

Compassionate Health Care Service and Associated Factors among Mothers Attending Public Hospitals of East Hararge Zone

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Abstract

Background: Respectful and compassionate care is a holistic, non-judgmental, empathetic, respectful and empowering concept of quality of healthcare. In Ethiopia, a significant proportion of health professionals see patients as just 'cases' and do not show compassion. This study assessed respectful and compassionate healthcare service and associated factors in public Hospitals in East Hararge Zone in Ethiopia.

Methods: Hospital-based cross-sectional study was conducted on 423 clients visiting maternity care units in three public hospitals at East Hararge Zone in Eastern Ethiopia from February 23 - April 24, 2020. Pretested structured questionnaire was used to collect data from participants through face to face interview. Data were entered into EpiData version 3.1 and analyzed by SPSS version 24. Descriptive statistics were used to determine the level of compassionate health care and the characteristics of participants. Bivariable and multivariable logistic regression analyses were used to identify factors associated with the outcome variable. Adjusted Odds Ratio (AOR) and 95% CI were used to report association and significance was declared at $P < 0.05$.

Results: A total of 417 (98.6%) participants were involved in the study. Two hundred ninety-nine (71.7%) participants received disrespect and abusive maternity care (95% CI: 66.9%, 76.0%). Age ≥ 45 years (AOR = 1.89, 95% CI: 0.37, 3.86), formal education (AOR = 1.75, 95% CI: 1.10, 2.81), Abnormal delivery (AOR = 0.54, 95% CI: 0.34, 0.87) and Staying in facility (AOR = 2.86, 95% CI: 1.76, 4.63) significantly associated with disrespect and abusive care.

Conclusion and Recommendation: Overall level of disrespect and abuse was common. Family monthly income, number of ANC visit, length of stay and type of health facility were some of factors associated with disrespect and abuse. High prevalence of disrespect and abuse in maternity care at health facilities calls for strengthened action to provide quality of maternity care for all childbearing mothers. Further facility based research in both urban and rural area will be needed.

Keywords: Compassionate; Health Care Services; Mothers; Public Hospitals; East Hararge Zone

Introduction

Different scholars have defined compassionate health care in different way with the same central meaning. Compassionate care was described as holistic, non-judgmental, empathetic, respectful, and empowering. Care is compassionate when patients and their families/ health care providers are treated with kindness and caring [1].

Medical care without compassion cannot be truly patient-centered, Patient centered care is defined as “respectful and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions”. “Patient-centered” means patients’ cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles [2].

Compassion lies at the intersection of empathy and sympathy. By empathy referring about understanding patients’ concerns and sympathy about feeling patients’ emotions, combines a response to the distress of others and a desire to alleviate that distress [3].

Studies in the United States, the United Kingdom, Australia and New Zealand in [4] have shown that adverse events may occur in anywhere from 3.7 percent to 16.6 percent of all hospital admissions and that a significant portion of these may be preventable. The other study done by Canadian 2004 [5] indicated adverse events study found an incidence rate of adverse events of 7.5 percent among patients in acute care hospitals.

Four recent studies in sub Saharan Africa (Kenya, Tanzania, Ethiopia and Nigeria) analyzed women’s experiences during childbirth to estimate prevalence of disrespect and abuse identified the prevalence of disrespect abuse as 20%, 20-28%, 78, and 98%, respectively [6].

The evidences in Ethiopia show that 21% of postpartum women reported any experience of disrespect or abuse. The most commonly reported categories of disrespect and abuse were non-consented care (17.7%), lack of privacy (15.2%), and non-confidential care (13.7%). As this study, it was observed that incidences of disrespect and abuse were as high as 70% during client-provider interactions. Most providers (82%) said that some form of disrespect and abuse towards clients occurred in their facility. Lack of information was also common. The study showed that clients, providers, and structural factors influence the occurrence of disrespect and abuse in facilities [7].

Ethiopian ministry of health has been intensively advocating companionate, respectful and caring health workforce in its second health sector transformational plan as one of the transformational agendas. The ministry of health has developed a national training manual and cascaded the training and developed the tool to measure the output/outcome. In spite of having the above procedures, measuring the output/outcome is not yet [8].

There are some proclamations endorsed in relation to different aspects of roles and responsibilities of health task force that leads to compassionate health care delivery. Some of regulations and civil code articles pertaining to compassionate health care are: regulation 299/2013, Article 77 Professional Confidentiality, regulation 299/2013, Article 52. Patient’s informed consent, Article 2031. Professional fault, Article 2032. Intent to injure, Article 2034 Purpose of rights, Article 2035 - Infringement of a law. Article 81-Mistake of Law and ignorance of Law. Article 744- Mistake [8].

Beyond much controversy, health care providers agree in principle that compassion should be the foundation of health care. It is considered to be crucial and the foundation of a health care system that provides caring, safe, and high quality care and is described as holistic, non-judgmental, empathetic, respectful, and empowering. However, a significant proportion of health professionals see patients as just ‘cases’ and do not show compassion. Lack of respect to patients and their families is also a common complaint and it is the common source of grievances in health facilities [8].

Even though there are some rules, regulations and paper works/documents, it is less effective and citizens are victims of uncompassionate health care service that leads to the failure in health seeking behavior and avoiding to come to health facility. According to Ethiopian ministry of health, a significant proportion of health professionals see patients as just ‘cases’ and do not show compassion in Ethiopia. In many of Ethiopian hospitals, senior physicians cancel their outpatient clinics without informing their patients; elective surgeries get cancelled; admitted patients are by default getting the care they need from relatives as nurses, for various reasons, have limited their role to providing injections and securing IV lines [8]. However, the qualitative and quantitative studies are inadequate both in quality and coverage for there is huge gap in studies regarding compassionate health care services in public hospitals.

Purpose of the Study

The purpose of this study was to explore compassionate health care practices and associated factors among mothers attending health facilities in East Hararge Zone. The result of this study will grant important indicators to the decision makers, planners and policy makers to take action toward improving compassionate health care. It also helps health facility leaderships and technical staffs to develop self working mechanism to address the changing needs of patients. The finding of this work will also serve as a baseline document for further research.

Materials and Methods

Study area

The study was conducted in three selected public Hospitals of East Hararghe Zone from February 23 - April 23/2020. East Hararghe Zone was one of the 20 Zones of the Oromia Regional State in Ethiopia and it comprises 24 districts. The capital city of the Zone, Harar town, were located at 525 KM in East of Addis Ababa. According to the national census of 2007 the projected total population of the Zone were 3,792,125 from which 1,858,141 males and 1,933,984 females with total households of 790,026. There are 131 public health institutions (392 health post, 63 health centers and 6 hospitals (2 general and 4 district hospitals) and 221 private health institutions found in the Zone. These Hospitals are one referral three General and two primary standards according to the Oromia regional health bureau classifications.

Study area, design and period

A facility based cross-sectional study design were used to study the status of compassionate health care and associated factors in public Hospitals in East Hararghe zone from February 23 - April 23.

Source population

The source population was all mothers living in East Hararge zone during the mentioned study period.

The study population

The study population was mothers attending health care services in public hospitals of East Hararge zone during the abovementioned study period.

Inclusion criteria

In this study, adult patients who came to visit OPD and also clients who were hospitalized for a minimum of 24 hours before data collection time to survey were included. Health care providers who was at frontier and have a chance to contact with clients were have chance to be selected in the sample.

Exclusion criteria

In this study, patients who need critical care and women in labor, patients with a primary psychiatric diagnosis, and those assessed by the nursing staff to be confused or experiencing pain a family member whom were caring were selected. Because, the majority of the

critical care patients were high acuity, intonated, and unable to comprehend questions or converse with interviewers.

Sample size and sampling procedure

The study subjects were a sample of client, who were visit health facility in the past one years prior to the survey and who were residents of the Woreda (Birmeta, Dibaba and Woldeyohannes, 2013). A sample size of 422 participants was determined using the formula for single population proportion based on the assumptions that in the absence of the previous prevalence data on the population under study (Birmeta Dibaba and Woldeyohannes 2013) and to obtain the maximum sample size, *p* was assumed to be 0.5. Moreover, a margin of error of 5%, a confidence interval of 95% assumed ($Z_{\alpha/2} = 1.96$) (Nikose., *et al.* 2015: 3). Population (N = 197, 336) and 10% contingency for non-response were used to calculate a sample size of 422 clients. Those by the formula of known single population ratio:

$$n = \frac{NZ^2_{\alpha/2} p(1-p)}{e^2(N-1) + Z^2_{\alpha/2} p(1-p)} = \frac{124470 \times 1.96 \times 1.96 \times 0.5(1-0.5)}{(0.05 \times 0.05)(124470-1) + 1.96 \times 1.96 \times 0.5(1-0.5)}$$

$$\frac{124,470 \times 1.96 \times 1.96 \times 0.5 \times 0.5}{(0.05 \times 0.05)(124,469) + 1.96 \times 1.96 \times 0.5 \times 0.5}$$

$$\frac{119,540.988}{311.1725+0.9604} = \frac{119,540.988}{312.1329} = 384; \text{ n of 10\% contingency } 383 \times 10\% = 38.3$$

Total sample (n) = 383+38.3 = 421.3 = 423

n = 423.

The samples from each hospital were also allocated proportionally based on the sum of total number of their inpatient and outpatient flow using stratification sampling method as follows.

East Hararghe Hosp	Total Popn 2017	Target Popn (22%)	Calculated Total Sample	Sampling Proportion (%)	Proportion of Sample Size
Dader	72,960	16, 051	423	37	157
Gara Mulata	42,089	9,260	423	21	89
Haramaya	82,287	18,103	423	42	177
Total	197,336	43,414		100	423

Table 1: Sample size for client of the study area.

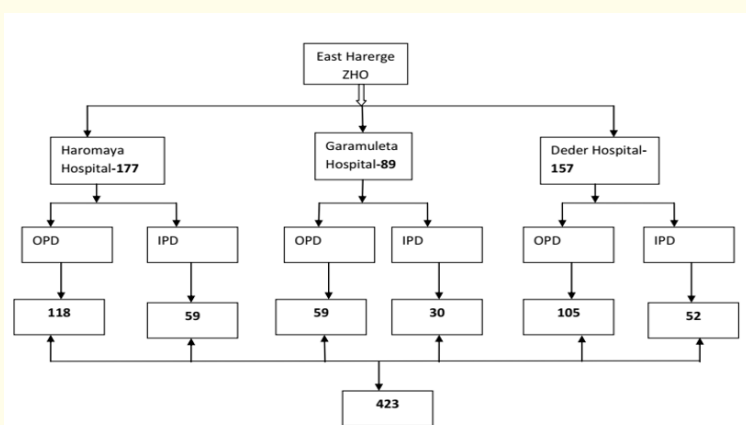


Figure 1: Sample proportional allocation.

Data collection tools and procedures

The quantitative data were collected using structured questionnaire. The questionnaire was translated into Afaan Oromo language and back translated into English language to check for consistency. Before undertaking actual data collection the questioner were pre-tested in Bisidimo and Chalenko hospitals which are also found in same study zone. The pre-testing of questionnaire was conducted on 5% of subjects who are not part of the study.

Data processing and analysis

Collected data were enter into Epi-info and exported to SPSS version 20 for data cleaning and analysis. Descriptive statistics were used to determine indices. Analysis of variance for comparing responses from respondents and binary logistic regression for identifying associated factors to compassionate health care practices among health care providers were done. A significance level of 0.05 were used in all cases. Finally, the results were summarized and presented by tables, charts and graphs.

Data quality control

To ensure quality of data the questionnaire were pre-tested before the actual survey. Data were collected by recruiting health professionals who are not employed in public health facilities and able to communicate in either Afaan Oromo or Amharic. Data collectors were trained on the overall aims of the study, data collection tools and procedures prior to the actual survey to reduce bias. In addition, regular supervision and checking of filled data for completeness, clarity and accuracy were made by the investigator.

Operational definition

- **Compassionate:** It is holistic, non-judgmental, empathetic, respectful, and empowering, being open, welcoming, giving comfort, reassuring the patient not being threatening.
- **Attitude:** A predisposition or a tendency to respond positively or negatively towards a certain idea, object, person, or situation. Attitude influences an individual's choice of action, and responses to challenges, incentives and rewards (together called stimuli).
- **Behavior:** is the way in which someone conducts oneself or behaves.
- **Communication:** Communication is the process of exchanging thoughts, ideas, facts, emotions and opinions between two or more than two persons.
- **Physical Abuse:** is any intentional act causing injury or trauma to another person.
- **None confidential care:** is a condition in which the medical record information is not kept secrets and exposed to be seen by other people.

Result of the Study

Characteristics of study participants

What follows are results of the characteristics of the study participants presented based on their socio demographic and economic characteristics. These results are presented in tables below.

Socio-demographic characteristics

Totally, 417 (98.6%) mothers were participated in the study. The majority, 182 (66.4%) and more than half forth, 226 (54.2%) of participants were rural residents and in the age group of 25 - 34 years, respectively. One hundred forty six (35.0%) of them could have not formal education. The majority, 352 (84.4%) and 198 (72.3%) of them were Oromo and married.

Characteristics		Frequency	Percentage (%)
Residence area	Rural	182	66.4
	Urban	92	33.6
Age categories (in years)	15 - 24	153	36.7
	25 - 34	226	54.2
	35 - 44	38	9.1
Religion	Orthodox	41	9.8
	Catholic	8	1.9
	Protestant	17	4.1
	Muslim	351	84.2
Ethnicity	Oromo	352	84.4
	Amhara	55	13.2
	Tigray/others	10	2.4
Current marital status	Married	198	72.3
	Others*	76	27.3
Educational status	No formal education	146	35.0
	Primary	169	40.5
	Secondary and above	102	24.5
Main occupation	Housewife	214	51.3
	Employee	89	21.3
	Merchant	47	11.3
	Student	67	16.1
Income status	> = 2000 ETB	235	56.4
	<2000 ETB	182	43.6

Table 2: Socio demographic characteristics of participants in public hospitals. Others* (Single, widowed, Divorced).

Reproductive and healthcare characteristics

Majority, 358 (85.9%) participants attended ANC service at least once and 201 (48.2%) and 214 (51.3%) of participants also received ANC for this pregnancy, and child birth, who ever gave birth including still births, respectively. Twelve (2.9%) mothers experienced Episiotomy delivery complications during child birth (Table 3).

Characteristics		Frequency	Percentage (%)
Any payment (paid) for delivery	No	335	80.3
	Yes	82	19.7
Ability to pay maternal service	Yes	83	19.9
	No	334	80.1
ANC visit	Yes	358	85.9
	No	59	14.1
Place of ANC service Main	Hospital	217	52.0
	Health center	116	27.8
	Health post/home	84	20.1
Have you seen anyone for antenatal care for this pregnancy	Yes	369	88.5
	No	48	11.5
Profession of ANC provider (HCP)	Health personnel	28	6.7
	Doctor	90	21.6
	Nurse	244	58.5
	Midwife	5	1.2
	HEW	2	.5
Where did you receive ANC for this pregnancy	Not at all	11	2.6
	Government hospital	201	48.2
	Government health center	116	27.8
	Health Post	73	17.5
	Private hospital	16	3.8
Number of ANC service received during this pregnancy	1	54	12.9
	2	205	49.2
	3	124	29.7
	4	28	6.7
	5	6	1.4
Number of birth given including still birth	1	214	51.3
	2	99	23.7
	3	56	13.4
	4	33	7.9
	5 and above	15	3.6
From total deliveries, how many of them had delivered at Health facility	1	173	41.5
	2	81	19.4
	3	104	24.9
	4	41	9.8
	5 and above	18	4.3

What was the type facility where you had your last delivery	Public HC	85	20.4
	Public District Hospital	231	55.4
	Public Referral Hospital	94	22.5
	Private Health Facilities	7	1.7
Who was main provider of conducting your delivery	Nurse	25	6.0
	Midwife	312	74.8
	Doctor	78	18.7
	Other (specify)	2	.5
What was the sex of main health provider who attends your deliver	Male	212	50.8
	Female	137	32.9
	Both	68	16.3
What was the type of your last delivery	Normal/SVD	318	76.3
	C/S	71	17.0
	Vacuum Extraction/forceps delivery	16	3.8
	Episiotomy delivery	12	2.9
Did you stayed in facility after delivery	Yes	324	77.7
	No	93	22.3
If yes how many days did you stayed	One day	203	48.7
	Two days	48	11.5
	More than two days in one weeks	21	5.0
	More than a week	145	34.8
Were there any complication during your last delivery	Yes (for self)	178	42.7
	Yes (for baby)	23	5.5
	Yes (both self and baby)	8	1.9
	No	208	49.9

Table 3: Socio economic characteristics of participants in public hospitals of East Hararge zone, Oromia; Ethiopia (n = 423).

Prevalence of disrespect and abuse

The overall prevalence of disrespect and abusive care was 299 (71.7%) in the study area (95% CI: 66.9, 76.0). Regarding the domains of disrespect and abuse in maternity care, the highest level of disrespect and abusive care observed in the physical abuse domain with the magnitude of 292 (70.0%) while the least level seen in discrimination of care with 13 (3.1%) (Table 4).

Disrespect and Abusive care and its domains	Yes (%)
Prevalence of overall disrespect and abusive care	299 (71.7), 95% CI: 66.9, 76.0
Physical abuse	292 (70.0), 95% CI: 65.5, 74.3
Non-confidential care	91 (17.7); 95% CI: 17.7, 26.1
Non-consented care	137 (32.9); 95% CI: 28.1,37.1
Non-dignified care	55 (13.2), 95% CI:10.1, 16.3
Abandonment/neglected care	64 (15.3); 95% CI: 12.2, 18.7
Discrimination of care	13 (3.1); 95% CI: 1.4, 4.8
Detention of care	140 (33.3); 95% CI: 29.3, 37.9

Table 4: Prevalence of disrespect and abusive cares in public hospitals in East Hararge Zone, Oromia Ethiopia, 2020 (n = 417).

Factors associated with disrespect and abuse

In bi-variable analysis, average monthly income and stayed in health facility were associated with disrespect and abusive care at P-value < 0.001; educational status, frequency of ANC visits, facility where last delivery occurred, type of delivery and birth complication were associated with disrespect and abuse at P-value < 0.01 and ability to pay for care was associated with associated with disrespect and abusive care at P-value < 0.05 while others were not significant at P < 0.05 but selected as a candidate for multivariable analysis at P-value < 0.25.

Associated Factors	Yes (%)	Disrespect and Abuse		COR (95%CI)	P-value
		No (%)			
Age (in years)	15 - 24	108 (70.6)	45 (29.4)	1.57 (0.75, 3.27)	0.234
	25 - 34	168 (74.3)	58 (25.7)	1.89 (0.37, 3.86)	0.082
	35 - 45	23 (60.5)	15 (39.5)	1	
Marital status	Single/divorced	27 (81.8)	6 (19.2)	1.85 (0.75, 4.61)	0.179
	Married	272 (70.8)	112 (29.2)	1	
Religion	Orthodox	27 (65.9)	14 (34.1)	1	
	Protestant	9 (52.9)	8 (47.1)	0.58 (0.19, 1.84)	0.359
	Catholic	4 (50.0)	4 (50.0)	0.52 (0.11, 2.39)	0.400
	Muslim	259 (73.8)	92 (26.2)	1.46 (0.73, 2.90)	0.281
Educational level	No formal education	115 (78.8)	31 (21.2)	1.75 (1.10, 2.81)	0.019
	Formal education	184 (67.9)	87 (32.1)	1	
Main occupation	Housewife	148 (69.2)	66 (30.8)	1	
	Employee	63 (70.8)	26 (29.2)	1.08 (0.63, 1.86)	0.779
	Merchant	31 (66.0)	16 (34.0)	0.86 (0.44, 1.69)	0.669
	Student	57 (85.1)	10 (24.9)	2.54 (1.22, 5.29)	0.012
Average monthly income of family	<2000 ETB	146 (80.2)	36 (19.8)	2.17 (1.38, 3.42)	0.001
	≥2000 ETB	153 (65.1)	82 (34.9)	1	

Asked a payment for delivery care	No	243 (72.5)	92 (27.5)	1.23 (0.73, 2.07)	0.444
	Yes	56 (68.3)	26 (31.7)	1	
Ability to pay for delivery care	No	247 (74.0)	87 (26.0)	1.69 (1.02, 2.81)	0.041
	Yes	52 (62.7)	31 (37.3)		
Frequency of ANC visit	<3	209 (76.6)	64 (23.4)	1.96 (1.26, 3.04)	0.002
	≥3	90 (62.5)	54 (37.5)	1	
Parity	≤1	175 (81.8)	39 (18.2)	2.22 (0.65, 7.52)	0.202
	2-3	91 (58.7)	64 (41.3)	1.98 (0.53, 7.34)	0.304
	≥4	33 (68.8)	15 (31.2)	1	
Health facility where you gave the last delivery	Health Center	75 (88.2)	10 (21.8)	10.0 (1.95, 51.34)	0.006
	District Hospital	161 (69.7)	71 (30.3)	3.07 (0.67, 14.06)	0.149
	Referral Hospital	60 (63.8)	34 (36.2)	2.35 (0.50, 11.14)	0.281
	Private H/Facility	3 (42.8)	4 (57.2)	1	
Sex of HCPs who assisted delivery	Male	153 (72.2)	39 (27.8)	1.077 (0.67,1.72)	0.782
	Both	49 (72.9)	19 (27.1)	1.06 (0.56, 2.03)	0.852
	Female	97 (70.8)	40 (29.2)	1	
HCP who assisted last delivery	Nurse	52 (63.0)	26 (37.0)	1.18 (0.47, 2.93)	0.727
	Midwife	230 (73.7)	82 (26.3)	1.65 (0.73, 3.75)	0.232
	Doctor	17 (63.0)	10 (36.0)	1	
Type of delivery	Normal delivery	238 (74.6)	80 (25.4)	1	
	Abnormal delivery	61 (61.6)	38 (38.4)	0.54 (0.34, 0.87)	0.011
Stayed in facility	Yes	249 (76.9)	75 (23.1)	2.86 (1.76, 4.63)	0.000
	No	50 (53.8)	43 (46.2)	1	
Any type of birth complication	Yes	164 (64.9)	45 (35.1)	1.97 (1.28, 3.05)	0.002
	No	135 (78.5)	73 (21.5)	1	
Significant at P < 0.001 = ***, P < 0.01 = **, P < 0.05 = *; COR = Crude Odds Ratio; HCP = Health care Providers					

Table 5: Bivariate logistic regression of factors associated with disrespect and abuse of participants in public hospitals in East Hararge Zone, Oromia; Ethiopia, 2020 (n = 417).

During multivariable analysis, compared to housewife, students were associated with significantly higher odds of disrespect and Abuse of women giving birth [AOR = 2.70 (1.22, 5.99)]. Odds of disrespect and abuse care was 2.62 times significantly higher among mothers who gave one birth compared to those who gave at least four births [AOR = 2.62 (1.21, 5.66)]. Compared to mothers who gave previous birth at private facility, those who gave previous birth at health center was 5.96 times more likely to face disrespect and abusive [AOR = 5.96 (1.06, 33.53)]. Odds disrespect and abusive care was 1.9 times higher among women who had abnormal delivery compared to those who had normal delivery [AOR = 1.9 (1.12, 3.21)]. Mothers who stayed in the facility and who had birth complication (of any type) were 2.11 times [AOR = 2.11 (1.25, 3.57)] and 1.72 times [AOR = 1.72 (1.06, 2.77)] times more likely to had disrespect and abusive care compared to their counterparts, respectively (Table 6).

Associated Factors Yes (%)		Disrespect and Abuse		AOR (95%CI)	P-value
		No (%)			
Age (in years)	15 - 24	108 (70.6)	45 (29.4)	1.60 (0.68, 3.77)	0.286
	25 - 34	168 (74.3)	58 (25.7)	2.19 (0.96, 4.98)	0.062
	35 - 45	23 (60.5)	15 (39.5)	1	
Marital status	Single/divorced	27 (81.8)	6 (19.2)	0.84 (0.27, 2.57)	0.759
	Married	272 (70.8)	112 (29.2)	1	
Educational level	No formal education	115 (78.8)	31 (21.2)	1.29 (0.75, 2.22)	0.353
	Formal education	184 (67.9)	87 (32.1)	1	
Main occupation	Housewife	148 (69.2)	66 (30.8)	1	
	Employee	63 (70.8)	26 (29.2)	1.41 (0.77, 2.61)	0.270
	Merchant	31 (66.0)	16 (34.0)	1.35 (0.65, 2.81)	0.424
	Student	57 (85.1)	10 (24.9)	2.70 (1.22, 5.99)	0.014
Average monthly income of family	<2000 ETB	146 (80.2)	36 (19.8)	1.27 (0.73, 2.22)	0.402
	≥2000 ETB	153 (65.1)	82 (34.9)	1	
Ability to pay for delivery care	No	247 (74.0)	87 (26.0)	1.62 (0.90, 2.90)	0.106
	Yes	52 (62.7)	31 (37.3)		
Frequency of ANC visit	<3	209 (76.6)	64 (23.4)	1.44 (0.87, 2.39)	0.162
	≥3	90 (62.5)	54 (37.5)	1	
Parity	≤1	175 (81.8)	39 (18.2)	2.62 (1.21, 5.66)	0.014
	2-3	91 (58.7)	64 (41.3)	0.92 (0.43, 1.98)	0.828
	≥4	33 (68.8)	15 (31.2)	1	
Health facility where you gave the last delivery	Health Center	75 (88.2)	10 (21.8)	5.96 (1.06, 33.53)	0.043
	District Hospital	161 (69.7)	71 (30.3)	1.99 (0.40, 9.91)	0.401
	Referral Hospital	60 (63.8)	34 (36.2)	2.09 (0.42,10.48)	0.3711
	Private H/Facility	3 (42.8)	4 (57.2)	1	
HCP who assisted last delivery	Nurse	52 (63.0)	26 (37.0)	1.18 (0.47, 2.93)	0.727
	Midwife	230 (73.7)	82 (26.3)	1.65 (0.73, 3.75)	0.232
	Doctor	17 (63.0)	10 (36.0)	1	
Type of delivery	Normal delivery	238 (74.6)	80 (25.4)	1	
	Abnormal delivery	61 (61.6)	38 (38.4)	1.90 (1.12, 3.21)	0.017
Stayed in facility	Yes	249 (76.9)	75 (23.1)	2.11 (1.25, 3.57)	0.005
	No	50 (53.8)	43 (46.2)	1	
Any type of birth complication	Yes	164 (64.9)	45 (35.1)	1.72 (1.06, 2.77)	0.028
	No	135 (78.5)	73 (21.5)	1	

Significant at P < 0.001 = ***, P < 0.01 = **, P < 0.05 = *, AOR = Adjusted Odds Ratio; HCP = Health care Providers

Associated Factors Yes (%)		Disrespect and Abuse		AOR (95%CI)	P-value
		No (%)			
Profession of HCP who assisted delivery	Doctors	20 (62.5)	12 (37.5)	1	
	Midwife	138 (71.5)	55 (28.5)	1.51 (0.69, 3.29)	0.305
	Nurse	45 (91.8)	4 (8.2)	6.75 (1.94,23.57)**	0.003``

Significant at P < 0.001 = ***, at P < 0.01 = **, at P < 0.05 = *, AOR = Adjusted Odds Ratio

Table 6: Multivariable logistic regression of factors associated with disrespect and abuse of participants in public hospitals in East Hararge Zone, Oromia, Ethiopia, 2020 (n = 417).

Discussion

This study assessed level of disrespect and abuse and associated factors among women giving birth in public health facilities of the district. In this study, the overall level of disrespect and abuse was 71.7% with 95% CI (66.9, 76.0). This figure is slightly lower than the study conducted in Addis Ababa, Ethiopia on respectful and non-abusive maternity care in governmental hospital and health center which showed that the prevalence of disrespect and abuse was 78% [23]. This discrepancy might be due to the small sample size of the previous study and it may be also due to study period difference. In contrary, this finding was higher than study conducted in Tanzania 15% and Kenya 20% [23]. Discrepancy may be due to the fact that there is socio cultural and socio economical difference.

According to this study the physical abuse is the most commonly experienced component of disrespect and abuse and its prevalence was high 70.0% with 95% CI (65, 74). This result was also supported by qualitative finding which showed that “pinching and slapping of mothers during labour and delivery were commonly practiced at maternity care unit in health facility”. This result was different from study done in Tanzanian 3.5%, Ghanaian 35.7% and Kenya 4.2% [6,18,23]. This discrepancy might be that due to good commitment of health care professional and large sample size of previous study. The other most common types of disrespect and abuse experienced in this study was non-consented care 32.9% with 95% CI (28.1, 37.1).

The result of this study was high as compared to the same study done in Addis Ababa on respectful and non-abusive maternity care during child birth in hospital and health center which showed that 48% of respondents experienced of non-consented care. The difference may be due to courtesy bias where women do not want to negatively evaluate health workers while they still need their services. Similarly, this finding was higher than the same study done in Palestine 36% and Kenya 4.3% [23,31]. These inconsistencies might be due to difference in health police, implementation program and study design. In addition, the other category of disrespect and abuse of women experienced during facility based child birth in this study was non-confidentiality care 17.7%. This finding is different from the study which was conducted in urban Tanzanian 2% and Kenya 8.5% [23,24]. This inconsistency might be due to policy of health care and implemented programs difference.

According to this finding, the other category of disrespect and abuse experienced by women were non-dignified care 13.2%. This study showed lower figure than the study conducted in Ghana, 29.6% and Kenya 18%, respectively [18,23]. This discrepancy might be due to study period and study place difference. Similarly, the other category of disrespect and abuse reported in this study was discrimination during provision of service which accounts for 2.2%. This result was also supported by qualitative finding of in-depth interviews of maternity care users and community leaders found that providing service first by relatives and friends were sometimes practiced in hospital and health center. A community leader from the study area said “In hospital, some health care providers give the service first to their relative or their family and this makes me unhappy” which shows this study indicated lower abuse practices than study conducted in Ghana, 20% [25]. The inconsistency may be due to socio cultural difference and commitments of health care provider. The other category of disrespect and abuse in this study was Abandonment/Neglect care during labor and delivery which accounts for 7.1%. This finding was lower than direct observational study conducted in five countries Ethiopia, Kenya, Nigeria, and Tanzania 9 - 29% [35]. This inconsistency may be due to small sample size of this study and study period difference.

In this study maternal family income were significantly associated with disrespect and abuse those mother whose maternal family income < 2000 birr were 2.17 times more likely disrespected and abused than mothers whose family income \geq 2000 (AOR = 2.17, 95% CI: 1.38, 3.42) this finding was consistent with similar study which was conducted at Addis Ababa, Ethiopia showed that poor were more disrespected than the rich [19]. This result was also similar with a study which was conducted in Bangladesh and Kenya showed that rich women received care earlier as compared to the poor, despite the seriousness of the medical condition [10,34].

The study finding also showed that number of ANC was associated with disrespect and abuse. Those mothers who had < 3 times visits during pregnancy were 1.96 times more likely disrespected and abused than those mothers who had \geq 3 times visit (AOR = 1.96, 95% CI:

1.26, 3.40). In addition to this other obstetrics factor associated with disrespect and abuse in this study was length of stay in health facility those mother who stayed in health facility after delivery were 2.86 times more likely disrespected and abused than others (AOR = 2.86, 95% CI: 1.76, 4.63). This study was consistent with the same study conducted in the Tanzania [6].

In this study in depth interview of maternity care users and community leader showed that normalization of disrespect and abuse, lack of good attitude of health care provider towards mothers and his work were identified factors for disrespect and abuse during labor and delivery. This study finding was almost similar to study conducted in Kenya on prevalence disrespect and abuse during facility based child birth [23].

In this study in depth interview of maternity care users, community leaders and health care providers which showed that the contributing factors for disrespect and abuse of women during facility based child birth was lack of infrastructures in health facility. So this finding was similar to the nationally representative surveys conducted in Ethiopia 14%, Kenya 26%, Rwanda 18%, and Tanzania 50%, lack infrastructure during labor and delivery [38]. In addition to this, shortages of human resources, poor professional development opportunities and provider distancing as a result of training were other challenges which was raised by almost all health care providers in both health center and hospital during in depth interview. This finding was the same with direct observational study which was conducted in five countries East and South Africa showed that lack of resource, staff shortage and lack of training was identified factor for disrespect and abuse during child birth [35]. And this finding was also same with study which was conducted in Kenya [23].

Conclusion

This study identified youth/adolescent pregnancy, large family size, not owning livestock, lacking basic sanitation/latrine, poor dietary feeding habits, maternal risky lifestyles/habits; substances use during pregnancy, lacking any advices/information and/or practices/exercises on optimal prenatal dietary feeding at health facility and kebele level were statistically significant independent risk factors for pregnant women's wasting.

The result revealed that the prevalence of disrespect and abuse is high in the East Hararge woreda were 71.7% during labor and delivery which is a prevalent issue that needs urgent intervention. The specific types of disrespect and abuse varied from woman to woman, but the most prevalent types of abuse were physical abuse 70.0% and non-consented care 32.9% followed by non-confidential care 17.7%. Majority of mothers who gave birth specially in governmental health institution were experienced of at list one form of disrespect and abuse. Since family monthly income, the number of ANC visit, type of health facility and length of stay in health facility after delivery were some of the identified factors significantly associated with disrespect and abuse. These factors may result in poor maternal health service utilization and also may cause increase of maternal death.

Ethical Approval and Consents to Participate

Ethical clearance for the study were obtained from the Institutional Review Board of Africa Medical College. Letter of cooperation were obtained from AMC and ORHB. Consent were received from East Hararge Zonal Health Department and selected Hospitals. The study subjects were informed about the purpose of the research, the benefit and the risk of participation. The confidentiality of the study subject were ensured through avoiding use of unique identifier of participants in data collection process. They were informed about their right to withdraw at any time from the study and this had no effect on their treatment. Permission letters were obtained from administrative body of the ORHB to be given to institutions selected for the study. Finally verbal consent were obtained from each subject. The privacy of the participants were ensured by arranging the appropriate area for interview and the participant's autonomy were ensured by respecting the decision of the subject to refuse the study.

Consent for Publication

Not applicable.

Availability of Data and Materials

Datasets and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing Interests

Both authors declare that they have no competing interests.

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Authors' Contribution

Both SAM and CKE designed the study, collected data, analyzed and interpreted data and contributed in manuscript writing. Both authors read and approved the final manuscript.

Bibliography

1. Community Health Advisory Councils Report, "Compassionate Care: Community Perspectives" (2007).
2. FDREMoH, August. Ethiopian Health Sector Transformational Plan (2015): 117-118.
3. Darshak M and Sanghavi MD. "Journal on quality and patient safety, Joint Commission on Accreditation of Healthcare Organizations, What Makes for a Compassionate Patient-Caregiver Relationship? 32.5 (2006).
4. Stephen G Post Ph.D. "The Joy of Giving, Compassionate Medical Care Benefits Professionals, Patients, Students and the Bottom Line, The forgotten factor in healthcare reform! (2011).
5. MacBeth A and Gumley A. "Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology". *Clinical Psychology Review* 32.6 (2012): 545-552.
6. International Council of Nurses. Safe staffing saves lives: Information and action tool kit". Geneva (2006).
7. Quality Worklife-Quality Healthcare Collaborative. Within our grasp: A healthy workplace action strategy for success and sustainability in Canada's healthcare system". Ottawa: Canadian Council on Health Services Accreditation (2007).
8. Beth A Lown., *et al.* "An Agenda For Improving Compassionate Care: A Survey Shows About Half Of Patients Say Such Care Is Missing". *Health Affairs* 30.9 (2011): 1772-1778.
9. Lown BA., *et al.* "An agenda for improving compassionate care: A survey shows about half of patients say such care is missing". *Health Affairs* 30.9 (2011): 1772-1778.
10. Van der Cingel M. "Compassion in care: A qualitative study of older people with a chronic disease and nurses". *Nursing Ethics* 18.5 (2011): 672-685.

11. Way D and Tracy SJ. "Conceptualizing compassion as recognizing, relating and (re) acting: A qualitative study of compassionate communication at hospice". *ComM* 79.3 (2012): 292-315.
12. Perry B. "Conveying compassion through attention to the essential ordinary". *Nursing Older People* 21.6 (2009): 14-21.
13. Graber DR and Mitcham MD. "Compassionate clinicians: Take patient care beyond the ordinary". *Holistic Nursing Practice - LWW Journals* 18.2 (2004): 87-94.
14. Burack JH., et al. "Teaching compassion and respect. Attending physicians' responses to problematic behaviors". *Journal of General Internal Medicine* 14.1 (1999): 49-55.
15. Abuya T., et al. "Exploring the prevalence of disrespect and abuse during childbirth in Kenya". *PLoS One* 10.4 (2015): e0123606.
16. Asefa A and Bekele D. "Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia". *Reprod Health* 12.1 (2015): 33.
17. Okafor II., et al. "Disrespect and abuse during facility-based childbirth in a low-income country". *International Journal of Gynecology and Obstetrics* 128.2 (2015): 110-113.
18. L10K. Assessment of disrespect and abuse during childbirth in two regions of Ethiopia: A qualitative study in four PHCUs (Kebet, Lante, Deneba and Denbecha) 3.1 (2014).
19. Federal democratic republic of Ethiopia ministry of health, 2017, compassionate, respect full and caring, health workforce training participant manual (2017).
20. Shane Sinclair., et al. "Compassion: a scoping review of the healthcare literature". *BMC Palliat Care* 15 (2016): 6.
21. Institute of Medicine Crossing the quality chasm: a new health system for the twenty-first century". Washington: National Academies Press (2001).
22. Wolf DM., et al. "Effect of patient-centered care on patient satisfaction and quality of care". *Journal of Nursing Care Quality* 23 (2008): 316-321.
23. Robinson JH., et al. "Patient-centered care and adherence: definitions and applications to improve outcomes". *Journal of the American Association of Nurse Practitioners* 20 (2008): 600-607.
24. Stewart M., et al. "The impact of patient-centered care on outcomes". *The Journal of Family Practice* 49 (2000): 796-804.
25. Stewart M., et al. "Patient-centred medicine: transforming the clinical method. 2nd edn Radcliffe Medical Press (2003).
26. Agency for Healthcare Research and Quality National Healthcare Quality Report (2005).
27. Little P., et al. "Observational study of effect of patient-centredness and positive approach on outcomes of general practice consultations". *British Medical Journal* 323 (2001): 908-911.
28. Epstein RM., et al. "Why the nation needs a policy push on patient-centered health care". *Health Affairs* 29 (2010): 1489-1495.
29. Mead N and Bower P. "Patient-centredness: a conceptual framework and review of the empirical literature". *Social Science and Medicine* 51 (2000): 1087-1110.
30. Del Canale S., et al. "The relationship between physician empathy and disease complications: an empirical study of primary care physicians and their diabetic patients in Parma, Italy". *Academic Medicine* 87 (2012): 1243-1249.

31. Lown BA, *et al.* "An agenda for improving compassionate care: a survey shows about half of patients say such care is missing". *Health Affairs* 30 (2011): 1772-1778.
32. Zuger A. "Dissatisfaction with Medical Practice". *New England Journal of Medicine* 350.9 (2004): 69-75.
33. Shanafelt TD. "Enhancing the Meaning of Work: A Prescription for Preventing Physician Burnout and Promoting Patient-Centered Care". *Journal of the American Medical Association* 302 (2009): 1338-1340.
34. Krasner, *et al.* "Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians". *Journal of the American medical Association* 302.12 (2009): 1284-1293.
35. Dyrbye LN. "Relationship Between Burnout and Professional Conduct and Attitudes Among US Medical Students". *Journal of the American Medical Association* 304 (2010): 1173-1180.
36. Bernard Lown MD. "The Lost Art of Healing: Practicing Compassion in Medicine". New York: Ballantine Books (1996).
37. Kiecolt-Glaser J, *et al.* "Hostile Marital Interactions, Proinflammatory Cytokine Production, and Wound Healing". *Archives of General Psychiatry* (2005): 1377-1384.
38. Stewart M. "Effective Physician-Patient Communications and Health Outcomes: A Review". *Canadian Medical Association Journal* 152 (1995): 1423-1433.
39. Harvey Max Chochinov, *et al.* "The Patient Dignity Inventory: A Novel Way of Measuring Dignity Related Distress in Palliative Care". *Journal of Pain and Symptom Management* 36 (2008): 559-571.
40. Harvey Max Chochinov, *et al.* "Dignity Therapy: A Novel Psychotherapeutic Intervention for Patients Near the End of Life". *Journal of Clinical Oncology* 23.24 (2005): 5520-5525.
41. Harvey Max Chochinov. "Dignity and the Eye of the Beholder". *Journal of Clinical Oncology* 22.7 (2004): 1336-1340.
42. Edward Hallowell, New York Times (2010): B5.
43. Joe_23(2) Collaborative_case_study_50 (www.ucdenver.edu/caianh).
44. B Rose Huber. "Sub-Saharan Africans Rate Their Health and Health Care Among the Lowest in the World (2015).
45. Harrowing J, *et al.* "Compassion Practice by Ugandan Nurses Who Provide HIV Care". *OJIN: The Online Journal of Issues in Nursing* 16.1 (2011).
46. Aiken LH, *et al.* "Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States (2012).
47. Branch C and Klinkenberg D. "Compassion fatigue among pediatric healthcare providers". *American Journal of Maternal Child Nursing* 40.3 (2015): 160-166.
48. Hinderer K A, *et al.* "Burnout, compassion fatigue, compassion satisfaction, and secondary traumatic stress in trauma nurses". *Journal of Trauma Nursing* 21.4 (2014): 160-169.
49. Hunsaker S, *et al.* "Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses". *Journal of Nursing Scholarship* 47.2 (2015): 186-194.

50. Mason VM., *et al.* "Compassion fatigue, moral distress, and work engagement in surgical intensive care unit trauma nurses: A pilot study". *Dimensions of Critical Care Nursing: DCCN* 33.4 (2014): 215-225.
51. Sacco TL., *et al.* "Compassion satisfaction and compassion fatigue among critical care nurses". *Critical Care Nurse* 35.4 (2015): 32-44.
52. Sinclair S., *et al.* "Compassion in Health Care: An Empirical Model". *Journal of Pain and Symptom Management* 51.2 (2016): 193-203.

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