THE PREVALENCE OF DISRESPECT AND ABUSE TO WOMEN GIVING BIRTH IN MBEYA CITY HEALTH FACILITIES FROM OCTOBER TO DECEMBER 2016

Maria Karlo, MD

MMed (Obstetrics and Gynaecology) Dissertation
Muhimbili University of Health and Allied Sciences
October, 2017

Muhimbili University of Health and Allied Sciences

Department of Obstetrics and Gynaecology

THE PREVALENCE OF DISRESPECT AND ABUSE TO WOMEN GIVING BIRTH IN MBEYA CITY HEALTH FACILITIES FROM OCTOBER TO DECEMBER 2016

By

Maria Karlo

A Dissertation Submitted in (Partial) Fulfilment of the Requirement for the Degree of Master of Medicine (Obstetrics and Gynecology) of

Muhimbili University of Health and Allied Sciences
October, 2017

CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled **''The Prevalence of Disrespect and Abuse to Women Giving Birth in Mbeya City Health Facilities from October to December 2016'',** in (partial) fulfilment of the requirements for the degree of Master of Medicine (Obstetrics and Gynaecology) of Muhimbili University of Health and Allied Sciences.

_____

Prof. Charles .D.S. Kilewo

(Supervisor)

_____

Date

DECLARATION AND COPYRIGHT

I, **Maria Karlo**, 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 a similar or any other degree award.

Signature ……..... **Date** ……..…….

ACKNOWLEDGEMENT

I am thankful to God, Almighty for bringing me to this level. I am thankful to all those whom I had worked with during this dissertation from proposal development, data collection, analysis, and results compilation.

Special complements to my supervisor, Prof. Charles.D.S. Kilewo, who is also my teacher. He has tirelessly been supportive to my professional goals and actively provides valuable critiques, guidance on this research work. His patience cannot entirely be acknowledged on this page**.**

I would also extend my appreciation to the members of academic staff in the Department of Obstetrics and Gynaecology; the Department of Epidemiology and Biostatistics; and my classmates for their continued support in every step of this research.

This would not be possible without my family members, especially my parents for the love, guidance and financial support. Thanks to my siblings for their continuous financial, technical and moral support.

DEDICATION

This dissertation work is dedicated to my family. It is dedicated to my youngest sister Kauye, and my daughter Upendo.

ABSTRACT

Background

Disrespect and Abuse (D&A) in delivering women is a global problem in many low and high income countries though not well documented. Apart from Cost and Distance, recently women's experience of disrespectful care and abuse related directly to providers actions have been found to affect their place of delivery, and hence many women continue to deliver at home, putting their health at even more risk. The high rates of D&A, along with its contributions to continued home deliveries with no skilled attendance push efforts toward finding possible interventions to decrease or eliminate it.

Objectives

The study aimed at finding the prevalence of disrespect and abuse to women during childbirth in Mbeya City Health Facilities.

Methods

A hospital-based cross sectional study was conducted in a period of three months from October 2016 to December 2016 involving 270 women who delivered in six Mbeya City Health Facilities. The women were observed during admission (247), during delivery (183), 23 women were not observed during admission and delivery and 64women were delivered by caesarean section (the study didn't aim at assessing disrespect and abuse during caesarean delivery). A postnatal observation and an Exit interview was administered to all 270 delivered women.

Data analysis was done using IBM SPSS version 20. Frequency and percentages was used to analyse the prevalence and reasons for disrespect and abuse. Categorical variables were compared among women with or without outcome of interest (D&A) and chi square test and p value <0.05 was taken as statistically significant to show association between social demographic and obstetrics characteristics and the experience of disrespect and abuse to the women.

Results

Total of 270 women were analysed. The prevalence of D&A during childbirth in Mbeya City health facilities is high 33.3%. Non confidential, non dignified-verbal and neglect were marked in the study.

Majority experience it while delivering at the Hospital, p value 0.004. The history of prior physical abuse had association with the report of disrespect and abuse at p value 0.031 and women who delivered by caesarean section reported more disrespect than those who delivered by SVD, at p value 0.001.

Women considering D&A as something normal (normalization) and perceiving that providers' harshness and providers' poor knowledge of human rights were the most reported reasons for disrespect and abuse

Conclusion

D&A is alarmingly high in our institutions, though majority of women took the fault to themselves.

Including topics on disrespect and abuse during childbirth during ANC visits and maternity blocks is essential to increase women awareness and to develop ways of dealing with D&A.

TABLE OF CONTENTS

LIST OF TABLES

DEFINITION OF TERM

Physical Abuse - being beaten or slapped during childbirth, roughed up, pinching, post-partum suturing of vaginal tears or episiotomy cuts without the use of anaesthesia.

Discrimination – treating women partially basing on their race, ethnicity, age, language, HIV/AIDS status, traditional beliefs and preferences, economic status, and educational level

Neglect/abandonment - failure of providers to attend women when in need, women being left alone during labour and birth, failure of providers to monitor women and intervene in life-threatening situations.

Non consented care - lack of informed consent for common procedures around the time of childbirth in many settings e.g. pelvic examination, augmentation of labour, caesarean sections, episiotomies, hysterectomies, blood transfusions, sterilization.

Non dignified care - Women being shouted at to push or yelled at to stop pushing, threatened with beating, telling patient that they are stupid, to stop pretending they are in pain and not to cry, and other demeaning words.

Lack of privacy- women labouring and deliver in public view (without any privacy barriers like screen or clothes covering)

Confidentiality - sharing without patient consent or taking patient's sensitive information such as HIV status, age, marital status, medical history, delivery outcome so loud that everyone can hear.

Detention - retaining recently delivered women and their babies in health facilities, usually due to failure to pay.(1)

1.0 INTRODUCTION

1.1 Background

Pregnancy and childbirth are important periods whereby a woman is very vulnerable physically and emotionally. In this period, she needs a better way of being treated to ensure positive physical and psychosocial outcome after the period(2)(3)(4).

In sub Saharan Africa, pregnancy and childbirth continues to put women at risk of significant mortality and morbidity. In the efforts to reduce maternal morbidity and mortality, many women continue to deliver at home (5) while the sustainable development goal 3 to ensure healthy lives and promote well-being for all at all ages encourages facility delivery by a skilled health personnel(6).

Cost and Distance have been emphasised as the reason why women fail to access and receive quality care. On top of these, the recent emphasis on quality of care has found women's experience of disrespectful care and abuse related directly to providers actions, affect their place of delivery (1)(4)(7).

The disrespectful care and abuse (D&A) come in different forms including physical abuse like Beating, Slapping and Pinching, Lack of consent for care: such as caesarean section or tubal ligation, episiotomies, hysterectomies, blood transfusions, sterilization, or augmentation of labour. Non confidential care: through lack of physical privacy or sharing of confidential information. Undignified care: such as shouting, scolding and giving demeaning comments. Abandonment; being left alone during delivery, and Discrimination on the basis of ethnicity, age, or wealth, or detention in facilities for failure to pay user fees (8)(1).

D&A results to anxiety, depression and post-traumatic stress disorder following childbirth, and women with pre-existing mental health conditions may suffer a recurrence. Therefore this poor maternal mental health can affect the mother-child relationship and outcomes for children (2)(9).

Also poor maternal and child health outcome affects patient's satisfaction and therefore reduce the rate of facility deliveries. Consequently, these have been contributing to higher levels of maternal mortality and morbidity.

Emphasis on the Universal right of quality maternal health care has brought up the need for examining interpersonal relationships between patients and providers and, more specifically, ensuring women give birth in respectful circumstances and are not subjected to disrespectful or abusive care (3)(10).

These efforts had resulted to the establishment of seven rights of a delivering woman which are; Every woman has the right to be free from harm and ill treatment. Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including the right to her choice of companionship during maternity care. Every woman has the right to privacy and confidentiality. Every woman has the right to be treated with dignity and respect. Every woman has the right to equality, freedom from discrimination, and equitable care. Every woman has the right to healthcare and to the highest attainable level of health. Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion (10).

Health care providers have a critical role to play in ensuring that women emerge from childbirth physically and psychologically healthy. Also women are able to develop a health relationship with their children (2)(11)(12) since treating women with dignity and respect is the centre for improvements of quality of care(13)(4).

1.2 Literature Review

Disrespect or Abuse (D&A) in delivering women is a global problem in many low and high income countries although not well documented (4)

In health facilities Disrespect or Abuse (D&A) is challenging to define since it is subjected to variation based on setting, time, birth outcome and personal expectations or opinions.

Proposed domains of abuse have been highlighted in two seminal articles. D'Oliveira's work divides violence or abuse in health care into four dimensions: neglect; verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation; physical violence, including denial of pain-relief when technically indicated; and sexual violence (8).

Bowser's review outlines a similar framework that includes: physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination of patients, abandonment of care, and detention in facilities (8)(1)

Pregnant women seeking maternity care may receive ill treatment that ranges from disrespect of their autonomy and dignity to abuse like physical assault, verbal insults, discrimination, abandonment, or detention in facilities for failure to pay (3)(4). The prevalence of D&A worldwide still unknown but its existence is so loud resulting to Human rights moves towards delivery care (10).

In Easten Africa the prevalence of at least one form of D&A falls between 19% to 28% (3)(8)(1)(14).

The prevalence according to categories of D&A was studied by Abuja et al 2015 with higher frequency in non dignified care 18% followed by neglect and abandonment 14.3%.

Non confidential care and Detainment had prevalence of 8%, while non consensual and physical abuse presented the lowest prevalence of 4%.

Also in the study of 'disrespect and abusive treatment during facility delivery' in Tanzania done by Kruk et al (8), 'the experience and response to disrespectful maternity care and abuse during child birth' (5) and The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania by Sando D et al (15), the verbal abuse in terms of shouting and scolding, threatening and negative comments and

neglect/abandonment/ignored when needed help was the most frequent reported. The physical abuse was rare, and if happen it was either slapping or pinching 3% to 5% or pushing. While giving birth alone without assistance accounted about 4% to 5%.

The level of health facility has been found to predispose the woman to the experience of disrespect and abuse during giving birth. A study done in Ethiopia by Asefa et al (14) had found women who delivered at hospital reporting more of the experience of D&A than those who gave birth in health centres.

Demographically most studies have shown that women who had secondary or higher education level; poor women, those with previous history of physical abuse or rape, referred women and those delivering during night shift had high frequency of reporting to have experienced D&A (8)(3).

The study done in Tanzania (16) with the title Disrespect and Abuse During Childbirth in Tanzania: Are Women Living With HIV More Vulnerable? Revealed women living with HIV were not more likely to report disrespect and abuse during childbirth than HIV-negative women.

There are less reporting of D&A in married women, those in their third or more birth, women coming directly to health facility, the middle wealth and those who undergo caesarean section (8)(3)

Age, educational attainment, and socio-economic status influence level of delivery satisfaction. Whereby, educated groups are less satisfied than less educated groups, because of their higher expectations. Patients with higher social class are often more satisfied. Patients with lower expectations tend to be more satisfied (17).

In the study of the effect of multi component interventions on disrespect and abuse during child birth in Kenya by Abuya T et al (13), there was a decrease in frequency of D&A of about 7% after interventions towards D&A.

There was overall decrease in physical abuse, verbal abuse, violation of confidentiality and detainment after institution of trainings to HCW, monitoring and raising community awareness. However, abandonment feeling increased from 13% to 17%.

Some factors associated with D&A categories were identified; they included delivering at night shift for physical abuse, while middle wealth and delivering at night shift accounted for verbal abuse.

Detainment was associated with un married status, referred women, history of physical abuse and multiparity. Middle wealth women, those from home and with their first delivery had low risk of being detained.

Among the contributors of disrespectful treatment include absent or inadequate national human rights policies and their enforcement, lack of leadership in the health system, poor standards of care in facilities, provider demoralization and shortages (1).

Together with this are poor physical and organizational working environments, including shortages of medicine and provider as well as low pay and weak supervision to health providers resulting to demoralization and thus dehumanization of patients (18)(7). The dynamics of power in health systems that strongly favour health professionals and low community engagement in health governance limit the accountability of health providers to users. This lowers community expectations of facility birth, and sustains high rates of home deliveries (18)(19)(20).

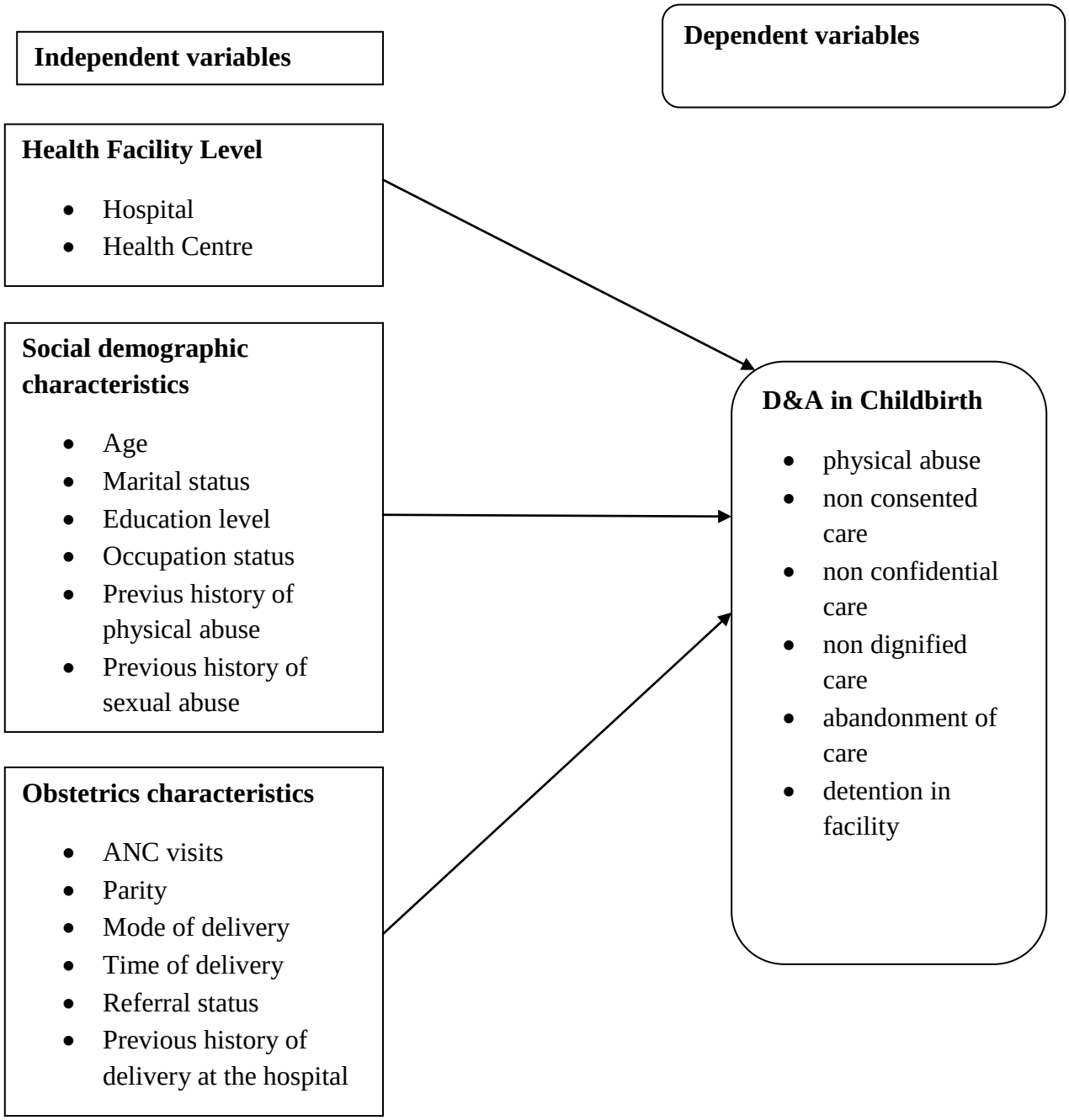
However for those delivering at health facility, long-standing patterns of poor quality and disrespectful care in a context of resource scarcity lead to their normalization in local cultures, making abusive care less visible (1)

Staff attitudes including abusive language denial of service and an absence of compassion represent one among many barriers to facility-based care by impinging client's service satisfaction , hence driving women to deliver at home (21)(22).

All women need good quality maternal health services to safeguard their lives and that of their unborn children. High -quality maternal care should be a continuum from the pregnancy to the postpartum period and in which women and health providers are partners in the care provision.

Kruk's discrete choice experiment of 2009 found that a provider's attitude and the availability of drugs were the most important characteristics influencing choice of a facility delivery and that improving these characteristics would lead to a 43-88% increase in facility delivery. Addressing D&A is therefore important to raise patient satisfaction and consequently causing patient to stick more to medical recommendations (23)(7).

1.3 Conceptual Frame Work



1.4 Problem Statement

Over recent decades, a growing body of research on women's experiences during pregnancy have found that many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities. This result to violation of trust between women and their health-care providers which consequently can also be a powerful reason for women not to seek and use maternal health care services.

While disrespectful and abuse to women may occur throughout pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth. Therefore Disrespectful and Abuse may have direct adverse consequences for both the mother and infant.

Some contributors of disrespect and abuse during child birth include absent or inadequate national human rights policies and their enforcement, lack of leadership in the health system, poor standards of care in facilities, poor physical working environments, including shortages of medicine and provider as well as low pay and weak supervision to health providers resulting to demoralization and thus dehumanization of patients.

Despite the existing evidence that suggests women's experiences of disrespect and abuse during facility-based childbirth are widespread the prevalence is still unknown worldwide.

1.5 Rationale of the study

Findings in this study will contribute to the already existing body of information.

The study aims at describing the prevalence, characteristics of women who are prone and women perceived reasons for disrespect and abuse during child birth so as to improve services during giving birth in Mbeya Health Facilities.

It will be used as a platform for future researches and facilitate the planning and implementation on the efforts to reduce and ultimately eliminate D&A, hence improving facility delivery and maternal morbidity and mortality.

1.6 Research Questions

What is the prevalence of Disrespect and Abuse to women during child birth in Mbeya City Health Facilities from October to December 2016?

Is there any association between Disrespect and Abuse to women during child birth in Mbeya City Health Facilities and their social demographic and delivery characteristics, from October to December 2016?

What do women perceive as the possible reasons for Disrespect and Abuse to women during child birth in Mbeya City Health Facilities, from October to December 2016?

1.7 Objectives

1.7.1 General objectives

To determine the Prevalence of Disrespect and Abuse to women giving birth in Mbeya City Health Facilities from October to December 2016.

1.7.2 Specific objectives

1. To determine prevalence of disrespect and abuse to women giving birth in Mbeya City Health Facilities, from October to December 2016.
2. To determine the association between the experience of disrespect and abuse to women giving birth and their social demographic characteristics in Mbeya City Health Facilities, from October to December 2016.
3. To determine the association between disrespect and abuse among women giving birth and women obstetrics characteristics in Mbeya City Health Facilities, from October to December 2016.
4. To determine the reasons for disrespect and abuse during childbirth as perceived by women in Mbeya City Health Facilities, from October to December 2016.

2.0 METHODOLOGY

2.1 Study design

It was a descriptive cross sectional study, involving six government Mbeya City health facilities with a sample size of 270 women, which was done from October to December 2016. The study used mixed methods, observation and interview. This is because literature has shown higher reporting during community survey compared to facility studies, hence we thought observation would potentiate sharing of the information during interview.

2.2 Study duration

The study was conducted for three months, from October to December 2016.

2.3 Study setting

Mbeya City Council has a total of 53 health facilities. Five hospitals, five health centres and thirty three dispensaries, six clinics and four maternity homes. Three hospitals are owned by government and two are private. Three health centres are governmental and two are owned by faith based organizations. Thirteen dispensaries are governmental and twenty are private owned. The six clinics and four maternity homes

The government health facilities were chosen for convenience since they cover majority of deliveries. Also, there was higher likelihood of the study to be accepted by facility managers in government than private facilities, due to its high sensitivity. The study was conducted in six government Mbeya City Health Facilities, three hospitals and three health centres. The dispensaries were excluded because deliveries occur only at emergency basis.

Of these facilities, only hospitals perform caesarean sections. These are Mbeya Zonal Hospital (META), Mbeya Regional Hospital and recently Mbeya City District Hospital (IGAWILO).

The average of deliveries per day in facilities were Mbeya Zonal Hospital (Meta) 17, Mbeya Regional Hospital 9, Igawilo 11, Ruanda 7, Kiwanjampaka 3, Iyunga 1, each dispensaries1.

A referral system exists between these facilities, from lower to higher facilities.

Mbeya region is one among the regions with high prevalence of gender based violence (GBV). There are programmes against GBV funded by Watereed and supported by ministry of health conducted both at facility and community levels.

There exists an insurance coverage for all pregnant women in Mbeya City. It is through Tanzanian-German project for safe deliveries in Mbeya and Tanga regions known as KfW. The enrolment is normally done during ANC visits or during labour. The coverage last through the whole period of pregnancy up to six months post-delivery. It also covers for the new born baby. After six month post-delivery the woman and the baby will be entered directly into a community health fund (24).

2.4 Study population

The study population included all women who attended maternity services in the six selected (3 hospitals and 3 Health Centres) Mbeya City Health Facilities, during the study period, from October to December 2016.

2.5 Study sample

The study sample was conveniently drawn from all women who gave birth in the six government Mbeya City Health Facilities during the data collection period, from October to December 2016.

2.6 Sample size estimation

$$N = \frac{Z^2 p(1-p)}{D^2}$$

Reference: (Lu Ann Aday and Llewellyn .J. Cornelius. *Designing and Conducting Health Survey,* A Comprehensive Guide, *3rd* edition, 2006 John Wiley & Sons, Print.)

Whereby;

N= estimated sample size

Z = coefficient corresponds to 95% level of significance, that is 1.96

P = proportion, Taken as 20% from study done in Kenya (3)

E = maximum error, estimated as 5%

Minimum sample size is 245.

When adjusting for 10% of non respondent, minimum sample size become 270.

2.7 Sampling technique

Three governmental hospitals and three health centre in Mbeya City were included in the study; dispensaries were excluded because women give birth there only at emergency basis.

Only government health facilities were included in the study because they serve the majority of the population which would fulfil the sample size in a given short period of study. Also, there was higher likelihood of the study to be accepted by facility managers in government than private facilities, due to its high sensitivity.

The contribution of facilities to sample size was according to the ratio of their average number of deliveries per day given above. This is to say Mbeya Zonal Hospital 96, Mbeya Regional Hospital 51, Igawilo 62, Ruanda 39, Kiwanjampaka 16, Iyunga 6.

Participants were recruited at the labour ward conveniently after obtaining their permission to be observed.

2.8 Exclusion criteria

All women who came in labour ward with obstetric emergencies or at second stage.

All women who were referred to another facility before delivery.

2.9 Data collection procedure

Data collection was done in three government hospitals and three health centres. It was done using observational check list in the labour ward and an exit interview questionnaire in the postnatal ward. Nurses with GBV background knowledge from the maternity block were used as research assistant, for easiness of understanding the forms of disrespect and abuse. These were trained the disrespect and abuse to delivering women and how to identify different categories during observation and interview and demonstration was done, for a week. They were supervised for six weeks by the principal investigator. The nurses in labour ward were aware of the ongoing study but were not aware of the particular patient observed.

Data was collected at an average of one woman per facility in one day.

Women admitted in labour ward were asked for permission to observe how they receive care in labour ward. Most of these patients were in active stage of labour because they start at Antenatal ward and when in active stage shifted to labour ward. A detailed consent that explained what was the study and its aim was given during a postnatal interview. Women were able to refuse to be interviewed or not to answer any question they felt sensitive to them. They were assured that the refusal would not deny them access to services.

The observation for any experience of disrespect and abuse was conducted during first examination in labour ward, and then during delivery where by the use of screen and women covering to provide privacy was checked. Also the asking for consent before examination, if the language used was polite or not and if there were any physical abuses encountered. Lastly they were observed in the postnatal ward to check for the bed sharing. The issues pertaining to disrespect and abuse were filled in the checklist, for the disrespect and abuse that was not in the checklist and patient encountered them research assistants noted them too. For the women who went for caesarean section the part of observation during delivery was left blank.

The same women were interviewed on their delivery experience within two to twelve hours post delivery by research assistants. The interview was conducted in a separate room to provide privacy and improve confidentiality. Proper consenting was administered before the interview. The women who were found to have experienced disrespect and abuse were counselled then advised to write their concerns in the suggestion box in the facility or to report the acts directly to the facility administrators, to help improve delivery experiences/services not necessarily to them but to other women too. There was no any woman among those who experienced disrespect and abuse needed a referral for further help.

A total of 247 were observed during labour and 183 were observed during delivery. All 270 women were both interviewed or observed during postnatal interview. 23 women had unfilled checklist during labour and delivery while 64 women went for caesarean section, hence no observation done during delivery. The flow chart below clearly explains

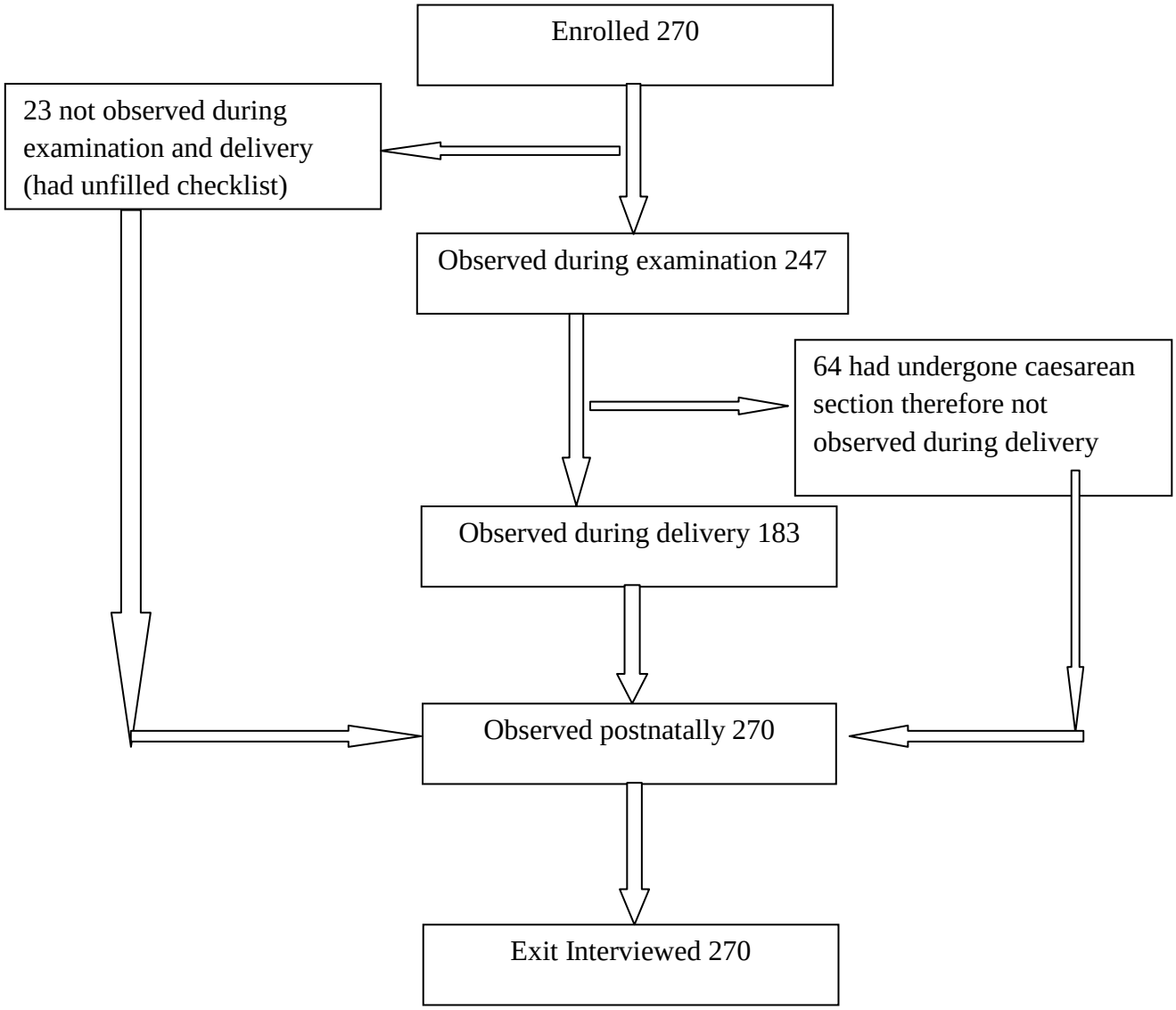


Figure 1: Patient flow chart

2.10 Data Collection Tool

Data was collected using an observational checklist and a questionnaire.

The observation check list consisted of the forms of disrespect and abuse that was experienced during labour, delivery and at post natal. The presence or absence of disrespect and abuse were recorded. Whenever other forms of disrespect and abuse occurred, and not indicated in the checklist, a commentary was given.

The questionnaire (appendix I&II) consisted of two parts. The first part had included socio-demographic and delivery characteristics of the subjects namely age, place of residence, occupation, marital status, level of education, parity, referral status, mode and time of delivery that was filled in the postnatal interview.

The second part consisted of questions on the woman experience of disrespect and abuse after delivery and the reasons. The questionnaire was filled two to twelve hours post delivery, during the postnatal interview.

The observational checklist and questionnaire were adopted from other similar studies and modified to suit the study setting(4)(15)(13). Pre testing of the observational checklist and questionnaire was done for one week before the start of data collection at Regional Hospital and necessary adjustment were made.

2.11 Data analysis

Data was entered and cleaned then analyzed using IBM SPSS version 20 statistical packages. The composite score of all forms of disrespect and abuse assessed during interview was created to analyse the experience of disrespect and abuse. Frequency and percentages were used to analyse the prevalence and reasons for disrespect and abuse. Categorical variables were compared among women with or without outcome of interest (D&A) to look for the association using chi square and p value <0.05 was taken as statistically significant.

2.12 Ethical consideration

Ethical clearance was sought from MUHAS research and publication committee as well as permission to conduct the study from the RMO office, Executive Director of Mbeya Zonal Hospital, Executive Director of Mbeya City and Medical Officer of the respective Hospitals and Health Centres.

Verbal consent was sought from each participant after explaining the study to her. The name of the patient was not taken during data collection.

The women who were found to have experienced disrespect and abuse were counselled and reminded that the report of the study was for the aim of improving care and will be disseminated to the administrators. Also they were encouraged to write their concerns in the suggestion box in the facility or report the abusive acts to the facilities administrator, to

help improve delivery experiences and services. Reporting of the events of disrespect and abuse was done to facility administrators to allow for the appropriate intervention to improve services during giving birth.

There was no any woman who experienced disrespect and abuse, needed a referral for further help**.**

3.0 RESULTS

A total of 270 women were interviewed. Among the selected participants eligible for the study none refused to participate.

They had a mean age of 26 years, with standard error of the mean 0.360. Majority of women were between the ages of 18 to 34years, they were married and had completed primary school. They were either in their 1st, 2nd or 3rd delivery. Most of them had ANC visits more than four. The previous history of ever been physically abused was reported in ten percent of women while previous history of ever sexual abuse in fifteen percent. More than a quarter had delivered in the same facility previously. Of the interviewed women, most of them delivered during the day and by SVD, 62.6% AND 76.3% respectively **(table 1).**

Table 1: Social demographic and obstetrics characteristics of the respondents from six facilities in Mbeya City

Social Demographic characteristics	Frequency (N=270)	Percentage (%)
Age of clients interviewed		
Mean age(SE)	**26 (0.360)**	
18-24	126	46.7
25-34	115	42.6
>34	29	10.7
Marital Status		
Single/Divorced/Separated	49	18.1
Married/Cohabiting	221	81.9
Education level		
Primary	159	58.9
Secondary	90	33.3
Tertiary	21	7.8
Occupation status		
Employed	224	83
Unemployed	46	17
Past Experiences		
Previous history of ever abused physically	27	10
Previous history of ever abused sexually	42	15
Obstetrics Characteristics		
ANC visits		
Less than four	88	32.6
Four or more	182	67.4
Parity		
Para1	108	40
Para 2 and 3	120	44.4
Para 4 and above	42	15.6
Time of delivery		
Day	169	62.6
Night	101	37.4
Mode of delivery		
SVD	206	76.3
Caesarean Section	64	23.7
Referral Status		
From home	245	90.7
From other facility	25	9.3
Previous delivery at facility	103	38.1

Table 2: The Prevalence of reported Disrespect and Abuse during childbirth in Mbeya City health facilities

Experience of Disrespect and Abuse	Frequency (N=270)	Percentage (%)
Any form of disrespect and abuse that made you feel bad	90	33.3
Non Consented Care		
Not asked for consent while Examined or given care	13	4.8
Physical Violence*	**16**	**5.9**
Pinched	1	0.4
Pushed	1	0.4
Slapped and pushed	3	1.1
Pinched and pushed	1	0.4
Pushed and shouted at	5	1.9
Slapped and scolded	3	1.1
Pushed and scolded	2	0.7
Slapped and shouted at	3	1.1
Non Confidential Care*	**115**	**42.6**
Privacy violation	106	39.3
Confidentiality violation	20	7.4
Non dignified care: Verbal violence*	**65**	**24.1**
Scolding	18	6.7
Shouting	25	9.3
Called by insulting names	5	0.7
Laughed at	4	0.7
Pushed and shouted at	5	1.9
Slapped and scolded	3	1.1
Pushed and scolded	2	0.7
Slapped and shouted at	3	1.1
Negligence/Abandonment	**37**	**13.7**

(*indicate the multiple response questions)

Table 2 shows in overall more than a quarter of the respondents experienced disrespect and abuse during giving birth.

Non confidential care violation was the most reported type of disrespect and abuse during giving birth, 42.6%. Non dignified care (verbal abuse) was in more than one fifth while negligence occurred in more than ten percent. Other forms occurred in less than ten percent of the respondent.

Table 3: The Prevalence of observed Disrespect and Abuse during childbirth in Mbeya City health facilities

D&A	**Frequency (N)**	**Percentage (%)**
During Examination (N=247)		
Informed consent	29	11.7
Verbal violence	34	13.8
Screen use	29	11.7
Negligence	8	3.2
During Delivery (N=183)		
physical or verbal	55	30.1
Physical	5	2.7
Verbal	36	19.7
physical and verbal	14	7.7
Patient covering	163	89.1
During Postnatal (N=270)		
Bed Sharing	57	21.1
Two	54	20
Three	3	1.1

Table3 shows the prevalence of disrespect and abuse was high in observation than reported by women. It occurs more during delivery, physical or verbal 30.1% and privacy violation 89.1%

Table 4: The association between experience of disrespect and abuse to women giving birth at Mbeya City Health Facilities and their social demographic characteristics

Social Demographic Characteristics	Total	Disrespect And Abuse Experience		
		Yes	No	P-value
Age group				
18-24	126	47(37.3%)	79(62.7%)	
25-34	115	31(27.0%)	84(73.0%)	0.146
>34	29	12(41.4%)	17(58.6%)	
Education level				
Primary	159	50(31.4%)	109(68.6%)	0.716
Secondary	90	32(36.6%)	58(64.4%)	
Tertiary	21	8(38.1%)	13(61.9%)	
Marital status				
Single/divorced/separated	49	18(36.7%)	31(63.3%)	0.577
Married/cohabiting	221	72(32.6%)	149(67.4%)	
Occupation status				
Employed	224	76(33.9%)	148(66.1%)	0.647
Unemployed	46	14(30.4%)	32(69.6%)	
History of physical abuse				
Yes	27	14(51.9%)	13(48.1%)	0.031
No	243	76(31.3%)	167(68.7%)	
History of sexual abuse				
Yes	42	16(38.1%)	26(61.9%)	0.476
No	228	74(32.5%)	154(67.5%)	

Of the 6 variables, only a history of prior physical abuse had association with the report of disrespect and abuse at p value 0.031.

Table 5: The association of disrespect and abuse among women giving birth in Mbeya City Health Facilities and their Obstetric Characteristics

Delivery Characteristics	Total	Disrespect And Abuse Experience		
		Yes	**No**	**P-value**
ANC visits				
Less than four	88	29(33.0%)	59(67.0%)	0.927
Four and above	182	61(33.5%)	121(66.5%)	
Parity				
Para 1	108	39(36.1%)	69(63.9%)	
Para 2&3	120	40(33.3%)	80(66.7%)	0.512
Para4 and above	42	11(26.2%)	31(73.8%)	
Previous Delivery At Health Facility				
Yes	103	29(28.2%)	74(71.8%)	0.156
No	167	61(36.5%)	106(63.5%)	
Referral Status				
Home	245	80(32.7%)	165(67.3%)	0.458
Other HF	25	10(40.0%)	15(60.0%)	
Delivery Time				
Day	169	55(32.5%)	114(67.5%)	0.722
Night	101	35(34.7%)	66(65.3%)	
Mode Of Delivery				
SVD	206	58(28.2%)	148(71.8%)	0.001
Caesarean	64	32(50%)	32(50%)	
Health Facility				
Hospital	209	79 (37.8%)	130 (62.2%)	0.004
Health centre	61	11 (18.0%)	50 (82.0%)	

The report of disrespect and abuse was more associated with the caesarean section than SVD at p value 0.001. It was more reported among women delivering at the hospital than those at the health centre at p value 0.004.

Table 6: The response of women's perceived reasons for disrespect and abuse in Mbeya City Health Facilities

Cause of disrespect and abuse	Frequency (N=270)	Percentage (%)
Normal in our settings	105	38.9
Women stubbornness/not complying to providers instruction	137	50.7
Women who don't give money/bribe	1	0.4
Providers poor knowledge of human rights	87	32.2
Women coming late at health facility	5	1.9
Others	95	35.2
Women poor knowledge of their rights	30	11.1
Providers harshness/violence	71	26.3
Heavy workload/overcrowding	23	8.5

(Women were giving multiple responses to what they thought as reasons for D&A)

Majority took blame to themselves by admitting their stubbornness or not complying with provider's instructions as the reason for disrespect and abuse during delivery. More than a quarter said it is something normal in the settings, pointing fingers to providers harshness or poor knowledge of human rights

Women poor knowledge of their rights, heavy work/overcrowding, late comers and bribe were less identified as reasons for disrespect and abuse during delivery.

4.0 DISCUSSION

The study used mixed methods, observation during labour, delivery and at postnatal aiming at increasing the likelihood of sharing the experiences during exit interview. However twenty three women had not been observed during labour and delivery and sixty four who delivered by caesarean section could not be observed during delivery. Since an exit interview was used to answer the objectives, the study was not affected in any way.

The overall disrespect and abuse was 33.3%, this was according to the composite score of the various forms of D&A asked during interview. The finding nearly corresponds to the study done by Abuya (3) whereby the reported prevalence ranged from 19%-28%. But in another study done in Tanzania the prevalence was 15% (15) which is less than our study findings. Our findings was far lower than study done in Ethiopia (14) whereby the overall disrespect and abuse was more than 75% both in hospital and health centres. The differences may be explained by the difference in methodological approach to the studies.

Considering the categories of disrespect and abuse in descending order, non confidential care was leading followed by non-dignified care (verbal), neglect, physical abuse and lastly non consented care. The pattern and prevalence of disrespect and abuse was a bit different and higher than other studies reported (3)(15) whereby non-dignified care was the leading disrespect. Also different from an observation study for Easten and Southern Africa (25) reported neglect as the most occurring D&A. This is due to the fact that at our study setting women were not covered during delivery which might have increased the proportion of non-dignified care. Also the methodology used which is observation then interview encouraged women to open up their experiences to the interviewers and therefore more prevalence was reported. This is the case when women were interviewed during community follow up done in other studies. The prevalence of respective categories was lower than study done in Ethiopia (14) except for non-dignified care.

The verbal abuse was mostly in the form of shouting or scolding. Calling with insulting names and laughing at the patient were less common. Physical abuse was mostly by pushing, pinching or slapping that resembled other studies (5)(8). There was neither use of instruments nor stitching without anaesthetic observed or reported contrary to a study by

Sando (15). Most of the time verbal and physical abuse occurred together and coexisted with other forms.

Contrary to other studies (3)(15), there were no any case of detention in the hospital reported. This was due to the fact that all pregnant women in Mbeya City health facilities are covered by an insurance scheme known as KfW that covers for medical expenses of a pregnant woman until six months after delivery together with her baby. Women would be enrolled in the insurance during ANC visits or during labour.

While looking at the association between the experience of disrespect and abuse with social demographic characteristics, only previous history of physical abuse was associated with disrespect and abuse. The findings are the same as studies (3)(8) while contrary to the study done in Tanzania (15) that reported less experience of D&A in this group of women. Our findings can be explained by the existing campaigns against gender based violence in the region and all over the country. This might have made the women more aware of the abusive events of any form but also capacitate them to share or report the abusive actions.

Other factors like age, marital status, education level and occupation was found to have no association with the experience of disrespect and abuse. This is contrary to other studies (3)(8)(17), and the differences may be accounted by the fact that our study was a simple survey considering disrespect and abuse as a composite score of its forms while other studies were analytical studies and they defined disrespect and abuse according to its forms.

In assessing the association between obstetrics characteristics of mothers and disrespect and abuse, it was found that the level of facility and mode of delivery were significantly relating to the experience of disrespect and abuse. Women who delivered by caesarean section significantly reported disrespect and abuse compared to those delivered by SVD. This might be due to the fact that we interviewed the women who had undergone caesarean section after staying in labour for a certain period of time. These women are likely to report the abuse due to the fact that their expectations on mode of delivery were not met and hence they were dissatisfied (22)(23).

Women who delivered in the hospitals had more reporting of the experience of disrespect and abuse than those in the health centres. This findings is similar to study done in Ethiopia (14). This can be explained by the fact that majority of deliveries in Mbeya City occur at hospitals as shown by average deliveries per day in the methodology. Though there is referral system within the district most of women would go directly to higher health facilities probably to seek more specialized care. Also, the existence of insurance coverage to all pregnant women, give them opportunity to utilize any facility of their choice. More women want to access specialised care and because every mother holds health insurance providers would accept clients without questioning since at the end they would be rewarded for the service provided. This results to more delivery load in the hospitals hence higher chances of experiencing D&A.

When women were interviewed on the perceived reasons for disrespect and abuse during delivery, majority took blame to themselves by admitting their stubbornness or not complying with provider's instructions as the main reason (20). This finding can be attributed to the fact that the interview took place at the facility while women were still in need of medical care. Therefore, they might have been worrying to project blame to the health facility factors (9).

Other reasons were, it is something normal in this settings (7)(1), is due to providers harshness (19)(20) and the providers have poor knowledge of human rights, which was reported by more than a quarter of the responders. Few women reported poor knowledge of their rights, heavy work/overcrowding, late comers and bribe as reasons for disrespect and abuse during delivery.

The findings that "not paying bribe to health providers being identified in low frequency", is promising in ensuring equal access for health care to all women. The credit should be given to the existing insurance system (KfW) that has saved women from potential consequences of not affording healthcare costs (24). The blame to the providers can be explained by the fact that when women are at the facility their major concern is to receive quality service and in short of that they would blame the direct people in contact with, and these are the health care providers.

The concept of normalizing abnormal care has been projected in our study through the discrepancy between observed incidences and reported prevalence of D&A whereby the observed a bit higher than reported.

This study brings about useful information due to the fact that it is a multi centre study representing facility according to their deliveries per day and hence can be generalized for the Mbeya City. The use of mixed methods observation and interview has potentiated the capturing the different forms of disrespect and abuse. Also, it has involved women giving birth who are the key people while providing services.

Though the use of nurses from the same block might have resulted to under reporting of events of D&A however the principal investigator tried to visit facilities for supervision from time to time to ensure proper observation as well as interview of the women by the research assistants. The fact that the study did not involve the providers and administrators to understand both providers and system factors for disrespect and abuse which would add more strength to the study for policy makers, calls upon a larger study.

Therefore as we move towards sustainable development goals we would want every woman to deliver at facility, however the prevalence of disrespect and abuse is alarming. Addressing other factors without forgetting disrespect and abuse during delivery will speed up the efforts. These findings call upon discussion as women will not shout to be heard rather shy away from using the facilities, an act which will hinder the efforts towards reduction of maternal and child mortality.

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

One out of three women experience D&A during delivery in Mbeya city facilities. Non confidential, non dignified-verbal and neglect were marked in the study. Majority experience it while delivering at the Hospital.

Though majority took blame to themselves, normalization, providers' harshness and providers' poor knowledge of human rights were mostly perceived as the reasons for D&A.

5.2 Recommendations

Matters pertaining disrespect and abuse should be discussed during ANC visits where birth preparedness is normally discussed. This should include what to expect during labour and delivery and how to behave accordingly.

Another study with bigger sample size should be done to complement the findings and explore provider and system factors to come up with comprehensive recommendation for a better outcome.

The findings of this study calls upon stakeholders' initiative to address the disrespect and abuse to promote maternal health.

5.3 Study Limitations

The use of nurses from the same block might have resulted to under reporting of events of D&A however the principal investigator tried to visit facilities for supervision from time to time to ensure proper observation as well as interview of the women by the research assistants.

The study did not involve the providers and administrators to understand both providers and system factors for disrespect and abuse which would add more strength to the study for policy makers.

REFERENCES

1. Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis. 2010. 1-57 p.
2. Prochaska E. Women's fundamental human rights are at stake in maternity care. Letter to the National Maternity Review Birthrights. 2015. p. 1–6.
3. Abuya T, Warren CE, Miller N, Njuki R, Ndwiga C, Maranga A, et al. Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. PLoS One [Internet]. 2015;10(4):e0123606.
4. Warren C, Njuki R, Abuya T, Ndwiga C, Maingi G, Serwanga J, et al. Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya. BMC Pregnancy Childbirth [Internet]. 2013;13:21.
5. McMahon S a, George AS, Chebet JJ, Mosha IH, Mpembeni RN, Winch PJ. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. BMC Pregnancy Childbirth [Internet]. 2014;14(1):268.
6. United Nations Statistical Commision E. Revised list of global Sustainable Development Goal indicators Annex III Revised list of global Sustainable Development Goal indicators. Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (E/CN3/2017/2). 2017. p. 1–26.
7. CARE International T. FACILITY-BASED CHILDBIRTH: The Perceptions and Experiences of Tanzanian Women, Health Workers, and Traditional Birth Attendants. 'WE HAVE NO CHOICE '. 2008.
8. Kruk M, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedm. Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. Health Policy Plan. 2014;1–8.
9. Schroll A, Kjærgaard H, Midtgaard J. Encountering abuse in health care; lifetime experiences in postnatal women - a qualitative study. BMC Pregnancy Childbirth. 2013;1–11.

10. Windau-Melmer T 2013. A Guide for Advocating for Respectful Maternity Care. 2013.
11. Human-Rights C. UN General Assembly. Technical guidance on the application of a human rights- based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. 2012.
12. Human-Rights C. UN General Assembly. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age. 2014.
13. Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N, et al. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. BMC Pregnancy Childbirth [Internet]. BMC Pregnancy and Childbirth; 2015;
14. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reprod Health [Internet]. 2015;12(1):33.
15. Sando D, Ratcliffe H, Mcdonald K, Spiegelman D, Lyatuu G, Mwanyika-sando M, et al. The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. BMC Pregnancy Childbirth [Internet]. BMC Pregnancy and Childbirth; 2016;1–10.
16. Sando D, Kendall T, Lyatuu G, Ratcliffe H, McDonald K, Mwanyika-Sando M, et al. Disrespect and abuse during childbirth in Tanzania: are women living with HIV more vulnerable? J Acquir Immune Defic Syndr [Internet]. 2014;67 Suppl 4:S228-34.
17. Melese T, Gebrehiwot Y, Bisetegne D, Habte D. Assessment of client satisfaction in labor and delivery services at a maternity referral hospital in Ethiopia. Pan Afr Med J. 2014;8688:1–9.
18. Mselle LT, Moland KM, Mvungi A, Evjen-olsen B, Kohi TW. Why give birth in health facility? Users ' and providers ' accounts of poor quality of birth care in Tanzania. 2013;

19. Reed R, Sharman R, Inglis C. Women ’ s descriptions of childbirth trauma relating to care provider actions and interactions. BMC Pregnancy Childbirth [Internet]. BMC Pregnancy and Childbirth; 2017;1–10.

20. Balde MD, Diallo BA, Bangoura A, Sall O, Soumah AM, Vogel JP, et al. Perceptions and experiences of the mistreatment of women during childbirth in health facilities in Guinea: a qualitative study with women and service providers. Reprod Health [Internet]. Reproductive Health; 2017;1–13.

21. Warren CE, Njue R, Ndwiga C, Abuya T. Manifestations and drivers of mistreatment of women during childbirth in Kenya: implications for measurement and developing interventions. BMC Pregnancy Childbirth. BMC Pregnancy and Childbirth; 2017;1–14.

22. Mrisho M, Schellenberg JA, Mushi AK, Obrist B, Mshinda H, Tanner M. Factors affecting home delivery in rural Tanzania. Trop Med Internatinal Heal. 2007;12(7):862–72.

23. Ambruoso LD, Abbey M, Hussein J. Please understand when I cry out in pain: women â€TM s accounts of maternity services during labour and delivery in Ghana. BMC Public Health. 2005;11:1–11.

24. KfW Development Bank G. How a Health Insurance Scheme for Poor Women Saves Lives. Enhancing Safe Deliveries in Tanzania. 2016. p. 1–3.

25. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. BMC Pregnancy Childbirth [Internet]. BMC Pregnancy and Childbirth; 2015;1–11.

APPENDICES

Appendix I: Observation Checklist

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

THE PREVALENCE OF DISRESPECT AND ABUSE AMONG WOMEN DELIVERING IN MBEYA MUNICIPAL HEALTH FACILITIES

During Examination

1. Did provider obtain permission from the mother before the initial vaginal examination?
   a. Yes.....
   b. No.....
2. Did provider use harsh tones or shout during asking consent?
   a. Yes.....
   b. No.....
3. Are there separating partitions between the beds providing privacy?
   a. Yes.....
   b. No.....
4. Were the partition used during examination?
   a. Yes.....
   b. No.....

During Delivery period

5. Is the staff being aggressive in any way ?
   a. Yes.....which one; a. physical.....b. verbal aggression..... c. both.....
   b. No.....

6. Is the mother being covered (excluding the perineal area).
    a. Yes.....
    b. No.....

Postnatal period

7. Was the mother allocated bed only to herself?
    a. Yes.....
    b. No.....
    If no; how many women per bed.....

Appendix II: Orodha

CHUO CHA AFYA NA SAYANSI SHIRIKISHI MUHIMBILI

IDARA YA MAGONJWA YA AKINA MAMA NA AFYA YA UZAZI

KIWANGO CHA UKATILI NA KUKOSEWA HESHIMA MIONGONI MWA KINA MAMA WANAOJIFUNGUA KATIKA VITUO VYA AFYA, KATIKA MANISPAA YA MBEYA.

Wakati wa Kupima

5. Je mtoa huduma aliomba ridhaa kwa mama kabla ya kumpima?
    a. Ndio.....
    b. Hapana .....
6. Je mtoa huduma alitumia maneno makali au sauti ya kukaripia wakati wa kuchukua historia?
    a. Ndio.....
    b. Hapana .....
7. Je kuna mapazia yanayompatia hifadhi/usiri mgonjwa?
    a. Ndio .....
    b. Hapana .....
8. Je mapazia yalitumika wakati wa kumpima mgonjwa?
    a. Ndio .....
    b. Hapana .....

Kipindi cha kujifungua.

9. Je mtoa huduma amekuwa mkali kwa namna yoyote ile?
    a. Ndio .....: Je ni kwa jinsi gani? 1. Kimwili 2. Maneno 3. Vyote
    b. Hapana .....
10. Je mama amefunikwa (ukiacha sehemu za siri tu).
    a. Ndio.....
    b. Hapana.....

Wodini baada ya kujifungua

11. Je mama alilala kwenye kitanda peke yake?
    a. Ndio.....
    b. Hapana.....; Je ni kinamama wangapi walilala katika kitanda kimoja?.....

Appendix III: Questionnaire

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

THE PREVALENCE OF DISRESPECT AND ABUSE AMONG WOMEN DELIVERING IN MBEYA MUNICIPAL HEALTH FACILITIES

A: PART ONE

DEMOGRAPHIC CHARACTERISTICS

1. Age.....
2. Residence.....
3. Occupation.....
4. Marital status
    a. Single
    b. Married
    c. Cohabiting
    d. Divorced
    e. Separated
5. Level of education
    a. No formal education
    b. Primary
    c. Secondary
    d. Higher
6. Referral status
    a. Self/from home
    b. Referred from other hospital

7. Accompanied adult.
    a. Yes
    b. No
8. Parity.....
9. Number of ANC visits made.....
10. Is there any identified obstetric risk? (name it).....
11. Facility
    a. Hospital
    b. Health center
    c. Dispensary
12. Past service utilization
    a. YES
    b. NO
13. Previous history of physical abuse
    a. YES
    b. NO
14. Previous history of sexual abuse
    a. YES
    b. NO
15. When did the mother deliver?
    a. Morning shift (0700-1300)
    b. Evening shift (1300-1800)
    c. Night shift (1800-0700)
16. The mode of delivery was:
    a. CS
    b. LCVE
    c. VAGINAL
    d. ABD

B: PART TWO

PATIENT EXPERIENCE OF DELIVERY SERVICES

17. In a scale of five, how would rate the quality of care?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor
18. In a scale of five, how can you rate the services you have received?
    a. Very satisfied
    b. Somewhat satisfied
    c. Satisfied
    d. Somewhat dissatisfied
    e. Dissatisfied
19. Would you recommend the facility for your nearby friend or relative
    a. Yes
    b. No
20. If you get another pregnancy where would you like to deliver?
    a. Public health facility, name.....
    b. Private health facility
    c. Home
21. Did the provider talk to you in a harsh way or did something to you that made you feel bad or humiliated during labour or delivery?
    a. Yes
    b. No
22. Did the provider asked you for permission before giving you any service (like examination, stitching, caesarean section, medication)
    a. Yes.....
    b. No

23. Were you physically abused by any of the health care workers? (slapped, punched, pinched, pushed, pinched with an instrument, stitching without anaesthesia)
    a. Yes.....
    b. No
24. Were you treated in a way that violated your privacy (eg. Screen use during examination or body cover except genitalia during delivery?)
    a. Yes
    b. No
25. Were you treated in a way that violated your confidentiality (eg. Being asked your information loud, provider sharing your information without your permission?)
    a. Yes.....
    b. No
26. Did any healthcare provider talk or use a tone or facial expression that made you feel uncomfortable? Were you insulted or laughed at?
    a. Yes.....
    b. No
27. Were you or your baby prevented from leaving this facility because you could not pay?
    a. Yes.....
    b. No
28. Were you left un attended by health providers when you needed care?
    a. Yes.....
    b. No
29. Were you using a bed for yourself or you were sharing with someone else?
    a. Oneself
    b. Sharing, how many.....
30. What do you perceive as the causes of disrespect and abuse during delivery?
    a. It is normal
    b. Women sturbonness
    c. Not giving money to providers
    d. Coming late to the facility
    e. Not knowing human rights
    f. Others.....

Appendix IV: Dodoso

CHUO CHA AFYA NA SAYANSI SHIRIKISHI MUHIMBILI

IDARA YA MAGONJWA YA AKINA MAMA NA AFYA YA UZAZI

KIWANGO CHA UKATILI NA KUKOSEWA HESHIMA MIONGONI MWA KINA MAMA WANAOJIFUNGUA KATIKA VITUO VYA AFYA, KATIKA MANISPAA YA MBEYA.

A: SEHEMU YA KWANZA

1. Umri.....

2. Makazi.....

3. Kazi.....

4. Hali ya ndoa

    a. Hajaolewa
    b. Ameolewa
    c. Wanaishi pamoja
    d. Ametalikiwa
    e. Ametengana

12. Kiwango cha elimu
    a. Hajasoma
    b. Msingi
    c. Sekondari
    d. Elimu ya juu

13. Hali ya rufaa
    a. Kutoka nyumbani.....
    b. Kutoka kituo kingine cha afya.....

14. Msindikizaji.
    a. Ndio.....
    b. Hapana .....
15. Uzazi wa ngapi?.....
16. Idadi ya mahudhurio ya kliniki wakati wa ujauzito.....
17. Je mama ana viashiria vyovyote vya hatari? (vitaje).....
18. Aina ya kituo cha afya
    a. Hospitali
    b. Kituo cha afya
    c. Zahanati
19. Umeshawahi kutumia kituo hikicha afya?
    a. Ndio
    b. Hapana
20. Umeshawahi kupatwa na ukatili wa kimwili?
    a. Ndio
    b. Hapana
21. Umeshawahi kupatwa na ukatili wa kingono?
    a. Ndio
    b. Hapana
22. Mama alijifungua saa ngapi?
    a. Asubuhi (0700-1300)
    b. Jioni (1300-1800)
    c. Usiku (1800-0700)
23. Mama alijifungua kwa njia gani?
    a. oparesheni
    b. vacuum
    c. kawaida
    d. Kusaidiwa mototo aliyetanguliza matako

B: SEHEMU YA PILI

MTAZAMO WA MGONJWA/MAMA JUU YA HUDUMA WAKATI WA KUJIFUNGUA

24. Katika kipimo cha moja mpaka tano, nini maoni yako juu ya ubora wa huduma wakati wa kujifungua?
    a. Nzuri mno
    b. Nzuuri sana
    c. Nzuri
    d. Kawaida
    e. Hafifu
25. Katika kipimo cha moja mpaka tano, nini maoni yako juu huduma ulizopata wakati wa kujifungua?
    a. Zinakidhi mno
    b. Zinakidhi sana
    c. Zinakidhi
    d. Kawaida
    e. Hazikidhi
26. Je unaweza kumshauri mtu wako wa karibu/ndugu/rafiki kutumia kituo hiki cha afya?
    a. Ndio
    b. Hapana
27. Ukipata ujauzito mwingine ungependa kujifungulia wapi?
    a. Kituo cha afya cha serikali : 1.Hospitali 2. Kituo cha afya 3. Zahanati
    b. Kituo cha afya cha binafsi
    c. Nyumbani
28. Je mtoa huduma alikusemesha kwa ukali au kukufanyia kitendo chochote kilichokufanya ujisikie vibaya ama kudhalilishwa wakati wa uchungu au wakati wa kujifungua?
    a. Ndio
    b. Hapana

29. Je uliombwa ridhaa kabla ya kupewa matibabu yoyote (kama kupimwa, kushonwa, kufanyiwa upasuaji, kupewa dawa) hapa hospitalini?
    a. Ndio.....
    b. Hapana
30. Je ulipatwa na ukatili wa kimwili(kupigwa, kufinywa, kusukumwa, kupigwa kutumia kifaa, kushonwa bila ganzi) kutoka kwa mtoa huduma yoyote?
    a. Ndio.....
    b. Hapana
31. Je unadhani haukusitiriwa vizuri au usiri wako haukuzingatiwa kwa namna yoyote ile? Mfano wakati wa kukupima mapazia hayakushushwa au mwili wako haukufunikwa wakati wa kujifungua.
    a. Ndio.....
    b. Hapana
32. Je taarifa zako za siri/binafsi ziliwekwa wazi kwa namna yoyote ile pasipo ridhaa yako? Mfano hali ya maambukizi ya virusi vya ukimwi, kipato chako,
    a. Ndio.....
    b. Hapana
33. Je mtoa huduma yoyote aliongea na wewe kwa ukali alikuonesha hasira ama kukutukana, ama kukucheka na ukajisikia vibaya?
    a. Ndio.....
    b. Hapana
34. Je wewe na motto mmezuiwa kuondoka kituoni hapa sababu hamkuweza kulipa gharama za huduma?
    a. Ndio.....
    b. Hapana
35. Je kuna wakati uliomba kuhudumiwa na mtoa huduma hakukupa huduma uliyoihitaji?
    a. Ndio.....
    b. Hapana

36. Je ulitumia kitanda peke yako au mlishirikiana na wakina mama wengine?
    a. peke yangu
    b. tulishirikiana.....
37. Je unafikiri zipi ni sababu zinazopeleke ukatili na kukosewa heshima kwa wakina mama wakati wa kujifungua?
    a. Ni kawaida f. mengine, taja.....
    b. Ukorofi wa kinamama
    c. Ukosefu wa fedha
    d. Kuchelewa kupata huduma hospitalini
    e. Kutokuzijua haki za binadamu