Author’s response to reviews

Title: Prevalence of disrespect and abuse during facility based child birth and associated factors, Jimma University Medical Center, Southwest Ethiopia

Authors:

Ahmed Siraj (sirajdrahmed@gmail.com)

Woubishet Girma (gwubdz@yahoo.com)

Habtemu Jarso Hebo (hjarso@rocketmail.com)

Version: 1 Date: 21 Apr 2019

Author’s response to reviews:

Response to Reviewers

First of all, we are highly indebted to reviewers for the time they spent reviewing this manuscript. This manuscript would not have this format without their invaluable comments and guidance. We have included the response to comments into the manuscript and also explained below point by point.

1. Sara Van Rompaey (Reviewer 1)
   Abstract
   Comment: Please clarify that mortality ratio (412) is expressed towards 100 000 live births.
   Response: we did it.

   Comment: The statement about female providers in the conclusions would be easier to place if somewhere in the abstract it is explained what is considered culturally appropriate in the specific context concerning the sex of the providers.
   Response: As discussion is not part of the abstract, we find it difficult where to explain in the abstract, but we have explained it in the discussion section of the (long) manuscript. In the abstract, we have included religion, educational level, occupation and residence of participants to enable readers understand why they preferred female professionals.

   Comment: I would advise to make the conclusions from the (long) manuscript more reflect in the conclusions of the abstract.
   Response: we have modified the conclusion of the abstract.

Methods
Comment: I imagine that not ‘All women who gave birth vaginally at JUMC during the study period were recruited for the Study’ because some of them may not have been given consent to be included?
Please specify the consent as an inclusion criterion.
Response: We agreed and revised inclusion criteria.

Comment: please clarify when and from which independent committee ethical clearance for the study was received. May this be the most important concern about this manuscript?
Response: The study was approved by an institutional review board (IRB) of Institute of Health, Jimma University, before starting any data collection. We have described ‘ethical clearance’ under declaration section of the manuscript. Thus, this can’t be the concern of this manuscript.

Discussion and conclusions
No further comments: well elaborated.

2. Ethel Burns, PhD (Reviewer 2)
Dear Authors - this is an interesting paper on a very important topic that has attracted global attention and been identified as an SDG goal. I hope you find my feedback helpful.

TITLE
Comment: I think that 'pattern' could be omitted because the content of the paper presents prevalence and associated factors. A pattern reflects a trend to me.
Response: Of course, in Epidemiology, the term pattern reflects a trend. But we are using it here to reflect range of Disrespect and Abuse. Because it may mislead readers, we have omitted it as per your suggestion.

ABSTRACT
Comment: clear - however, CONCLUSION - please see comment below.

GENERAL
Comment: The term 'skilled provider' should be defined as the reader has no idea about who they are: for example, midwives only, a mix of midwives and obstetricians or whoever else. This limits a reader's ability to explore transferability of the research to other areas of and beyond Ethiopia.
Response: we have included the following description in the operational definition section.
• Skilled providers or skilled health personnel or skilled birth attendants are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards (2). They are competent to:
  (i) Provide and promote evidence-based, human-rights-based, quality, socioculturally sensitive and dignified care to women and newborns;
  (ii) Facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and
  (iii) Identify and manage or refer women and/or newborns with complications.

BACKGROUND
Comment: second sentence - SDGs have replaced MDGs - suggest that authors adopt these as their reference point https://sustainabledevelopment.un.org/?menu=1300.
Response: we have revised the sentence replacing it by statement of SDGs.

Comment: Here and throughout this paper, there is no mention of midwives, yet the positive demonstrated impact of being cared for during childbirth by a skilled, empathetic midwife irrespective of country and context, was illustrated unequivocally in the Lancet's Global Midwifery seminal series
of papers https://www.thelancet.com/series/midwifery. The series includes a paper on abuse and disrespect of women during childbirth https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)60859-X.pdf and I think contextualising this research to that would enrich this paper.

In setting the scene for this research it is important to have information beyond the proportion of 'skilled providers' are available to women.

Response: We have read the indicated paper, but we could not understand why this research should be contextualized to that paper. The paper talks about definition and scope of D&A. We could not see the aspect of the paper from which our research benefits. We also could not see the importance of specifically talking about midwives. The aim of our research was not to evaluate which health professional is better than another. For instance, in Ethiopia, although the coverage of trained midwives increased to 72.7% in fiscal year 2015/16, the proportion of births attended by skilled providers was low (26%). The proportion of births attended by 'skilled providers' is what was used by MDG and is being used by SDG as indicator of achieving targets related to maternal mortality. Our research aimed to look at D&A as one factor of low proportion of births attended by skilled providers. Most mothers are not attending health facility for child birth may be because of D&A encountered during previous delivery or heard D&A encountered by another mother. In our study, mothers attended by female attendants reported significantly lower level of D&A. This could because of their cultural and religious preference of female provider and it might not be because they are midwives. Of course, in our context, there are also male midwives and in JUMC, the involvement of midwives as attendants of child birth is limited.

METHODS & MATERIALS

Comment: METHODS only mentions the range of medics working in JUMC - are there also midwives and if so, have they completed an education programme? Again, this information increases readership appreciation of potential transferability.

Response: Because we were focusing on senior gyn/obs, residents and medical interns, we forgot to describe the presence of professional nurses and midwives. There were also nursing and midwifery students involved in service provision under supervision. We have revised the description now.

Comment: I have a few queries about the data tool and the modus operandi of the data collection for the 'interviewer-administered questionnaire'

* Did the allocated four nurses give the women the questionnaire to complete themselves or did they ask the women the questions and they logged their responses?

Response: the nurses asked the women the questions and they logged their responses. We have clarified the description.

*Comment: The women received and completed the questionnaire shortly after giving birth and before hospital discharge. On average, exactly how soon after delivery, did they complete it? How long is the usual hospital stay postpartum?

Response: the women did not receive and complete the questionnaire. Rather, the data collectors asked the women the questions and they logged their responses. The interview was also not shortly after giving birth. It was immediately prior to discharge from the health facility after childbirth (i.e. when the mother is ready to leave the hospital finishing all her businesses or just minutes before discharge). The soonest is 6 hours after delivery and the length of hospital stay postpartum depends on the maternal and neonatal outcome. The usual hospital stay for uncomplicated pregnancy was 24 hours. Accordingly, 250 (86.2%) participants stayed in the hospital at most 24 hours and only 40 (13.8%) participants stayed in the hospital more than 24 hours. We were concerned about social desirability bias more than recall bias; i.e. women may not tell us the truth (genuine information) if they think they will be denied service. This is the main reason for delaying data collection very near to time of discharge. Another reason was to obtain information on abuses and disrespect that occurred during postpartum before
discharge. Other studies have even delayed data collection until the mother returns back home. The role
of recall bias is bidirectional in this kind of study. Some women may not remember what happened
during childbirth unless they are given adequate time to recall. Others may forget what happened
during childbirth soon after childbirth. But because we thought the former outweighs the later, we
delayed the interview with mothers until the time of discharge from the hospital.

*Comment: I understand this was perhaps a pragmatic decision to secure data completion, however,
were the women given an opportunity to decline to participate, could they ask any questions before
taking part and was the questionnaire completed in a quiet, private area of the unit with one woman and
one 'interviewer'?

Response: In the “Ethics approval and consent to participate” section, we have described that
“All participants were told about the study and verbal informed consent was obtained. Participants
were also told that they have the right to withdraw from the study at any time during data collection.
Participants were given the chance to ask question before participating in the study”.

*Comment: How many questions comprised the questionnaire, were they closed (yes/no responses) and
on average how long did it take to complete it?

Response: A total of 38 questions (15 background and 23 D&A questions) comprised the questionnaire
and most questions were closed ended (yes/no or multiple choice). The average time required to
complete the questionnaire was 30 minutes.

*Comment: Is it possible to add the questionnaire as a supplementary file?

Response: We have uploaded the questionnaire as supplementary file.

Comment: The queries above should be addressed to ascertain if adequate ethical considerations,
including respect, were considered and the rigour of the research.

Response: Definite; this is unquestionable. As we have responded above, details of ethical
considerations are explained under “Ethics approval and consent to participate” section.

Comment: DATA QUALITY CONTROL - ‘The supervisor checked filled questionnaires for accuracy
and completeness on daily basis’ - did the supervisor take any action if data were incomplete?

Response: The supervisor replaced grossly incomplete filled questionnaires if the participants had left
the hospital or returned to data collectors to fill the incomplete sections if the participants not yet left
the hospital.

Comment: Clear explanation of sample size calculation and clear presentation of data analysis and
RESULTS overall.

Comment: Table 1 - would be helpful to include the mode of birth - for example, to know how many
women in the sample had a spontaneous vaginal birth and if they had an episiotomy. This is important
information in the context of examining maternal experiences of abuse and disrespect during childbirth.

Response: All participants of the current study were vaginal deliveries. We didn’t collect separate data
for episiotomy as all mothers may not differentiate it from other interventions. But we have collected
data on the complication status of delivery (e.g. if instrument was used to assist delivery or there
existed any neonatal complication). Accordingly, 58 (20%) participants had complicated delivery
(Table 2). Episiotomy was considered as part of normal delivery as it’s performed for most mothers
these days.

DISCUSSION

Comment - If the INTRODUCTION was enhanced by use of wider key literature - for example, the
Lancet series, I think the discussion would be enriched. There is very limited about the care of women
during labour in the JUMC - apart from that the care appears to be highly medicalised as no mention
again of the presence of midwives or if they play a role in childbirth care. The authors touch on context
in the second # but it is less than clearly presented and could be developed.

Response: We have described under comment on “background” section.
CONCLUSION
Comment- It is simplistic to seize on the 'care provider's' gender in and of itself as a key finding because the issue is more complex than gender - it is around the 'how' women (and their families) are treated.
Response: Of course, what matters more is around the ‘how women’ (and their families) are treated. But in our research, we assessed only ‘how women’ were treated during child birth. In our assessment for factors associated with D&A, we found that being attended by female providers was associated with reduced chance of reporting D&A. We did not assess the profession of service providers and thus, we could not conclude about what we don’t have the data.

LIMITATIONS
Comment- should acknowledge the constraint on rigour and ethical considerations of asking women about their care so soon after they give birth, in the place where they give birth and by staff employed by the hospital, albeit not part of their care provision.
Response: We agree with the constraints of asking women about their care in the place where they give birth and by staff employed by the hospital, albeit not part of their care provision. Thus, we have revised the limitations of our study. But the interview was not conducted soon after giving birth. As we have explained in previous comments, the soonest was 6 hours after delivery.

OVERALL
Comment- this script would benefit from proof reading and tightening for ease of reading and understanding.
Response: We have proof read and revised manuscript.