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Disrespectful care towards mothers giving birth at selected hospital in Kigali/Rwanda

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Abstract

Background Over the past decade, global public health has increasingly focused on studying the mistreatment towards women during facility-based childbirth. However, in Rwanda, research on disrespectful and abusive care experienced by mothers during childbirth remains limited. This study aimed to assess disrespect and abuse experienced by women during their recent childbirth at a selected district hospital in Kigali, Rwanda.

Methods We conducted a cross-sectional study in a selected urban district hospital in Kigali, Rwanda. We employed systematic random sampling to select 246 mothers who recently delivered at the study site and had been discharged from the hospital but were still on the premises. We utilised descriptive statistics and calculated a summation score of nine items of disrespect and abuse to determine our outcome of interest. Subsequently, we dichotomised the outcome. Additionally, we employed chi-square analysis and logistic regression to identify predictors of disrespect and abuse.

Results The prevalence of disrespect and abuse was 67.48%. During the follow-up questions, 28.86% of participants reporting experiencing disrespect and abuse once and 32.52% reporting experiencing it two to eight times. Participants experienced disrespect and abuse between one and eight times. The most prevalent forms of disrespect and abuse experienced were; abandonment ($n=77$), undignified care ($n=76$), and lack of information on received care ($n=65$). The unadjusted logistic analysis indicated that gravida 3 was significantly associated with disrespect and abuse, with a *P*-value of 0.022 and a crude odds ratio of 3.2 (95% CI: 1.18–9.08). However, after adjusting for other variables, this association was no longer statistically significant, as reflected by an adjusted odds ratio with *P*-value of 0.061.

Conclusion Our study revealed the high rate of disrespect and abuse towards women during labour and childbirth. Disrespect and abuse remains a significant issue in our study setting, emphasising the need for interventions to mitigate this problem by enhancing accountability mechanisms among healthcare providers working in maternity services.

Keywords Mistreatment, Childbirth, Intrapartum, Undignified care, Maternity

Introduction

Countries worldwide, including Rwanda, are working towards achieving the Sustainable Development Goals (SDGs) by 2030. This study aimed to contribute to SDG target 3, which focuses on ending preventable maternal and newborn deaths [17], and SDG target 5, which seeks to eliminate all forms of violence against women and girls [8]. Despite Rwanda's remarkable progress in

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increasing skilled birth attendance [39], there is limited knowledge regarding the extent of disrespect and abuse (D&A) experienced by women during childbirth. D&A during childbirth undermines the quality of care and poses risks for adverse perinatal outcomes [6, 52], thereby impeding progress towards achieving the SDG targets. D&A represents a violation whether by commission or omission of a woman's rights and dignity, as a recipient of maternity care and as a human being [6, 56]. Such mistreatment compromises quality of maternity care and can result to psychological trauma [14, 19, 31]. The term"mistreatment"is often used interchangeably with D&A, as some researchers perceive it to be less contentious [41]. Little is known about the extent of D&A received by mothers who give birth in health facilities in Rwanda highlighting a critical gap in this area.

Research has consistently documented a high prevalence of disrespectful care experienced by mothers during childbirth [1, 25], underscoring the urgent need to explore, address, and resolve this issue across high, middle, and low-income countries [3, 11, 26, 30, 38, 45, 51]. The intrapartum and immediate postpartum periods are critical for both maternal and neonatal health, demanding the provision of high-quality care [54]. However, the mistreatment of mothers during childbirth has been identified as a key contributor to substandard maternity care [6, 32, 43, 52]. Evidence indicates that women and their newborns often experience a mixture of mistreatment and positive practices [20]. This duality highlights the complexity of maternity care experiences and the pressing need for interventions to promote respectful for all. D&A during childbirth represents a breach of basic human rights [6] Research also reported that D&A can lead to long-term psychological damage and emotional trauma, reducing women's confidence and self-esteem [6, 25, 52]. Being disrespected may cause shame, sorrow, and insecurity; distrust and loss of confidence in the health care staff; a sense of powerlessness; and reluctance to call for help [31]. Research has indicated that women retain memories of their labour and delivery experiences throughout their lives, often sharing them repeatedly with other women [6, 29, 52]. Disrespectful and abusive treatment instils fear of using maternity services in the future, compromises safe motherhood, resulting in higher rates of adverse maternal and neonatal outcomes [9, 12, 50].

Studies assert that D&A during childbirth is a pervasive global issue [21, 22, 30, 51]. The first significant research on D&A during childbirth in healthcare facilities, published in 2010, brought attention to the concept of"birth abuse" [6]. In 2014, the World Health Organization underscored the urgency of eliminating D&A in maternity care as a global health priority [55]. Studies consistently demonstrated that women worldwide, regardless of their country's income level, frequently experience mistreatment during maternity care. Vedam's study highlighted disparities and mistreatment during pregnancy and childbirth in the United States where mistreatment was consistently higher among women of colour and those having black partners compared to white women [51].In 2010, Bowser and Hills classified D&A during childbirth into seven categories, including physical mistreatment, care administered without consent, breaches in confidentiality, treatment lacking in dignity, discrimination, abandonment, and the detainment of mothers within healthcare facilities [6]. Gebremichael reported that women often endure disrespectful and abusive treatment during childbirth, which they perceive as more distressing than labor pains themselves [16].

D&A during childbirth are often culturally normalized, preventing women from openly discussing or reporting such experiences. This negative experience discourages future utilization of maternity services, thereby contributing to high maternal and infant morbidity in African countries [27]. Some midwives rationalize practices like slapping women in labor, believing it benefits the baby by expediting delivery or helps to prevent complications, serves as means of encouraging women to comply with instructions, [28, 37]. A study conducted in 2015 across five African countries, including Rwanda [38], highlighted systematic violations of women's rights during childbirth. Women were physical abused, denied information and autonomy. They were refused to choose the birth positions they preferred. They were subjected to verbal abuse, including shouting and derogatory remarks from healthcare providers [38]. D&A extends beyond interpersonal relationships between healthcare providers and women or their families. Poor health facility environments and insufficient staff can contribute to disrespectful care [47, 50]. Freedman and Kruk argue that D&A reflects a deeper systemic crisis of health systems in quality of care and accountability [14, 24].

In 2017, a qualitative study explored the negative experiences of women during childbirth in Rwanda [31]. Women reported instances of slapping, verbal abuse, humiliation, reprimands, physical assault, insults, and abandonment by healthcare providers. Many also faced yelling for not following instructions, while others were detained in hospitals due to unpaid bills [31, 32]. A key limitation of this study was the extended interval between childbirth and the interview, ranging from one month to a year, which increased the risk of recall bias. Further studies in Rwanda in 2018 emphasized mothers'preferences for privacy and the presence of their husbands during childbirth and staff shortages posed

substantial barriers to delivering optimal maternity care [33, 34]. This current study aimed to assess the prevalence and experiences of disrespect and abuse (D&A) among women during their most recent childbirth at a selected district hospital in Kigali, Rwanda.

Methods

Study design and setting

The study design was non-experimental, descriptive, cross-sectional, with a quantitative approach and we used a questionnaire to gather the data from the participants. We conducted this study at an urban public district hospital located in Kigali city, the capital of Rwanda. The hospital has a high volume of births; the monthly birth rate at our study site was 430 babies. We conducted a survey on 246 mothers across the hospital. This study included mothers who gave birth at the study site and were ready to be discharged home.

Participants, sampling, and data sources

Researchers obtained ethical clearance (Ref: 385/CMHS-IRB/2021) from the Institutional Review Board (IRB) at the University of Rwanda, College of Medicine and Health Sciences, and secured permission from the hospital's ethical review committee. We conducted the study from October 5, 2022, to December 5, 2022. The researcher was present daily to identify recently discharged mothers, explain the study objectives, obtain informed consent, and administer a structured questionnaire. Participant recruitment occurred in postpartum wards prior to discharge. Eligible participants included women aged 18 years and above who had undergone vaginal or Cesarean delivery. Women under 18 years were excluded due to Rwanda's legal age of consent and the unavailability of their parents to provide consent. We employe systematic sampling, selecting every third discharged woman. We conducted surveys within hospital premises as families prepared to leave. Data collection commenced 12 h after vaginal delivery and 36 h after Cesarean section. All participants provided informed consent before enrollment. We conducted survey in a private hospital room to ensure confidentiality, with the researcher documenting responses during the survey process.

Sample size determination and sampling methods

The research employed systematic random sampling to select mothers who were about to be discharged from postnatal care. We conducted the survey with 246 mothers who had undergone either normal or complicated deliveries at the selected hospital. Eligible participants were those admitted to the postnatal unit and prepared for discharge. Mothers who delivered elsewhere and admitted at the study site after delivery were excluded. We included every third discharged woman in the study. A z-score of 95% confidence level (z_1-$\alpha/2 = 1.96$) and a relative precision (d) of 5% were used to calculate the sample size as shown in the following equation [44].

$$\frac{n = z2\ (p(1-p))}{e2}$$

z = 1.96.
e is less than 0.05.
p = 0.20 according to the study done by Abuya [1]
n = 246

Instrument

We used the validated tool in this research with the permission from a similar project conducted by the Population Council in Kenya (Client Exit survey tool) [1]. The tool encompassed questions about labour, childbirth and immediate post-partum obstetrical care experience, which was translated into local language (Kinyarwanda) mainly spoken nationally, and we performed back-translated to English to ensure translation consistency. We conducted the pilot study on 10% of the overall participants as a means of testing reliability for checking ambiguous, unnecessary questions. We did not include these participants in the final investigation.

Data analysis

Data were entered and cleaned, and then we used STATA software version 16 for analysis. We summarised sociodemographic data using descriptive statistics, including frequencies and percentages. We presented the data using bar graphs and frequency and percentage tables. We evaluated the association between explanatory variables and the reported D&A score in chi-square analysis. We used logistic regression to find predictors of D&A. Primarily, bivariate logistic regression models were fitted to identify factors possibly associated with D&A, using a *P*-value of 0.20 to investigate all possible confounders. We used backward elimination with a P-value of 0.05 to select the final model. The strength of association was expressed as odds ratios with 95% confidence limits. Potential multicollinearity was investigated, but no multicollinearity was found.

Outcome variable

The outcome variable was a self-reported D&A score measured using types of D&A developed by Bowser and Hills in 2010 and was used in other related studies [6]. The D&A scale was validated in Kenya in the study done by Abuya and colleagues in 2015 [1], and we got permission from the author to use the tool. The tool we used had 9 items of D&A with 9 follow-up questions about

explanations of reported types of D&A. Each reported item was based on binary responses and was scored 1 for"yes"for disrespect and abuse, and 0 for"no"for non-disrespect and abuse. We did the score summation of the self-reported 9 D&A items. The total score was the sum of responses to the 9 D&A questions. In this study, the participants can experience more than one item of disrespect. The"0"indicates that the mother experienced no disrespect at all. Note that we used the word disrespect and D&A interchangeably after performing the summation of those who responded yes on the 9 Disrespect items (each reported yes item was scored 1) and the maximum score was 9. We specified a binary outcome:"not disrespect"and"disrespect"as categorical variables. For the follow-up questions, the multiple responses were allowed and we analysed the data from the follow-up questions using frequency and percentages.

Explanatory variables and covariates

Explanatory variables were the mother's socio-demographic and obstetric history data. There were 6 variables, namely gravida, age of the mother, marital status, highest education, occupation, and condition of the baby at delivery. We categorised these variables where necessary and summarised them by frequencies and percentages. Gravida is categorised into 4 categories: the mother's age into three categories and occupation into three main categories. Marital status was classified into three categories: single, married and cohabitation. The highest education level that our participants attended had 2 categories: no formal education and primary education, which were combined, and those who reached secondary and above were also combined. The condition of the baby at delivery was dichotomous, defined as the baby is well/healthy and the baby is admitted to neonatology.

Results

About one in three women were primigravida (34.1%) and aged between 18 and 24 years (36.9%). The majority had primary or no formal education (55.2%) and cohabited with their partners (50.4%). The highest proportion engaged in small-scale businesses (37.4%). Notably, 86.9% had healthy babies and were staying with their newborns (Table 1).

In total, 246 mothers were interviewed; the majority, 151(67.48%), reported experiencing D&A during their recent childbirth. This means those participants have reported experiencing at least one type or more types of disrespect.

Figure 1 presents a follow-up question in which participants were asked to specify the types of D&A they experienced. In contrast, 38.62% of respondents did not describe any type of D&A they had experienced. This discrepancy of approximately 6% suggests that some participants who initially reported experiencing D&A may have refrained from providing further details. In Fig. 1, among the participants who experienced D&A, 28.86% experienced D&A at once type of D&A and 32.52% reported receiving from two to eight types of D&A. The mean of D&A experienced by mother was 1, the minimum number of participants who experience D&A is once, and the maximum is eight times.

Table 1 Description of socio-demographic and obstetric characteristics ($n = 246$)

Variables	Frequency	Percentage
Gravida		
Gravida 1	84	34.15
Gravida 2	59	23.98
Gravida 3	50	20.33
Gravida 4 and more	53	21.54
Age of the mother		
18–24	91	36.99
25–30	77	31.30
31 and above	78	31.71
Education level		
No formal education and primary	136	55.28
Secondary and above	110	44.72
Marital status		
Single mother	45	18.29
Legally married	77	31.30
Cohabitation	124	50.41
Occupation of the mother		
Homemaker	88	35.77
Farming	66	26.83
Small sales	92	37.40
Condition of the baby		
Healthy baby	214	86.99
Baby admitted to neonatology	32	13.01

Figure 2 presents types of disrespect and abuse reported by participants. Among the 246 participants, the most commonly experienced forms of disrespect and abuse were abandonment ($n = 77$), undignified care ($n = 76$), and lack of information regarding received care ($n = 65$). Note that here the multiple response was allowed.

Table 2 depicts the types of care that showed D&A to the participants. These responses were received during the follow-up questions we only asked to the mothers who responded *yes* in order to capture the explanation on what exactly happened. There were six follow-up questions in total. A total of 151 participants responded yes to at least one of the D&A items. During the follow-up questions, we asked the participants to explain the kind of disrespect and abuse they experienced. For instance,

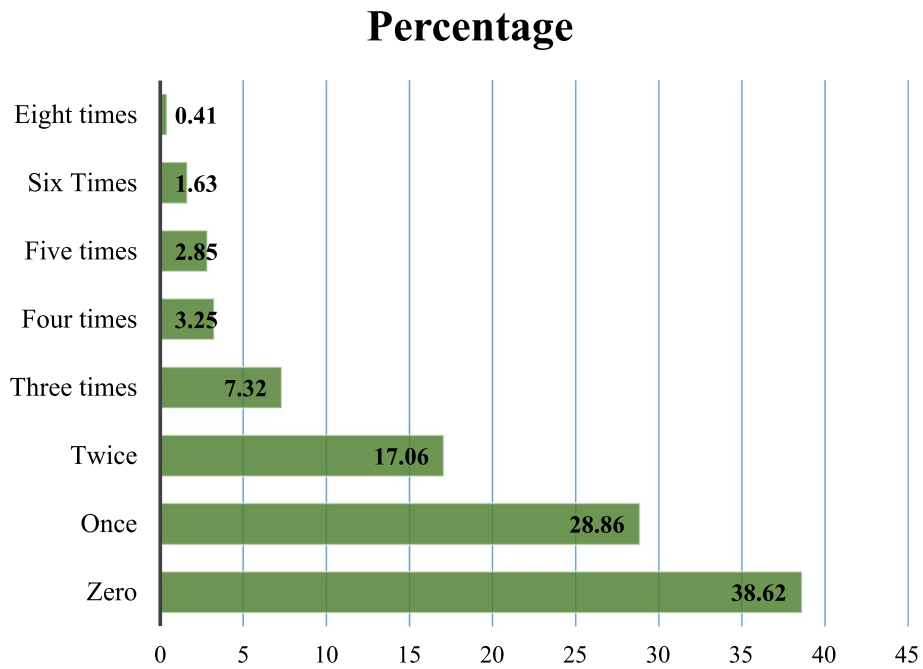

Fig. 1 Frequency of D&A experienced by the participants

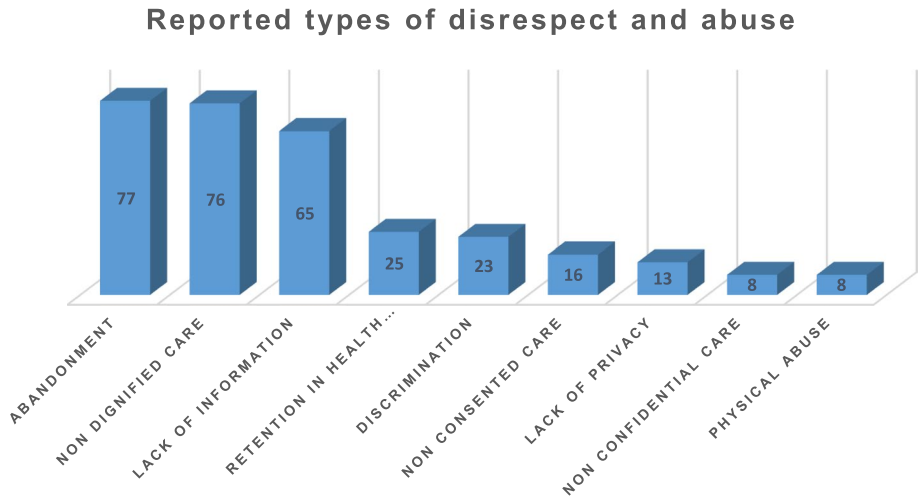

Fig. 2 Types of disrespect and Abuse reported by the participants

we posed the question:"At any point during your stay for this delivery, were you physically abused by any of the health care worker? Those who responded"yes"were asked to explain what exactly happened. The most women (15.85%) reported that they were not provided care after birth, (10.16%) reported being less cared in general (Table 2).

All variables (explanatory and outcome) were categorical data. The outcome of categorical variables was (no disrespect and disrespect). After chi-square analysis, we found no association between explanatory variables and outcome, as shown in the table below.

This table displays the results from the bivariate model and multivariate logistic regressions that examined the association between the explanatory variables and the outcome (disrespect). The unadjusted logistic analysis showed that gravida three was statistically significant with a P-value of 0.022 and crude odds ratio of 3.2 with a confidence interval of [1.18–9.08]. This means that in the unadjusted model, there is an association between

Table 2 Explanations on types of disrespect experienced by mothers ($n = 151$)

Physical Abuse	Frequency	Percentage
1. Beaten	2	0.81
2. Repaired episiotomy without anesthesia	4	1.63
3. Pinched	1	0.41
4. Kicked	1	0.41
Lack of privacy		
1. Multiple vaginal examinations by multiple people	1	0.41
2. Left uncovered	5	2.03
3. No screen blocking views	7	2.85
Non-confidential care		
1. Gave birth in waiting room	2	0.81
2. Information was discussed with non-health staff	6	2.44
Non consented care		
1.Vaginal examination	8	3.25
2.Caesarian section	3	1.22
3.Placement of intra-uterine device (IUD)	2	0.81
4.Abdominal palpation	3	1.22
Discrimination		
1. Omitted care	18	7.32
2. Told bad words	3	1.22
3. Judged	2	0.81
Abandonment		
1. Left unattended after birth	39	15.85
2. Left unattended while pushing the baby	12	4.88
3. Left unattended during labour	15	6.10
4. Left unattended when experiencing post-partum pain	11	4.47

Follow-up questions

gravida 3 and the outcome (disrespect) compared to gravida 1. However, the association between gravida 3 and D&A was later not statistically significant after controlling for other variables (with a p-value of 0.061 in AOR). This could have been because the sample size to establish factors associated with D&A was not calculated in this study. The study was based on the sample size to determine the prevalence of D&A. Thus, independent characteristics of the study were not significantly associated with D&A in final model of multivariate logistic regression Table 3.

Discussion

The results showed the widespread of all types of D&A in our study settings. Some types were reported at the highest level; over the total of 246 participants, 77 participants were abandoned 76 experienced non-dignified care and 65 were not provided information on care received (See Fig. 2). The prevalence of D&A in this study is still high (67.48%), and this number is high because the majority experienced more than one type of D&A (See Fig. 1), where 28.86% experienced one form of D&A and 32.52% reported experiencing two to eight types of disrespect. This indicated how interventions are still needed in Rwanda to mitigate the D&A during the intrapartum period because disrespectful care violates fundamental human rights and significantly hampers maternity service delivery. Note that the participants were asked a binary question to determine whether they had experienced D&A during their care. Among the respondents, 32.52% reported no experience of D&A. In contrast, Fig. 1 presents a follow-up question in which participants were asked to specify the types of D&A they experienced. In contrast, 38.62% of respondents did not describe any type of D&A they had experienced. This discrepancy of approximately 6% suggests that some participants who initially reported experiencing D&A may have refrained from providing further details. This difference could stem from various reasons, such as a reluctance to revisit traumatic experiences, difficulty articulating what occurred, or perceiving their experiences as neutral rather than explicitly disrespectful or abusive.

This prevalence of 67.48% found in our study is comparable to the study conducted by Tekle in public health

Table 3 Chi-Square analysis of categorical variables ($n = 246$)

Variables	No Disrespect (%) $n = 95$	Disrespect (%) $n = 151$	*P*-value
Gravida			0.131
Gravida 1	37(44.05)	47(55.950	
Gravida 2	21(35.59)	38(64.41)	
Gravida 3	13(26)	37(74)	
Gravida 4 and more	24(45.28)	29(54.72)	
Age of the mother			0.837
18–24	35(38.46)	56(61.54)	
25–30	28(36.36)	49(63.64)	
31 and above	32(41.03)	46(58.97)	
Education level			0.146
No formal education and primary	47(34.56)	89(65.44)	
Attended secondary	48(43.64)	62(56.36)	
Marital status			0.719
Single mother	15(33.33)	30(66.67)	
Legally married	31(40.26)	46(59.74)	
Cohabitation	49(39.52)	75(60.48)	
Occupation of the mother			0.923
Homemaker	33(37.50)	55(62.50)	
Farming	25(37.88)	41(62.12)	
Small sales	37(40.22)	55(59.78)	
Condition of the baby			0.597
Healthy baby	84(39.25)	130(60.75)	
Baby admitted in neonatology	11(34.38)	21(13.91)	

Chi-Square analysis

facilities in western Oromia, Ethiopia, where 74.8% of women reported experiencing at least one form of D&A during childbirth [48]. Furthermore, our findings are comparable to findings from a multicenter study in eastern public health facilities of Ethiopia, which revealed that 85.2% of respondents reported experiencing at least one form of D&A, with the most common types being non-consented care (73.9%), abandonment (71.4%), and non-dignified care (60.4%) [15]. In another study conducted in Nigeria, at least one dimension of mistreatment was reported by 66% of participants across 10 health facilities in Gombe State, Nigeria [50]. Similarly, in another study in Nigeria, 98.0% of participants reported experiencing at least one form of D&A during their last childbirth [36] (Table 4).

In unadjusted logistic regression, our findings showed an association with gravida 3 and D&A with a *P*-value of 0.022 and a crude odds ratio of 3.2 with a confidence interval of [1.18–9.08]. This means the mother with gravida 3 was three times more likely to be disrespected compared to the mother with gravida 1. These findings align with a study conducted in Kenya, which revealed that women with higher parity were three times more likely to be detained due to lack of payment [1]. However, due to the nature of our study, we did not establish why the mother with gravida 3 was disrespected. Moreover, a recent anecdotal report from a health facility in Rwanda highlighted instances where healthcare providers used dehumanizing language towards multigravida women, particularly those delivering at a young age with multiple children [49]. This observation contrasts with a study

Table 4 Logistic regression

	$n = 246$	Disrespect (%)		Crude OR [CI 95%]	*P*-value	Adjusted OR [CI 95%]	*P*-value
Variable	**Category**	**Respect (%)**	**Disrespect (%)**				
Gravida	Gravida 1	37(44.05)	47(55.950	1	0.133	1	0.282
	Gravida 2	21(35.59) 13(26)	38(64.41)	1.43[.83- 3.99]	**0.022**	1.45[.73–2.90]	0.061
	Gravida 3	24(45.28)	37(74)	2.24[1.18–9.08]	0.597	2.09[.96- 4.53]	0.683
	Gravida 4 and more		29(54.72)	0.95[.47- 3.59]		.86[.42- 1.75]	
Age of the mother	18–24	35(38.46)	56(61.54)	1	0.585		
	25–30	28(36.36)	49(63.64)	.79[.35- 1.79]	0.281		
	31 and above	32(41.03)	46(58.97)	.57[.20- 1.57]			
Education level	No formal & primary	47(34.56)	89(65.44)	1	0.118	1	0.147
	Secondary& above	48(43.64)	62(56.36)	.61[.33- 1.12]		.67 [.39- 1.14]	
Marital status	Single	62(56.36)	30(66.67)	1	0.836		
	Married	31(40.26)	46(59.74)	.90[.36- 2.23]	0.324		
	Cohabitated	49(39.52)	75(60.48)	.67[.31- 1.46]			
Occupation of the mother	Homemaker	33(37.50)	55(62.50)	1	0.707		
	Farming	25(37.88)	41(62.12)	1.15[.54–2.41]	0.571		
	Small sales	37(40.22)	55(59.78)	1.21[.62–2.35]			
Condition of the baby	Healthy baby	84(39.25)	130(60.75)	1	0.503		
	Baby not well	11(34.38)	21(13.91)	1.32[.57–3.04]			

Logistic regression model

conducted in Ethiopia, which found that being multigravida was associated with receiving more respectful maternity care from service providers [23].

The issue of D&A presents a dual challenge, affecting both mothers and healthcare providers, particularly midwives, as evidenced by the 2017 World Health Organization report [53]. This is exacerbated by the fact that many providers, predominantly women, encounter societal prejudice and violence [5, 12, 13, 18, 40]. This problem persists in a vicious cycle, as the research contends that midwives who have experienced violations are more likely to perpetrate similar mistreatment towards others over whom they hold authority [5, 7, 13, 40, 46]. A global survey of 2,470 midwives across 93 countries revealed disrespect at work and in the community [53]. About 36% reported a lack of respect from senior medical staff, highlighting their lower status and subordination within the medical profession, compounded by limited legal and regulatory support [53] Gender discrimination and harassment were widespread, with 20–30% encountering such issues, reflecting the undervaluation of midwifery and nursing compared to other medical roles [53]. Despite their dedication to saving lives, midwives endure challenging working conditions, including understaffed facilities and inadequate compensation. Reports from Rwanda noted a lack of public awareness about the role of midwives, while Nigerian midwives highlighted issues of poor remuneration and a lack of career progression [53].

The recent review of Respectful Maternity Care interventions reported that adopting multi-faceted strategies can successfully reduce the mistreatment of women during maternity care and improve the respectful care provision. These comprehensive strategies address a range of factors, including the attitudes and conduct of healthcare personnel, staff morale, community engagement, and the removal of barriers in healthcare facilities and systems [10, 21]. Interventions beyond a sole focus, like staff training, are more likely to bring about meaningful change [9, 21].

In Rwanda, the issue of disrespect and abuse during childbirth has largely remained unaddressed due to the absence of formal research prior to 2015, resulting in underreporting. This pervasive silence likely exists because pain and suffering during labour and childbirth are often widely perceived as routine aspects of the birthing process in many countries [1, 6] Bowser and Hills contend that various forms of mistreatment during childbirth are deemed normal, which dissuades mothers from voicing concerns or reporting incidents [6]. Pioneering researchers recommended that respectful actions should be contextualised locally [6], as responses to labour pain or behaviour during childbirth can differ across cultures [4, 42]. In Rwandan cultural norms, for instance, labouring women are often dissuaded from vocalising their pain; societal expectations encourage them to remain calm and quiet.

Disrespectful care during childbirth is not solely an individual concern but also a systemic issue within the healthcare system [14, 24, 52, 56]. Findings from the Heshima project in Kenya revealed that the lack of respectful maternity care extends beyond interactions between mothers and healthcare providers, becoming a broader problem concerning the functionality of the healthcare system [52]. Inadequate quality of maternity services, such as deficient infection control, poor hygiene standards, and limited resources, has been associated with disrespectful maternity care [41, 43]. Women's privacy may be compromised simply because healthcare facilities lack curtains or partitions to provide visual protection from third parties [52, 56]. Mothers may receive news of adverse outcomes without proper psychological preparation simply because healthcare institutions lack sociologists or psychologists [2]. Warren and colleagues stress that addressing D&A cannot be achieved solely at the individual level; it requires systemic changes within the healthcare system [52]. Therefore, stakeholders such as health administrators, political actors, and media should be actively involved in addressing this issue [35, 52].

Conclusion and recommendations

Our study revealed a high prevalence of disrespect and abuse experienced by women during labor and childbirth. The most frequently reported types of D&A were abandonment, non-dignified care, and a lack of information regarding the care provided. Notably, participants reported experiencing all nine types of D&A assessed in the study, with many reporting exposure from two to eight types of disrespect and abuse.

Disrespectful care remains a pervasive issue in the study setting, underscoring the urgent need for interventions aimed at addressing this problem. We recommend the implementation of enhanced accountability mechanisms for healthcare providers in maternity services to promote respectful care. Additionally, further prevalence studies on disrespectful care in various healthcare settings across Rwanda are necessary to better understand the scope of the issue. We also advocate for more qualitative research to explore the underlying factors contributing to D&A and to inform targeted interventions. Strengthening accountability measures within maternity services should be prioritized to ensure improved care quality and uphold the dignity of women during childbirth.

Strengths and limitations

A notable strength of this study lies in the use of a validated tool previously employed in similar studies, enhancing the reliability of the findings. Furthermore, the study applied systematic random sampling to select participants meeting the inclusion criteria during the study period, potentially supporting the generalizability of the findings to comparable contexts. However, the study has certain limitations. First, it was conducted at a single hospital, which may restrict the broader applicability of the results. Second, the relatively small sample size limited the scope of the analysis. Additionally, the study did not consider potentially additional variables such as antenatal care attendance, economic status, religion, or the characteristics of healthcare providers. Another limitation is the reliance on self-reported responses, which may be subject to recall or reporting biases. Conducting the study on hospital premises, even after participants had been discharged and were preparing to leave, may have introduced desirability bias. To mitigate this, the research team ensured confidentiality by conducting interviews in a private room and reassuring participants that their responses would remain anonymous and inaccessible to healthcare providers. Despite these efforts, the possibility of bias cannot be entirely excluded.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12884-025-07804-9.

Supplementary Material 1.

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Clinical trial registry and registration number

Not applicable.

Authors' contributions

AM: Protocol development, methodology, data collection, data cleaning and curation, formal analysis, interpretation, and writing (original draft preparation and editing); IJK: writing (original draft preparation, reviewing, and editing); AN: and writing (reviewing and editing); TO: Protocol development, procedure; AU, VB, CM,PU: data analysis, and writing (reviewing and editing).

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Data availability

Availability of data and materials: All data generated or analysed during this study are included in this published article [and its supplementary information files]. The datasets generated and analysed during the current study are available in the Supplementary Data1_ STATA do file repository DA 2024.do.

Declarations

Ethics approval and consent to participate

We conducted this study in accordance with the Declaration of Helsinki. Ethical clearance was received from the Institutional Review Board of the College of Medicine and Health Sciences of the University of Rwanda with a reference 385/CMHS-IRB/2021.Permission was obtained from the hospital. Informed consent was obtained from all participants involved in the study. None of the participants were minors.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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