

Research Article

Obstetric Violence and Its Associated Factors Among HIV-Positive Women Receiving Birth Care at Public Health Facilities in Addis Ababa, Ethiopia

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Abstract

Background: Obstetric violence is an emerging health problem in the utilization of maternal health services. In the study context, there was limited evidence on obstetric violence. Hence, the aim of this study was to assess obstetric violence and its associated factors among HIV-positive women who received birth care at public health facilities, in Addis Ababa, Ethiopia. **Results:** A total of 318 HIV-positive women participated in this study, yielding a 100% response rate. In this study, 79% of the HIV-positive women reported that they had been subjected to at least one form of obstetric violence during birth care. The top three reported forms of obstetric violence were as follows: 249 (78.3%) failed to provide informed consent, 227 (71.4%) did not complete medical procedures and 140 (44%) did not suffer life-threatening complications. The multivariable logistic regression analysis revealed that female birth status (AOR= 2.85; 95% CI 1.57, 5.15), fewer than three ANC visits (AOR= 2.99; 95% CI 1.39, 6.45), age >35 years old (AOR= 2.47; 95% CI 1.25, 4.90) and primary school attendance (AOR= 2.13; 95% CI 1.08, 4.17) were significantly associated with obstetric violence. This study revealed a high prevalence of obstetric violence among HIV -positive women. Hence, mitigation needs to be undertaken by taking the reported forms of obstetrics obstetric violence, and socio-demographic and obstetric variables by ensuring a systematic and strategic intervention for quality birth care utilization through the involvement of families, communities, the government and stakeholders.

Keywords

Birth Care, HIV-positive Women, Obstetric Violence, Public Health Facilities

1. Introduction

Obstetric violence is a violation of women's fundamental rights, denying them control over their bodies and experiences during childbirth. It stems from a medicalized approach that disrespects the natural processes of pregnancy and labor, leading to the overuse of medications that can be harmful. This disrespect for women's autonomy and dignity has serious physical, emotional, and psychological consequences, in-

cluding increased rates of postpartum depression, traumatic birth experiences, and even long-term health complications for both mothers and their babies. Obstetric violence is rooted in a system that often prioritizes medical interventions over women's autonomy and well-being. This unacceptable practice must be addressed through greater awareness, education, and accountability within healthcare systems. We need to

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advocate for policies that protect women's rights during childbirth and ensure respectful, evidence-based care [1-5].

The impact of OV extends beyond individual suffering. It incurs substantial social, economic, and health costs for healthcare systems, social services, and the overall economy. Studies have shown that obstetric violence can lead to significant increases in healthcare expenditures, including longer hospital stays, additional medical treatments, and mental health services. The need for additional medical care, lost productivity due to missed work, and the social and psychological consequences of OV exert a heavy toll on societies. It can contribute to a culture of fear and silence around childbirth, making it more difficult for women to advocate for themselves and access quality care. Studies have shown that the psychological stress and trauma associated with obstetric violence can impact fetal development and trigger early labor [6-10].

Disrespectful and abusive treatment during birth care has been reported in numerous countries worldwide. These reports indicate that progress in maternal and child health outcomes has been hindered. The mistreatment of women during birth care creates a psychological distance between them and healthcare providers, driving them away from formal maternal health systems. This fear of violence can be a more significant obstacle than financial barriers in preventing women from accessing care [11-16].

In Africa, the prevalence of obstetric violence (OV) is among the highest globally, exceeding rates in both developed and developing countries. For example, in Gambia, 61% of women reported experiencing OV, whereas in Zimbabwe, the prevalence was 34%, and in Ethiopia, it was 25%. In Nigeria, the prevalence was 43.5% in the 12 months prior to pregnancy and 28.3% during pregnancy [19, 20]. The overall prevalence of OV in Ethiopia has been reported to be between 50% and 76.5% during women's lifetimes, and between 30% and 72.5% before pregnancy. Additionally, three out of four Ethiopian women experienced OV during their lifetime. Addressing obstetric violence is an urgent priority in Ethiopia and should be prioritized on the health agenda. Recent studies have identified factors that predict OV, including the number

of antenatal care (ANC) visits, age, and educational status [13-18]. Hence, no single studies have been conducted in the study setting on obstetric violence and associated factors among HIV-positive women in Addis Ababa, Ethiopia. Therefore, this study aims to assess the prevalence of obstetric violence and associated factors among HIV-positive women receiving birth care at a selected public hospital in Addis Ababa, Ethiopia.

2. Methods and Material

This institutionally based cross-sectional study was conducted from January 1 to January 30, 2022, at three public hospitals in Addis Ababa, the capital city of Ethiopia. Addis Ababa has 11 public hospitals and 98 health centers providing health services for the city. The study hospitals—Alert Specialized Hospital (ASH), Gandhi Memorial Hospital (GMH), and Zewditu Memorial Hospital (ZMH) were purposely selected because they serve as central referral points for all obstetric emergencies, including high-risk pregnancies, throughout the city. These hospitals are staffed with interns, midwives, obstetricians, and support staff.

The sample size was determined on the basis of specific objectives via Epi Info version 7, with the following assumptions: 95% confidence interval (CI), 80% power, and a 1:1 ratio. Factors considered for the study included marital status (single/separated vs. married/stable union) and monthly income (less than 2 MW vs. greater than 10 MW). The proportion of OVs in the exposed group was 27.1%, and that in the non-exposed group was 72.9%. The proportion of OVs among the exposed group was 23%, and that of the non-exposed group was 8.2%, which are usually characterized in the literature as having a significant association with obstetric violence: the influence of the Senses of Birth Exhibitions on pregnant women's childbirth experience [19]. The largest sample size was selected for representativeness, and the required sample size with a 10% non-responding rate was $n=318$ HIV-positive women (Table 1).

Table 1. Sample size determination on obstetrics violence and associated factors among HIV-positive women receiving birth care at public health facilities in Addis Ababa, Ethiopia.

Factor Considers	Reference	Outcome Prevalence Among Exposed	Outcome Prevalence Among Unexposed	Adjusted Odd Ratio	10% Non-Response	Final Sample Size
Family income (<2 MW & >10 MW)	Sonia Lansky 2811-2823 (2017) [19]	23%	8.2%	2.81	21	235
Marital status (Single/Separated & Married/stable union)	Sonia Lansky 2811-2823 (2019) [19]	27.1%	72.9%	2.06	5	49

The sample size was allocated to the selected public hospitals via a systematic random sampling technique. The K-interval was determined by dividing the number of cases that flow in the first month, which was 1308 divided by the sample size (i.e., $1308/318 \sim 4$). The first respondent was selected via the lottery method, and then the first four women who had earned a decision for discharge were selected. The selection of participants was preceded by every four intervals.

The outcome variables of OV are explanatory variables, including socio-demographic, gynecological, and obstetric variables. Therefore, OV was measured via seven performance standards. HIV -positive women who replied 'yes' to at least one form of OV were labeled "Obstetric Violence". In total, 26 verification criteria of OV were used to measure the seven performance standards on the composite scale.

The data were collected via a structured, pretested, close-ended questionnaire administered through face-to-face interviews. The questionnaire was adapted from WHO multi country studies [16]. The questionnaire was designed in English, translated into Amharic (the local language), and then back-translated into English to ensure data accuracy. Data collectors and supervisors received two days of training from the principal investigator, covering the objectives of data collection and including basic communication skills. Before data collection, informed consent was obtained from each respondent. Data were collected via face-to-face interviews. Supervisors were responsible for checking the completeness and accuracy of the questionnaires during the data collection period. Finally, the principal investigator reviewed the data for completeness and accuracy, providing important feedback.

Data quality was ensured through two- days of training with data collectors through the development of a training manual. To assess data quality and minimize potential bias, 10% of questionnaires were pretested on a similar population

at a non-selected public health hospital in Addis Ababa city, Ethiopia. This pretest helped to identify potential problems related to interviewer misclassification, recall bias, and inter and intraobserver bias. After data collection, the data were checked for completeness, consistency, and accuracy, coded and entered into EPI-Info version 7. The data were exported to SPSS version 23 for analysis. All covariates with a p- value <0.2 during bivariate analysis were considered for further multivariate analysis to control for potential confounders to identify true predictors of OV. Those variables that showed p-for which the p value was <0.05 in the multivariate analysis were considered important predictors of OV. Finally, adjusted odds ratios (ORs) along with 95% confidence intervals (CIs) were estimated to measure the strength of the association level of statistical significance at a p- value <0.05 .

3. Results

3.1. Socio-demographic Characteristics

A total of 318 HIV-positive women in Addis Ababa city participated in the study, resulting in a 100% response rate. The participants' ages ranged from 25-34 years for 141 individuals (44.3%), with a mean age of 29.95 years (standard deviation [SD] ± 5.96). Educational attainment was as follows: 121 (38.1%) participants completed primary school, whereas 175 (55%) completed secondary school or higher. In terms of employment status, 205 (64.5%) participants were privately employed, and 80 (25.2%) were housewives. The majority (118 or 37.1%) of women reported a monthly income between \$61 and \$100 (Table 2).

Table 2. Socio-demographic characteristics of HIV-positive women receiving birth care at public health facilities, Addis Ababa, Ethiopia, (n=318).

Variable	Category	Frequency	Percentage
Age	15-24	104	32.7%
	25-34	141	44.3%
	>35	73	23%
Permanent resident	Addis Ababa	285	89.6%
	Others	33	10.4%
Marital status	Married	271	85.2%
	Divorced	19	6%
	Widowed	11	3.5%
	Formal Boy Friend	17	5.3%
Educational Status	No formal education	22	6.9%
	Primary school	121	38.1%

Variable	Category	Frequency	Percentage
Occupational status	Secondary and above	175	55%
	Government employee	33	10.4%
	Private employee	205	64.5%
	House wife	80	25.2%
Monthly income (ETB)	10\$-20\$	16	5%
	21\$-60\$	114	35.8%
	61\$-100\$	118	37.1%
	>101\$	70	22%
Husband/male partner educational status (288)	No formal education	9	2.8%
	Primary school	59	18.6%
	Secondary and above	220	69.2%
Husband/Male partner employment status (288)	Government employee	71	22.3%
	Private employee	212	66.7%
	Unemployed	5	1.6%

*Others=Lived in outside Addis Ababa city.

3.2. Obstetric and Gynecological Characteristics

With respect to antenatal care (ANC) visits, 179 (56.3%) respondents had completed all recommended visits, whereas 89 (28%) had attended only three visits. For birth care, 165

(51.9%) respondents received care at public hospitals, and 153 (48.1%) received care at health centers. The mode of delivery was reported to be spontaneous vaginal delivery for 181 (56.9%) respondents and cesarean section for 69 (21.7%) respondents. Finally, 173 (54.4%) respondents reported giving birth during the day, whereas 145 (45.6%) reported giving birth at night (Table 3).

Table 3. Obstetrics and gynecological characteristics among HIV-positive women receiving birth care at public health facilities, Addis Ababa, Ethiopia (n=318).

Variable	Category	Frequency	Percentage
Parity	Prim parous	97	30.5%
	Multi parous	162	50.9%
	Grand multiparous	59	18.6%
Gravidity	1	72	22.6%
	2-4	159	50%
	>4	87	27.4%
Number of ANC visit	ANC 1	4	1.3%
	ANC 2	46	14.5%
	ANC 3	89	28%
	ANC >4	179	56.3%
Place of ANC visit	Hospital	165	51.9%
	Health Center	153	48.1%

Variable	Category	Frequency	Percentage
Sex of birth attendant	Male	121	38.1%
	Female	197	61.9%
Number of birth attendant	1-3	18	5.7%
	4-6	191	60.1%
	>6	109	34.3%
Number of main birth attendant	<2	201	63.2%
	>2	117	36.8%
Route/type of delivery	Assisted vaginal delivery	44	13.8%
	C-Section	69	21.7%
	Delivery by episiotomy	24	7.5%
	Spontaneous vaginal delivery	181	56.9%
Excessive bleeding	Yes	39	12.3%
	No	279	87.7%
Need blood transfusion	Yes	31	9.7%
	No	287	90.3%
Time of delivery	Day	173	54.4%
	Night	145	45.6%
Sex of birth attendant	Male	121	38.1%
	Female	197	61.9%

3.3. Prevalence and Forms of Obstetric Violence

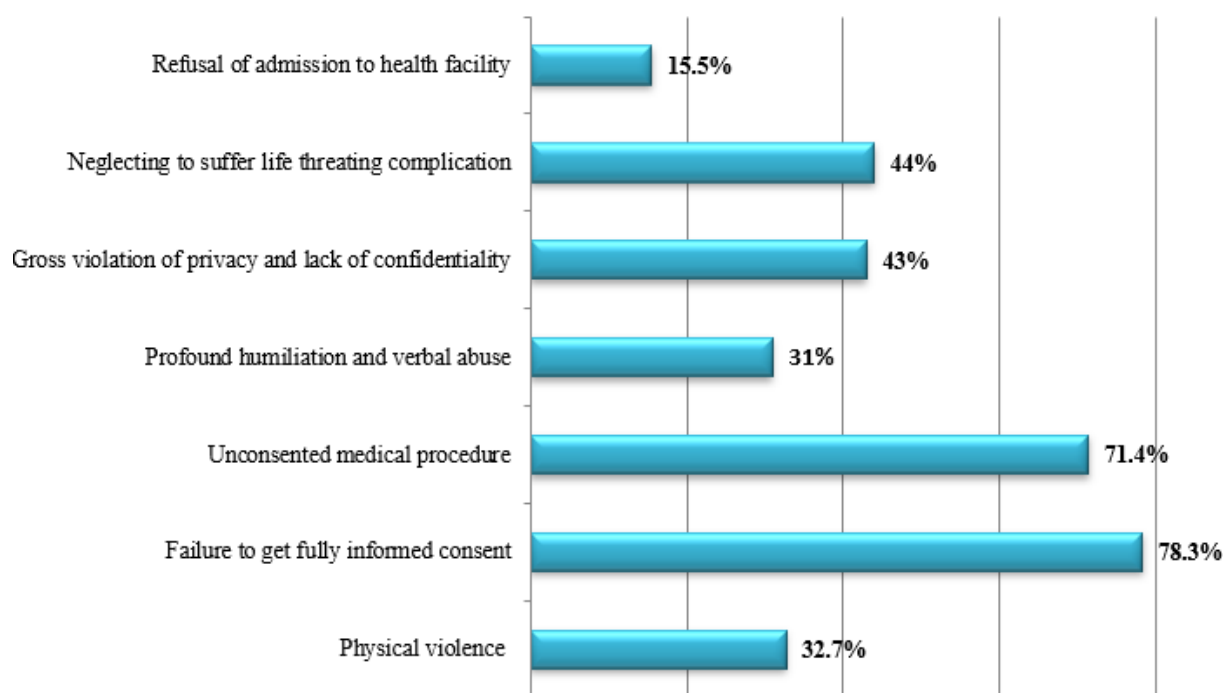


Figure 1. Prevalence and forms of obstetrics violence among HIV-positive women receiving birth care at public Hospitals, Addis Ababa, Ethiopia, (n=318).

In the study setting, the overall prevalence of obstetric violence among HIV-positive women was 79%, with a 95% CI of 73.6–82.7. Hence, all forms of OV were experienced by the study participants. Among the study participants, 249 (78.3%) failed to provide informed consent, 227 (71.4%) did not complete medical procedures, 140 (44%) did not suffer a life-threatening complication, 137 (43%) experienced gross violation of privacy, 104 (32.7%) experienced physical violence, 99 (31%) experienced profound humiliation and verbal abuse, and 49 (15.5%) refused admission to a health facility (Figure 1).

3.4. Factors Associated with Obstetric Violence

The bivariate regression model, revealed that age, educational status, number of ANC visits, and sex were significantly

cantly associated with OV. After adjustment in the multivariate analysis, the following variables were significantly associated with OV: female birth attendant, number of ANC visits, age, and educational level. Hence, HIV-positive women who had been assisted by female birth attendants were 2.85 times more likely to be at risk of OV than women who had been assisted by male birth attendants (AOR = 2.85; 95% CI = 1.58, 5.15); respondents who had been assisted by female birth attendants were 2.99 times more likely to be at risk of OV than their counterparts were (AOR = 2.99; 95% CI = 1.39, 6.45); respondents aged >35 years were 2.47 times more likely to be at risk of OV than respondents aged between 15 and 24 years (AOR = 2.47; 95% CI: 1.25, 4.90),; and respondents who had attended primary school were 2.13 times more likely to be at risk of OV than respondents who had attended secondary school and above (AOR = 2.13; 95% CI: 1.08, 4.17) (Table 4).

Table 4. Factors associated with obstetric violence among HIV-positive women receiving birth care at public health facilities, Addis Ababa, Ethiopia, (n=318).

Variable	Obstetrics Violence		COR with 95% CI	AOR with 95% CI
	Yes N (%)	No N (%)		
Age of respondents				
15-24	74 (71.2)	30 (28.8.)	1	1
25-34	119 (84.4)	22 (15.6)	1.44 (0.72, 2.90)	2.02 (0.93, 4.38)
>35	57 (78.1)	16 (21.9)	2.19 (1.18, 4.08)	2.47 (1.25, 4.90) *
Educational status				
No formal education	17 (77.3)	5 (22.7)	1.18 (0.44, 3.37)	1.61 (0.49, 5.34)
Primary school	103 (85.1)	18 (14.9)	1.98 (1.08, 3.63)	2.13 (1.08, 4.17) *
Secondary and above	130 (74.3)	45 (25.7)	1	1
Occupational Status				
Governmental	21 (63.6)	12 (36.4)	0.43 (0.18, 1.07)	0.68 (0.25, 1.87)
Private employee	165 (80.5)	40 (19.5)	1.03 (0.54, 1.97)	1.97 (0.54, 2.33)
House wife	64 (80)	16 (20)	1	1
Number of ANC visit				
ANC 1	2 (50)	2 (50)	0.37 (0.05, 2.67)	0.54 (0.06, 4.56)
ANC 2	39 (84.8)	7 (15.2)	2.04 (0.86, 4.87)	2.36 (0.91, 6.09)
ANC 3	78 (87.6)	11 (12.4)	2.61 (1.27, 5.29)	2.99 (1.39, 6.45) *
ANC >4	131 (73.2)	48 (26.8)	1	1
Sex of birth attendant				
Male	81 (66.9)	40 (33.1)	1	1
Female	169 (85.8)	28 (14.2)	2.98 (1.72, 5.18)	2.85 (1.58, 5.15) *
Number of birth attendant				

Variable	Obstetrics Violence		COR with 95% CI	AOR with 95% CI
	Yes N (%)	No N (%)		
1-3	14 (77.8)	4 (22.2)	1.21 (0.37, 3.98)	0.93 (0.25, 3.43)
4-6	155 (81.2)	36 (18.8)	1.49 (0.85, 2.61)	1.56 (0.84, 2.90)
>6	81 (74.3)	28 (25.7)	1	1
Time of delivery				
Day	129 (74.6)	44 (25.4)	0.58 (0.33, 1.01)	0.56 (0.31, 1.03)
Night	121 (83.4)	24 (16.6)	1	1

NB: variables not entered into the model because they hadn't found significant in the bivariate analyses (P value >0.2).

4. Discussion

This study revealed that the overall prevalence of obstetric violence (OV) among HIV-positive women was 79.6%, with a 95% CI (73.6–82.7). Multivariate analysis revealed that the sex of the birth attendant, number of antenatal care (ANC) visits, age of the respondent and educational level was significantly associated with OV. The prevalence observed in this study was higher than that reported in studies globally (15–70%), including in Brazil (49.4%). Furthermore, the prevalence was higher than that reported in a study conducted in Mexico (32.2%) [15, 20]. This difference might be due to variations in socioeconomics, study subjects, and study areas as determinants.

The prevalence of OV in this study was also significantly higher than that reported in other studies conducted in Zimbabwe (34% and 61%), Gambia (61%), and South Africa (41%). Additionally, the prevalence was higher than that reported in a study conducted in Nigeria, where it was 43.5% during the 12 months before pregnancy and 28.3% at the time of childbirth [4, 15, 21, 25]. This difference might be due to variations in the study areas, study subjects, and socioeconomic status.

The prevalence of OV in this study was significantly higher than that reported in a study conducted in Cairo, Egypt, where it ranged from 1% to 19%. Additionally, the prevalence was higher than that reported in a study conducted in the northwestern part of Ethiopia, where 58.4% of women reported experiencing OV during pregnancy. Furthermore, the prevalence in this study was almost higher than that reported in previous studies in the northwestern part of Ethiopia (75.1%) [10, 12, 14]. This is also due to differences in the subjects and the behavioral and environmental factors of the study populations.

This study revealed a significant association between the sex of the birth attendant and the risk of experiencing obstetric violence (OV). Women who were assisted by male birth at-

tendants were nearly three times more likely to report experiencing OV than those assisted by female birth attendants were. However, this finding contradicts previous studies conducted in Brazil and the northwestern part of Ethiopia, which did not find a significant association between the sex of the birth attendant and OV [23–27]. Hence, women who are assisted by female birth attendants are less likely to report being subjected to OV. This might be due to factors, such as, training practices, and healthcare system dynamics, which may influence the relationship between birth attendant sex and the risk of OV.

This study revealed a significant association between the number of antenatal care (ANC) visits and the risk of experiencing obstetric violence (OV). Women who had fewer than three ANC visits were 2.994 times more likely to experience OV than those who had completed all recommended ANC visits. This finding is consistent with previous research conducted in Cairo, Egypt, and Jimma town in the Oromia Region of Ethiopia, which also identified a strong association between inadequate ANC and the risk of OV [22, 23]. This might be due to women who had increased ANC follow-up to better understand their right and quality of birth care services. Hence, women who had completed their ANC visit were less likely to be at risk of being subjected to OV.

Another interesting finding of this study was that there was a significant association between the age of the respondents and OV. Thus, women aged >35 years were 2.471 times more likely to be at risk of OV than women aged 15–24 years were. These findings contrast with those of studies performed in the United States and South Africa [17, 26]. This might be because the age of the respondents increased their experience with OV. Younger individuals are more likely to understand their rights during birth care services. Hence, women aged 15–24 years are less likely to be subjected to OV.

This finding also revealed that there is a significant association between the educational status of the respondents and OV. The odds ratio of respondents who had only attended primary school was 2.126 greater for those at risk of OV than

for those who had attended secondary education or above. Accordingly, these findings are consistent with those of studies performed in the northwestern part of Ethiopia and Egypt, Cairo [10, 23]. This could be due to educated women having a better understanding of their rights during birth care services. Thus, HIV positive women who had attended secondary school and above are less likely to be subjected to OV.

5. Conclusions

A study in Addis Ababa reported a high prevalence of obstetric violence among HIV-positive women, including various forms such as lack of informed consent and physical abuse. Factors such as sex, age, education level, and number of antenatal care visits were associated with OV. To address this issue, the study recommends a multipronged approach that includes: educating women about their rights, training healthcare providers on respectful care, involving communities in promoting awareness, and establishing robust monitoring systems. The study concludes that improving the quality of birth care services requires the active involvement of families, communities, the government, and relevant stakeholders.

6. Limitations of the Study

This study faced limitations due to the limited availability of resources directly related to obstetric violence among HIV-positive women. However, relevant information was used to design the study, and the findings provide valuable insights into the prevalence and associated factors of OV in this population. Furthermore, the cross-sectional study design inherently limits the ability to establish causality and identify specific risk factors for OV. Additionally, the findings primarily rely on interviews rather than direct observations. To gain a deeper understanding of this issue, further qualitative research is recommended.

Abbreviations

HIV	Human Immuno Deficiency Virus
OV	Obstetric Violence

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Author Contributions

Anteneh Wondimagegn Assefa: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Visualization, Writing – original draft

Basha Ayele: Conceptualization, Writing – original draft

Seteamlak Adane Masersha: Supervision, Writing – review & editing

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Ethics Approval and Consent to Participate

Ethical approval was obtained from the Woldia University College of Health Science Department's Public Health Research Review Board Committee. Permission was also granted by the Addis Ababa Regional Health Bureau directorate for conducting research in selected public hospitals in Addis Ababa, Ethiopia. All procedures involving human participants were conducted in accordance with the principles outlined in the Declaration of Helsinki. Informed written consent was obtained from each study participant prior to data collection. The participants had the right to decline participation or withdraw from the study at any time. To ensure confidentiality, identifying information was excluded from the questionnaires.

Consent for Publication

Not applicable.

Availability of Data and Materials

The data used in this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The author declares no conflicts of interest.

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