱ ሴት በወሊድ ጊዜ የተከበረ የወሊድ እንክብካቤ የማግኘት መብት አላት?	4. አዎ 5. አይ 6. አላውቅም	
Q311	ከሚከተሉት ውስጥ አንዲት እናት በወሊድ ወቅት ያላት መብት የትኛው ነው?	4. ያለፈቃድ የሕክምና ምክሮችን መከተል ብቻ ነው 5. በአክብሮት እና በአክብሮት የመስተናገድ መብት 6. የጤና እንክብካቤ አቅራቢዎች	

		ሁሉንም ውሳኔዎች ያደርጋሉ	
Q312	ከሚከተሉት ውስጥ አክብሮት የጎደለው የወሊድ እንክብካቤ ምሳሌ የትኛው ነው?	4. ስለ ሂደቶቹ ግልጽ መረጃ መስጠት 5. ያለ ማብራሪያ የእናት ምርጫን ችላ ማለት 6. በወሊድ ጊዜ ርኅራኄ እንክብካቤ መስጠት	
Q314	በወሊድ እንክብካቤ ውስጥ "በመረጃ ላይ የተመሰረተ ስምምነት" ምንድን ነው?	4. ለእናትየው ሳታውቅ ውሳኔዎችን ማድረግ 5. የእናትየውን ሂደት የመምረጥ እና የማብራራት መብትን ማክበር 6. እናቱን በማንኛውም የውሳኔ አሰጣጥ ሂደት ውስጥ አለማሳተፍ	
Q315	መክፈል ባለመቻሉ በጤና ተቋማት መታሰር ክብር የጎደለው እና የእናቶች አያያዝ ነውን?	4. አዎ 5. አይ 6. አላውቅም	
Q316	እንክብካቤን መተው ወይም መከልከል እንደ አክብሮት የጎደለው እና አስነዋሪ የወሊድ እንክብካቤ ተደርጎ ይቆጠራል?	4. አዎ 5. አይ 6. አላውቅም	
Q317	ልጅ በሚወልዱበት ጊዜ አክብሮት የጎደለው ወይም የሚያንገላቱ እንክብካቤ ካጋጠመዎት ምን ማድረግ አለብዎት?	4. ዝም ብለህ ምንም አታድርግ። 5. ጉዳቱን ለሚመለከታቸው የጤና ባለስልጣናት ያሳውቁ። 6. የጤና እንክብካቤ አቅራቢውን ይበቀል።	
አክብሮት የጎደለው እና አስነዋሪ የወሊድ እንክብካቤ ላይ ያለ አመለካከት			
Q318	በወሊድ ጊዜ የተከበረ የወሊድ እንክብካቤ ለእያንዳንዱ ሴት መሠረታዊ መብት ነው ብዬ አምናለሁ.	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ	

		9. አልስማማም። 10. በጣም አልስማማም።	
Q319	በወሊድ ጊዜ ማንኛውንም የሕክምና ሂደቶች ከማድረጋቸው በፊት ለጤና አጠባበቅ አቅራቢዎች የእኔን በመረጃ የተደገፈ ፈቃድ ማግኘት በጣም አስፈላጊ ነው።	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ 9. አልስማማም። 10. በጣም አልስማማም።	
Q320	በወሊድ እንክብካቤ ላይ ያለ ክብር አለመስጠት፣ ለምሳሌ ምርጫዬን ያለ ማብራሪያ ችላ ማለት በህዝብ ጤና ተቋማት ውስጥ አሳሳቢ ጉዳይ ነው።	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ 9. አልስማማም። 10. በጣም አልስማማም።	
Q321	እኔ ካጋጠመኝ አክብሮት የጎደለው ወይም አስጸያፊ የሆነ የወሊድ እንክብካቤን ሪፖርት ለማድረግ ምቾት ይሰማኛል።	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ 9. አልስማማም። 10. በጣም አልስማማም።	
Q322	የእኔን ግላዊነት እና ክብሬን መጠበቅ ለእኔ አስፈላጊ ነው፣ እና የጤና እንክብካቤ አቅራቢዎች እነዚህን ገጽታዎች እንዲያከብሩ እጠብቃለሁ።	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ 9. አልስማማም። 10. በጣም አልስማማም።	
Q323	አክብሮት የጎደለው ወይም አላግባብ የሚደረግ የእናቶች እንክብካቤ የእናትን አጠቃላይ ደህንነት ላይ አሉታዊ ተጽዕኖ ሊያሳድር ይችላል።	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ 9. አልስማማም። 10. በጣም አልስማማም።	
Q324	እያንዳንዱ ሴት በወሊድ እና በወሊድ ጊዜ የማያቋርጥ ድጋፍ የማግኘት መብት እንዳላት አውቃለሁ።	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ	

		9. አልስማማም። 10. በጣም አልስማማም።	
Q325	አክብሮት የጎደለው ወይም አስነዋሪ የወሊድ እንክብካቤ ላጋጠማቸው እናቶች በቂ የድጋፍ ስርዓቶች እንዳሉ አምናለሁ።	6. በጣም ተስማማ 7. ተስማማ 8. ገለልተኛ 9. አልስማማም። 10. በጣም አልስማማም።	

ክፍል IV. አቅራቢ እና አገልግሎት ተዛማጅ ምክንያቶች			
ኮድ	**ጥያቄዎች**	**ሊሆኑ የሚችሉ ምላሾች**	**ዝለል**
Q401	ማድረስዎን ሲመራ የነበረው ዋናው አቅራቢ ጾታ ምን ነበር?	3. ወንድ 4. ሴት	
Q402	በዚህ ማድረስ ወቅት ማን ረዳህ?	5. ዶክተር 6. የጤና መኮንን 7. ነርስ/አዋላጅ 8. ሌላ (ይግለጹ)_____	
ጥ 403	በወሊድዎ ላይ ስንት የጤና ባለሙያዎች ተገኝተዋል?	_____ በቁጥር	
Q404	የመገልገያ አይነት?	3. ሆስፒታል 4. ጤና ጣቢያ	
Q405	መገልገያውን ለመምረጥ ምንም ምክንያት አልዎት? (ከአንድ በላይ መልስ ማግኘት ይቻላል)	6. ከሌሎች የጤና ተቋማት የተወሰደ 7. በቂ መድሃኒቶች እና መሳሪያዎች ይኑርዎት 8. ጥሩ የጤና አቅራቢዎች 9. ምላሽ ሰጪው ብዙውን ጊዜ የሚሄድበት ተቋም 10. ሌላ (ይግለጹ)_____	
ጥ 406	በማድረስዎ ወቅት በአስተዳዳሪዎች/ዋና	4. አዎ	

	ኃላፊዎች የአቅራቢዎች ቁጥጥር ነበረ?	5. አይ 6. አላውቅም	
ጥ 407	በማዋለድ ሂደትዎ ወቅት፣ ከተለያዩ ተቋማት የሚመጡ መድኃኒቶችን ወይም ሌሎች አቅርቦቶችን ለማዘዝ የሚያስፈልግ የአቅርቦት እጥረት አጋጥሞዎታል?	4. አዎ 5. አይ 6. አላውቅም	

ክፍል V: በወሊድ ጊዜ አክብሮት ማጣት ወይም ማጎሳቆል			
አካላዊ ጥቃት			
ኮድ	ጥያቄ	ምላሽ	አስተያየቶች
Q501	የወሊድ ረዳቶች/ተንከባካቢዎች በምጥ ህመም ላይ እያሉ አካላዊ ሃይሎችን (**በጥፊ፣መቆንጠጥ፣ድብደባ/መምታት**) **ተጠቅመዋል?**	3. አዎ 4. አይ	
Q502	ያለፍላጎትህ ወይም ያለ ግልጽ የሕክምና አስፈላጊነት በወሊድ ወቅት በአካል ተገድበህ ነበር?	3. አዎ 4. አይ	
Q503	አስፈላጊው የህመም ማስታገሻ ሆን ተብሎ እንደተከለከለ የተሰማዎት ሁኔታዎች አጋጥመውዎታል? (አብራራ፡ የፔሪንየም እንባ በመስፋት ወቅት፣ ኤፒሲዮቶሚ)	3. አዎ 4. አይ	
Q504	ያለ ግልጽ የሕክምና ምክንያት ክልጅዎ ተለይተዋል ?	3. አይ 4. አዎ	
Q505	የጤና እንክብካቤ አቅራቢዎች እርስዎን እንደነኩዎት ወይም ሂደቶችን ተገቢ ባልሆነ መንገድ አሳይተዋል ብለው ተሰምቷቸው ነበር?	3. አዎ 4. አይ	
Q506	በወሊድ ኮርስ ውስጥ ማንኛውንም ፈሳሽ ከመጠጣት ተገድበዋል?	3. አዎ 4. አይ	
ያልተፈቀደ እንክብካቤ			
Q507	ተንከባካቢው እሱ/ራሷን ከእርስዎ እና ከጓደኛዎ ጋር አስተዋውቋል?	3. አዎ 4. አይ	
Q508	በወሊድ ጊዜ ጓደኛዎ (እንደ የቤተሰብ አባል ወይም ጓደኛ) እንዳይገኝ ተስፋ ቆርጦ ነበር ወይም ተከልክሏል?	3. አዎ 4. አይ	

Q509	ተንከባካቢዎቹ ጥያቄዎችን እንዲጠይቁ አበረታተውዎታል?	3. አዎ 4. አይ	
Q510	ጥያቄዎችዎ ከጤና አጠባበቅ አቅራቢዎች መዘግየቶች ወይም ተገቢ ያልሆኑ ምላሾች ያጋጠሙባቸው ሁኔታዎች አጋጥመውዎታል?	3. አዎ 4. አይ	
Q511	የጤና እንክብካቤ አቅራቢዎች ሂደቶችን በማብራራት እና በወሊድ ጊዜ ምን እንደሚጠብቁ ግልጽ ነበሩ?	3. አይ 4. አዎ	
Q512	ስለ ጉልበትህ እድገት በየጊዜው አዘምነሃል፣ እና የጤና እንክብካቤ አቅራቢዎች ስለማንኛውም ለውጦች ግልጽ ነበሩ?	3. አይ 4. አዎ	
Q513	ልጅ በሚወልዱበት ጊዜ ምንም ዓይነት የሕክምና ሂደቶች ከመደረጉ በፊት ፈቃድዎን ጠይቀዋል?	3. አይ 4. አዎ	
Q514	ለሂደቶች ፈቃድዎ በግዴታ ወይም በቂ ጊዜ ሳይሰጥ የተገኘባቸው አጋጣሚዎች ነበሩ?	3. አይ 4. አዎ	
Q515	አንድምታውን ሙሉ በሙሉ ሳይረዱ በህክምና ጣልቃ ገብነት ለመስማማት ግፊት ወይም ተገድደዋል?	3. አዎ 4. አይ	
ሚስጥራዊ ያልሆነ እንክብካቤ			
Q516	በወሊድ እና በወሊድ ሂደት ውስጥ የእርስዎ ግላዊነት እንዲጠበቅ የጤና እንክብካቤ አቅራቢዎች መጋረጃዎችን ወይም ሌሎች አካላዊ መሰናክሎችን ተጠቅመዋል?	3. አይ 4. አዎ	
Q517	ወሊድ ረዳቶቹ ሚስጥራዊ መረጃዎን ለሌሎች ለማይጨነቁ ሰዎች አጋርተዋል? ወይስ ሚስጥርህ ለሌሎች ሊነገር እንደሚችል አታምኗቸውም?	4. አዎ 5. አይ 6. አላውቅም	
ክብር የሌለው እንክብካቤ			
Q518	ተንከባካቢው በጉልበት ጊዜ ሁሉ በትህትና አነጋግሮዎታል?	3. አይ 4. አዎ	
Q519	በወሊድ ጊዜ የጤና እንክብካቤ አቅራቢዎች እርስዎን ሲሰድቡ ወይም አፀያፊ ቋንቋ ሲናገሩ አጋጥሞዎታል?	3. አዎ 4. አይ	
Q520	ባህላዊ ልማዶችዎን ወይም ምርጫዎችዎን እንዲለማመዱ ተፈቅዶልዎታል፣ ለምሳሌ ለእርስዎ ባህላዊ ፋይዳ ያለው የተለየ የልደት ቦታ መቀበል?	3. አዎ 4. አይ	

በልዩ የታካሚ ባህሪያት ላይ የተመሰረተ መድልዎ			
Q521	በወሊድ ልምድዎ ወቅት፣ የጤና እንክብካቤ አቅራቢዎች እርስዎ ለመረዳት የሚያስቸግርዎትን ቋንቋ ወይም የቃላት አነጋገር ተጠቅመዋል?	3. አዎ 4. አይ	
Q522	በወሊድዎ ወቅት በዘርዎ፣ በጎሳዎ፣ በትምህርትዎ ወይም በኢኮኖሚዎ ሁኔታዎ ላይ የተመሰረተ አድልዎ ወይም ልዩነት አጋጥሞዎታል?	3. አዎ 4. አይ	
እንክብካቤን መተው			
Q523	እርስዎ ምጥ ውስጥ እያሉ እና እርዳታ በሚፈልጉበት ጊዜ ያለ ተንከባካቢዎ ብቻዎን ትተው ያውቃሉ?	3. አዎ 4. አይ	
Q524	ተንከባካቢዎቹ በአጠገብህ ስላልነበሩ ብቻህን በጤና ተቋም ወለድክ?	3. አዎ 4. አይ	
Q525	እርዳታ ለማግኘት የጮህክበት ነገር ግን በጊዜው ማንም ሊደርስህ ያልቻለበት ለሕይወት አስጊ የሆነ ሁኔታ አጋጥሞህ ያውቃል?	3. አዎ 4. አይ	
በጤና ተቋማት ውስጥ መታሰር			
Q526	በጤና ተቋሙ ንብረት ላይ ጉዳት በማድረስ በክፍያ ምክንያት የጤና አገልግሎት ሰጪዎች በጤና ተቋም አስረውዎት ይሆን?	3. አዎ 4. አይ	

አባሪ VII፡ለእናቶችጥልቅቃለመጠይቅመመሪያ

መግቢያ፡- በዶክተር ምትኩ በተካሄደ ጥናት ላይ እንድትሳተፉ ተጋብዘዋል ደጀኑ ከሐዋሳ ዩኒቨርሲቲ። ይህ ጥናት በሻሸመኔ ከተማ በወሊድ ወቅት የተከበሩ የወሊድ እንክብካቤ ተግባራትን በተመለከተ የሴቶችን ልምድ እና አመለካከት ለመዳሰስ ያለመ ነው ።

ለመሳተፍ ከወሰኑ፣ በቅርብ ጊዜ ስለማድረስ ልምድዎ ጥያቄዎች በሚጠየቁበት ጥልቅ ቃለ መጠይቅ ላይ እንዲሳተፉ ይጠየቃሉ። ቃለ መጠይቁ ከ60-90 ደቂቃ ያህል ይወስዳል። በእርስዎ ፈቃድ፣ ቃለ መጠይቁ ትክክለኛነትን ለማረጋገጥ በድምጽ ይቀዳል። የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ነው። በዚህ ጥናት ውስጥ ከመሳተፍ ጋር የተያያዙ ምንም የሚታወቁ አደጋዎች የሉም. ነገር ግን፣ ስለግል የወሊድ ልምዶች አንዳንድ ጥያቄዎችን ለመመለስ ምቾት ሊሰማዎት ይችላል። መመለስ ለማትፈልጋቸው

ጥያቄዎች መልስ ለመስጠት እምቢ ማለት ትችላለህ። የእርስዎ ምላሾች ሚስጥራዊ ሆነው ይቆያሉ እና ምንም መለያ መረጃ በሪፖርቶች ውስጥ አይካተትም። ውሂብ በይለፍ ቃል በተጠበቁ ፋይሎች ውስጥ ደህንነቱ በተጠበቀ ሁኔታ ይቀመጣል።

ስለ ጥናቱ ማንኛውም አይነት ጥያቄ ካሎት ተመራማሪውን በ [0913896621] ማግኘት ይችላሉ።

በዚህ ጥናት ውስጥ ያለዎት ተሳትፎ የተከበረ የወሊድ እንክብካቤ ልምዶችን ግንዛቤ ለማሻሻል እና በወሊድ ጊዜ የሴቶችን እንክብካቤ ጥራት ለማሻሻል ጥረቶችን ያሳውቃል። በዚህ ጥናት ውስጥ ለመሳተፍ ምንም አይነት ማካካሻ የለም. ሆኖም፣ ያበረከቱት አስተዋፅዖ በጣም የተመሰገነ ነው።

የስምምነት ቅጽ

የመረጃ ወረቀቱን አንብቤያለሁ እናም የዚህ ጥናት ዓላማ ተረድቻለሁ። የሚያረካኝ መልስ የተሰጣቸውን ጥያቄዎች ለመጠየቅ እድል አግኝቻለሁ።

በዚህ ጥልቅ ቃለ መጠይቅ ለመሳተፍ እና በድምጽ እንዲቀረጽ ለመፍቀድ ተስማምቻለሁ።

ይገባኛል:

- የእኔ ተሳትፎ በፈቃደኝነት ነው እናም በማንኛውም ጊዜ ማቋረጥ እችላለሁ።
- የእኔ ምላሾች በሚስጥር ይጠበቃሉ እና በጥናት ሪፖርቶች ውስጥ መለየት አልችልም።
- ላልመልስ የመረጥኩትን ማንኛውንም ጥያቄ ለመመለስ እምቢ ማለት እችላለሁ።

ስም፡ _____ ፊርማ፡ _____ ቀን፡ _____

የስነ ሕዝብ አወቃቀር ዳራ ፡ ስም፣ ዕድሜ፣ ጾታ፣ ትምህርት እና ሥራ።

የቃለ መጠይቅ ነጥቦች፡-

1. በቅርብ ጊዜ በወሊድዎ እና በድህረ ወሊድ ጊዜዎ በጤና እንክብካቤ ተቋሙ ያጋጠሙትን አጠቃላይ ተሞክሮ ማካፈል ይችላሉ?
2. በወሊድዎ እና በድህረ ወሊድ እንክብካቤዎ ወቅት ከህክምና ባለሙያዎች፣ ከዶክተሮች እና ነርሶች ጋር ያለዎትን ግንኙነት እንዴት ይገልፁታል?
3. በጉልበት እና በወሊድ ሂደት ውስጥ ክብርዎ እንደተከበረ ተሰምቷችኋል? የተወሰኑ ምሳሌዎችን ማቅረብ ይችላሉ?
4. በወሊድ ወቅት ያገኙት አካላዊ እና ስሜታዊ ድጋፍ ምን ያህል እንደሆነ መግለፅ ይችላሉ?
5. የመውለጃ ልምድዎን እና ለእርስዎ እና ለልጅዎ የሚሰጠውን እንክብካቤ በተመለከተ በውሳኔ አሰጣጥ ሂደት ውስጥ ምን ያህል ተሳትፎ ነበረዎት?
6. ከጤና አጠባበቅ ባለሙያዎች ስነምግባር የጎደላቸው ድርጊቶች ወይም አክብሮት የጎደለው እና አስነዋሪ ባህሪ ሲያጋጥሙህ ምን ምላሽ ሰጡ?

7. በእርስዎ አስተያየት፣ ለዚህ ክብር መጓደል ወይም መጎሳቆል ሊሆኑ የሚችሉ ምክንያቶች ምን ሊሆኑ ይችላሉ?
8. በዚህ ተቋም ውስጥ የተከበሩ የወሊድ እንክብካቤ ልምዶችን ለማሻሻል ምንም ምክሮች አሉዎት?
9. ስለ የማድረስ ልምድ ማጋራት የሚፈልጉት ሌላ ነገር አለ?

አባሪ VIII፡ለጤናእንክብካቤአቅራቢዎችቁልፍየመረጃሰጪቃለመጠይቅመመሪያ

መግቢያ፡- በሻሸመኔ ከተማ በወሊድ ጊዜ እና ተያያዥ በሆኑ ጉዳዮች ላይ ያተኮረ በዚህ ቁልፍ የመረጃ ሰጭ ቃለ ምልልስ ላይ ስለተሳተፉ እናመሰግናለን ። በክልላችን ውስጥ አክብሮት የጎደለው እና አስነዋሪ የወሊድ እንክብካቤን የሚነኩ ምክንያቶችን ሁሉን አቀፍ ለመረዳት እንደ ቁልፍ የወሊድ እንክብካቤ አቅራቢነት የእርስዎ እውቀት እና ግንዛቤዎች ወሳኝ ናቸው። የተሰበሰበው መረጃ ለጥናቱ አላማዎች ከፍተኛ አስተዋፅዖ ያደርጋል፣ እና ጊዜህን እና ጠቃሚ አስተዋጾህን እናደንቃለን።

መመሪያዎች ፡ ግንዛቤዎችዎ በጣም የተከበሩ ናቸው፣ እና ሃሳብዎን በግልፅ እንዲገልጹ እናበረታታዎታለን። በቃለ መጠይቁ ወቅት፣ እባክዎን የእርስዎን ልምዶች እና ምልከታዎች ለማብራራት ነፃነት ይሰማዎ። ሁሉም የተጋሩ መረጃዎች በከፍተኛ ሚስጥራዊነት ይያዛሉ፣ እና የእርስዎ ግብአት አክብሮት የጎደለው እና አላግባብ የሆነ የእናቶች እንክብካቤን ለመከላከል ውጤታማ ስልቶችን ለመቅረጽ ጠቃሚ ነው። ምንም ትክክለኛ ወይም የተሳሳቱ መልሶች የሉም - የእርስዎን አመለካከቶች፣ ልምዶች እና ምክሮች እንፈልጋለን። ለዚህ አስፈላጊ ውይይት ስላደረጉት ቁርጠኝነት እናመሰግናለን።

የስነ ሕዝብ አወቃቀር ዳራ ፡ ስም፣ ዕድሜ፣ ሙያ፣ የሥራ መደብ እና የሥራ ልምድ።

1. በወሊድ ጊዜ፣ በወሊድ ጊዜ እና በወሊድ ወቅት እናቶችን በመንከባከብ ረገድ ያላችሁን ሚና እና ልምድ መግለፅ ትችላላችሁ?
2. የተከበረ የወሊድ እንክብካቤን በተመለከተ በዚህ ተቋም ውስጥ ምን ፖሊሲዎች ወይም ፕሮቶኮሎች አሉ? በርህራሄ፣ ታጋሽ-ተኮር የእንክብካቤ አቀራረቦች ላይ ምንም አይነት ስልጠና ወስደዋል?
3. እናቶች የአሰራር ሂደቶችን እንዲገነዘቡ፣ በመረጃ ላይ የተመሰረተ ስምምነት እንደሚሰጡ እና እንደተከበሩ እንዲሰማቸው እንዴት ታረጋግጣላችሁ? የተቀጠሩትን የግንኙነት አቀራረቦች ምሳሌዎችን ማጋራት ይችላሉ?

4. በእርስዎ ምልከታ መሰረት፣ እናቶች በተቋም ላይ የተመሰረተ ልጅ በሚወልዱበት ወቅት የሚደርስባቸውን እንግልት ወይም ንቀት ይቋቋማሉ? ከሆነ በጣም የተለመዱ ምሳሌዎች ምንድናቸው?
5. አንዳንድ የሕክምና ባልደረቦች እንደ አክብሮት የጎደለው በሚመስሉ ባህሪያት ውስጥ የሚሳተፉት ለምን ይመስልዎታል?
6. ለተገኙት ሂደቶች በመረጃ ላይ የተመሰረተ ስምምነት እና እናቶች በውሳኔ አሰጣጥ ላይ ምን ያህል የራስ ገዝነት አላቸው?
7. በወሊድ ጊዜ እና ወዲያውኑ ከወለዱ በኋላ የሚሰጠውን የስሜታዊ ድጋፍ እና ማረጋገጫ ደረጃ መግለጽ ይችላሉ?
8. ጥሩ ታካሚን ያማከለ፣ በአክብሮት የተሞላ፣ ርህራሄ ያለው እንክብካቤ በወሊድ ጊዜ ለማቅረብ ምን መሰናክሎች አሉ? አክብሮት የተሞላበት እንክብካቤን ለማበረታታት ምን ሀብቶች ወይም ጣልቃገብነቶች ሊረዱ ይችላሉ?
9. በተቋምዎ ወይም በስርዓተ-አቀፍዎ ውስጥ የተከበረ የወሊድ እንክብካቤን ለማሻሻል ሌላ አስተያየት አለዎት? ሌላ ማከል የሚፈልጉት ነገር አለ?

Dabalata IX: Foormii ragaan itti guuttamu (Afan Oromoo version)

Title: Disrespectful and abusive maternity care during childbirth and associated factors at public health facilities in Shashemene Town, Southern Ethiopia: A mixed cross-sectional study

Nama qo’annaa taasisu: Dr. Miteku Dejenu

Qo’annoo kabaja dhabuu fi dhiibbaa yeroo da’umsaa haadholii irra ga’u adda baasu irratti akka hirmaattu affeeramtee jirta. Argannoon asirraa argamuu sadarkaa kunuunsi haadhalee kan kabaja hin qabnee fi dhiibbaa qabu irra jiru nutty agarsiisa..

Hirmaachuudhaaf hayyamamaa yoo taate gaafiwwan bu’uuraa, kan da’umsa wajjiin wolqabatan, kansadarkaa nama dhuunfaa, nama tajaajila kennuu fi tajaajilaan wolqabatu, muxannoo kee ni gaafatamta. Gaafileen kunneen hanga daqiiqaa 30 fudhachuu danda’u.

Hirmaannaan kee guutumatti fedhii irratti kan hundaa’eedha. Hirmaachuu dhabuu yookin giddutti mirga addaan kutuu ni qabda.

Ragaan ati kennitu icciitiin isa kan eggameedha.. Bu’aan qo’annoo kanaa akka barruutti kan maxxanfamu yoo ta;u garuu maalummaan hirmaataa hin ibsamu.

Qo’anicha irratti gaaffii yoo qabaatte nama qo’annoo adeemsisu bilbila asiin gaditti jiruun dubbisuun ni danda’ama.

Gaaffii yo qabaattan kanaan bilbilaa:

Maqaa: Miteku Dejenu

Lakk bil: +251913896621

Galatoomaa!

Uunkaa namni gaaffii gaafatamu hayyamamaa akka ta’e itti mirkanaa’u

Ergaa qu’annoo dhiibba haadholii irra yeroo da’umsaa ga’anii fi sababoota isaan wolqabatan irratti dhaabbilee fayyaa magaalaa shaashamannee keessatti taasifamu hubadhee jira. Gaaffilee qu’annoo kanaan wolqabatanii jiran gaafachuuf carra ni qaba.

Hirmaannaan koo fedhii irratti kan hunda’e akka ta’e hubadhee jira hirmaannaa koo sa’aatii kamitti addaan kutuu ni danda’a.

Ragaan ani kennu qo’annaadhaaf akka ta’u nan amana.Icciitiin raga kanaas akka eeggamu hubadhee jira.

Qu’annaa kana keessatti akka hirmaadhu mallattoo kootiin ni mirkaneessa.

_____ _____

Mallattoo nama hirmaatuu Guyyaa

_____ _____ _____

Maqaa nama raga sassaabuu Mallattoo Guyyaa

Dabalata X: Gaaffilee

Lakkoofsa addaa: _____

Lakkoofsa adda dhaabbata fayyaa: _____

Kutaa I. Ragaa Bu'uuraa			
Koodii	***Gaaffilee***	***Deebii***	***darbi***
Q101	Umriin kee meeqa?	_____ Waggaadhaan	
Q102	Haala ga'ilaa?	1. Kan hin fuudhin 2. Kan fuudhe 3. Kan hiike 4. Abbaan manaa/haati manaa kanduute	
Q103	Sadarkaa barumsaa?	1. Kan hin baratin 2. Sadarkaa 1ffaa 3. Sadarkaa 2ffaa 4. Kolleejii fi isaa oli	
Q104	Hojiin keessan maaliidha?	1. Haadha manaa 2. Qotee bulaa 3. Hojjataa mootummaa 4. Hojjataa guyyaa 5. Daldalaa 6. Kan biro (haa ibsamuu)_____	
Q105	Iddoo amma jiraatan?	1. Magaala 2. Baadiyyaa	

Q106	Galii ji'aa?	_____ Birriidhaan	

Kutaa II. Ragaa ulfaan wolqabatee jiru			
Code	**Gaaffilee**	**Deebii**	**Darbi**
Q201	Ulfa kana dabalatee yeroo meeqa ulfoofte?	_____ Lakkoofsan	'1' yoo ta'e gara gaaffii 205 darbi
Q202	Ijoolleen lubbuun dhalatan meeqa?	_____ Lakkoofsan	
Q203	Daa'imni du'ee dhalate jira?	1. Eeyye 2. Miti	
Q204	Ijoollee kanaan duraa eessatti deesse?	1. Manatti 2. Hospitaalatti 3. Buufata fayyaatti 4. Dhaabbata dhuunfaa 5. Kan biraa(Haa ibsamuu)	
Q205	Ulfa kanaaf hordoffii da'umsa duraa taasistee?	1. Eeyyen 2. Miti	Miti yoo ta'e gara gaaffii 208 darbi
Q206	Ulfaa ammaa kana eessatti hordofte?	1. Hospitaala mootummaa 2. Buufatafayyaa mootummaa	

		3. Keella fayyaa 4. Dhaabbata dhuunfaa 5. Kan biroo (haa ibsamuu)_____	
Q207	Hordoffii ulfaa yeroo meeqa taasiste?	1. altokko 2. yeroo lama 3. yeroo sadi 4. afurii fi isaa ol	
Q208	Da'umsi inni ammaa karaa kamiiniidha?	1. Ciniinsuu salphaan 2. Baqaqsanii hodhuun 3. Meeshaan deeggaramuun	
Q209	Sa'aatii akkamii deesse?	1. Guyyaa (sa'aa 6:00 – 12:00) 2. Galgala (6:00 PM - 6:00 AM)	
Q210	Osoo hin da'in dhaabbata fayyaa keessa hammam turte?	_____ sa'aatiidhaan	
Q211	Da'umsaan wolqabatee rakkoon sirra ga'e jiraa?	1. Eeyyen 2. Miti	

Kutaa III: Rakkoolee dhuunfaa			
Code	**Gaaffilee**	**deebii**	**darbi**
Q301	Haala kunuunsa gaarii haadholeef godhamu irratti barumsa argattee beekta?	1. Eeyyen 2. Miti	

Q302	Hawaasa keessa jiraattu biratti ilaalchonni haadha deessu irratti dhiibbaa geessisan kan fudhatama qabuudha?	1. Eeyyen 2. Miti	
Q304	Ilaalchii fi gochii haadholii miidhu yoo si mudate qaama dhaabbata fayyaa bulchutti himtee beekta?	1. Eeyyen 2. Miti 3. Hin yaadadhu	
Q305	Kunuunsi ati argatte kan yaaddeen wolsima moo garaagarummaa qaba?	1. Wolsima 2. Wol hinsimu	
Q306	Murtee daa'ima argachuun wolqabatee gargaarsi fi hirmaannaan ati maatii irraa argatte jira maal fakkaata?	1. Deegarsa cimaa 2. Deeggarsa giddugaleessa 3. Deegarsa muraasa 4. Deegarsa hin arganne	
Q307	Yeroo ulfaa fida'umsaa daangaan ati murteessuu dandeessu maal fakkaata?	1. Mirga guutuu ta'e 2. Mirga giddu galeessa 3. Mirga murtaa'e 4. Mirga murteessuu hin qabu.	
Beekkumsa haadholiin kabajamuu dhabuu fi dhiibbamuu ilaalchisee qaban			
Q309	Kunuunsa kabajaa hadholiif yoo jennu maal jechuudha?	1. Manatti da'uu 2. Tajaajila kennnamuu kabajaan argachuu 3. Adeemsa dafanii dhaluu	
Q310	Haati kamuu yeroo deessu kabaja	1. Eeyyen	

	argachuu qabdii?	2. Miti 3. Hin beeku	
Q311	Mirgi haati yeroo deessu qabdu isa kami?	1. Hayyama osoo hin gaafatin gorsa argachuu 2. Mirga kabajaa fi ulfinnaan yaalamuu 3. Murtee hundumaa ogeessi fayyaa kennuu qaba	
Q312	Tajaajilli haadholii irratti dhiibbaa geessisu isa kami?	1. Wonta hojjatamu hunda ergaa guutuu dabarsuu 2. Filannoo haadholii dhageeffachuu dhiisuu 3. Yeroo da'umsaa kunuunsa gara laafummaan kennuu	
Q314	Kunuunsa haadholiif godhamu keesatti dursanii woliigaltee uumuun maal?	1. Haati osoo hin beekin murtii kennuu 2. Mirga haati akka filattuu fi wonta hojjatamu irratti yaada akka kennitu kabajuu 3. Yaada murtee kamuu haati akka itti hin hirmaanne taasisuu	
Q315	Haati sababa kafaluu dadhabdeef dhaabbata fayyaa keessa akka turtu	1. Eeyyen 2. Miti	

	taasisuun adeemsa kabaja haadhaa midhuudha?	3. Hin beeku	
Q316	Haadholiif taajaajila kennuu diduun adeemsa kabaja haadhaa miidhuu keessaa isa tokkoo?	1. Eeyyen 2. Miti 3. Hin beeku	
Q317	Yeroo da'umsaa dhiibbaan kabaja argachuu dhabuu sirra yoo gahe maal goota?	1. Ni callisa. 2. Qaama ilaallatutti himadha. 3. Ogeessa fayyaatti haaloo ba'a.	
Ilaalcha dhiibbaa yeroo da'umsaa haadholii irra ga'u			
Q318	Kabajni haadhoolii yeroo deessu kennamuuf mirga bu'uura haadholii hundaati.	1. Sirritti woliinagalcha 2. woliinagalcha 3. giddugaleessa 4. itti hin amanu 5. guutumatti itti hin amanu	
Q319	Dursanii haadha woliigaltee mallatteesisuun yeroo da'umsaa dhimma murteessaadha.	1Sirritti woliinagalcha 2.woliinagalcha 3.giddugaleessa 4.itti hin amanu 5.guutumatti itti hin amanu	
Q320	Dhaabbilee fayya mootummaa keessatti dhimmoonni haadholii kabaja kennuu dhabuu kan akka filannoo haadhaa	1Sirritti woliinagalcha 2.woliinagalcha 3.giddugaleessa	

	fudhachuu dhabuu ni jiraatu.	4.itti hin amanu 5.guutumatti itti hin amanu	
Q321	Yeroo kabaja ogeeyyii irraa argachuu dhabee qaama ilaallatuuf raga kennuuf wontina rakkisu hin jiru.	1.Sirritti woliinagalcha 2.woliinagalcha 3.giddugaleessa 4.itti hin amanu 5.guutumatti itti hin amanu	
Q322	Yeroo da'umsaa qaamni dhuunfaa koo nama biraatti akka hin mul'annee gochuu fi kabaja argachuun anaaf murteessaadha, fi ogeessi fayyaa illee kana kabajuu qaba	1.Sirritti woliinagalcha 2.woliinagalcha 3.giddugaleessa 4.itti hin amanu 5.guutumatti itti hin amanu	
Q323	Haati kabajadhabuu fi dhiibbaan irra ga'e akka woliigalatti miidhamuu dandeessi.	1.Sirritti woliinagalcha 2.woliinagalcha 3.giddugaleessa 4.itti hin amanu 5.guutumatti itti hin amanu Strongly Disagree	
Q324	Haati kamuu yeroo da'umsaa deeggarsa itti fufiinsa qabu akka argattu nan amana.	1.Sirritti woliinagalcha 2.woliinagalcha 3.giddugaleessa 4.itti hin amanu 5.guutumatti itti hin amanu	
Q325	Haadha kabaja dhabuuniif dhiibbaan irra	1.Sirritti woliinagalcha	

	ga’e malli ittiin gargaaran ifatti ni jira..	2.woliinagalcha 3.giddugaleessa 4.itti hin amanu 5.guutumatti itti hin amanu	

Kutaa IV. Nama tajaajila kennuu fi tajaajila ilaalchisee			
koodii	**Gaaffilee**	**deebii**	**darbi**
Q401	Nama si deessise saalli isa maal?	1. Dhiira 2. Dubara	
Q402	Yeroo deessu eenyutu sigargaare?	1. Doktora 2. Qondaala fayyaa 3. Narsii woliigalaa/narsii deessistuu 4. Kan biraa (haa ibsamuu)_____	
Q403	Yeroo deessu ogeessa meeqatu si gargaare?	_____ Lakkoofsaan	
Q404	Akaakuu dhaabbatichaa?	1. Hospitaala 2. Buufata fayyaa	
Q405	Maaf dhaabbata kana filatte? (filannoo tokkoo ol)	1. Iddoo birootii ol ergame 2. Meeshaa yaalaa fi qoricha ga’aa waan qabuuf 3. Ogeeyyii gaarii waan qabuuf	

		4. Iddoo tajaajilamaan baay'een deemu 5. Kan biraa(haa ibsamuu)_____	
Q406	Yeroo deessu ogeeyyii deessisan itti gaafatamaan ykn hoogganaan ni ilaalamu?	1. Eeyyen 2. Miti 3. Hin beeku	
Q407	Yeroo deessu hanqinni dhiyeessi si mudatee jira?	1. Eeyyen 2. Miti 3. Hin beeku	

Kutaa V: Kabaja kennuu dhabuu fi dhiibbaa yeroo da'umsaa ga'u			
Physical abuse			
Code	**Gaaffii**	**Deebii**	**Yaada**
Q501	Qaamni si deessise yeroo dhukkubbii da'umsaa irra jirtu dhiibbaa akka rukutuu,mushuushuu sirra geessisee jira	1. Eeyyen 2. Miti	
Q502	Dhiibbaan qaamaa akka fedhii kee akka hin taane sirra ga'e jiraa?	1. Eeyyen 2. Miti	
Q503	Qoricha dhukkubbii tasgabbeessuf ta'u yeroon ogeessi osoo beeku siif kennuu dide jira	1. Eeyyen 2. Miti	
Q504	Daa'ima deesse wajjiin akka adda baatu wonti taasisu osoo hin jiraatin adda si baasanii jiru?	1. Eeyyen 2. miti	
Q505	Ogeessi fayyaa yeroo deeggarsa siif kennu akkaataa sirri hin taaneen si tajaajilee jira?	1. Eeyyen 2. Miti	
Q506	Yeroo deessu dhangala'oo akka hin dhugne si dhoowwanii	1. Eeyyen	

	jiru?	2. miti	
Osoo hin hayyamsiisin gargaarsa kennuu			
Q507	Ogeessi tajaajila siif kenne siif ykn nama si wajjiin jiruuf ofbarsiisee jira?	1. Eeyyen 2. miti	
Q508	Yeroo deessu maatiin siwajjiin akka hin taane dhoowwamanii jiruu?	1. Eeyyen 2. miti	
Q509	Ogeessi si deessise gaafii akka gaafattu carraa siif kennaa?	1. Eeyyen 2. Miti	
Q510	Yeroo gaafiin kee ogeessa irraa turee siif deebi'e yookin amala gaarii hin ta'iniin siif deebi'e jira?	1. Eeyyen 2. Miti	
Q511	Ogeessi fayyaa wonta siif hojjatee sirritti ifa godhee siif ibsee jiraa?	1. Eeyyen 2. miti	
Q512	Ogeessi adeemsa da'umsaa yeroo yeroonii fi bifa ifa ta'een sitti himee jira?	1. Eeyyen 2. miti	
Q513	Ogeessi wonta siif hojjate dura hayyama kee gaafatee jira?	1. Eeyyen 2. miti	
Q514	Hayyamamummaa ta'uun kee osoo hin mirkanaa'in jarjaraan yeroon tajaajilli siif kenname jira?	1. Eeyyen 2. miti	
Q515	Taajaajila siif kenname osoo sirritti hin hubatin yeroon dhiibbaadhaan fudhatte jiraa?	1. Eeyyen 2. Miti	
Gargaarsa icciitii haadholii hin eegin			
Q516	Ogeessi fayyaa yeroo deessu golga akka namoonni biro qaama kee hin argine taasisu fayyadamee jiraa?	1. No 2. Yes	
Q517	Ogeessi si deessise iccitii kee qaama hin barbaachifne wajjiin haasa'aa turee jiraa? Yookin iccitii kee nama biraatiif ni dabarsu jettee shakkitaa?	1. Eeyyen 2. miti	

		3. hin beeku	
Tajaajila haadholiif ulfina hin eegne /hin kennine			
Q518	Ogeessi yeroo turtii da'umsa keetii amala gaariin si haasofsiisaa turee jira?	1. Eeyyen 2. Miti	
Q519	Yeroo da'umsaa ogeessi si arrabsee yookin jecha gadhee sitti dubbatee jira?	1. Eeyyen 2. Miti	
Q520	Yeroo da'umsaa akka barbaaddee fi haala aadaatiin akka deessu siif hayyamee jira?	1. Eeyyen 2. miti	
Qoodinsa haadholii irra ga'u			
Q521	Yeroo deessu ogeessi jechoota fi afaan ati hubachuu hin dandeenye sitti dubbatee jira?	1. Eeyyen 2. Miti	
Q522	Yeroo deessu qoodiinsi yookin garaagarummaan sabaan,barumsaanii fi sadarkaa barumsaan sirra ga'e jiraa?	1. Eeyyen 2. Miti	
Kophaa akka taatu			
Q523	Ogeessi si deessisu yeroon qophaa si dhiisee si hin ilaalin hafe jiraa?	1. Eeyyen 2. Miti	
Q524	Ogeessi si biraa dhabamee qophaa kee deessee beekta ?	1. Eeyyen 2. miti	
Q525	Yeroo gargaarsa cimaa barbaaddee iyyitee nama sigargaaru ofbiraa dhabde jira?	1. Yes 2. No	
Dhaabbata fayyaa keessa turuu/tursiisuu			
Q526	Sababa kafaltii hin raawwatiniif akka dhaabbata fayyaa turtu si taasisanii jiru?	1. Eeyyen 2. Miti	

Dabalata XI: Gaaffii fi deebii haadholii wajjiin

Seensa:qorannaa Dr.Mitiku Dejenu univarsitii hawaassa irra taasisu akka itti hirmaattan filatamtanii jirtu.. Qo'annoon kun muxannoo fi ilaalcha haadholiin kabaja haadholii yeroo da'umsaa ogeessu kennu adda baasuuf.

Hirmaachuuf hayyamamaa taanaan muxannoo ati da'umsa kana wajjiin qabdu si gaafanna. sa'aatin fudhatu daqiiqaa 60-90. Hayyama keetiin gaaffii fi deebiin ni woraabbama. Hirmaannaan keessan guututti kan fedhii irratti hundaa'eedha.Miidhaan sababa hirmaachuutiin isin irra ga'u hin jiru. Garuu gaafilee tokko tokko yeroo deebistan isn dhipphisuu danda'a. Gaaffii deebisuu hin barbaanne dhiisuu ni dandeessu. Icciitiin dubbii keessanii kan eeggameedha. Ragaan faayila passwordiidhaan hidhame keessa taa'a

Waa'ee qo'annichaa ilaalchisee gaaffii yoo qabaatte lakkoofsa kanaan nama qo'anno kana hajjatuu gaafachuu dandeessu [0913896621].

Uunkaa woliigaltee

Ragaa kana dubbisee kaayyoo qu'annichaa hubadhee jira.. carraa gaaffilee gaafachuu ni qabaadha.

Gaaffi fi deebii kana irratti hirmaachuuf akka woraabamus hayyamamaadha

Isa kana hubadhee jira:

- Hirmaannaan kook an fedhii fi sa'aatii barbaadetti akka addaan kutuu danda'u.
- Ragaan narra sassaabame icciitiin isaa akka eeggamu.
- Gaaffilee deebisuu hin barbaanne akka dhiisuu danda'u.

Maqaa: _____ mallattoo _____ guyyaa: _____

Ragaa bu'uuraa: Maqaa, umrii, saalar, sadarkaa barnootaa, fi hojii.

Interview points:

1. Hubannoo woliigalaa yeroo da'umsaa fi booda turee nuuf qooduu dandeessa?
2. Turtii yeroo da'umsaa kee ogeeyyii wajjiin dabarsite akkamitti ibsuu dandessa?
3. Did yeroo da'umsaa kabajni kee siif eeggamee jira? Fakkeenya kaasuu dandeessa?

4. Deeggarsa mul’atuu fi kan hamilee yeroo da’umsaa argatte nuuf ibsuu dandeessa?
5. Dhimma da’umsaa fi daa’ima kee irratti murtii kennuu irratti hammam hirmaatte jirta?
6. Ogeeeessa fayya irra yoo dhiibban si qaqqabu,kabaja siif kennuu dhaban maal goota?
7. Ogeessi haadholii yeroo da’umsaa akka hin kabajinee fi dhiibbaa geessisu maaltu taasisa?
8. Kabaja haadholii yeroo da’umsaa akka fooyyesanii fi cimsan ergaan akkamii dabarsita?
9. Muxannoo da’umsaa wajjiin wolqabatee qabdu kan nuuf ibsitu jiraa?

Dabalata XII: Uunkaa ogeeyyiin filataman ittiin gaafataman

Seensa: Gaaffii kabaja fi dhiibbaa haadhalii yeroo da;an taasifamuuf kana akka magaalaa shaashamanetti taasifamu irratti ogeessa keessaa filatamtee hirmaachuu keetiif galatoomi. Akka ogeessa murteessatti ragaan sirraa argamu kan bu’aa qabuudha. Ragaan sirra argannu kaayyoo qo’annaa kan cimsuu waan ta’eef yeroo kee aarsa waan nuuf gooteef ulfaadhu.

Ajaja: Yaadni ati nuuf kennitu galtee guddaa waan qabuuf iftoominnaan akka nuuf ibsitu si jajjabeessina.. Ragaan argannu icciitiin isaa kan eeggameedha. Deebiin nuuf kennitu sirrii yookin sirriimiti kan jennu hin jiru Nuti kan xiyyeefannu ilaalcha,muxannoo fi kallattii isin nuuf ibsitan irratti. Gaaffii fi deebii kana irratti kaka’umsa agarsiiftaniif galatoomaa.

Ragaa bu’uuraa: Maqaa, Umrii, ogummaa, gahee hojii, fi muxannoo.

1. Gahee fi muxannoo kee kunuunsa haadholii yeroo da’umsaa fi da’umsa boodaaa nuuf ibsuu dandeessa?
2. Dhaabbata kana keessa kabaja haadholii ilaalchise pirotokooliifi dambiin jira? Garalaafummaa fi tajaajila haadholii giddugaleessa godhate itti kennamu irratti leenjii fudhattee beektaa?
3. Haadholiin yeroo tajaajila argatan hayyamamaa ta’uu,adeemsa hundaa akka dursani hubatanii fi kabaja akka argatan akkamitti mirkaneefatta? Haala haadholii dubbistan yookin mariisistan nuuf kaasuu dandeessuu?
4. Akka ilaaltetti haadholiin yeroo da’umsaa kabaja dhabanii yookin dhiibban irra ga’ee beekaa? Eeyyen yoo ta’e dhiibbaa akkamittu irra ga’e?

5. Ogeeyyiin tokko tokko amaloota haadholii dhiibba irra geessan maaf agarsiisu jettee yaadda?
6. Haadholiin tajaajila argatanii fi dursanii hayyamamoo ta’u akkamitti mirkaneeffanna .akkasumas yaada murtee kennuu danda’uu?
7. Sadarkaan yeroo haadholiin da’an mooraalii haadholii deeggaruu akka dhaabbata keessaniitti beekkamaa ?
8. Haadholiin tajaajila isaan giddugaleessa ta’e,garalafummaa fi kabaja qabu akka hin arganne wonti danqaa ta’u maaliidha? Maal yoo godhame tajaajilli kabaja haadholii kennuu kun cimuu danda’a?
9. Tajaajila kunuunsa haadholii kan kabaja gaarii qabu gochuuf yaada akkamii qabda? Dhuma irratti wonti dabaltu jiraa?