ASSESSMENT OF MAGNITUDE AND FACTORS ASSOCIATED WITH DISRESPECTFUL AND ABUSIVE MATERNITY CARE DURING CHILDBIRTH IN HEALTH FACILITIES IN TABORA MUNICIPALITY

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By

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A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Public Health of Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled; ***Assessment of Magnitude and Factors Associated with Disrespectful and Abusive Maternity Care During Childbirth in Health Facilities in Tabora Municipality,*** in partial fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

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Dr. Tumaini Nyamhanga

(Supervisor)

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Date

DECLARATION AND COPYRIGHT

I**, Phillipina Phillipo,** declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other University for similar or any other degree award.

Signature**……** Date……..

ACKNOWLEDGEMENT

Writing is generally a solitary task which requires peace of mind, time and cooperation of many individuals so as to convert their idea into text.

First, I give glory to Almighty God for protecting, giving me strength and courage throughout the whole course. Without him, I wouldn't have passed through all this difficult period and finally have this document.

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DEDICATION

This work is dedicated with love to my beloved parents, my father *Mr Titus Phillipo* and my late mother *Mrs Zeulia Phillipo* (May her soul rest in peace) for bringing me up and allowing me to attain my education.

ABSTRACT

Background: Despite considerable qualitative evidence reporting disrespectful and abusive (D&A) treatment of women during childbirth in health facilities by health providers, there is limited data regarding the actual prevalence and associated factors from the perspective of both mothers and health workers.

Aim: This study aimed at assessing the magnitude and factors associated with disrespectful and abusive maternity care during childbirth in health facilities as perceived by both mothers and health workers in Tabora Municipality.

Methodology: This is a hospital based cross-sectional descriptive study which involved both mothers and health care workers from two hospitals. Non probability sampling techniques was used. Data collection was done using both quantitative methods through interviewer administered questionnaires and qualitative methods through Focus Group Discussion (FGD) and Key Informant Interview (KII). A total of 263 mothers were interviewed, 4 FGD and 8 KII were conducted. Quantitative data analysis was done using SPSS version 16. Chi - square tests were used to assess the relationship between dependent and independent variables. P – Value of < 0.05 was considered significant. Multivariate logistic regression analysis was employed to explain the association between social demographic variables and disrespectful and abusive maternity care. Thematic analysis was done for qualitative data.

Results: In this study 31.2 % of the interviewed mothers reported having perceived at least one form of disrespectful and abusive maternity care as defined by Bowser and Hill (2010) during health facility childbirth. The types of disrespectful and abusive maternity care included “non-dignified care” (17.9%), “neglect” (11.4%), “non confidential care” (6.1%), “physical abuse” (5.7%), non - consented care and informal payments. Mothers aged < 21 years and those aged 21 -31 years were more likely to be disrespected and abused compared to those aged 32 - 42 years [AOR= 4.30 (1.09 -17.0) ; p =0.04] and [AOR = 3.60(1.10 – 12.03);p- value =0.04] respectively. Factors which contribute to disrespectful and abusive maternity care have been found to be limited accountability mechanisms and staff frustration as a result of heavy workload and poor motivation.

Conclusion: This study has shown that the proportion of the perceived D & A during health facility childbirth in Tabora Municipality is 31.2 %. Also it has highlighted the factors associated with D & A maternity care at health facilities during childbirth. The generated knowledge of the prevalence of D&A and the contextual factors is critical in developing interventions for reduction of maternal mortality and morbidity.

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LIST OF ABBREVIATIONS

AOR	Adjusted Odds Ratio
CI	Confidence Interval
COR	Crude Odds Ratio
D &A	Disrespectful and abusive
EmOC	Emergency Obstetric Care
FGD	Focus Group Discussion
HCW	Health Care Worker
KII	Key Informant Interview
MMR	Maternal Mortality Radio
MDG	Millennium Development Goal
MUHAS	Muhimbili University of Health and Allied Sciences
MoHSW	Ministry Of Health and Social Welfare
NBS	National Bureau of Statistics
OR	Odds Ratio
PHC	Population and Housing Census
RMC	Respectful Maternity Care
SPSS	Statistical Package for Social Sciences
UNFPA	United Nations Family Planning Association
UNICEF	United Nations International Children's Education Fund
USAID	United States Agency for International Development

WHO	World Health Organization
WRA	White Ribbon Alliance

DEFINITIONS OF TERMS

Delivery

This is all activities performed on a pregnant woman by health care workers from the time she is admitted into the antenatal ward in labor up to the time she is discharged from postnatal ward after having delivered vaginally or through cesarean section. This term is also used interchangeably with child birth.

Disrespect and Abuse (D&A)

A range of provider behaviors, such as shouting at, - scolding patients, requesting bribes, threatening to withhold health care, physical abuse, abandonments in times of need, conducting procedures without consent (e.g. pelvic examinations), and detaining mothers or babies at the facility due to failure to pay.

Parity

Is defined as the number of times that the woman has given birth to a fetus with gestation age of 28 weeks or more, regardless of whether the child was born alive or was still born.

CHAPTER ONE: INTRODUCTION

1.1 Background Information

Maternal health refers to the health of woman during pregnancy, childbirth and postpartum period (WHO, 2016). While motherhood is a positive and fulfilling experience, in many women it is associated with suffering, ill-health and even death.

World Health Organization (WHO) defines maternal death as the death of woman while pregnant or within 42 days of termination of pregnancy, irrespective of duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (Wilmoth et al. 2010).

Globally by 2015 Maternal Mortality Radio (MMR) was estimated to be 216 per 100,000 live births. The 2015 annual number of maternal death was estimated to be 303,000 deaths. The approximate global lifetime risk of maternal deaths was 1 in 180. Developing regions accounted for approximately 99% (302 000) of the estimated global maternal deaths in 2015, with Sub-Saharan Africa alone accounting for roughly 66% (201 000). Followed by Southern Asia (66 000) (WHO 2015).

Major direct causes of maternal morbidity and mortality include hemorrhage, infection, high blood pressure, unsafe abortion and obstructed labor (WHO, 2016) .WHO estimates that about 15% of all pregnancies in all countries have one or more complications that require “rapid and skilled obstetric care to prevent death or serious long term morbidity (Nieburg, 2012). Hence it is important for women to give birth in health facilities.

The magnitude and factors determining the utilization of maternal health care services vary by geographic areas, socioeconomic and cultural settings (Ayele et al. 2014). Factors mentioned to hinder delivery in heath facility includes cultural factors, bad attitude of health care providers, bad previous experience with health system, long waiting time, negligence of the health care workers, Presence of alternative delivery services and lack of transport to health facilities (Abugri, 2013).

Tanzania is the 6th among ten countries that account for nearly 59% of global maternal deaths (WHO 2015). According to the 2012 Population and Housing Census (PHC) for the United Republic of Tanzania, the maternal mortality ratio for Tanzania, was estimated at 432 maternal deaths per 100,000 live births (National Bureau of Statistics, 2015). The causes of maternal deaths includes; obstetric hemorrhages, puerperal sepsis, hypertensive disorders and eclampsia, abortion complications and obstructed labor (Pembe et al. 2014, Illah et al. 2013)

Despite high coverage (96 %) of pregnant women who attend at least one antenatal clinic, only half of Tanzania's births (51%) occur in health facilities, primarily in public sector facilities. Home births are more common in rural areas (56%) than urban areas (17%). The major perceived barriers to women access to health care services are lack of money (24%), distance to health facilities (19%), not willing to go alone (11%) while only 2% of women cite obtaining permission as big problem (Tanzania National Bureau of Statistics, 2011).

Although Tanzania has achieved Millennium Development Goal (MDG) 4, progress towards MDG 5 has been slower and the percentage of women who deliver in a facility has stagnated at or below 51% for more than 20 years. The slow decline in maternal mortality is linked to various issues including low utilization and inadequate quality of maternity services. The MOHSW has highlighted the need to "improve access to quality of health services" for mothers, newborns, and children (MoHSW, 2014).

Respectful Maternity Care (RMC) is considered an essential component of quality maternal and newborn health services. WHO 's publication "Quality of Care for pregnant women and newborns – the WHO vision" has three domains which are directly relevant to RMC namely effective and responsive communication, care provided with respect and dignity and emotional support(Tunçalp et al. 2015).

In Tanzania even the 51% of Tanzanian women who access facility childbirth services may experience various forms of disrespectful maternal care including verbal abuse, neglect (abandonment of care), discrimination, non-confidential care, and detention in facilities (Sando et al. 2014, McMahon et al. 2014,M. Kruk et al. 2014).

Respectful Maternity Care (RMC) focuses on the interpersonal interaction that a woman encounters during labor, delivery, postpartum. While RMC primarily emphasizes the absence of disrespect and abuse by health care providers and other staffs, its definition also advocates positive and supportive staff attitudes and behaviors that increase woman's satisfaction with her birth experience(Hastings, 2015).

Disrespectful and abusive maternity care during childbirth in health facilities covers a range of provider behaviors, such as shouting or scolding at patients, requesting bribes, threatening to withhold health care, physical abuse, abandonments in times of need, conducting procedures without consent and detaining mothers or babies at the facility due to failure to pay. (Columbia,University 2015).

While it is likely that disrespectful and abusive maternity care during childbirth in health facilities is sometimes normalized depending on the specific setting, many maternal health stakeholders agree that it represent important causes of suffering for women, a barrier to skilled care utilization and often a violation of women's human rights(Bowser & Hill, 2010).Due to the bad effects of disrespectful and abusive maternity to skilled birth care utilization, more evidence based control intervention are needed are needed in order to reduce maternal mortality.

According to Merriam Webster English dictionary (2015), the word abuse is as treating a person or an animal in a harsh or harmful way that causes damage(Merriam Webster, 2015a). Additionally it also means physical maltreatment or using something or someone in a way that causes damage. Likewise the word disrespect is defined as speech or behavior which shows something or someone is not valued and important and may include the use of impolite, offensive, and insulting language (Merriam Webster, 2015b).

From the above dictionary definitions abuse has an element of physical contact while disrespect occurs mainly through speech and attitude. In this research Disrespect and abuse will be taken as one measurable perspective. This poses problems because currently there is no single agreed definition of the construct meaning thus researchers could be measuring different things.

Likewise, Freedman & Kruk (2014) views disrespect and abuse as health system lacking accountability to the women it is supposed to serve and that it is a sign of health system crisis. In this definition disrespect and abuse goes above the individual health care provider and involves the wider social structure that creates a conducive environment for it to occur(Freedman & Kruk 2014).Just as there is no agreed definition of D & A, there is no agreement about what acts constitutes D & A.

For the construct Abuse in Healthcare used in Nordic countries three categories are used: mild abuse, moderate abuse and severe abuse. However, details of specific types of abuses experienced by clients are not included meaning that the scale depends on the perception rather than actual acts. The classifications do not appear to capture all the dimensions of the disrespect and abuse of women during facility delivery construct (Brüggemann et al. 2012).

It is apparent that the many definitions and types of D & A may introduce differences when it comes to measurement. This study will define D& A of women when comes to measurement. In this study D & A of women during facility based delivery will be defined as a range of provider behaviors, such as shouting at scolding patients, requesting bribes, threatening to withhold health care, physical abuse, abandonments in times of need and conducting procedures without consent for example pelvic examinations(Columbia University, 2015).

In order to make this definition operational, the seven categories of D & A as suggested Bowser & Hill in their landscape analysis(Bowser & Hill, 2010) will be used.

1.2 Problem Statement

Low delivery in health facilities is a challenge in developing countries in which higher number of women attend antenatal clinic but still they deliver at home without assistance of skilled health professionals (Samson, 2012). This leads to high maternal mortality and morbidity therefore proper intervention must be taken to increase number of delivery in health facilities.

In Tanzania 96% women receive antenatal care (ANC) from a skilled provider at least once, however about 50 % of births occur in health facilities (Tanzania National Bureau of Statistics, 2011).

Factors affecting delivery in health facilities includes socio demographic factors, socio economic factors, availability of health services, accessibility of health services, behavior and attitudes of health care providers and socio cultural issues (Samson, 2012).

Evidence suggests that in countries with high maternal mortality, the fear of disrespect and abuse that women encounter in facility – based maternity care is more powerful deterrent to the use of skilled care than commonly recognized barriers, such as cost or distance. However many maternal death reduction interventions aim to improve access to skilled birth care than the respect to mothers by caregivers during maternity care (White Ribbon Alliance, 2015).

In Tanzania studies have shown the nature of disrespectful and abusive maternity care during health facilities childbirth to vary in different areas. Its prevalence in Tanga and Temeke has been found to be 19.5% and 12.2% respectively (Kruk et al. 2014, Sando et al. 2014)

Studies conducted from mothers' perspectives have shown that; the factors for disrespectful and abusive maternity care during health facility childbirth includes low maternal parity, being unmarried woman, low social economic status, low level of education and bad provider attitude to women. Its manifestation are feeling ignored , discrimination, unpredictable financial charges, fear of detention, verbal and physical abuse.(McMahon et al. 2014, Kruk et al. 2014)

However the magnitude and factors associated with disrespectful and abusive maternity care during childbirth in health facilities have not been explored from both mothers and health care workers perspectives.

Therefore this study will assess the magnitude and factors associated with disrespectful and abusive maternity care during childbirth in health facilities as perceived by both mothers and health workers in Tabora Municipality.

1.3 Conceptual Framework on the Factors for Disrespectful and Abusive Maternity Care

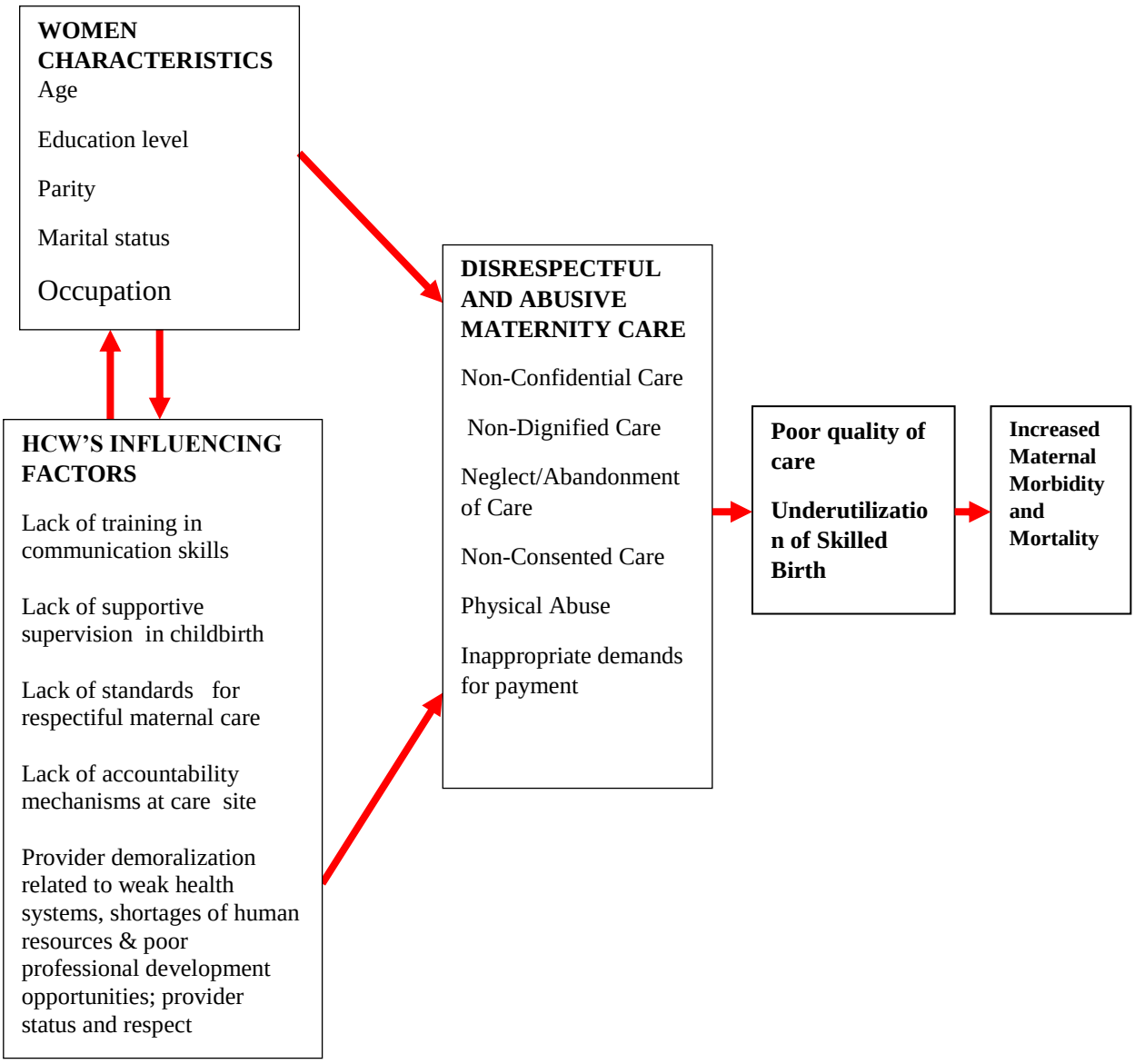

Figure 1: Conceptual Framework that illustrates the Types and Factors for Disrespectful and Abusive Maternity Care in Tabora Municipality

Source: Author 2016

On the left side of the framework are characteristics of women that can predispose them to be disrespected and health care workers factors that can influence them to disrespect women. Women characteristics and health workers factor do influence each other. On one hand, women with higher parity will be more likely to encounter disrespectful and abusive maternity care than those with low parity. Probably because health care workers assume that they are well prepared as they have birth experiences. Also women married women are less likely to be detained for lack of payment, bribed or neglected as compared to those who are single as they lack support (Abuya et al. 2015).

Additionally, adolescent pregnant women have increased risk of disrespectful and abusive maternity care because of health care workers assumption of moral stance. They judge girls and in their opinion they should not have became pregnant at their age. Their risks increases further due to existing risks of complications such as prolonged labor (Makumi, 2015).

Moreover, women with higher education are less likely to be disrespected than those who are not because they are aware of their rights. Likewise those with better occupation are less likely to be disrespected compared to those who are not (Kruk et al. 2014).

On the other hand, provider demoralization related to weak health systems, shortages of human resources & poor professional development opportunities are common causes of stress to health care workers that affect their interaction with clients causing them to disrespect and abuse women during childbirth (Holmes & Goldstein, 2012).

Furthermore, lack of training in communication skills ,lack of supportive supervision in childbirth ,lack of standards for respectiful maternal care and lack of accountability mechanisms at care site are the health sysytem factors that providde a chance for health workers to disrespect women during health facility childbirth (Mannava et al. 2015).

Finally, the interaction of women's characteristics and health workers factors may lead to different forms of disrespectful and abusive maternity care which can lead to poor quality of care and low utilization of skilled birth services. The eventual outcome is likely to be

increased maternal morbidity and mortality - as it has been illustrated on the right side of the above diagram.

1.4 Study Rationale

This study will contribute to develop evidence based interventions which can be implemented to increase the utilization of maternal health services and skilled birth attendance which subsequently will contribute in reduction of maternal death and improvement of health services in the long run in Tabora municipal.

1.5 Research Questions

1.5.1 Main Research Question

What is the magnitude and factors associated with disrespectful and abusive maternity care during childbirth in health facilities as perceived by mothers and health workers in Tabora Municipality?

1.5.2 Sub Research Questions

1. What is the proportion of disrespectful and abusive maternity care as perceived by mothers during childbirth in health facilities?
2. What are the types of disrespectful and abusive maternity care perceived by mothers during childbirth in health facilities?
3. What is the relationship between socio – demographic characteristics of mothers and disrespectful and abusive maternity care during childbirth in health facilities?
4. What are the factors that contribute to disrespectful and abusive maternity care during childbirth in health facilities from both mothers and HCW’s perspectives?

1.6 Objectives

1.6.1 Broad Objective

To assess the magnitude and factors associated with disrespectful and abusive maternity care during childbirth in health facilities as perceived by mothers and health workers in Tabora Municipality.

1.6.2 Specific Objectives

1. To determine the proportion of disrespectful and abusive maternity care as perceived by mothers during childbirth in health facilities.
2. To identify the types of disrespectful and abusive maternity care perceived by mothers during childbirth in health facilities.
3. To determine the relationship between socio – demographic characteristics of mothers and disrespectful and abusive maternity care during childbirth in health facilities.
4. To explore the factors that contributes to disrespectful and abusive maternity care during childbirth in health facilities from both mothers and HCW's perspectives.

CHAPTER TWO: LITERATURE REVIEW

2.1 Prevalence of Disrespectful and Abusive maternity care during Health Facilities Childbirth

Information on disrespectful and abusive maternity care during childbirth in health facilities are limited and especially data on global prevalence (Makumi, 2015). A systematic review of mistreatment of women during childbirth in health facilities has been published by Bohren at al. They applied mixed methods of Systematic Review of Mistreatment and reviewed 65 studies that met pre-defined criteria. It was revealed that majority of studies published to date continue to be qualitative and descriptive with limited measures of prevalence or evaluation of interventions to reduce D&A. Approximately two-thirds of the reviewed articles were published after the 2010 USAID-founded Landscape Analysis of Disrespect and Abuse in Childbirth(Bowser & Hill, 2010). Only three of the 65 studies included in the systematic review are quantitative studies that include a measure of prevalence of D&A (Kruk, Sando, Okafo.) (Bohren et al. 2015).

In a community-based cross sectional survey conducted in women who had delivered in the past one year at a health facility from two rural blocks of Varanasi district, Uttar Pradesh India the 28.8% women reported facing any form of disrespectful and abusive treatment during facility-based childbirth(Bhattacharya, 2015) while in another community based cross sectional study carried out by interviewing women who had government facility based child birth in last one year residing in urban slum area of Ahmedabad Gujarat, India 57.7% of respondents reported at least one form of form of disrespectful and abusive treatment during childbirth in health facilities (Patel et al. 2015).

The study conducted to explore mistreatment in a teaching hospital in southeastern Nigeria, basing on interviewing a convenience sample of women accessing newborn services at an immunization clinic revealed that almost all (98%) of the women reported at least one kind of mistreatment during childbirth (Okafor et al. 2015). On the other hand in the Kenyan study based on exit interview from health facility, 20% of the women reported any form of disrespect and abuse during facility based delivery (Abuya et al. 2015). While in another

Kenyan community survey carried out in Uringu Division, Meru Country to investigate prevalence of disrespectful maternal care during child birth in Uringu Division, 71.9% of women reported having experienced at least one form of disrespectful and abusive treatment during facility based childbirth (Makumi, 2015).

A cross-sectional study was undertaken in four health facilities (one specialized teaching hospital and its three catchment health centers) in Addis Ababa, Ethiopia, to quantitatively determine the level and types of disrespect and abuse faced by women during facility-based childbirth, along with their subjective experiences of disrespect and abuse. Among multigravida mothers 71.8% had a history of a previous institutional birth and 78% of respondents experienced one or more categories of disrespect and abuse (Asefa & Bekele, 2015).

The prevalence of Disrespectful and Abuse during childbirth in maternity units in Tanzania closely approximates the Kenyan scenario. In a facility and community survey carried in rural Tanzania, which based on women's self-reported experiences during a facility exit survey and during a follow-up survey with a sub-sample of the same omen 5 to 10 weeks postpartum; 19.5% of women in the exit sample and 28.2% in the follow-up sample reported having experienced at least one form of disrespect and abuse (Kruk et al. 2014).

Another study was conducted to explore whether women living with HIV were more vulnerable to mistreatment during childbirth in Dar es Salaam, Tanzania, basing on interviews with women at 3 to 6 hours postpartum and direct observation of labor. In this study the proportion of women who reported experiencing any form of mistreatment was 12.2% in HIV-positive women and 15.0% in HIV-negative women (Sando et al. 2014).

In all the studies, the prevalence of disrespectful and abusive during facility based childbirth is likely to be an underestimate. In the study conducted in Tanga, the prevalence of women reporting disrespectful and abusive maternity care during facility based child birth increased from 19% to 28% when they were interviewed in the community five to ten weeks after hospital exit interview. Also in Kenya the exit and community interview were 20% and 71.9% respectively. This has been attributed to courtesy bias where women tend not to report

disrespectful maternity care while still in the health facility (Kruk et al. 2014, Abuya et al. 2015,Makumi, 2015).

2.2 Types of Disrespectful and Abusive maternity care during health facility based childbirth

In a community-based cross sectional survey conducted in India the reported types of disrespectful and abusive treatment during health facility based childbirth were: non-dignified care including verbal abuse (19.3%); physical abuse (13.4%); neglect or abandonment (8.5%); non-confidential care (5.6%); and feeling humiliation due to the lack of cleanliness bordering on fifth (4.9%) (Bhattacharya, 2015) while in another community based cross sectional study carried out by interviewing women who had government facility based child birth in last one year residing in urban slum area of Ahmedabad Gujarat, India non-consented services (57.3%) and verbal abuse (55%) were the most common types of disrespectful maternal care reported (Patel et al. 2015).

A study to explore mistreatment among women during childbirth in teaching hospital in southeastern Nigeria reported 35.7% of women were physically abused including being "restrained or tied down during labor"(17.3%) and being "beaten, slapped, or pinched"(7.2%); being "sexually abused by the health worker" was reported by 2.0% of the women (Okafor et al. 2015). On the other hand the study in Kenya reported the categories of disrespectful maternal care actions to be as follows non confidential care 8.5%, non-dignified care 18%, abandonment 14.3%, non consented care 4.3%, physical abuse 4.2% and detention for nonpayment was 8.1%(Abuya et al. 2015) while in another Kenyan community survey carried out in Uringu division, Meru county most frequent types of disrespectful maternal care were; denial of companionship during labor 73%, vaginal examinations without consent 56% and episiotomies without consent 38%(Makumi, 2015).

Another cross-sectional study conducted in Ethiopia showed that there was violation of the right to information, informed consent, and choice/preference of position during childbirth to all women who give birth in the hospital and 89.4% of respondents in health centers. Mothers

were left without attention during labor in 39.3% of cases. Also 78.6% of respondents objectively faced disrespectful maternal care and 16.2% subjectively experienced disrespectful maternal care(Asefa & Bekele, 2015).

According to the study conducted in Tanga common specific experiences of disrespectful and abusive treatment during health facility based childbirth included “non-dignified care” (facility exit survey: 8.7%, follow-up survey: 13.8%), “neglect” (facility exit survey: 8.5%, follow-up survey: 15.5%), and “physical abuse” (facility exit survey: 2.9% follow-up-survey: 5.1%(Kruk et al. 2014).

The direct observations of labor in a study conducted to explore whether women living with HIV were more vulnerable to mistreatment during childbirth in Dar-es-salaam, Tanzania recorded the following types of mistreatment: “partitions did not provide privacy” to women were not asked for consent during vaginal examination”(HIV-positive women: 100.0% , HIV-negative women: 79.8%); “women’s legs tied” during delivery was rarely noted (HIV-positive women: 0.0%, HIV-negative women: 3.3%(Sando et al. 2014).

2.3 Factors for disrespectful and abusive maternity care during health facility based childbirth

While the types of disrespectful and abusive maternity care vary, it is not clear whether violations are caused by partitioned behavior or by systemic failures. For example, if staff abandons a woman during childbirth, it could be due to health providers’ disregard of her needs, or it could be a result of poor client-to-provider ratio. Other abuses are easier to classify. Placing multiple women in one bed is generally a failure of the health system to provide sufficient beds, while physical and verbal abuse is a behavioral failure. However, the researchers has noted that provider behavior can also be heavily influenced by the health system, as poor staffing, pay, and schedules create a stressful environment that can undermine respectful care(Hastings, 2015).

In a Kenyan study it was found that women between 20 and 29 years old were less likely to experience non-confidential care compared to those under 19 years of age; OR:[0.6 95% CI

(0.36,0.90); p = 0.017]. Clients with no companion during delivery were less likely to experience inappropriate demands of payment; OR: [0.49(0.26,0.95); p = 0.037] while women of higher parity were three times more likely to be detained for lack of payment and five times more likely to be requested for a bribe compared to those who had just given birth to their first child.(Abuya et al. 2015).

The level of education is also associated with disrespectful maternal care. In a facility and community survey carried in rural Tanzania, in the follow-up sample women with secondary education were more likely to report abusive treatment [OR:1.48 , CI :1.10 - 1.98] as were poor women [OR :1.80 CI : 1.31 -2.47] (Kruk et al. 2014). This can be explained by the fact that the educated women are more aware of their rights compared to those who are not.

2.4 Factors influencing the health workers' disrespectful treatment towards women during health facility childbirth

In a landscape analysis of evidence for disrespectful maternal care in facility-based childbirth by Bowser and Hill's (2010) the factors influencing the healthcare worker to disrespect women during facility childbirth includes; healthcare worker prejudice, healthcare worker distancing from patients as result of training, healthcare worker demoralization related to weak health systems, shortage of human resources and professional development opportunities and health care worker assuming to have high status and respect as compared to women(Bowser & Hill, 2010).

The review of evidence and experiences in relation to the attitudes and behaviors of maternal health care providers identified factors influencing health care providers disrespect women during facility childbirth such as lack of training in communication skills among providers, poor working conditions, lack of supportive supervision, gender inequality and discrimination, fear of occupation exposure to infection, difficult in reconciling clinical practice with cultural traditions and health providers desire to guard class boundaries(Holmes & Goldstein, 2012).

The brief report of the Kenyan Heshima project which was based on confronting disrespectful maternal care showed the following causes for health care workers to disrespect women; lack

of understanding of clients rights, poor working conditions, shortage of staffs leading to high stress, poor supervision and weak implementation of standard and quality care guidelines(Population Council, 2014).

In another systematic review on attitudes and behaviors of maternal health care providers in interactions with clients the factors identified included; provider belief that they are of higher status, provider frustration with patients behaviors, patients not complying the medical advice and differences in cultural understanding on the knowledge of giving birth between providers and patients (Mannava et al. 2015).

2.5 Summary of Literature Review

Although the literature on disrespectful and abusive maternity care of women during facility based childbirth is limited, available evidence-both qualitative and quantitative-shows that it is a prevalent phenomenon with many negative consequences. It is present all over the world and cross all socio-economic groups but its prevalence appears to be higher in developing countries and particularly in Sub-Saharan Africa and South Asia. These same regions are noted to have the highest maternal and neonatal mortality and low utilization of skilled maternity services.

In Tanzania, studies that established prevalence of disrespectful and abusive maternity care were conducted in Tanga (19%) and Dar es Salaam (15%). These studies were not nationally representative and the prevalence is likely to be higher since women tend to normalize disrespectful and abusive maternity care and many choose to suffer in silence.

In the absence of a nationally representative study, then regional studies using the same approach are required in order to understand local disrespectful maternal care prevalence and how it affects maternity service utilization. It is for this reason that a study will be done in Tabora Municipality to assess the magnitude and factors for disrespectful and abusive maternity care.

CHAPTER THREE: METHODOLOGY

3.1 Study area

The study was conducted within health facilities in Tabora Municipality. Tabora Municipality is among the eight (8) districts of Tabora region. It is located at the Tabora region in the Western part of Tanzania. It lies between latitudes $4^0$52' and $5^0$09' south and between longitudes $32^0$39' and $33^0$00' east.

According to National Census of 2012, the District population was estimated to be 355,619 in 2015(NBS 2012), with annual growing rate of 2.36%. The district has 2 divisions, 29 wards, 41 villages and 137 hamlets, which are jurisdiction area covering 1092.26 square kilometers.

The district has 43 health facilities (3 hospitals, 2 health Centers, 37 dispensaries and 1 maternity waiting home. In year 2015 maternal mortality rate was 287/ 100,000 live births. In this study two hospitals were purposively selected (those with high number of deliveries).

Tabora Municipality was selected purposively for this study because of existence of the gap among regions in health facilities delivery and Tabora region being among the regions with low health facility deliveries in Tanzania mainland (Tanzania National Bureau of Statistics, 2011). This has necessitated the need to find out factors that have to be considered significant to improve delivery in health facilities in this region particularly in Tabora Municipal Council.

3.2 Study design

The design was cross sectional study.

3.3 Study population

The study population were mothers who had delivered in selected hospitals during the study period and Health care workers (Clinicians and Nurses) working in maternity section in selected hospitals during the study period.

3.4 Sample Size Determination

Single population proportion formula was used to estimate the sample size of mothers who had delivered in health facilities with assumptions of 5% maximum likely error, 95% confidence, and a 10% non-response rate. An assumption that 19% of delivered mothers would face at least one form of disrespectful maternal care during childbirth was taken(Kruk et al. 2014).

The sample size for the recent delivered mothers was obtained by the following formula;

$$n = \frac{Z^2 p(100-p)}{\varepsilon^2}$$

Where

n = Total number of facility delivered mothers required in the sample

P = Proportion of disrespect among mothers delivering in health facilities in the district which was estimated at 19% in Tanga (Kruk et al. 2014).

Z = A standardized normal deviate value that correspond to a level of statistical significance equal to 1.96 set up at the level of 95% confidence interval.

$\varepsilon =$ Maximum likely error was estimated at 5%.

$$n = \frac{(1.96)^2 0.19(1-0.19)}{(0.05)^2}$$

$$n = 236$$

Using the above formula, the estimated sample size of the study were 236 recent health facility delivered women. Due to non-respondence of ten percent of calculated sample size was adjusted as follows:

$$n = \frac{236 \times 1}{R}$$ where R is the Response Rate = 90%

$$n = \frac{236 \times 1}{0.9}$$

$$= 263$$

Therefore the minimum number of health facility delivered mothers recruited for the study was 263 women.

The allocation of the sample to health facilities was made proportionately basing on the number of mothers who has received delivery services at each facility in the month preceding the data collection period by using the formula;

$$n = \frac{\text{Number of deliveries in a selected health facility in previous month before data study}}{\text{Number of deliveries in all selected health facilities in previous month before study}} \times 263$$

Where n = Number of women to be taken as a sample in each selected health facility

The selected hospital had a total delivery of 497 deliveries for month June 2016 where one had 60 deliveries and the other 437 deliveries. So the sample sizes for each hospital were 32 and 231 mothers respectively.

The sample size of clinicians, nurses and mothers who participated in focus group discussion was based on saturation principle that is data collection was stopped at the point saturation (the point in data collection when no new data and data collected no longer bring additional insights to the research question) of the collected information. In this study 5 nurses and 3 clinicians were selected. For FGD 24 mothers were recruited.

3.4.1 Inclusion criteria

- Mothers who had given birth in the selected health facilities during the study period.
- Health care workers working in maternity section in selected facilities during the study period.

3.4.2 Exclusion criteria

- Mothers who are health care workers by profession and gave birth in selected health facilities during the study period because it is likely that health care workers will be treated well with their fellows.

3.5 Sampling Technique

This study used non probability techniques to obtain the estimated sample size. Tabora Municipality was selected purposively.

Two hospitals were purposively selected (those with high number of deliveries) in Tabora Municipal.

At the selected facility women were conveniently selected i.e. all women who met the required criteria and conveniently found were recruited for exit interview until the required sample size for that facility was reached. Participants for focus group discussion were purposively selected from reproductive and child health clinic using community health workers.

Before conduction of the interview to mothers the researcher obtained the list of women who have been discharged from ward supervisor so that she can identify the women who are eligible for interview. Then the women were approached and asked for their permission to be interviewed. Those who agreed were interviewed within the health facility compound in a private place. They were given numbers so that they can be called one after another.

Stratified purposive sampling was employed in obtaining clinicians and nurses. They were purposively chosen from maternity section in selected hospitals. A list of nurses and clinicians which showed how long they have practiced in maternity section was separately prepared in each selected hospital. Then they were chosen basing on the experience in maternity section. In this case both nurses and clinicians with high experience (those have been working in the maternity section for one year and above) and those with low experience (those who have been working in maternity section for less than one year) were chosen. It helped to get a better understanding of their perception in disrespectful and abusive maternity care until the saturation point was reached.

3.6 Data Collection tools

In order to answer the research questions both qualitative and quantitative methods were used**.**

In quantitative approach, an interview administered questionnaire with semi structured questions i.e. consisting of closed and open ended questions was prepared in English and then translated into Kiswahili version. It was used in conducting exit interviews to women who have been discharged from the postnatal ward in order to capture information on socio demographic characteristics of these women, their disrespectful experiences and its factors.

In qualitative approach, an English version Key Informant Interview (KII) guide questions and a Focus Group Discussion (FGD) guide questions were prepared and then translated into Kiswahili version which was used in guiding the KII of the selected health care workers and FGD of the selected mothers. The guides comprised of unstructured questions that captured information on factors that contributes to disrespectful and abusive maternity care during childbirth in health facilities from both mothers and HCW's perspectives. The tape recorder was used to record the information during KII and FGD conduction. A field notebook was also used to in monitoring and recording emerging themes.

3.7 Variables

3.7.1 Dependent Variables

Perceived disrespectful and abusive maternity care during health facility childbirth among women was the dependent variable. It was measured as the proportion of women who had perceived one or more forms of disrespectful and abusive maternity care which were categorized as non-confidential care, non-dignified care, neglect, non-consented care, physical abuse and inappropriate demands for payment during giving birth in selected facilities.

3.7.2 Independent Variables

The independent variables in this study included;

- Age of mothers
- Education level of mothers

- Parity of mothers
- Marital status of mothers
- Occupation of mothers

3.8 Recruitment and Training of Research Assistants

Two research assistants were recruited and trained by the researcher for 2 days on how to use the research instrument and the easier way to collect data from respondents. The research assistants were selected basing on knowledge on social sciences and previous experience in similar research.

3.9 Pre Testing of Tools

The Kiswahili version questionnaire was pre tested in the field to know if it will be clearly understood by the respondents. No corrections aroused. The questionnaire was pretested on conveniently selected sample of 27 mothers.

Prior to the conduction of KII and FGD the tape recorder was checked for its function ability.

3.10 Data Collection Procedures

Mothers were interviewed by the research assistant for approximately 20 minutes in a private separate area but within the health facility compound.

Health care workers were interviewed by the principal investigator and one research assistant in a private separate area within the facility compound for approximately 30 minutes.

The Focus Group Discussions were conducted by the principal investigator and one research assistant in private area away from the facility compound for approximately 1 hour.

3.10.1 Measurement

Perceived disrespectful and Abuse during facility based childbirth was measured by asking women whether they had perceived specific events during giving birth at the facility. Questions were basing on the disrespectful and Abusive maternity care categories as defined

by Bowser and Hill (Bowser & Hill, 2010) and they were further adapted for Tanzania context by removing the items that are not be applicable in Tanzanian setting e.g. removing the discrimination item which explains that the service being provided according to race. The categories were reworked as non-confidential care, non-dignified care, neglect, non-consented care, physical abuse and inappropriate demands for payment.

Table 1: Categories and events of Disrespectful and Abusive Maternity Care

NO	CATEGORY	EXAMPLES OF MOTHERS EXPERIENCES
1	Non confidential care	Treated in a way that violated privacy and/or confidentiality
2	Non-dignified care	HW said/used a facial expression that made you feel uncomfortable
3	Neglect/ Abandonment	Left unattended when needed help Requests for pain relief ignored
4	Non-consented care	Treatment given without permission
5	Physically abused	Slap, pinch, push, beat, poke
6	Inappropriate demands for payment	Request for a bribe for services

The items in the questionnaires were threatening comments or negative or discouraging comments shouting/scolding; body seen by others; request or suggestion for bribes or informal payments for better care; threatening to withhold treatment; ignored or abandoned by health worker when in need; delivered alone; non-consent for pelvic examination; hitting, slapping, pushing, pinching or otherwise beaten by the health worker.

Although some of the items overlap in meaning (e.g. shouting and negative comments), they helped to gain greater specificity in understanding the women's experience; thus, multiple responses may represent a single disrespectful category incidence. Responses to each question was categorized as 'yes', 'no' or 'don't know'.

Mothers were also asked if they perceive the events mentioned in the questions as being definitely D & A, somewhat D&A, not D & A and if they don't know whether it is D & A or not in order to establish their perception towards actions done by health care workers. Mother were considered to have perceived D & A if they answer definitely D & A or somewhat D&A.

A participant was labeled as having perceived disrespectful and abusive maternity care during health facility childbirth if she answered 'yes' and perceive the named questions as D & A to one or more of the questions. The item of disrespect and abusive for a mother was filled in the questionnaire after coming from the field by checking if the participant has answered yes and perceive it as D & A.

3.11 Data Management

Data were collected on daily basis from morning to evening including weekends until the number required in each facility was obtained. The researcher was supervising the research assistants to see if they follow standards. On daily bases the researcher was counterchecking for accuracy and completeness of the filled questionnaire and all completed questionnaire were given number after completing the work. Only questionnaires that were properly and completely filled were used. Data entry after finishing data collection activity was done using Statistical Package for Social Sciences (SPSS) version 16. Frequencies were run to check for missing data and corrections in the entered data were made.

Data generated from KII and FGD were daily cleaned, verified and checked for quality and consistency, sorted and organized carefully. The interview guide was labeled to identify code numbers of interviewee identification number for the informants. Identification of informants included; age, sex, job title, education level, duration of stay in the job title and name of the facility. Characteristics of FGD participants such as age and parity were recorded. Transcription was done concurrently with data collection. Transcripts were typed into computer files using Microsoft word 2007. The computer files were given serial numbers and location based on the date of the interview.

Questionnaires and recorded tapes were stored safely in the data storage box while the soft copy data were stored in laptop computer and backup in flash disk.

3.12 Data analysis

Quantitative data analysis was done using Statistical Package for Social Sciences (SPSS) version 16. Frequencies of different categories of disrespectful and abusive maternity care were reported in tables. Chi - square tests were used to assess the statistical significance of the association between dependent and independent variables. Bivariate and multivariate logistic regression analyses were employed to explain the association between social demographic variables and disrespectful and abusive maternity care. Factors associated with perceived disrespectful and abusive maternity care was generated from this regression. After bivariate logistic regression variables with p – value of ≤ 0.2 were then entered in multiple regression model. Association between independent and dependent variable was considered significant if p-value is less than 0.05.

Qualitative data were analyzed by using thematic analysis approach. The process of analysis in thematic approach involves five phases were used in analysis of the findings(Guest & Namey, 2012).

Phase 1: Familiarizing with data after completing data collection. Data recorded during the field were transcribed verbally in written form. The researcher did read and re - read the notes so as to make her to be familiar with the data and to get the general idea. In addition, non verbal utterances noted during interview were drawn upon in order to get a richer understanding of the meaning of data(Guest & Namey, 2012) .

Phase 2: Generating initial codes. The Principle investigator and Research assistants created start list and initial codes where by data reduction was done. Codes helped to identify the future data that appears to be interesting and to get the meaning of the data. Coding involved going back and forth between phases of data analysis as needed until the researcher was satisfied with the final themes. The researcher strived to refine codes by adding, subtracting, combining or splitting potential codes. Start codes were produced through terminology used

by participants during the interview and were used as reference point of their experience during interview. Dependability was increased when the researcher used concrete codes that were based on dialogue were descriptive in nature. These codes facilitated the researcher ability to locate pieces of data later in the process and identified why they included them. Initial coding set the stage for detailed analysis later by allowing the researcher to reorganize the data according to the ideas that have been obtained throughout the process (Saldana, 2013).

Phase 3: Searching for themes. Themes are sentences of phrases that identify what data means. The themes were developed through examination and interpretation of codes. It involved noticing similarities, differences and patterns among codes.

Phase 4: Reviewing themes. A broader meaning of the data was obtained by examining relationships among the identified themes. At this point, some identified themes collapsed into each other; other themes were condensed into smaller units. Connection between overlapping themes served as important sources of information on the possibility of new pattern. By the end of this phase, the researcher had an idea of what themes are and how they fit together so that they will convey a story about participants' perception on disrespect and abusive maternity care.

Phase 5: Presenting the result. The identified themes were used to guide in writing of concise and logical account of participants' perception on disrespect and abusive maternity care. The summarized information and relevant quote(s) connected with each theme will be presented in chapter four.

3.13 Validity and Reliability

To ensure that the questionnaire measured what it was designed to measure, its validity was checked. Comparison test of the research topic and the specific objectives was done. This made sure that it measured disrespect and abuse of mothers during health facility childbirth. The questionnaire was administered to a sample of 27 mothers conveniently selected in one hospital among the two.

To increase reliability of the result the research assistants were selected from amongst social sciences skilled personnel. They were trained on the administration of the interview in local language (Kiswahili) to minimize errors due to presentation.

Trustworthiness of qualitative data was accomplished in four aspects.

Conformability which has to do with the collected data whether they are real and not produced by the researcher being biased was achieved by recording interview and note taking. Steps were taken to help ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher.

Credibility that is the ability of the study to capture what the research really aimed at studying was achieved by providing rich information related to the study. Suitable participants were identified and they were given description before the interview. Also they were asked for the rapport to increase willingness to participate and give information. The interviews were recorded and notes taken to ensure that information provided was not missed.

Dependability refers to getting the same findings if the research is repeated in the same context with the same subjects. That is, assessment of the quality of the integrated processes of data collection and analysis. In addressing the issue of reliability, different techniques were employed to show that, if the work was repeated, in the same context, with the same methods and with the same participants, similar result would be obtained. Thus, the research design was viewed as a prototype, that is, research design and its implementation, describing what was planned and executed and the operational detail of data gathering, addressing the minuet of what was done in the field like non – verbal cues of participants which were noted and followed up by researcher during the interview to enrich the process.

Transferability refers to the degree which result of the study can be applied to a setting or sample other the one studied, that is applicability of result to other subjects and other context. It was achieved through describing study settings and participants.

3.14 Ethical consideration

Research clearance was sought from institutional review board (IRB) of Muhimbili University of Health and Allied Sciences. Permission was also granted from the Municipal Executive Director and Respective Facility Management.

During field work, Swahili summary information about the study was given out, explaining why the study was carried out, by whom, and what it involves. Women and health workers were asked for consent to be interviewed with assurance of no retribution for not participating. Those unwilling to participate were excluded to participate. Confidentiality of all study participants was assured. Everybody was informed that no names or direct indication made to the questionnaire except numerical identification.

All questionnaires and tapes which were given to research assistant were counted and signed by the principle investigator at the back for easy identification as original copies. The research assistant was returning the questionnaires and tapes to principal investigator daily. Upon their receipt they were counted and checked. To ensure maximum security of data they were stored safely in the data storage box whose access was limited to principal investigator. Also the soft copy data were stored in principal investigator's computer and backup in her flash disk. At the end of this study, all the study materials were placed in a box, well secured and handed over to the supervisor for safe storage until a safe disposal will be performed.

3.15 Dissemination of the research findings

The final dissertation report was submitted to MUHAS for evaluation. It will be available in the medical library of MUHAS. All attempts will be made to bring the findings to the notice of policy makers by publishing the findings in peer review journals, and presenting in scientific meetings and conferences.

The findings from the study were also discussed with municipal medical officer of Tabora Municipality and the in - charges of the selected health facilities.

CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter presents major findings of this study. It consists of five main sections, which are socio – demographic characteristics of participants, the results of the proportion and specific types of disrespectful and abusive maternity care as perceived by mothers during childbirth in health facilities. It also presents the relationship between socio – demographic characteristics of mothers and disrespectful and abusive maternity care during childbirth in health facilities and the factors that contributes to disrespectful and abusive maternity care during childbirth from both mothers and health care workers' perspectives.

4.2 Socio – demographic characteristics of participants

This study included 263 mothers and 4 health care workers. Majority (51%) of the mothers who participated in face to face interview were aged between 21 and 31 years, 61.2 % had attained primary level of education while 85.2% were married. Their main occupation was farming (47.9 %) and others were housewives (22.80%) and remaining (29.3%) were employed in formal and non formal sectors. In terms of the mothers' parity 40.7 % had one child, 28.1 % had 2 -3 children, 18.3 % had 4 – 5 children and 12.9 had more than 5 children.

Table 2: Socio – demographic characteristics of participants

Characteristics (n=263)	**Frequency (%)**
Age(years)	
20 and below	83(31.6%)
21-31	134(51.0%)
32-42	46(17.5%)
Level of Education	
No formal education	53 (20.2%)
Primary	161(61.2%)
Secondary	35(13.3%)
College	14(5.3%)
Marital Status	
Married	224(85.2%)
Not married	39(14.8%)
Occupation	
House wife	60(22.8%)
Farmer	126(47.9%)
Others	77(29.3%)
Parity	
1child	107(40.7%)
2 -3 Children	74(28.1%)
4 – 5 Children	48(18.3%)
> 5 Children	34(12.9%)

4.3 Proportion of disrespectful and abusive maternity care as perceived by mothers during childbirth in health facilities

Out of 263 respondents interviewed 37.3% reported having experienced at least one form of specific events during giving birth at the facility – which are categorized as disrespectful and abusive maternity care, as defined by Bowser and Hill (2010) .Upon asking them whether they themselves perceive the events they experienced during childbirth as D & A, 31.2 % perceived those events as D&A during health facility childbirth.

4.4 Specific types of disrespectful and abusive maternity care as perceived by mothers during childbirth in health facilities

Mothers were asked to state the specific types of disrespectful and abusive maternity care they perceived based on the six categories as suggested by Bowser & Hill (2010)**.**

Non dignified care was quite prevalent, it occurred among 47 (17.9%) among the respondents who were disrespected and abused. Among them a total of 39(14.8%) respondents reported having received negative comments; being scolded or shouted at 31(11.8%) and 9(3.4%) reported being threatened. No participant reported the perception of withholding treatment due to failure of payment or lack of supplies.

Neglectful/ Abandonment care was reported by 11.4 %(n=30) of the respondents. 37(14.1%) reported having been ignored when needed help or called help and 2.7 %(n=7) reported having delivered without assistance of health provider.

Non confidential care was reported by 16(6.1%) of the respondents and all of them reported about disclosing health information by health providers.

Around 4.2% (n=11) of the respondents have reported being **physically abused** in forms of being slapped, pushed, pinched or otherwise beaten 5.7 %(n=15) and 0.8 %(n=2) of mothers have undergone procedures without anesthesia or other forms of pain relief.

In **non consented care** 3 %(n=8); nobody reported non consented episiotomy or suturing an episiotomy. However 4.6 %(n=12) reported non consented augmentation of labor and 2.3 %(n=6) reported non consented vaginal examination.

Inappropriate demands of payment was experienced by 3.4 %(n=9) of the participants.

Table 3: Proportion of Specific types of disrespectful and abusive maternity care as perceived by mothers during childbirth in health facilities n = 263

Category(Bold) and Specific Types of Disrespect and Abuse	**Perceived Disrespect and Abuse**
Non Consented Care	**8(3%)**
Episiotomy	0(0%)
Augmentation of labor	12(4.6%)
Shaving of pubic hair	0(0%)
Vaginal Examination	6(2.3%)
Suturing an Episiotomy	0(0%)
Physical Abuse	**11(4.2%)**
Slapped, pushed, pinched or otherwise beaten	15(5.7%)
Restrain during labor/delivery/examination	0(0%)
Procedures done without anesthesia or other forms of pain relief	2(0.8%)
Non Dignified Care	**47(17.9%)**
Scolded or shouted at	31(11.8%)
Received negative comment(s)	0(0%)
threatened to withhold treatment because of failure to pay or lack supplies	2(0.8%)
Threatened for any reason.	9(3.4%)
Abandonment/Neglect	**30(11.4%)**
Ignored or abandoned when in need for help	37(14.1%)
Delivered without any assistance	7(2.7%)
Non – Confidential Care	**16(6.1%)**
Private health information discussed in a way that others could hear	16(6.1%)
Body seen by other people (apart from health providers) during delivery	0
Inappropriate Demands for Payment	**9(3.4%)**
Asked by anyone for money other than the official cost of service to access services or any favors	9(3.4%)

4.5 Relationship between socio – demographic characteristics of mothers and disrespectful and abusive maternity care during childbirth in health facilities

The result showed that a higher percentage (45.8%) of mothers aged below 21 years perceived being disrespected and abused. In terms of marital status 38.5% of mothers who were not married perceived being disrespected and abused. Also 32.9% of mothers who had attained primary level of education perceived being disrespected and abused while 31.4% of mothers who had attained secondary education perceived being disrespected and abused. Most of the mothers who had one child (46.1%) perceived being disrespected and abused.

Also the result showed that there is statistical significance relationship between age (p- value < 0.0001) and parity (p- value < 0.0001) of mothers with the perceived disrespect and abusive maternity care while education level,marital status and occupation had no significance statistical relationship.

Table 4 is given below which shows the result of the analysis to find out the relationship between the various predictor and outcome variables.

Table 4: Perceived Disrespect and Abusive maternity care by characteristics of mothers

Predictor variable	Perceived Disrespect and Abusive maternity care		Total n (100%)	P- value
	Yes	No		
Age(years)				
20 and below	38(45.8%)	45(54.2%)	83(100%)	<0.0001
21-31	39(29.1%)	95(70.9%)	134(100%)	
32-42	5(10.9%)	41(89.1%)	46(100%)	
Level of Education				
No formal education	14(26.4%)	39(73.6%)	53(100%)	0.842
Primary	53(32.9%)	108(67.1%)	161(100%)	
Secondary	11(31.4%)	24(68.6%)	35(100%)	
College	4(28.6%)	10(71.6%)	14(100%)	
Marital Status				
Married	67(29.9%)	157(70.1%)	224(100%)	0.287
Not married	15(38.5%)	24(61.5%)	39(100%)	
Occupation				
House wife	16(26.7%)	44(73.3%)	60(100%)	0.656
Farmer	42(33.3%)	84(66.7%)	126(100%)	
Others	24(31.2%)	53(68.8%)	77(100%)	
Parity				
1child	50(46.1%)	57(53.3%)	107(100%)	<0.0001
2 -3 Children	17(23.0%)	57(77.0%)	74(100%)	
4 – 5 Children	8(16.7%)	40(83.3%)	48(100%)	
> 5 Children	7(20.6%)	27(79.4%)	34(100%)	

In bivariate and multivarite logistic regression analyses the variables age, education level,marital status,occupation and parity were separately entered in the bivariate model as predictor variables and perceived disrespect and abuse during health facility childbirth as the outcome variable**.** Variables with p – value of ≤ 0.2 were then entered in multiple regression model.In bivariate analysis age and parity qualified to be taken into multivariate analysis. In multivariate analysis mothers aged <21 years were more likely to be disrespected when compared with those aged 32 – 42 years ;AOR =4.30, 95%CI =1.09 – 17.0 and p- value

=0.04.Also mothers aged 21 – 31 years were more likely to disrespected when compared with those aged 32 – 42 years ;AOR =3.60, 95%CI =1.10 – 12.03 and p- value =0.04.

Table 5: Bivariate and Multivariate logistic Regression analyses for factors associated with Perceived Disrespect and Abuse among mothers in Tabora Municipality

Predictor variable	**Bivariate Regression**		**Multivariate Regression**	
	COR(95%CI)	**P- Value**	**AOR(95%CI)**	**P- Value**
Age(years)				
20 and below	6.92(2.49 – 19.28)	<0.0001	4.30(1.09 – 17.0)	0.04
21-31	3.37 (1.24 – 9.16)	0.017	3.60(1.10 – 12.03)	0.04
32-42	Reference		Reference	
Parity				
1child	3.38 (1.36 – 8.44)	0.09	1.35 (0.39 – 4.67)	0.63
2 -3 Children	1.15(0.43 – 3.10)	0.78	0.54 (0.17 – 1.79)	0.31
4 – 5 Children	0.78 (0.25 – 2.50)	0.65	0.45 (0.13 – 1.58)	0.21
> 5 Children	Reference		Reference	
Level of Education				
No formal education	0.90 (0.24 – 3.33)	0.87		
Primary	1.22 (0.37 – 4.10)	0.74		
Secondary	1.15 (0.29 – 4.47)	0.85		
College	Reference			
Marital Status				
Married	0.68 (0.34 – 1.38)	0.29		
Not married	Reference			
Occupation				
House wife	0.80(0.38 – 1.70)	0.57		
Farmer	1.10(0.60 – 2.03)	0.75		
Others	Reference			

4.6 Factors that contribute disrespectful and abusive maternity care during childbirth in health facilities from both mothers and HCW's perspectives in Tabora Municipality

During this study, the following factors contributing to disrespectful and abusive maternity care during childbirth in health facilities were identified. They are categorized as those from mothers and HCW perspectives'.

4.6 .1 Factors for D&A according to mothers perspectives'

Analysis of factors contributing to D & A from mothers' perspectives resulted to three main themes; poor accountability mechanisms, health system constraints and HCW personal attributes.

4.6.1.1 Poor accountability mechanisms

The first theme that emerged from the data relating to D&A is poor accountability mechanism. These were the factors found to be the cause of poor accountability of health care workers:

a) Providers prejudice and stereotyping

Mothers complained that they were not happy with the way service providers judge them depending on their characteristics. For instance, if a woman had given birth many times and happened to request for support in following certain instructions that required physical strength she was scolded and labeled as a pretender. They felt being disrespected in spite of the fact that they are giving life to someone else. One of the FGD participant reported the way she was told by a HCW:

"*You just give birth every now and then, 5th kid now what makes you not to be able to lie in the bed "mnazaa zaa,zao ya tano unashindwa kujijua mpaka upandishwe kitandani" Can't you use the family planning methods?"(Mother, aged 38 years old).*

This makes mothers feel imbalanced due to such harsh responses from HCW.

b) Corruption practices among health care workers:

Economic hardship was identified as one of the factors contributing to D&A. Respondents reported incidences where they were required to give money or something in order to access standard care and attention. For instance one respondent had this to say

"……until you provide money is when you will be given first priority; so anyone who does not have money is not given any attention, we truly don't understand them.

I think it is a behavior to some of them. if you give the person money s/he will attend you very well but if you do not have money you can neither be attended well nor respected. For instance, I witnessed one mother who bribed five thousands shillings to health care provider and attended very quickly while mothers who had no money to bribe were told to wait. What was painful is when I saw a mother bleeding and who was about to give birth but the health care provider did not bother and give maximum attention to others who provided money" (Mother aged 32 years old)

Another respondent said

"……While waiting to give birth in the room, I saw my fellow woman mistreated since she had no money to bribe." (Mother aged 32 years old)

4.6.1.2 Health system constraints

The findings from interviews indicated a health system – related problems that contribute to D & A during childbirth. These were:

c) Policy–practice gap in implementation of cost sharing scheme:

Mothers felt that they were disrespected when they are asked to pay for the service while the government has been announcing that delivery is for free. This sometimes contributes to hard working conditions for nurses. A participant in FGD reported that:

"…I arrived at the hospital and stayed for one hour without receiving any services…..the nurse asked me for items that needed to be used during delivery. I told her that I don't have because I know the delivery service is free and all the items are available in the hospital. The nurse told me that items available are in scarce so you have to pay ten thousand shillings in order to replace them. Regardless of the available item in the hospital, catheter was not available; and the nurse insisted to go and find it elsewhere outside the hospital. By that time, it was too late around 2:00 AM and I was alone since relatives who escorted me were already left." (Mother aged, 37years)

d) Shortage of human resource for health

Despite several complaints against nurses and doctors, mothers acknowledged that shortage of staff has a role. But this should not be an excuse because it may result into many deaths of mothers and babies. There should be enough staff to attend several mothers during childbirth; for example you find one nurse attending one mother at a time which may lead unattended mothers feel disrespected as one of FGD participant pointed out that.

"Ideally, when the patient enters in the ward; nurses should start attending to her immediately and not a situation whereby a HCW moves from one place to another place while doing other things. There should not be only one doctor in the ward and nurses should be as many as possible. Sometimes you find one nurse in the labor ward while there is more than one mother, how do you think that she will be able to take care of both patients at the same time? When I was giving birth; there was just one nurse in the ward." *(Mother, aged 25 years)*

4.6.1.3 Personal attributes – failure to control tamper

HCW behaviors' of disrespecting mothers may be caused by individuals' character. Some health care workers cannot control their temper. For example if a nurse/doctor gives instructions to the mother and the mother fail to comply promptly she/he may scold or beat her due to anger. One participant in FGD wondered by saying:

"Such a problem may be caused by someone's character. Actually a nurse can't do evil things to the patient while she is required to help. But it depends on the nurse although there are other annoyance done when the patient is asked to do something and do not cooperate, it is good for nurses to tolerate them because they are in pain. However other nurses can't and they end up scolding and beating mothers regardless of the pain they are experiencing due to anger" (Mother aged, 30years).

4.6 .2 Factors for D&A according to Health Care Workers perspectives'

Analysis of factors contributing to D & A according to health care workers perspectives' resulted into three main themes: frustration, poor communication skills and negligence.

4.6.2.1 Frustrations

Frustration of maternity staff emerged as a major contributing factor. It appeared to be a result of challenges related to health system and those related to the behavior of the mother in labor pain. Specific findings are presented in the sections that follow**.**

a) Heavy workload and poor infrastructure

Poor working conditions including heavy workloads, overcrowding of patients, lack of equipment and supplies are common causes of stress to health care workers that affect their interaction with patients. For example one of the respondents of KII said:

"The main contributing factor is the person's character, but at what time does that character become prominent? It is when there is overcrowding of patients, many complaints and overwhelmed with patients. Nurse fails to provide service according to standards. So if there would be no overcrowding may be the services would be better. On the other hand there is insufficiency of equipment and supplies" (*Registered nurse with 5 years working experience)*

b) Poor of motivation by the employer

Health care workers are demoralized by the employer such as poor remuneration and understaffing are common causes of stress that affect interactions with patients. Nurses pointed out that their responsibilities and duties greatly exceeded those of doctors but they are paid low salary. The consequent stress may negatively affect the way nurses communicate with mothers, also they may feel exhausted and 'display harshness' while attending to mothers during labor and delivery process. Also it can make them ask for bribe from mothers. For example during KII one of the participants said:

"We are also human beings. We really need appreciation. It discourages us to work hard and yet there is no appreciation. Sometimes we give nasty answers to our clients due to our problems" (Registered nurse with 3 years working experience).

c) Frustration as a result of patients' behaviors

Frustration to health care workers is caused by patients' failure to comply with the instruction(s) given to them. When re-instructed, mothers perceive it as been disrespected and abused. This can force the health care worker to become furious and she/he may use abusive

language. For example during KII a health care worker revealed the challenge she got when removing blood clots after delivery from one of her client as reported below:

"..We asked a mother to lie down so that we can clean her; but she refuted and attacked us using abusive language. We still insisted her about the impact of not cleaning her but the mother asked us to give a book to sign to accept anything that may happen. As a registered nurse, such situation is so frustrating." (Enrolled nurse with 1 year working experience).

4.6.2.2 Poor communication skills of health providers

Sometimes mothers feel that they are disrespected by health care workers because of the languages used by health care workers when they are giving instructions to them or explaining some information. Instead of being friendly considering that their clients are in pain they tell them in a negative way. Also due to poor communication mothers may not understand what they are supposed to do. For example a participant in KII said:

"*…… mother may be admitted and then told to do exercise in the antenatal section while waiting for labor pain but not told which symptoms will make her to go the labor ward. The mother may go to the toilet and gave birth there or can deliver at the antenatal ward instead of the labor ward. The mother complains that she has given birth without assistance"* (*Enrolled nurse with 5 years working experience)*

4.6.2.3. Negligence of health care workers

Negligence on the side of nurses particularly those at the antenatal wards was also highlighted. It can be noted that when mothers' labor progress is contrary to the expectation of health care worker, a nurse may fail to properly interpret the examination findings in line with the mothers' cry for help. This makes mothers feel that they are not respected. When this happen mother fail to understand why the HCW failed to do so. For example a participant in KII reported that

"It happens in a situation when a nurse examines the mother and detect that she is about to deliver may be after three hours but within one hour such mother do deliver.

And when the mother calls the nurse, the nurse may feel that the mother is stubborn and continue to ignore her and then the mother will complain that she called the nurse but the nurse refused to listen" (*Doctor with 6 months working experience*) **.**

CHAPTER FIVE: DISCUSSION

5.1 Proportion of Disrespectful and Abusive maternity care

The study revealed that 37.3% of interviewed mothers experienced at least one form of specific events during giving birth at the facility. According to the findings, most of the events were categorized as disrespectful and abusive maternity care as defined by Bowser and Hill (2010). However it is 31.2 % of the interviewed mothers who perceived those events as D&A during health facility childbirth. The two versions of prevalence – the first one (37.3%) established through D & A questions as defined by Bowser and Hill (2010) and the second (31.2%) which represent D&A as perceived by Tanzanian mothers in Tabora are not quite different. Thus, to large extent, the findings of the current study validate Bowser and Hill's D & A categories.

All in all, the findings of this study suggest that concerns about D & A are real and they need to be addressed. However, the prevalence of 37.3% is higher than that reported by studies that have hitherto assessed prevalence of D & A in Tanzania. These previous studies established a prevalence of 19.5% in Tanga (Kruk et al. 2014) and 15% in Temeke (Sando et al. 2014). Nevertheless, all these studies were hospital based and consequently respondents had limited freedom to express their concerns. It is no wonder that a community based study conducted in Kenya by Makumi (2015) found a prevalence of 71.9%(Makumi, 2015). Only one community based study in Tanzania has been published (Kruk et al 2014) and reported of 28.2%(Kruk et al. 2014). Similar hospital and community based studies should be conducted in Tanzania to get a national estimate of the magnitude of D & A.

5.2 Types of Disrespectful and Abusive maternity care

In this study, the common specific perceived disrespectful and abusive treatment during health facility based childbirth included non-dignified care, neglect, non confidential care, physical abuse and non consented episiotomy. These findings indicate a worrisome picture of the quality of care for Tanzanian women in labor and delivery and they need to be addressed. Similar findings were found by Kruk et al (2014). In their study they found the most common

type of D&A maternity care were non dignified care and neglect and abandonment(Kruk et al. 2014).

5.3 Relationship between Socio – Demographic Characteristics of mothers and Perceived Disrespect and Abuse

The association between the respondent's characteristics of age, parity, education level,marital status and occupation was examined. Mothers aged below 20 years had increased risk of being disrespected and abused compared to those aged 32 - 42 years. This may reflect anxiety about the birth experience as well as a greater need for care from providers who may have resented the demands and onsequently were disrespetful. Similar findings were reported by Abuya et al (2015) in Kenya. According to their study mothers between 20 and 29 years were less likely to experince non confidential care compared to those below 20 years (Abuya et al. 2015).

5.4 Context of disrespectful and abusive maternity care during childbirth

In this study mothers identified factors which contribute to disrespectful and abusive maternity care. These factors can be categorized in three main forms, namely: poor accountability mechanisms (corruption, staff prejudice and stereotyping) health system challenges (shortage of staff and policy – practice gap in implementation of cost sharing scheme) and personal attributes. The findings call for a need to strengthen health system management.

On the other hand, data from health care workers suggest that frustration is the main factor underlying staff involvement in disrespectful and abusive maternity care. The frustration experienced is a result of problems in the health care system (heavy workload and poor infrastructure, poor motivation/ job satisfaction) and mother's uncooperative behavior which may jeopardize both the mother's and unborn baby's lives. Moreover, staff pointed out that poor communication skills as a factor that contributes to scolding of patients. These findings imply that there is need to pay attention to the well-being and rights of health workers who often work in poor and stressful condition. Provision on monetary and non-monetary incentives, improvement of staffing, and on-the job staff training on communication skills may

have a positive impact on the way maternity staff behave towards mothers in labor and delivery rooms.

Similar findings have been found by Holmes and Goldstein (2012) in the review of attitudes and behavior of reproductive and maternal health care providers. They found that factors range from bad attitudes of maternal health care providers to lack of enabling environment, feelings of superiority in relation to socio – economic status , differences in knowledge and understanding of childbirth , frustrations at patients' behavior and cultural and workplace norms(Holmes & Goldstein 2012).

The factors indentified to be influencing D & A may have significant impacts on health – care seeking behavior, on the physical, psychological and emotional health of women and their babies, and on the job satisfaction, motivation and retention of health care workers themselves. These impacts are greatest on the poorest in the population and so add to inequalities in health outcomes. In order to improve maternal health the evidence – based intervention are to be implemented and at scale then greater attention to the relationship between mothers and health care workers.

5.5 Study limitation

1. Information bias.

The study relied on self reported data hence there was no objective measure of the prevalence. This was reduced by probing during interview.

The participants were interviewed in the health facility settings so they may not have been free to give the information. This was reduced by good establishment of good rapport, providing privacy and assuring their confidentiality.

2. Recall bias

Some mothers may have not remembered well their D & A events because others were interviewed 3 weeks post delivery. This was addressed by adding the opt- out choice in the

question in the form of don’t know and also by proper screening of the questions where by only those who experienced D&A were asked about the perception towards D&A

3. Sampling biases

Since mothers were conveniently selected at the hospitals and not randomly selected from the target population, mothers who have positive attitude towards facility based childbirth were likely to be chosen thus the collected data may not accurately represent the situation in the general population. The impact of this bias will be minimized by not generalizing the results. Nevertheless, the result obtained contributed significantly to the body of knowledge regarding D&A maternity care.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study has shown that the proportion of the perceived D & A during health facility childbirth in Tabora Municipality is 31.2 %. Mothers identified factors which contribute to disrespectful and abusive maternity care. The identified factors are categorized in three main themes, namely; poor accountability mechanisms (corruption, staff prejudice and stereotyping), health system challenges (shortage of staff and policy – practice gap in implementation of cost sharing scheme), and personal attributes.

On the other hand, data from health care workers suggest that frustration is the main factor underlying staff involvement in disrespectful and abusive maternity care. Moreover, staff pointed out that, poor communication skills is a factor that contributes to scolding of patients.

D &A maternity care during facility based childbirth is an important barrier that erodes trust in a health system. This contributes to delay decisions in seeking facility-based childbirth services. Furthermore D &A maternity care during facility based childbirth can lead to increase of cases of maternal and neonatal deaths and disability which are preventable. Therefore, the generated knowledge of the prevalence of D&A and the contextual factors is critical in developing interventions at the municipal and health facility levels. Overall, the findings suggest a need for strengthening health system management.

6.2 Recommendations

Basing on the findings of this study, it is recommended that:

1. Mothers centered approach should be used to help them voice out their opinion on quality of maternal health services.
2. Maternal health services supportive supervision should be strengthened in order to improve health care workers accountability.
3. On job training on communication skills should provided to health care workers.

4. Attention should be paid to the welfare and rights of health care workers, and improve their working conditions in order to motivate them in delivering quality services.
5. Professional Associations like Tanzania Nurses Association and Tanganyika Medical Council should investigate and institute disciplinary actions against members found to have disrespected and abused mothers during health facility childbirth.
6. A larger nationally representative study is needed in order to understand a national burden of D &A and its correlates.

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APPENDICES

Appendix I: Consent Form English Version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)
DIRECTORATE OF RESEARCH AND PUBLICATIONS

No …… Date ……..……

Introduction

Greetings! My name is Phillipina Phillipo a student of Master of Public Health at Muhimbili University. I am conducting a research on magnitude and factors associated with disrespect and abuse experiences that women go through during childbirth in health facilities.

About the study:

A total of 263 mothers will be interviewed in this study. Hence, including you in the study will also mean that I will ask you few questions regarding your experiences during your last delivery and the type of care you received at the facility. This would take approximately 20 minutes of your valuable time.

What Participation Involve

If you agree to join this study, you will be required to sign this consent form and answer the question that you will be asked by the interviewer.

Benefits

You will not get direct benefits from the study. But, the information provided by you will help us to understand the type of care women receive during delivery and the improvements needed at the facilities.

Risk

We do not that expect any harm will happen to you because of participating in this study.

Confidentiality

I wish to assure you that, this information will be treated in confidentiality between you and the researcher. All the information collected in the questionnaire forms will be entered in the computer with only the study identification number.

Voluntary participation

Taking part in this study is totally voluntary, that is, you can decide to participate or not. You can stop participating in this study at any time, even if you have already given your consent. Refusal to participate or withdrawal from the study will not involve penalty or loss of any benefits to which you are otherwise entitled.

Who to contact If you have any question about this study

You can contact the researcher, Phillipina Phillipo of Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam, or the supervisor Dr Tumaini Nyamhanga. If you ever have questions about your rights as a participant, you may call Prof. Said Aboud chairman of the Research and Publication Committee, Muhimbili University of Health and Allied Sciences, P.O. Box 65001, Dar es Salaam. Telephone 2150302- 6 or 2152489

Do you agree? Yes…….. No……

Participant agrees ……..... Participants does not Agree. ……...…

I, …… Have read the contents of this consent form and my questions have been adequately answered. I therefore agree to participate in this study.

Signature of the participant ……. Date ……

Signature of the interviewer …… Date ……

Appendix II: Consent Form Kiswahili Version

CHUO KIKUU CHA SAYANSI YA TIBA MUHIMBILI
IDARA YA UTAFITI NA UCHAPISHAJI

Namba ya Dododso …… Tarehe ……..……

Utambulisho.

Habari!! Naitwa Phillipina Phillipo, ni mwanafunzi wa chuo kikuu cha sayansi ya afya Muhimbili.Ninasoma shahada ya uzamili katika fani ya afya ya jamii. Ninafanya utafiti kuhusu ukubwa na mambo yanayohusiana heshima na matusi kwa wakina mama wanaojifungua katika vituo vya kutolea huduma ya afya hapa manispaa ya Tabora.

Kuhusu utafiti

Jumla ya akina mama 263 watahojiwa katika utafiti huu. Hivyo,ushiriki wako katika utafiti huu utahusu mimi kukuuliza maswali machache kuhusu uzoefu wako wakati wa kujifungua kwa mara ya mwisho na aina ya huduma uliyopokea katika kituo cha huduma ya afya. Hii itachukua takriban dakika 20 ya muda wako.

Ushiriki wako katika utafiti huu.

Kama unakubali kujiunga na utafiti huu, utatakiwa kusaini fomu hii ya idhini na kujibu maswali utakayoulizwa na mtafiti.

Faida

Huwezi kupata faida moja kwa moja kutokana na utafiti huu. Lakini, habari zitakazotolewa na wewe zitatusaidia kupata kuelewa aina huduma ambayo wanawake hupokea wakati wa kujifungua na hivyo, kufanya maboresho yanayohitajika katika vituo vya kutolea huduma ya afya.

Madhara

Hatutarajii kuwa madhara yoyote yatatokea kwako kwa sababu ya kushiriki katika utafiti huu.

Usiri

Napenda kuhakikishia kuwa habari hii itakuwa ni siri kati ya wewe na mtafiti.Taarifa zote zitakazokusanywa katika a dodoso hili zitaingizwa katika kompyuta kwa namba ya utambulisho wa utaafiti.

Ushiriki wa Hiari

Ushiriki wako katika utafiti huu ni hiari, unaweza kuamua kushiriki au la. Unaweza kuacha kushiriki katika utafiti huu wakati wowote, hata kama tayari ulishatoa idhini ya kushiriki.
Kukataa kushiriki au kujiondoa kutoka utafiti hakutahusisha adhabu au kupoteza faida yoyote ambayo ungeipata.

Mtu wa kuwasiliana naye kama una swali lolote kuhusu utafiti huu

Unaweza kuwasiliana na mtafiti, Phillipina Phillipo wa Chuo Kikuu cha Sayansi ya Afya S.L.P. 65001, Dar es Salaam, au msimamizi Dr Tumaini Nyamhanga**.** Endapo una swali lolote kuhusu haki zako kama mshiriki unaweza kuwasiliana na Prof. Said Aboud mwenyekiti wa kamati ya utafiti na machapisho, Chuo kikuu cha Sayansi na Tiba –Muhimbili, S.L.P 65001, Dar Es Salaam. Simu 2150302-6 au 2152489

Unakubali? Ndio …… Hapana.....

Mshiriki amekubali .... Mshiriki amekataa.....

Mimi, ... Nimesoma yaliyomo kwenye fomu hii na maswali yangu yamejibiwa vya kutosha . Hivyo kwa ridhaa yangu naridhia kukubali kushiriki katika utafiti huu.

Saini ya mshiriki ..... Tarehe ……

Saini ya mtafiti ..... Tarehe .....

Appendix III: Interviewer based Questionnaire – English Version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)

DIRECTORATE OF RESEARCH AND PUBLICATIONS

ASSESMENT OF MAGNITUDE AND FACTORS ASSOCIATED WITH DISRESPECTIFUL AND ABUSIVE MATERNITY CARE DURING CHILDBIRTH IN HEALTH FACILITIES IN TABORA MUNICIPALITY.

INSTRUCTIONS

1. Answer all questions honestly
2. Filling one questionnaire will take approximately 20 minutes

SECTION A: IDENTIFICATION

A1. Serial No._____

A2. Date _____

A3. Start time _____

A4. End time _____

SECTION B: SOCIO – DEMOGRAPHIC DATA

B5. What is your age in years? _____

B6. What is your current marital status (Circle the correct answer)

a) Married

b) Single

c) Divorced

d) Separated
e) Widowed
f) Others (Specify) _____

SECTION C: SOCIO – ECONOMIC DATA

C7. What is your level of education? (Circle the correct answer)

a) No formal education
b) Primary education level
c) Secondary education level
d) College level

C8. What is your occupation? (Circle the correct answer)

a) A housewife
b) A farmer
c) Health care worker
d) Employed in formal sector other than health sector
e) Self employed
f) Other (Specify) _____

Section D: Delivery History

D9. How many times have you given birth? _____

Section E: Experiences of Disrespectful and Abuse during Childbirth

(For the questions below tick the correct answer – the information asked are with regard to your recent giving birth status)

Q CODE	QUESTION	**YES**	**NO**	**DON'T KNOW**
E10	At any point during your stay in this facility for this delivery were you treated in a way that made you feel disrespected			

E11. During facility giving birth, did any of following procedure done to you without your consent?

Q CODE	QUESTION	YES	NO	DON'T KNOW(DK)
	An episiotomy			
	Augmentation of labor			
	Shaving of pubic hair			
	Vaginal Examination			
	Suturing an episiotomy or tare			

E12. During giving birth did you experience any of the following types of physical abuse?

		YES	NO	DK
	Health provider (s) hit, slapped, pushed, pinched or otherwise beat you			
	Health provider used force as a restrain during labor/delivery/examination			
	Procedures were done without anesthesia or other forms of pain relief **Specify the procedure** **……..**			

E13. During giving birth did you experience the following types of non dignified care?

		YES	NO	DK
	Health providers scolded at you or shouted at you			
	Health providers made a negative comment(s) about you			
	Health providers threatened to withhold treatment because you could not pay or did not have supplies			
	Health providers threatened you for any reason. Please specify ……			

E14. During giving birth did you experience the following types of abandonment/ neglect care?

		YES	NO	DK
	Health providers ignored or abandoned you when you called for help			
	You delivered without any assistance			

E15. During giving birth did you experience the following types of non – confidential care?

		YES	NO	DK
	Health providers discussed your private health information in a way that others could hear			
	Your body was seen by other people (apart from health providers) during delivery			

E16. During giving birth did the health provider demand from you informal payment such as bribe for better care?

		YES	NO	DK
	At any point during this delivery in this facility did you feel/ perceive or were you asked by anyone for money other than the official cost of service to access services or any favors.			

E17. Did anything else disrespectful happen to you that I did not ask you about?

What exactly happened?.....

Section F: Perception of Disrespect and Abuse during childbirth in Health Facility

(1.For the questions below circle the correct answer – the information asked are with regard to your recent giving birth status. 2. Status for D&A is considered yes if the question has been answered yes in section E and either 1 or 2 in section F and this will be filled by the research assistant after coming back from the field.)

To what extent do you perceive the events mentioned as disrespect and abuse during delivery in healthy facility?

Q CODE	**NON CONSENTED CARE**	**RESPONSE AND CODING**	**STATUS OF D&A**	
			YES	**NO**
F18	Non consented episiotomy	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F19	Non consented augmentation of labor	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F20	Non consented shaving of pubic hair	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F21	Non consented vaginal Examination	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F22	Non consented suturing an episiotomy or tare	1 = Definitely D & A 2 = Somewhat D & A		

		3 = Not D&A 4 = Don't know		
	PHYSICAL ABUSE			
F23	Health provider (s) hit, slapped, pushed, pinched or otherwise beat you	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F24	Health provider used force as a restrain during labor/delivery/examination	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F25	Procedures were done without anesthesia or other forms of pain relief	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
	NON DIGNIFIED CARE			
F26	Health providers scolded at you or shouted at you	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F27	Health providers made a negative comment(s) about you	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F28	Health providers threatened to withhold treatment because you could not pay or did not have supplies	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		

F29	Health providers threatened you for any reason.	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
	ABANDONMENT/NEGLECT			
F30	Health providers ignored or abandoned you when you called for help	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F31	Delivered without any assistance	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
	NON – CONFIDENTIAL CARE			
F32	Health providers discussed your private health information in a way that others could hear	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
F33	Your body was seen by other people (apart from health providers) during delivery	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		
	INAPPROPRIATE DEMANDS FOR PAYMENT			
F34	Asked by anyone for money other than the official cost of service to access services or any favors	1 = Definitely D & A 2 = Somewhat D & A 3 = Not D&A 4 = Don't know		

For use by Research Assistant

F35.Did the respondent experience any form of disrespect and abuse treatment during giving birth in a health facility?

1. Yes 2. No

Appendix IV: Interviewer based Questionnaire – Kiswahili Version

CHUO KIKUU CHA SAYANSI YA TIBA MUHIMBILI

IDARA YA UTAFITI NA UCHAPISHAJI

UTAFITI KUHUSU UKUBWA NA MAMBO YANAYOHUSIANA HESHIMA NA MATUSI KWA WAKINA MAMA WANAOJIFUNGUA KATIKA VITUO VYA KUTOLEA HUDUMA YA AFYA KATIKA MANISPAA YA TABORA.

MAELEKEZO

1. Jibu maswali yote kwa uaminifu.
2. Kujaza moja dodoso kutachukua takriban dakika 20.

SEHEMU A: UTAMBULISHO

A1. Nambari ya dodoso_____

A2. Tarehe _____

A3. Muda wa kuanza _____

A4. Muda wa kumaliza _____

SEHEMU B: TAARIFA BINAFSI

B5. Una umri wa miaka mingapi? _____

B6. Hali yako ya ndoa ya sasa (Zungushia jibu sahihi)

g) Nimeolewa
h) Sijaolewa

i) Nimetalikiwa

j) Nimeachika

k) Mjane

l) Mengineyo (taja) _____

SEHEMU C: TAARIFA ZA KIUCHUMI

C7. Una ngazi gani ya elimu ? (Zungushia jibu sahihi)

e) Sijasoma.

f) Elimu ya Msingi.

g) Elimu ya Sekondari.

h) Elimu ya juu.

C8. Unafanya kazi gani ? (Zungushia jibu sahihi)

g) Mama wa nyumbani.

h) Mkulima.

i) Mhudumu wa afya

j) Nimeajiriwa katika sekta rasmi tofauti na sekta ya afya.

k) Nimejiajiri.

l) Nyingine (Taja). _____

SEHEMU D: TAARIFA ZA UZAZI

D9. Umewahi kujifungua mara ngapi? _____

SEHEMU E: KUTOKUHESHIMIWA NA MATUSI WAKATI WA KUJIFUNGUA

(*Kwa maswali hapa chini Jibu jibu sahihi – utaulizwa taarifa kuhusu uzazi wako wa mara ya mwisho)*

Q CODE	SWALI	NDIYO	HAPANA	SIJUI
E10	Katika hatua yoyote wakati wa kukaa kwako katika kituo hiki wakati wa kupata huduma kuna kipindi ambacho umejiskia kutohesheshimiwa wakati wa kupewa huduma?			

E11. Wakati wa kujifungua kwenye kituo cha kutolea huduma ya afya, je kuna huduma yoyote kati ya hizi ambayo ilifanyika kwako bila idhini yako?

Q CODE	SWALI	NDIYO	HAPANA	SIJUI
	Kuongezwa njia ya uzazi			
	Kuongezwa maji ya uchungu			
	Kunyolewa nywele za sehemu za siri			
	Kupimwa ukeni			
	Kushonwa msamba			

E12. Wakati wa kujifungua je ulifanyiwa aina zifuatazo za unyanyasaji wa kimwili?

Q CODE	SWALI	NDIYO	HAPANA	SIJUI
	Mtoa wa afya alikupiga au kukusukuma au finya au vinginevyo			
	Matibabu yalifanyika bila ganzi au aina nyingine ya kutuliza maumivu Taja ……..			

E13. Wakati wa kujifungua je ulipewa aina zifuatazo za huduma zisizo na heshima?

Q CODE	SWALI	NDIYO	HAPANA	SIJUI
	Mtoa huduma ya afya alikukaripia			
	Mtoa huduma za afya alitoa maoni hasi kuhusu wewe			
	Mtoa huduma za afya alitishia kutotoa matibabu kwa sababu wewe hukuweza kulipa au hapakuwa na vifaa.			
	Watoa huduma za afya walikutisha bila sababu yoyote. Tafadhali fafanua……			

E14. Wakati wa kujifungua ulipata aina zifuatazo kutelekezwa wakati wa huduma?

Q CODE	SWALI	NDIYO	HAPANA	SIJUI
E17	Watoa huduma za afya walikupuuza au walikuacha ulipowaita wakupe msaada.			
	Ulijifungua bila msaada wowote.			

E15. Wakati wa kujifungua ulipata aina zifuatazo za huduma zisizo - huduma za siri?

Q CODE	SWALI	NDIYO	HAPANA	SIJUI
	Watoa huduma za afya kujadili habari za afya yako binafsi kwa namna ambayo wengine wanaweza kusikia.			

E16. Wakati wa kujifungua kuna mtoa huduma alihitaji kutoka kwako malipo yasiyo rasmi kama vile rushwa kwa ajili ya huduma bora?

Q CODE	**SWALI**	**NDIYO**	**HAPANA**	**SIJUI**
	Wakati wa kujifungua kuna mtoa huduma alihitaji kutoka kwako malipo yasiyo rasmi kama vile rushwa kwa ajili ya huduma bora.			

E17. Je, kitu kingine chochote cha kisicho cha heshima kilichotokea wakati wa kujifungua ambacho sijakuuliza?

Elezea.....

SEHEMU F: MTAZAMO WA KUHUSU HUDUMA ZISIZOKUWA NA HESHIMA WAKATI WA KUJIFUNGUA KATIKA VITUO VYA KUTOLEA HUDUMA YAAFYA.

(1. Kwa maswali yaliyopo hapa chini zungushia jibu sahihi - habari zitahusu huduma ulizopata wakati wa kujifungua kwa mara ya mwisho 2. Mshiriki atachukulia kama hakuheshimiwa endapo atajibu ndiyo kwa swali husika katika katika sehemu E na aidha 1 au 2 katika sehemu F kwa swali hilo hilo. Kipengele hiki kijazwe na msaidizi wa utafiti baada ya kurudi kutoka kukusanya taarifa.)

Ni kwa kiwango gani wewe unayachukulia matukio yaliyotajwa kama ni kutokuheshimu na unyanyasaji wakati wa kujifungua katika kituo cha kutolea huduma ya afya?

Q CODE	**KUPEWA HUDUMA BILA RIDHAA**	**MAJIBU**	**ANACHUKULIA HAKUHESHIMIWA?**	
			NDIYO	**HAPANA**
F18	Kuongezwa njia ya uzazi bila ridhaa	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F19	Kuongezwa maji ya uchungu bila ridhaa	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F20	Kunyolewa nywele za sehemu za siri bila ridhaa.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F21	Kupimwa ukeni bila ridhaa.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F22	Kushonwa msamba bila ridhaa.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima		

		3= Ni heshima 4 = Sijui		
	KUNYANYASWA KIMWILI			
F23	Mtoa huduma ya afya kukupiga au kukusukuma au kukufinya au vinginevyo	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F24	Mtoa huduma ya afya kukushika kwa nguvu wakati wa kujifungua au kukupima.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F25	Matibabu kufanyika bila ganzi au aina nyingine ya kutuliza maumivu	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
	HUDUMA ISIYO YA HESHIMA			
F26	Mtoa huduma ya afya kukukaripia	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		

F27	Mtoa huduma za afya kutoa maoni hasi kuhusu wewe.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F28	Mtoa huduma za afya kukutishia kutotoa matibabu kwa sababu wewe hukuweza kulipa au haukuwa na vifaa	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F29	Watoa huduma za afya kukutisha bila sababu yoyote. .	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
	KUTELEKEZWA			
F30	Watoa huduma za afya kukupuuza au kukuacha ulipowaita wakupe msaada.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F31	Kujifungua bila msaada wowote.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		

	HUDUMA BILA SIRI			
F32	Watoa huduma za afya kujadili habari za afya yako binafsi kwa namna ambayo wengine wanaweza kusikia.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
F33	Mwili wako kuonwa na watu wengine tofauti na wahudumu wa afya.	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		
	MALIPO YASIYO HALALI			
F34	Wakati wa kujifungua kuna mtoa huduma kuhitaji kutoka kwako malipo yasiyo rasmi kama vile rushwa kwa ajili ya huduma bora	1=Dhahiri sio heshima 2= Kiasi fulani sio heshima 3= Ni heshima 4 = Sijui		

Kwa matumizi ya mtafiti

F35. Je, mhojiwa amefanyiwa tendo lolote linalohusu unyanyasaji na matusi wakati wa kujifungua katika kituo cha huduma ya afya?

1. Ndiyo 2. Hapana

Appendix V: Key Informant Interview Guide – English Version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)

DIRECTORATE OF RESEARCH AND PUBLICATIONS

ASSESMENT OF MAGNITUDE AND FACTORS ASSOCIATED WITH DISRESPECTIFUL AND ABUSIVE MATERNITY CARE DURING CHILDBIRTH IN HEALTH FACILITIES IN TABORA MUNICIPALITY.

IDENTIFICATION

Name of the Facility_____

Serial No._____

Date _____

Age _____years

Sex _____

Education Level _____

Job Title _____

Duration of stay in job title

Start time _____

End time _____

INSTRUCTIONS TO INTERVIEWER

1. The interview should be conducted in Privacy.
2. Introduce yourself and assign an ID to interviewee.
3. The interview will take approximately 30 minutes.
4. Every bit of the interview should be clearly tape recorded.

EXPERIENCE OF DISRESPECTFUL AND ABUSIVE MATERNITY CARE

1. To get started, could you tell me about the work that you have done or are currently doing in maternity care? (Prompt: location of work, role/ title, time in position)
2. Who typically cares for women during labor and delivery? (Prompt for midwife vs. nurse etc.)
3. Can you talk me through the process that women would go through when they come to a facility to deliver? (Prompt: registration, rules, who's allowed/not, etc.)
4. During this work, have you ever witnessed or heard about instances of disrespect and/or abuse during childbirth?
5. If so, what exactly did this D&A consist of? (Prompt: 6 categories of D&A: Physical abuse, non-consented care, non-confidential care, non-dignified care, abandonment, detention.)
6. What cadres of health workers were involved in these incidences?
7. In your experience, how common or rare are events such as these?
8. How, if at all, does incidence of disrespect and abuse differ by type of health worker?
9. In your opinion, what factors led to or enabled this disrespect and abuse to occur? [Prompt: patient characteristics (age, education, etc), provider characteristics (prejudice, job dissatisfaction, lack of time, etc), facility factors (poor management, lack of standards, lack of accountability, *and lack of supervision), policy factors (guidelines, laws, accountability, etc)]*.

Appendix VI: Key Informant Interview Guide – Kiswahili Version

CHUO KIKUU CHA SAYANSI YA TIBA MUHIMBILI

IDARA YA UTAFITI NA UCHAPISHAJI

UTAFITI KUHUSU UKUBWA NA MAMBO YANAYOHUSIANA HESHIMA NA MATUSI KWA WAKINA MAMA WANAOJIFUNGUA KATIKA VITUO VYA KUTOLEA HUDUMA YA AFYA KATIKA MANISPAA YA TABORA.

UTAMBULISHO

Jina la kituo_____

Nambari ya dodoso_____

Tarehe _____

Umri(miaka) _____

Jinsia_____

Kiwango cha Elimu _____

Cheo _____

Muda wa kukaa katika cheo cha kazi_____

Muda wa kuanza _____

Muda wa kumaliza _____

MAELEKEZO KWA MTAFITI

1. Mahojiano yafanyike katika usiri.
2. Jitambulishe na toa namba ya utambuisho kwa mhojiwa.
3. Mahojiano yatachukua takriban dakika 30.
4. Mahojiano yote yanapaswa kurekodiwa kwenye mkanda kumbukumbu.

KUTOKUHESHIMIWA NA MATUSI WAKATI WA HUDUMA ZA UZAZI

1. Ili kuanza, unaweza kuniambia kuhusu kazi ambayo umekuwa ukiifanya au unayoifanya kwa sasa katika huduma za uzazi? (eneo la kazi, jukumu / cheo, muda katika nafasi)
2. Kawaida nani anahusika na kutoa huduma kwa wanawake wakati wa kujifungua? (mkunga au daktari)
3. Unaweza kuzungumzia mchakato ambao kuwa wanawake hupitia wakati wanapokuja kujifungua katika kituo cha kutolea huduma za afya?(usajili, sheria nani anaruhusiwa/ haruhusiwi)
4. Katika kazi hii, umewahi kushuhudia au kusikia kuhusu matukio ya kutoheshimu na / au kutukana wakati wa kujifungua?
5. Kama ni hivyo, matukio hayo yalihusisha vitendo gani hasa? (unyanyasaji wa kimwili, kupewa huduma bila ridhaa, huduma zisizo za siri, huduma isiyo ya heshima, kutelekezwa, kuwekwa kizuizini)
6. Ni wafanyakazi wa afya wa kada gani walihusika katika matukio hayo?
7. Kwa uzoefu wako, ni kwa kiwango gani matukio kama hayo hutokea?
8. Ni kwa kiwango gani, kama kuna tofauti katika matukio ya kutoheshimu na unyanyasaji wa kina mama wakati wa kujifungua baina ya kada za wafanyakazi wa afya?
9. Kwa maoni yako, ni sababu gani imesababisha matukio ya kutoheshimu na unyanyasaji wakati wa huduma za uzazi kutokea?
10. [sifa za mgonjwa (umri, elimu, nk), jumuiya sifa (kanuni), sifa za mtoa huduma (chuki, kutoridhika na mazingira ya kazi, ukosefu wa muda, nk), usimamizi wa huduma za afya kituoni (usimamizi duni, ukosefu wa viwango, ukosefu wa uwajibikaji, ukosefu wa usimamizi), mambo ya sera (miongozo, sheria, *uwajibikaji, nk]).*

Appendix VII: Focus Group Discussion Guide – English Version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES (MUHAS)

DIRECTORATE OF RESEARCH AND PUBLICATIONS

ASSESMENT OF MAGNITUDE AND FACTORS ASSOCIATED WITH DISRESPECTIFUL AND ABUSIVE MATERNITY CARE DURING CHILDBIRTH IN HEALTH FACILITIES IN TABORA MUNICIPALITY.

IDENTIFICATION

Name of the Facility_____

Date _____

Start time _____

End time _____

INSTRUCTIONS TO RESERCHER

1. The FGD should be conducted in Privacy.
2. Introduce yourself and assign an ID to participants.
3. The discussion will take approximately 90 minutes.
4. Every bit of the discussion should be clearly tape recorded.

EXPERIENCE OF DISRESPECTFUL AND ABUSIVE MATERNITY CARE

1. During your most recent childbirth in hospital how was your experience?
2. Is there anything done during labor that made you unhappy ?(Probe on vaginal examinations, abandonment, Privacy)
3. Please describe your experience during second stage/Childbirth (Probe on position,instructions, encouragement, episiotomy)
4. During your entire stay in maternity were you physically or verbally abused? (please explain, probe on; inappropriate touching, slapping, pinching)

5. Why do you think health workers are disrespecting and abusing mothers during health facility childbirth?
6. What recommendations are you giving to avoid disrespect and abuse during health facility childbirth

Appendix VIII: Focus Group Discussion Guide – Kiswahili Version

CHUO KIKUU CHA SAYANSI YA TIBA MUHIMBILI

IDARA YA UTAFITI NA UCHAPISHAJI

UTAFITI KUHUSU UKUBWA NA MAMBO YANAYOHUSIANA HESHIMA NA MATUSI KWA WAKINA MAMA WANAOJIFUNGUA KATIKA VITUO VYA KUTOLEA HUDUMA YA AFYA KATIKA MANISPAA YA TABORA.

UTAMBULISHO

Jina la kituo_____

Tarehe _____

Muda wa kuanza _____

Muda wa kumaliza _____

KUTOKUHESHIMIWA NA MATUSI WAKATI WA HUDUMA ZA UZAZI

1. Wakati wa kujifungua mara ya mwisho kwa uzoefu ilikuwaje ?
2. Kuna kitu chochote kibaya kilifanyika kwako wakati wa kujifungua?(uliza kuhusu kupimwa ukeni , kutelekezwa, usiri)
3. Tafadhali elezea kuhusu wakati wa kusukuma mtoto(uliza kuhusu jinsi ya kukaa, maelekezo, kutiwa moyo, kuongezwa njia)
4. Katika kipindi chote ulichokaa kwenye wodi ya wazazi je ulipigwa (uliza kuhusu kupigwa, kufinywa, kushikwa kwa nguvu)
5. Unafikiri kwa nini watumishi wa afya wanawanyanyasa wakina mama wakati wa kujifungua hospitalini?
6. Unashauri nini kifanyike ili kuzuia kutokuheshimwa na matusi wakati wa uzazi?

Appendix IX: Approval of Ethical Clearance

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR OF POSTGRADUATE STUDIES

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Ref. No. MU/PGS/SAEC/Vol. XIV/

13th July, 2016

Dr. Phillipina Phillipo
Master of Public Health
MUHAS.

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED "ASSESSMENT OF MAGNITUDE AND FACTORS ASSCOAITED WITH DISRESPECTFUL AND ABUSIVE MATERNITY CARE DURING DELVIERIES IN HEALTH FACILITIES IN TABORA MUNICIPALITY."

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from 12th July, 2016 to 11th July, 2017. In case you do not complete data analysis and dissertation report writing by 11th July, 2017, you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. E. Balandya
DEPUTY DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
cc: Dean, School of Public Health and Social Sciences