UNIVERSITY OF NAIROBI

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

Disrespect and Abuse of Women during Facility based Deliveries and its Effects on Intent to Use Maternity Services in Uringu Division Meru County

By

Ishmael Wango Makumi

Research Project Report Submitted in Partial Fulfillment for the Requirements for the Award of Master of Arts Degree in Sociology (Medical Sociology), University of Nairobi

October 2015

This research project is my original work and to the best of my knowledge has not been presented in any other University.

Signature: _____ Date: _____

Ishmael Wango Makumi

C50/71314/2014

This research project has been submitted for examination with my approval as the University supervisor.

Signature: _____ Date: _____

Prof. Edward Mburugu

Professor, Department of Social work and Sociology

University of Nairobi.

Dedication

To my family; my dear wife Catherine Wanjiku and my two daughters Bobo and Nimo who stood by my side to the end of the Project.

This project is also dedicated to all women who suffer in the hands of the caregivers when bringing forth life.

Acknowledgments

I would like to express my heartfelt gratitude to my supervisor and mentor Prof. Edward Mburugu for guidance, encouragement and support throughout the project period. My thanks also go to Dr. Wairire who started off with me.

I also owe gratitude to my wife Catherine for material and emotional support throughout the study period. It is also my pleasure to thank my classmates Collins, Ellen, and Hellen for their encouragement and support.

I cannot forget the Chief Uringu Division Mr. Charles Mbaabu without whose assistance this project would not have been possible.

Table of Contents

Preliminary Pages

List of Tables

List of Figures

List of Abbreviations and Acronyms

D & A	Disrespect and Abuse
W.H.O	World Health Organization
UNICEF	United Nations International Children's Education Fund
UNFPA	United Nations Family Planning Association
UN	United Nations
USA	United States of America
KNBS	Kenya National Bureau of Statistics
HRW	Human Rights Watch
KDHS	Kenya Demographic and Health Survey
PTSD	Post Traumatic Stress Disorder
FCI	Family Care International

Simple Definition of Terms

Delivery	This is all activities performed on pregnant woman by the health care workers from the time she is admitted into the antenatal ward in labor up to the time she is discharged from post natal ward having delivered vaginally or through caesarean section. This term is also used interchangeably with childbirth.
Disrespect and Abuse (D&A)	Management that is devoid of care characterized by inhumane treatment of women during facility based delivery
Facility	This refers to a health institution-Public or private- in Uringu division which has qualified medical personnel and functional maternity unit.
Women	Those beings of female gender aged 14 to 49 years and residing in Uringu division
Personal characteristics	These are personal attributes of women who had facility delivery within the last five years. The attributes to be studied are; Age, Level of education, Economic status, and parity.
Parity	Number of living children born in a health facility
Household	A person or groups of persons who reside in the same homestead/compound but not necessarily in the same dwelling unit, have the same cooking arrangements, and are answerable to the same household head/s.

Abstract

This is a community survey carried out in Uringu Division, Meru County to investigate Disrespect and Abuse of women during facility based deliveries. Objectives of the study were to determine; the prevalence of D&A, the types of D&A experienced by women, the relationship between socio-demographic characteristics and D&A of women during facility based deliveries, and how D&A affects intent to use maternity services. This was a cross sectional survey that utilized both quantitative and qualitative approaches. Area and purposive sampling methods were used while data collection was by use of structured questionnaires and in-depth interviews. Data analysis was done by using Statistical Package for Social Sciences (SPSS 20) and thematic analysis for qualitative data. Prevalence of disrespect and abuse during child birth in Uringu Division was high with 71.9 % (n=149) of women having experienced at least one form. Most frequent types of D&A were; denial of companionship during labor 73% (n=151), vaginal examinations without consent 56% (n=115) and episiotomies without consent 38% (n=79). There was significant relationship between disrespect and abuse and intent to use service (X^2 =9.097, p=0.04, α=0.05) which could be explained by two categories namely non-dignified care and discrimination in service provision. Majority of women who choose to deliver in health facility experienced at least one form of Disrespect and Abuse. This Disrespect and abuse affects all women irrespective of their socio-demographic characteristic with women who have experienced being more likely not to use maternity services. County government of Meru needs to address this problem with relevant training to the healthcare workers. In addition the public needs to be trained about their rights to quality care devoid of abuse.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Maternal and child health is core component of the global health agenda especially health issues around pregnancy, delivery and postpartum care. This is because the outcome of pregnancy depends on provision of skilled care during the entire perinatal period (World Health Organization, 2014b). The provision of maternity services continues to be problematic especially in developing countries as evidenced by maternal, perinatal and neonatal mortality rates.

In 2013, 289,000 women died in pregnancy, childbirth and after childbirth and this translated to 239 maternal deaths per 100,000 live births. Over 99% of these deaths occurred in low income countries especially sub-Saharan Africa (World Health Organization, 2014c). There is a big disparity in maternal deaths between the developed and the developing world. The maternal mortality ratio in developing world was 230 deaths per 100,000 live births in 2013 while it was 16 per 100, 0000 live births in developed countries. This means a 15 year old woman in developing countries has a 1 in 160 chance of dying during pregnancy and childbirth compared to a risk of 1 in 3700 in developed countries (WHO, 2014c)

In Kenya maternal mortality ratio was estimated at 400 deaths per 100,000 live births which is almost double the global ratio of 230 deaths per 100,0000 live births (WHO, 2014b). This is however a decline since the 1990s when it was 548 maternal deaths per 100,000 live births but the pattern of maternal deaths remains disparate with poor and rural communities suffering the most (Kenya National Bureau of Statistics[KNBS], 2008).

Maternal deaths can be prevented because the causes are known and that is why countries of the world agreed to reduce it by 75% by 2015 in what is called Millennium Development goals. According to a systematic review by the World Health Organization, the main causes of maternal deaths globally are; bleeding after giving birth, infections before and after delivery and hypertensive diseases of pregnancy (Say et al., 2014). The three accounted for over 50% of maternal deaths while the rest of the deaths are due to indirect causes.

The identified causes of maternal mortality are important for the design of maternal mortality prevention programs. The prevention involves attendance of four antenatal visits during pregnancy, delivery in health facility conducted by a skilled workers and then attending all postnatal visits (WHO, 2014c).The expectant women should be attended to by skilled workers like doctors, nurses or midwives so that they can diagnose any potential cause of death and deal with it early enough.

However, the situation on the ground is different. According to estimates from UNICEF, only 68% of all women in the world have a skilled attendant during delivery. In developed countries almost all women get skilled attendant before, during and after birth. The problem is therefore more pronounced in developing countries where about 55 % of women are attended by a skilled worker (United Nations International Childrens Education Fund, 2013).

In a study by Crowe, Utley, Costello, & Pagel (2012), it was estimated that between 2011 and 2015 there would be 130 and 180 million non skilled births in South East Asia and Sub-Saharan Africa(SSA) respectively. This would present a huge potential for maternal and infant deaths and complications majority of which could be avoided if all women had facility based deliveries. A case in point is Ethiopia where only 9.9% of women had skilled births in 2011 meaning that over 90 % of women had non facility based deliveries.

This may explain why Ethiopia had the highest maternal mortality ratio in the world standing at 676 deaths per 100,000 live births in the same year (Asefa & Bekele, 2015).

The Tanzanian situation is a bit better than in Ethiopia because 50.2% of deliveries are facility based and maternal mortality rate stands at 554 deaths per 100,000 live births in the urban areas (Mcmahon et al., 2014). In rural areas of Tanzania only 41.9% of deliveries are facility based pointing to the inequality in healthcare utilization between urban and rural areas a scenario that is repeatedly seen in developing countries (Mcmahon et al., 2014).

Likewise, Kenya is also facing the problem of low maternity service utilization. The latest figures indicate that on average 55% of women had non facility based births in the years preceding the survey (Kenya National Bureau of Statistics, 2008) while the estimated maternal mortality ratio in 2013 was 400 deaths per 100,000 live births (World Health Organization, 2014b).This figures are based on Kenya demographic and Health survey[KDHS] 2008 and at the time it was conducted the government had imposed user charges on maternity services. This was scrapped in 2013 and hence the situation may have improved.

The utilization of health services in Kenya is also not uniform but disparate with a bias to urban areas. Rural, pastoral and nomadic areas report particularly low use. A case in point is the former Eastern province in Kenya where this study will be done. According to KDHS 2008, 54.8% of women had deliveries at home and yet 93 % of the women attended antenatal clinic where among other things health workers emphasize the need for facility based delivery during health education sessions (KNBS, 2008). This may indicate a deliberate choice by women to use antenatal services and avoid delivering in the hospital and yet this is the critical period when death and disability can occur.

There appears to be a consensus on the reasons or barriers to maternity service utilization in developing countries like Ethiopia, Tanzania and Kenya. Among the barriers often cited include; poor quality of service, bad staff attitude, disrespect, distance to the health facility and lack of supplies (Kruk, Paczkowski, Mbaruku, De Pinho, & Galea, 2009; Kruk et al., 2014; Mcmahon et al., 2014). The provision of poor quality maternity services especially related to poor client-practitioner relationship in health facilities is under-investigated despite the fact that it may lead to low satisfaction with health services and hence low re-use of the services (Gage et al., 2002).

This study will therefore investigate an aspect of quality client-practitioner relationship during facility delivery. It will be done in Uringu Division, Meru County. The county is located in the former Eastern province where according to KNBS 2008 report , 93% of the women attended antenatal clinic, but only 45.2 % of the women had a facility delivery while 2% delivered enroute to the health facility. This raises questions on accessibility and quality of maternity services provided and especially the quality of client-provider interaction.

1.2 Statement of the Problem

The improvement of maternal and neonatal health remains an important global health agenda and especially the reduction of maternal morbidity and mortality. To achieve this goal nations of the world agreed to reduce maternal mortality by seventy five percent from 1990 to 2015 as contained in the millennium development goal number 5 (Hogan et al., 2008). If achieved this would translate to a reduction from 576000 global maternal deaths in 1990 to 144000 maternal deaths in 2015. It is estimated that globally the maternal deaths dropped by almost fifty percent from a high of 576000 in 1990 to 289000 in 2013 (World Health Organization, 2014c).

While this commendable, a lot still remains to be done and especially in developing countries. Out of the 289,000 maternal deaths in the world, over 90 % occurred in developing countries and while maternal mortality ratio is 230 per 100,000 in developing countries it is only 16 per 100,000 in developed countries (World Health Organization, 2014c). The Kenyan situation is not much different. In 1990 maternal deaths were 4800 translating to 490 maternal deaths per 100000 live births. In 2013 maternal deaths in Kenya were 6300 translating to 400 maternal deaths per 100000 live births (World Health Organization, 2014b).

The causes of maternal and neonatal deaths are known and include excessive bleeding before, during and after delivery, infections, high blood pressure and complications during delivery (World Health Organization, 2014c). These deaths can be prevented when women access quality maternity services from skilled workers but globally only a third of women are delivered by skilled health care workers (United Nations International Childrens Education Fund, 2013). In developing countries the proportion is even lower like in Kenya for instance, only 45% of women had skilled delivery in the five years preceding KDHS 2008 (KNBS, 2008).

Why do women fail to deliver in health facilities? There are many reasons for this. In Kenya Demographic and health survey 2008-9, women gave the following reasons: Long distance to the health facility, unaffordable services, lack of transport while approximately 20% of the women saw no good reason to deliver in a health facility (KNBS, 2008). In a systematic synthesis of qualitative research to establish why women fail to deliver in facilities Bohren et al. (2014) found that one of the main barriers to skilled delivery was abuse and disrespect by health workers. They found health workers to be verbally abusive, quick to anger, critical, had poor attitude and were generally unhelpful.

This disrespect and abuse of women during childbirth is an important determinant of maternity service quality and utilization. The World Health Organization has recognized D&A during facility based delivery as a worldwide problem that violates women's rights to respectful care and also threatens their lives, freedom and bodily integrity (WHO,2014a). In addition, it called for dialogue among stakeholders as well as advocacy and increased research in order to gain more understanding of the problem.

Although disrespect and abuse of women during facility based deliveries has always been there, only anecdotal reports have been available for a long time. In 1958 an article titled *'Cruelty in maternity wards'* was published in *Ladies Home Journal* in the United states of America. It explained how women were being mistreated by midwives and doctors during deliveries. The complaints included; a woman's legs being tied together to prevent delivery as her obstetrician took dinner, being struck , being threatened with birth of a dead baby for crying in pain and a doctor suturing an episiotomy without pain killers as the woman screamed in pain (Shultz,1958 in Goer, 2011).

This brought a huge public outcry in the United States and North America and triggered reforms in provision of maternity services. In addition it may also have opened discourse on quality of childbirth in hospitals throughout the world.

Qualitative research done in south Africa indicates rampant disrespect and abuse during delivery to an extent that a polite and caring behavior in a nurse is viewed as unusual and rare (Kruger & Schoombee, 2010). Women reported being left to labor alone, being verbally abused, being denied pain killers when technically required, and even being pinched and slapped (Kruger & Schoombee, 2010). Furthermore, the nurses also discriminated HIV positive women by putting them in one ward and refusing to touch or even examine them (Human Rights Watch, 2011). All this instances may explain why the republic of South Africa has a high maternal mortality ratio of 627 deaths per 100,000 live births (Human Rights Watch, 2011).

The above scenario is also repeated in Tanzania. In a facility and community survey carried out in eight health facilities by Kruk et al. (2014) 19.48 % of women in an exit sample and 28.21% of women in the follow-up sample reported at least one incidence of disrespect and abuse during childbirth. The specific types of D&A events reported were; being ignored 14.24%,being shouted at 13.18%, receiving negative or threatening comments 11.54%, being slapped or pinched 5.1% while 5.13% of women were abandoned and delivered alone (Kruk et al., 2014). A similar pattern of D&A has also been reported in Ethiopia (Asefa & Bekele, 2015),Nigeria (Okafor, Ugwu, & Obi, 2015),Ghana (Ambruoso, Abbey, & Hussein, 2005) and Kenya (Centre for Reproductive Rights & Federation of Women Lawyers-Kenya, 2007).

Research done in some districts of Kenya indicated that 17 % of women had experienced at least one form of disrespect and abuse while nine out of ten health workers reported having witnessed a colleague abuse a woman (Population Council, 2014).

However, the prevalence is likely to be higher due to under reporting and normalizing of disrespect and abuse by both clients and service providers (Bowser & Hill, 2010).

Since D&A is a multidimensional social phenomenon, a lot is yet to be known. For instance, national prevalence in Kenya, socio-demographic characteristics of the abused & disrespected, and factors influencing it. There are studies exploring the effect of D&A on maternity service utilization but most are qualitative in nature apart from a study done in Tanzania that demonstrated that if staff attitude and drug supplies were improved, then utilization of delivery services would almost double (Kruk et al., 2014). In Kenya and certainly in Uringu division of Meru County no systematic study on how D&A affects intent to use maternity services has been done before. This study therefore seeks to determine whether there is D&A of women during facility based deliveries, the prevalence, types of, and how it affects use of services in Uringu division.

1.3 Study questions

This study was guided by the following questions;

i. What is the prevalence of disrespect and abuse of women during facility based deliveries in Uringu Division?
ii. What are the types of disrespect and abuse of women during labor and delivery are experienced by women in Uringu Division?
iii. What is the relationship between socio-demographic characteristics of women and disrespect and abuse during facility based delivery in Uringu Division?
iv. How does disrespect and abuse of women during facility based delivery affect intent to use maternity services in Uringu Division?

1.4 Study Objectives

1.4.1 Broad objective.

The main aim of the study was to investigate the nature, prevalence of Disrespectful and Abusive treatment of women during facility based delivery and how it affects intent to deliver in the health facilities in Uringu Division of Meru County.

1.4.2 Specific objectives.

The study was guided by the following specific objectives;

i. To determine the prevalence of Disrespect and Abuse of women during facility based delivery.

ii. To establish the types of disrespect and abuse experienced by women during facility based delivery.

iii. To determine the relationship between socio-demographic characteristics of women and disrespect and abuse during facility based deliveries.

iv. To investigate how disrespect and abuse of women during facility based delivery affects intent to use maternity services.

1.5 Justification of the Study

Globally an unacceptably high number of women and newborn continue to die during the process of childbirth and this is there an important public health problem especially in developing countries where most the deaths and disability occur. The causes of maternal and neonatal deaths during childbirth are known and can be handled when deliveries are conducted by health care workers in hospitals. However, almost 50% of women do not deliver in health facilities.

The reasons for failing to use skilled services during delivery have been studied a lot and include increased distance, high cost of services, low staffing levels and even lack of supplies. There is inadequate research on the role of disrespect and abuse of women during facility based deliveries in decreased utilization of maternity services. This study aimed at filling this gap in knowledge.

The information that has been generated through this research will also assist policy makers to design appropriate programs addressing disrespect and abuse of women during delivery. Once addressed this would lead to increased maternity service utilization during delivery and hence decrease in maternal and neonatal mortality & morbidity.

1.6 Scope and Limitations of the Study

Disrespect and abuse in health care facilities is a broad concept affecting all cadres of staff and all the departments. It affects children, men and women seeking various types of health services. However this study focused on disrespect and abuse of women during facility based delivery. The study was carried out in Uringu division Meru County and as such the sample could not be nationally representative.

The study investigated the prevalence of D&A, the types of D&A experienced by women, the relationship between D&A and personal characteristics and finally the relationship between D&A and intent to use of maternity services in Uringu division. The variables investigated were Disrespect and abuse, personal characteristics and utilization of maternity services. Data was collected from women who resided in Uringu Division and had delivered at least one child within the last five years in the division or within Meru County and in either private or public health facility.

During delivery women may be assisted technically by doctors, nurse-midwives, laboratory technologists, radiographers, general practitioners and even auxiliary staff. The study focused on the personal and physical interaction between nurses and doctors. This is because it is the nurses and doctors who are mainly involved in the process of childbirth.

The study was done in an area inhabited by Kimeru speakers and since it's a rural area some women did not understand English. This language was a limitation but was overcome by the recruitment of research assistants who were fluent in both English and Kimeru language.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Empirical Literature Review

2.1.1 Introduction.

The objective of this chapter is o find out what is already known about disrespect and abuse of women by healthcare workers during childbirth. The information will be obtained from social experiments, surveys, policy documents, unpublished works and even expert opinions. The data bases to be searched include; Pub-med, The lancet, Cochrane database of systematic reviews, Google scholar, HINARI, Research gate, and University of Nairobi repository. Websites to be searched are; World Health Organization (WHO), United Nations International Children Education Fund (UNICEF), and Family Care International (FCI). The search terms to be used will be; disrespect of women in maternities, Disrespect and abuse of women in maternities, Physical abuse of women during labor , disrespect and Abuse of women during childbirth, cruelty during childbirth and violence during childbirth.

2.1.2 State of maternal child health.

The ill health of a mother and her child continues to be an important public health issue globally and especially in the developing countries where the greatest burden of disease lies. Approximately 289,000 maternal and 2.8 million newborn deaths are reported annually (United Nations International Childrens Education Fund, 2013). However, 85% of all these maternal deaths occur in Sub-Saharan Africa and South East Asia.

Almost all these reported maternal deaths- especially in developing countries- can be prevented since their causes are known and include bleeding during and after delivery, high blood pressure, and even infections (World Health Organization, 2014c). These deaths can be prevented through access to skilled attendant during their delivery but this is not the case in developing countries where above 50% of the mothers do not deliver in health facilities and hence no skilled attendance.

Women often give various reasons for failing to utilize available maternity services. Common reason often given include; staff attitude, large distance t the health facility (Kumbani, Bjune, Chirwa, Malata, & Odland, 2013), prohibitive cost, lack of supplies and inadequate staffing (Kitui, Lewis, & Davey, 2013; Kruk et al., 2009). Limited number of studies have investigated disrespect and abuse as one possible barrier to the utilization of maternity services and it has been termed as an emerging problem by Flávia, Lucas, Diniz, & Schraiber(2002).

2.1.3 Definition and types of Disrespect and Abuse

According to Merian webster English dictionary (2015), the word abuse is defined as treating a person or an animal in a harsh or harmful way. 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, 2015)

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 sociological construct. This poses problems because currently there is no single agreed definition of the construct meaning researchers could be measuring different things.

In Nordic countries for instance researchers have been concentrating on a broader construct of Abuse in Health Care (AHC) and they defined it as any act perceived as abusive by the child or adult patient in any health care setting (Brüggemann, 2012).

This definition is too broad and may not be applicable in this study. An alternative definition of AHC is that it involves the violation of ethical principles of physical nonmaleficence, sexual nonmaleficence, autonomy, justice and integrity during the provision of healthcare service (Brüggemann, 2012).

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 in crisis. In this definition disrespect and abuse goes above the individual healthcare provider and involves the wider social structure that creates a conducive environment for it to occur.

Just as there is no agreed definition of D&A, there is no agreement about what acts constitutes D&A. Different authors have different categorization. In their work titled '*Violence against women: an emerging problem'* D'Oliviera et al. (2002) talks about four types of violence on women during labor and delivery. These are neglect, verbal abuse, physical, and sexual abuse. Other researchers like Schroll, Kjærgaard, & Midtgaard (2013) talked about three categories namely; abusive acts of unintentional harm, dehumanization, and bodily remembrance. For the construct Abuse in Healthcare used in Nordic countries three categories are used: Mild abuse, Moderate abuse, and severe abuse. However, details of the specific types of abuses experienced by the clients are not included meaning that the scale depends on the perceptions rather than on the actual acts. The classifications do not appear to capture all the dimensions of the disrespect and abuse of women during facility delivery construct.

It is apparent that the many definitions and types of D&A may introduce differences when it comes to measurement. As a result the current study will define D&A of women during facility based delivery as service delivered by skilled workers that transgresses the ethical principles of physical non-maleficence, sexual non-maleficence, justice, integrity and autonomy.

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

2.1.4 Global burden of Disrespect and Abuse.

Studies on disrespect and abuse during facility based deliveries are limited and especially the studies on global prevalence. This apparent lack of adequate research on the phenomenon prompted the World Health Organization to release a press statement calling for accelerated research and advocacy (World Health Organization, 2014a). The available studies are not based on a universally agreed operational definition and most are small studies that not nationally representative. Nevertheless, a commendable research on D&A has been done in Nordic countries although the work is based on a wider construct called Abuse in Health Care (AHC) of which D&A is a subset (Brüggemann, 2012).

In study on patients experiences of AHC its prevalence and associated factors, Swahnberg et al(2007) found that the prevalence of AHC among women attending gynecology clinic varied from 13% to 28 %. The study also revealed that high education level, physical complaints and presence of post traumatic stress disorders were factors associated with abuse in health care. It should be noted that the study subjects were women seeking preventive, diagnostic or curative gynecological services and were not in labor or delivering. Similarly, a Swedish study revealed that 20% of women had experienced AHC in course of their life while only 8% of male patients reported the same (Brüggemann & Swahnberg, 2013).

In a nationally representative Swedish study, 7% of all women reported having experienced negative birth experience that included loss of control, lack of support by health care workers, little or no information on birth process and pain control during labor (Waldenström, Hildingsson, Rubertsson, & Rådestad, 2004).

In the United States where 99% of the deliveries occur in healthcare institutions, cases of disrespect and abuse are rife. However, the evidence is anecdotal and qualitative in nature and there is no national estimate of D&A (Hodges, 2009).

Women in labor in the USA reported non-consented care, operative delivery without indication, misrepresentation of medical situation, and even verbal abuse like scolding, shaming, coercing, and mocking (Hodges, 2009). In a study titled *listening to mothers II*, it was revealed that over 32% of all women deliver through caesarean operations majority of which are requests by the physicians with little or no regard to women's preference (Declercq, Sakala, Corry, & Applebaum, 2006). In addition, only 2% of women were allowed to have a vaginal delivery after caesarean delivery even though majority of women would opt for vaginal deliveries due to the risks associated with such a major operation (Declercq et al., 2006). In the cases cited above women's right of making informed decisions affecting their care was disrespected by the obstetricians.

In the above report from the United States, an emerging dimension of D&A of women during childbirth is the excessive use of medical procedures even where not indicated. For instance 83% of women were put on an intravenous drip, 25% had episiotomies, 61 % had some stitching near the vagina, while in 17% of the mothers fundal pressure-which is potentially harmful-was applied during delivery. Other unnecessary procedures done included shaving of pubic hair, administration of enemas and laxatives.

In 50 % of women, syntocinon drip was administered in order to speed up labor so that the doctors could get over with the delivery quickly (Declercq et al., 2006).

This interruption with natural process without indication is what Illich termed as medicalization of life which is the process through which normal life events are brought under the sphere of medical practice (Illich, 1976).

Such life events include pain and dying. Administration of syntocinon, fundal pressure, giving laxatives and giving of intravenous fluids can be viewed as attempts to medicalize childbirth which in the absence of a complications could be expected to be a normal physiological event.

2.1.5 Regional situation of Disrespect &Abuse

Disrespect and Abuse of women during facility based delivery occur globally. However there still is limitation of studies especially on national prevalence and majority of the studies are qualitative. Such descriptive studies have been done in Tanzania (Kruk et al., 2014), South Africa (Human Rights Watch-SA, 2011) , and Malawi (Kumbani et al., 2013).

In the republic of South Africa cases of D&A are numerous and paint a picture of the suffering experienced during labor and delivery. A woman describes what she went through;

> In 2009, I gave birth at Dora Ngiza. The nurses were shouting and pinching us on the thighs telling us to open up. After delivery, I was feeling very weak but the nurses told me to leave the bed and carry the baby to another ward. She was very rude and said I was lazy. After this experience I told myself I will never again go to government hospitals. If I have no money to deliver in a private hospital, I will deliver at home.
>
> (Salenta,2010; In Human Rights Watch-SA, 2011,p.37)

Although no prevalence of D&A in South Africa was found, the case above illustrates the categories of D&A that women experience all over Africa and also gives an explanation of low utilization of maternity services. Similar experiences of maternity services have been recounted by women in Ghana (Ambruoso et al., 2005), Malawi (Kumbani et al., 2013), and Tanzania (Mcmahon et al., 2014).

The few quantitative studies available paint a picture of high prevalence of D&A. In a cross sectional study that used Bowser and Hill's (2010) landscape analysis and done in four health facilities in Ethiopia, 78% of all women reported having experienced a form of D&A during delivery in the maternity unit (Asefa & Bekele, 2015). Specifically, 32.9% were not protected against physical harm, 48% of them had medical procedures done without consent, and 39.3% of the mothers were left in labor without attention while in 33% of the cases women's privacy was not observed (Asefa & Bekele, 2015).

In a Ghanaian study, 98% of all the respondents reported experiencing at least one form of disrespect and abuse during delivery in the maternity units. The most common manifestation of D&A was non consented care 54.5% and physical abuse 35.7%. Non dignified care accounted for 29.6% of the cases, abandonment 29.1%, detention in health facility 22%, and discrimination 20% (Okafor et al., 2015). On the other hand in the Kenyan study, 20 % of the women reported any form of D&A during facility based delivery. In terms of categories of D&A, non confidential care accounted for 8.2%, non-dignified care 18%, abandonment 14.3%, non consented care 4.3%, physical abuse 4.2% while detention for nonpayment was 8.1 % (Abuya et al., 2015).

The prevalence of Disrespect and Abuse during childbirth in maternity units in Tanzania closely approximates the Kenyan scenario. In a facility and community survey carried in rural Tanzania, 19.1% of women in the exit sample and 28% in the follow-up sample reported having

experienced at least one form of disrespect and abuse (Kruk et al., 2014). According to the same study the, specific D&A events reported by women were; being ignored by the health worker 14.24%, being shouted at 13.18%, threatening or abusive comments 11.54%, being slapped or pinched 5.1% .Approximately 5.31% of the women delivered without any assistance from a health worker.

In all the studies, the prevalence of D&A is likely to be an underestimate. In the Kenyan study, the number of women reporting D&A almost doubled when they were interviewed in the community five weeks after hospital exit interview. This has been attributed to courtesy bias where women tend not to report D&A while still in the health facility (Abuya et al., 2015). In a Nordic study, Brüggemann (2012) describes the silence of women after experiencing abuse in health care as worrying. This is because 60% of women who experienced AHC did not report it and this information is lost to the healthcare system and cannot be used to institute structural changes.

2.1.6 Factors associated with Disrespect and Abuse.

Although disrespect and abuse in facility based deliveries has not been exhaustively studied, there are socio-demographic characteristics that appear to be associated with it. In the Nordic study by Brüggemann (2012) abuse in health care was found to associated with young women, women who experienced childhood abuse and women with little or no knowledge of their rights in a health care set-up.

In maternity units women with a higher parity were found to be more likely to be detained for non-payment and be solicited for bribes (Abuya et al., 2015).

The explanation here is that health care workers tend to think that since these women have had birth experiences before then they should have been well prepared.

According to the same study women who had no companion during labor and delivery and single women were more likely to be disrespected and abused.

The economic status of women also tends to be related to D&A maybe because women who are well educated are able to pay and demand for quality services. In an Ethiopian study, women with a higher monthly incomes were less likely to experience D&A as compared to those with a lower monthly income (Asefa & Bekele, 2015).This is an important factor especially in Sub-Saharan Africa where women are not as economically empowered as men and one would therefore expect to find many women with very low monthly income. In countries that still have a user fee system, poor women may be detained in the hospitals for failure to clear the required bills after delivery as indicated in the research in Ghana by Okafor et al. (2015) where 22% of the women in the sample were detained.

Adolescent pregnant women appear to be at an increased risk of disrespect and abuse and this appears to be because the healthcare providers assume a moral stance. They judge the girls and in their opinion they should not have become pregnant at such an age. A case in point is in South Africa where a client in a maternity ward had this to say;

> Because they work very poorly with the girls. Very poorly. Especially if you are a girl and not married and you arrive there. And they are rough with you. Especially if you are a black girl. They are *sommer* hit, if they do not want to open their buttocks (…), then they are hit between the buttocks.
> (Lea,2010 in Kruger & Schoombee, 2010.p.95)

This abuse of pregnant adolescents further increases the already existing risk of complications like prolonged labor, death of the newborn and even psychological trauma post delivery. The problem is further compounded by the fact that adolescence pregnancies are on the increase.

For instance in Nyanza Kenya, 27% of adolescent girls deliver by the age 19 with some even delivering at the age of 12 years (National council for Population and Development, 2013). This present a huge potential for abuse of the girls during facility based deliveries.

2.1.7 Consequences of Disrespect and Abuse.

Disrespect and abuse during facility based deliveries appear to have many direct and indirect consequences. Denial of pain killers during labor, delivery and when performing and repairing episiotomies causes extreme pain and suffering as reported in Republic of south Africa and Kenya (Centre for Reproductive Rights & Federation of Women Lawyers-Kenya, 2007; Human Rights Watch, 2011). Post delivery, the psychological impact is so much such that it can lead to childbirth related post traumatic stress disorder. In the *Listening to Mothers II* follow up study carried out in the USA, 18% of the women experienced some PTSD symptoms while 9% of the women had symptoms that met full diagnostic criteria for PTSD related to childbirth (Declercq et al., 2006). Some mothers are so traumatized such that even maternal infant bonding and parenting ability was affected. Rose conveyed the following from her delivery experience: "I was left feeling like a total failure. I left the hospital thinking I was a horrible mom….I did not even want to hold the baby or be left alone with him" (Rose, Personal communication,September 22, 2007 in Declercq et al., 2006).

So even though D&A may not affect maternity service utilization in developed countries, it negatively affects the women's quality perception of the maternity services and as indicated above may also have both short term and long term psychological sequelae. This dissatisfaction with service quality has been seen in South Africa where there are widespread reports of abuse and disrespect and yet skilled delivery is at a commendable 87% (Human Rights Watch, 2011).

When mothers are dissatisfied with maternity service quality, they are less likely to utilize the services again. In the Kenya National Bureau of Statistics (2008) survey, it was found out that as the number of deliveries per woman increases the likelihood of delivering in a health facility decreases. For instance, in the survey, for women giving birth the first time 61.1 % of them delivered in a health facility while for women having a 6^{th} delivery and above only 24.8% delivered in a health facility. Among the possible explanations for this observation is that dissatisfying birth experience-including D&A-during previous births dissuade pregnant women from re-utilizing maternity services.

Moreover, there appears to be an association between facility based deliveries and maternal morbidity, maternal mortality ratio (MMR), and neonatal mortality. In developed countries, over 99 % of women have facility based deliveries and only 1% of all maternal deaths occur in these countries (World Health Organization, 2014c). On the other hand 99 % of all maternal deaths occur in developing countries with Sub-Saharan Africa and South Asia accounting for over 85% of the deaths (World Health Organization, 2014c). The region has the lowest level of skilled births averaging at about 50%. This is a critical issue because two thirds of maternal and neonatal deaths occur during and immediately after delivery (United Nations International Childrens Education Fund, 2013). Disrespect abuse of women during labor can therefore lead to decreased facility deliveries which in turn lead to increased maternal & neonatal morbidity and mortality.

2.1.8 Summary of Empirical Literature Review

So far there is no internationally agreed upon definition of disrespect and abuse of women during facility based deliveries. In the Nordic countries a general construct called Abuse in Health Care is used. It measures abuse in any health care setting using three nominal categories of Mild,

Moderate or severe abuse. This is too general for use in the study of D&A of women in facility based deliveries. An alternative construct based on the landscape analysis by Bowser and Hill (2010) is increasingly gaining acceptance internationally.

Although the literature on disrespect and abuse of women during facility based deliveries 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 across 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. This observation-though not empirically proven- suggests a relationship between D&A and maternity service utilization.

In Kenya, only one study on D&A during facility based delivery was found and was done by population council. The study was not nationally representative. According to the study-which used Bowser and Hills approach-the prevalence of D&A was found to be 20%. This is likely to be higher since women tend to normalize D&A and many choose to suffer in silence. The study did not investigate the relationship between D&A and maternity service utilization.

In the absence of a nationally representative study, then regional studies using the same approach are required in order to understand local D&A prevalence and how it affects maternity service utilization. It is for this reason that a study will be done in Uringu division Meru County in order to determine prevalence, effects, types of D&A and the relationship between personal characteristics and D&A.

2.2 Theoretical Framework

This section will review sociological theories that may explain disrespect and abuse of women during facility based deliveries. The epistemological stance assumed is that of social constructivist as elucidated by Berger & Luckman (1966). According to their treatise, everyday reality is socially constructed by people as they interact with each other and with their social environment. Likewise, disrespect and abuse of women during facility based delivery is socially constructed. Various sociological theories that may explain the dynamics of the multidimensional phenomenon of D&A will be explored.

2.2.1 Knowledge, power and truth discourse by Michel Foucault.

Mitchell Foucault's conception of power is in opposition to the Marxist repressive hypothesis (Pylypa, 1998). To him power is diffused throughout the social structures and is manifested through daily micro-level interactions. He called this type of power exercised on individuals as 'Bio-power'. The control of the body through bio-power is not through domination and external punishment, but it's through habitual daily practices, norms and self-discipline guided or motivated by knowledge. According to Foucault bio-power operates at two levels; the level of human species and that of human body. The former is concerned with application of scientific principles to control mortality, fertility and population while the later involves the direct control of individual bodies.

In Foucault's discourse, power, knowledge and truth are inseparable. Once an individual acquires knowledge and distinguishes the truth from untruth then he gains power to influence the day to day interaction with other people. He applied this concept in his work '*Birth of the clinic: an archeology of medical perception'*. According to this work medical practice changed in 18th century due to a change in the way medical knowledge was perceived and communicated

through precise language (Foucault, 2003). Diseases could now be understood through detailed anatomical description, thorough understanding of the pathological process and observation of signs and symptoms. This is what Foucault termed as the 'medical gaze'. This immediately transformed an individual from a social person to an object of scientific inquiry.

The medical workers- through the medical knowledge- acquired power and therefore freedom to investigate the human body as much as they wanted without regard to an individual's preference. Patients on the other hand were supposed to comply as the doctor listened to the body, palpated it, struck here and there, and took tissue samples from the body, stool, blood, sputum and urine for laboratory investigation. Once admitted in the hospitals surveillance of the patient commences in accordance with principles of panopticon. The patient's body is now placed in what Foucault referred to as 'anatomo-chronological schema' meaning that changes on the body in space and time are continuously monitored and recorded.

Although the medical gaze has led to rapid development in the field of medicine, it has had two negative consequences. First, it made the doctors indifferent to the social person and encouraged paternalistic relationship with the patient. Because of this the doctors and nurses feel so powerful over the patients to an extent that they can misuse the gaze. Second, the gaze has made patients docile and complacent to any requirements of the gaze even though such requirements are harmful and constitute disrespect and abuse.

2.2.2 The structuration theory.

Anthony Giddens theory of structuration is an integration of structural and functional social theories (Ritzer, 1996). He rejects the dichotomy and instead views structure and function as a duality. Giddens theory consists of agents and Structures. Agents are defined as social actors who continuously monitor their own thoughts, activities as well as their interaction with the

physical and social environment. Agents rationalize their social world by developing routines that assist them in dealing or creating security and stability in their social lives. Additionally, agents have motivations- resulting from wants and desires-which prompt them to act (Ritzer, 1996).

Structures on the other hand are not physical but are rules, regulations and resources that permit similar social pattern to exist across time and space. So, what is structured is social phenomena and hence structures can only exist through the social activities of man as Giddens summarizes it; "In my usage, structure is what gives form and shape to social life, but it is not itself that form and shape" (Giddens, 1989,p.256 in Ritzer, 1996,p.531). These persistent social rules and regulations can on one hand constrain the actions of human agents and may also create an enabling social environment.

At the realm of consciousness, Giddens opined that consciousness is of two types; practical consciousness where agents act without thinking about their actions because it has become internalized and routine and discursive consciousness where agents are able to describe their intents and actions. Health workers as agents interacting with clients operate mostly at practical consciousness as a result of the knowledge, attitude and skills acquired during medical training.

2.2.3 Violence Triangle by Johan Galtung

Violence ,according to Galtung (2008) can be defined as the avoidable impairment of human needs or any avoidable harm that increases the gap between actual and potential development of human beings. According to this definition, pregnant women who unable to access delivery services because of user charges can be said to be experiencing violence. Likewise, woman who is in labor and is being scolded and verbally abused because she is black is also experiencing violence.

Galtung divided violence into three. The first type is direct violence. In this case an individual is harmed by another in a face to face incident by insults or physically. The second type of violence is the structural violence which is not committed by a single perpetrator but is caused by the arrangement of social systems and leads to injustices to particular individuals. Imposition of user fees which denies the poor access to publicly funded health care leading to illness, disability and even death is an example. The third type of violence is the cultural violence. It is defined as those aspects of a culture-like religion, language, ideology, Science-that can be used to legitimize both direct and structural violence and hence making them socially acceptable. This type of violence is learned since childhood and examples include anti-Semitism as was practiced in Nazi Germany and apartheid in South Africa.

The three types of violence are related in a triangular fashion. Cultural and structural violence are located towards the base of the triangle with the former being invisible and forming the ground from which pro-violence social structures spring. The structures may include health systems, education system, political system and even the economic system. At the top of the violence triangle is located the direct violence which is most visible and supported by the other two types of violence.

2.2.4 Combining Theories to explain Disrespect and Abuse

Applying the clinical gaze, labor and delivery was put in body-time schema where changes in particular parameters are observed over time and are compared to previously established normal standards. Thus according to prevailing medical knowledge labor is divided into four phases and each has normal characteristics and duration. Doctors and nurses are expected to apply the gaze through periodic surveillance-usually after every 30 minutes-and put the observations in clinical

notes and labor chart. If everything goes well normal delivery is expected and the gaze continues until mother and infant are discharged from hospital.

In hospitals there are problems in applying the gaze. In most D&A studies women complain of abandonment and being left to labor and deliver alone (Abuya et al., 2015; Ambruoso et al., 2005; Kruk et al., 2014; Kumbani et al., 2013). This can be viewed as failure to apply the gaze and for this reason women felt there was no need to deliver in a hospitals since main reason for hospital delivery is to benefit from the clinical gaze (Human Rights Watch-SA, 2011). The process of labor and delivery has become so medicalised such that women feel overburdened by the barrage of investigations and procedures like; emptying bladder using catheter, giving enemas, giving intravenous fluids, frequent digital vaginal examinations, and continuous electronic foetal monitoring (Declercq et al., 2006). This over application of the clinical gaze makes women feel powerless, inhumanely treated and increases their anxiety.

Disrespect and abuse during labor and delivery may also be situated within Anthony Giddens agency-structure theory. Agents are social actors and in this case include patients, expectant women, lay people on one hand and doctors, nurses and other health professionals on the other hand. The social rules and regulations that dictate how these two groups interact is what constitute structure and their locale is in health care institutions. The structure is not made elsewhere and imposed on the agents; rather it is the actors who make the structure forming an inseparable duality. In respect to the therapeutic encounter, the structure may or may not enable the actors to interact in a beneficial way such that a woman in labor may or may not be satisfied.

Doctors and nurses operate at two levels of consciousness, discursive and practical consciousness. The former means that they can describe each and every action they perform in words and in this case their actions are according to their training and it proves that they have

mastered the clinical gaze. Practical consciousness means that the healthcare workers may not be able to describe their actions in words and this means that they obtained attitudes and behaviors in course of the medical training and this can be viewed by lay people as unusual and unfriendly behavior. This may explain why a midwife can make a 10 cm cut on the vaginal wall of a woman in labor without giving analgesic medication without feeling any omission. This is clinical detachment which has become internalized and practiced as a routine without thinking about it.

Applying Johann Galtung's violence triangle, disrespect and abuse during facility based delivery can be understood in three ways as; Cultural violence, structural violence, and direct violence. Cultural violence is deeply rooted and includes tribalism, racial & ideological discrimination, and religion. In the republic of South Africa for instance, young black women are abused and disrespected more as compared to young white females (Human Rights Watch-SA, 2011). Moreover, this type of violence lays the groundwork for further D&A by influencing location and number of health institutions, number and distribution of healthcare workers, allocation of materials, drugs and equipments required for provision of health care services. This is structural violence.

A doctor or nurse exposed to cultural or structural violence-by for example tribalism and poor pay- is more likely to engage in face to face acts of violence against the patient. This direct violence takes the form of slapping, pinching, shoving, and verbal abuse. To a lay person this acts committed to a woman in labor are unacceptable and cruel. However according to Rest's theory of moral action, health workers moral identity is neutralized during the process of being socialized as health professionals such that their acts of direct violence become acceptable within the profession(Rest, 1986)

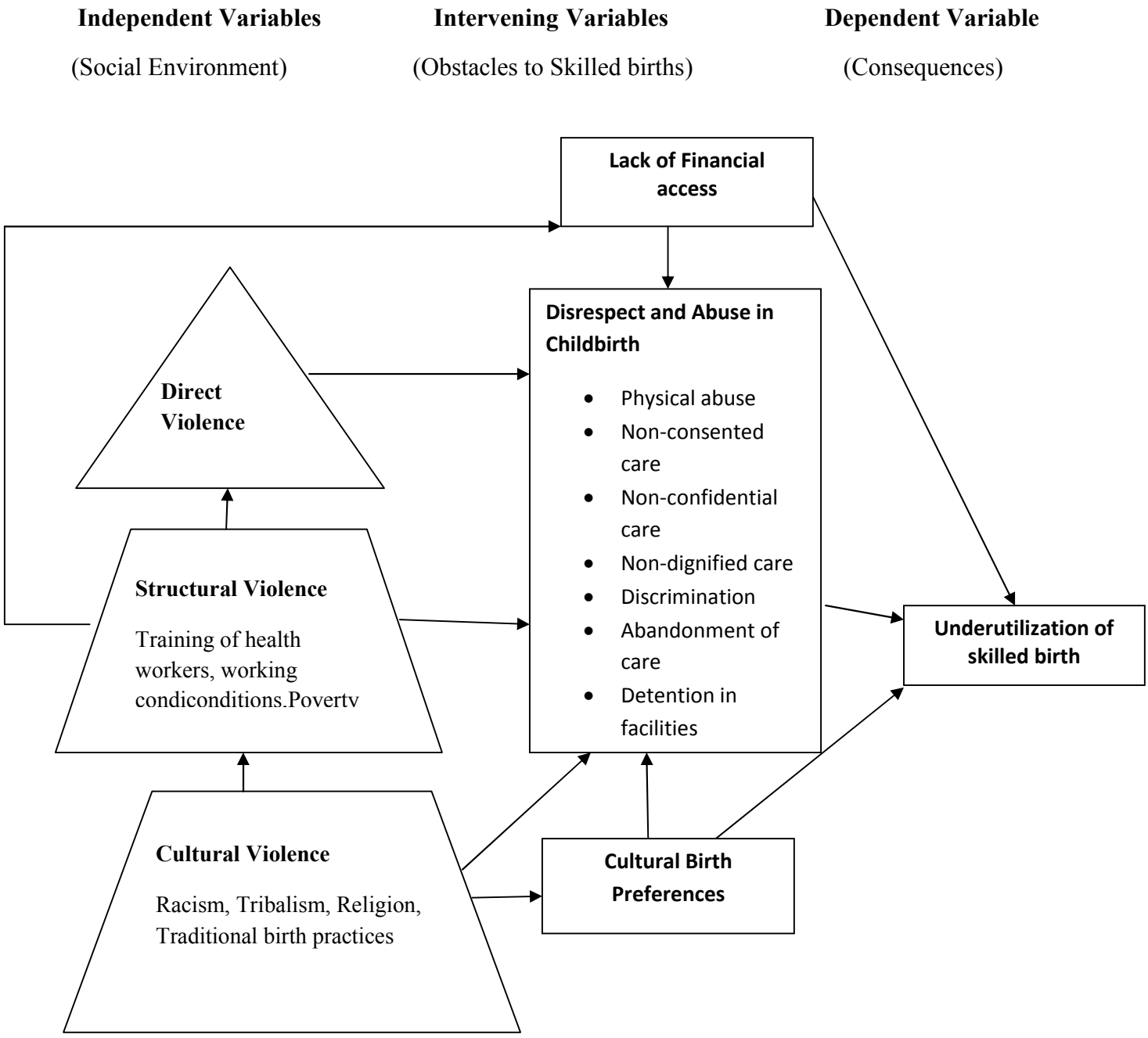
2.3 Conceptual Framework

Disrespect and abuse of women during facility based deliveries has many dimensions, contributing factors and consequences. According to Giddens's theory of structure –agency, individuals and the community as whole carries some responsibility for D&A. Individuals refuse to talk about abuse and do not report it to authorities once it happens to them while the community lacks oversight function.

Disrespect and abuse can also be viewed as a form of violence. According to Galtung (2008), individual exposure to violence begins in childhood where children are socialized in a way that they acquire negative perception to people from different race, tribe or religious inclination. This is cultural violence and is invisible. It creates an environment where pro-violence structures are put in place. This may include; inequitable resource distribution, poor remuneration, lack of education opportunities, lack of equipments and drugs or poor transport and telecommunication structures. This type of violence is also invisible but it creates anger and a violent disposition on individuals.

Once individuals experience cultural and structural violence then they become involved in direct violence where they engage in direct person to person physical violence. In a health care setting the three forms of violence translates into the seven categories of D&A as described by Bowser & Hill (2010) and include pinching, slapping, shoving, sexual assault, verbal abuse, detention in health facility, denying pain medication when appropriate. This D&A leads to low skilled service utilization which in turn leads to increased maternal and neonatal deaths and disability as illustrated in figure 2.1 below.

Fig 2.1: Conceptual Framework showing variables that determine underutilization of skilled birth



Source: Author, 2015

2.5 Operational Definition of Terms

1. Disrespect and abuse during facility based delivery

This sociological construct is abbreviated as D&A and to make it operational, the typology used by Bowser & Hill (2010) in their landscape analysis will be employed. Accordingly, D&A is categorized into six and within each category are specific types of D&A. The six categories are;

Non-consented care: Episiotomies, Caesarean sections(C/S), Shaving pubic hair, blood transfusion, digital vaginal examinations, augmentation of labor

Physical abuse: Restrained during labor, episiotomy given and sutured without analgesia, beaten, slapped, pinched, sexually abused by health worker

Non-dignified care: Blamed, intimidated during labor, threatening with C/S, Slanderous remarks, being shouted at, being called stupid.

Abandonment/Neglect of care: Denied companionship during labor, Left unattended during second stage of labor, Failure to intervene when medically indicated, Failure to grant mothers request.

Non-confidential care: Age disclosure without consent, Provision of care without privacy, Medical history disclosure without consent, Disclosure of HIV status without consent

Discrimination on the basis of: Social class, ethnic group, Age (< 19 yrs), HIV status.

2.6 Study Hypothesis

First Hypothesis

Null Hypothesis ($\mathbf{H_0}$): There is no relationship between sociodemographic characteristics and disrespect and abuse during facility based deliveries in Uringu Division

Alternate Hypothesis ($\mathbf{H_a}$): There is a relationship between sociodemographic characteristics and disrespect and abuse during facility based deliveries in Uringu Division

Second Hypothesis

Null Hypothesis ($\mathbf{H_0}$): There is no relationship between Disrespect and abuse during facility based delivery and intent to use maternity service in Uringu Division

Alternate Hypothesis ($\mathbf{H_a}$): There is a relationship between Disrespect and abuse during facility based delivery and intent to use maternity service in Uringu Division

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter expounds on the methods that were used in the study. First the study area is described in details followed by the description of the study design that was adopted. Study population, inclusion and exclusion criteria have also been explained. Next the sampling method and sampling procedure are delineated followed by data collection procedures. The method used for both quantitative and qualitative analysis- as well as the rationale- has been described in detail. Finally logistical and ethical considerations adopted have also been detailed.

3.2 Study Area

This study was carried out in Uringu Division Meru County which is one of the 47 counties in Kenya. The division is located in Tigania west sub-county. It has four locations namely; Mbeu, Kimachia, Nkomo, and Kiorimba. The estimated population in the Division is 45,333 with 22,292 being male, 23,041 female and 10,071 households. The population density is 433 persons per square kilometer (KNBS, 2010). The Division is populated by Kimeru speaking people who are mainly small scale mixed farmers. They grow maize, beans, sorghum, potatoes and keep goats, chicken and pigs for subsistence. There is small scale growing of tobacco as a cash crop although most farmers prefer to farm food crops for domestic consumption and for sale.

Health care services in the Division are provided by both public and private institutions. The public health institutions in the division are Kiorimba health centre and Mbeu sub-district hospital. Referral cases are sent to Meru level 5 teaching hospitals. Private health services are mainly provided by catholic hospital at Chaaria and Kiirua.

The common conditions treated include; Malaria, Upper respiratory tract infections, pneumonia, parasitic infections, HIV and related conditions. Maternal and child health services are also provided including antenatal, intra-partum and postal services. Over 93% of pregnant women attend antenatal clinic but only 42.8% of the women delivered in a health facility while majority 54.8% delivered at home (Kenya National Bureau of Statistics, 2008)

3.3 Research Design

The design adopted in the study was cross sectional descriptive survey. Data was collected and analyzed using both quantitative and qualitative methods. This design was appropriate for the study because data was collected at one point in time hence saved both time and money. The design also enabled the researcher to describe variables, and also explore the relationship between them. This design also enabled the researcher to test hypothesis and answer questions regarding the status of the phenomenon under investigation.

3.4 Study Population

The study population consisted of all women of reproductive age residing in Uringu Division and had delivered in Meru County within the last five years. The unit of analysis was the household and within these households data was sourced from women who met the inclusion criteria. These women-who were the units of observation-, provided information on their experiences during facility based delivery which was then analyzed to answer the study questions.

3.5 Sampling Design and Procedure

The Uringu division was selected conveniently because the researcher is familiar with the area and it is near Meru town hence easing transport arrangements. The sampling design adopted was area sampling which is a type of cluster sampling. In this method, the division was divided into four locations which formed the primary sampling units (PSU). One of the four locations was selected through simple random sampling which was done by simple lottery.

Ten pieces of paper were allocated to the four locations according to probability proportional to number of households. Thus one paper was written Kiorimba, four Mbeu, two Kimachia, and three Nkomo as indicated in the table 3.1. The papers were put in a container and thoroughly mixed then a research assistant picked one paper without looking. This way, Kimachia location was picked.

Table 3.1: *Locations in Uringu Division*

	Location	Sub-locations	Households	PPS	No. Papers
	Kiorimba	3	1015	0.1008	1
	Mbeu	4	3597	0.3572	4
	Kimachia	3	2500	0.2482	2
	Nkomo	3	2959	0.2938	3
Totals		**13**	**10071**	**1.00**	**10**

The sub-locations in Kimachia-which are three-, then formed the secondary sampling Units (SSU). The assumption was that the sub-locations were homogenous units because they are populated by people who have the same social and cultural background.

In the second stage of sampling, one sub-location in the selected location was selected by simple random sampling (SRS), lottery method. Ten papers were allocated to sub-locations proportionately according to number of households. Three were labeled Ntoombo, three Kamaroo, and four Amwari as illustrated in table 3.2. They were put in a container, mixed and one paper picked without looking. The sub-location picked was Amwari.

Table 3.2: Kimachia Sub-locations and their selection Probabilities

Sub-location	**No. Households**	**PPS**	**No. Papers**
Ntoombo	836	0.3344	3
Kamaroo	808	0.3232	3
Amwari	856	0.3424	4
Total	**2500**	**1**	**10**
Note : PPS means probability Proportional to size			

All the households in the selected sub-location formed the sampling frame. Women in the households, who delivered in a health facility within last five years, were available, and accepted to participate formed the sample. The women were identified by walking from household to household through the assistance of the unit managers. This method was appropriate for the study because no list of women who delivered within the last five years in the Division existed and hence other probability sampling methods like simple random sampling and systematic sampling could not be applied.

3.6 Data Collection tools and Procedure

Both quantitative and qualitative data collection methods were used. For the former, a structured questionnaire that consisted of closed ended questions was employed while for the later an in-depth interview guide was used. The data collectors were introduced to the households by village headmen after whom the questionnaires were administered in a face to face interview.

For the qualitative data, the interview was tape recorded and later transcribed verbatim. A field notebook was maintained and it helped gather information not elicited by the above mentioned tools and assisted in monitoring and recording emerging themes.

3.7 Validity and reliability

To ensure that the questionnaire measured what it was designed to measure, its validity was determined. First, face validity was ensured by comparing test items with the research topic and the specific objectives. This made sure that it measured disrespect and abuse of women during facility based deliveries. Secondly, the questionnaire was administered to a sample of 15 women from households conveniently selected from neighboring Tigania Central Division for pre-testing. Ambiguities in wording, irrelevant items were corrected while missed items were included.

The test items were then compared with the operational definition of D&A according to Bowser &Hill, (2010). This ensured that items that measured the seven categories of D&A were included and hence content validity. In order to determine internal validity of the structured questionnaire, inter-item correlation of the pre-test data was calculated to get Cronbach's alpha coefficient. The determined Cronbach's alpha was 0.690. However, when two items that measured detention in health facilities were removed, it rose to 0.707. This was acceptable as the minimum recommended is 0.7 (Bryman, 2008,p.151).

Trustworthiness of the qualitative data was accomplished through respondent validation. A sample comprising 10% (3) of the transcribed in-depth interviews was taken and the respondents contacted through the phone by a research assistant who was not involved in the interview and asked to confirm the content of the transcript. The three transcribed interviews were confirmed, and this implied credibility.

3.8 Ethical considerations

Participation in the research was voluntary and the respondents were assured of confidentiality. They were also required to give verbal consent after being alerted that the interview would involve private and reproductive issues. The respondents were also allowed to terminate the interview at any point in case they felt uncomfortable. Clearance to carry out the research was also granted by University of Nairobi department of social work and sociology (see appendix iii). Permission to enter the community was granted by the Chief and Sub-chief of the selected location and sub-location respectively.

3.9 Data analysis and Presentation

After collection of quantitative data, the questionnaires were cleaned, sorted then coded. Data entry was then done into SPSS data editor followed by analysis as outlined by Bryman & Cramer, (2009). Only the questionnaires that were properly and completely filled were analyzed. The tape recorded interviews were be transcribed verbatim. The researcher went through the coded transcripts and identified emerging themes. Five themes were identified; physical abuse, verbal abuse, failure to intervene, service provided without privacy, and discrimination in service provision. Quotations supporting the themes were identified and grouped together in an excel worksheet. The quantitative and qualitative data was integrated and presented using narrative descriptions, tables and figures. Relationship between variables was explored using odds Ratio and Chi-square as shown in table 3.3.

Table 3.3: *Data Analysis per Objective*

No	Objective No	Analysis and Presentation
1	To determine the prevalence of Disrespect and Abuse of women during facility based delivery in Uringu Division	Counting, Percentages and narrative description. Will be presented by Compact tables.
2	To establish the types of disrespect and abuse experienced by women during facility based delivery in Uringu Division	Counting, Percentages and narrative description. Tables used for presentation.
3	To determine the relationship between personal characteristics of women and disrespect and abuse during facility based deliveries in Uringu division	Counting, then Odds Ratio (OR) and narrative description. Compact Tables. Hypothesis tested at 95% CI and α=0.05
4	To investigate how disrespect and abuse of women during facility based delivery affects intent to use maternity services in Uringu division	Cross tabulation. Narrative description. Hypothesis tested using Chi-square, 95% CI and α=0.05

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

In this chapter, the results of the research will be presented starting with the response rate and then the socio-demographic profile of the respondents. Then results of the prevalence and specific types of Disrespect and Abuse of women during facility based delivery in Uringu Division will follow. The association between (1) Sociodemographic characteristics and disrespect and abuse and (2) Intent to use maternity services and disrespect and abuse will lastly be explored.

4.2 Response Rate

After walking through Amwari sub-location of Kimachia Location, 237 households had children under five years and who had been delivered in a health facility. Out of the 237 households 214 female members agreed to the face to face interview while 23 did not. Seven questionnaires were so incomplete such that they could not be included for analysis. Hence a total of 207 questionnaires were properly filled and this gives a response rate of 87.3 % which is acceptable for face to face interviews. Those who declined did not appear to have common characteristics that could bias the results. A total of 21 in-depth interviews were conducted and analyzed.

4.3 Socio-demographic Profile of Respondents

In terms of demographic characteristics, 56.5 % (n=115) were aged between 21 and 31 years, 88.4% (n=183) were married, 79.1% (n=163) had primary level of education. The main occupation of the respondents was farming 63.3% (n=131) while 62.3% (n=129) had an estimated monthly income of below Ksh. 3000. Among those who were disrespected and abused

during facility based delivery, 55% (n=82) were aged between 21-31 years. In terms of marital status, majority that is 89.3% (n=133) of the abused were married while 79.2% (n=118) of those who experienced disrespect and abuse had attained primary education. Only 20.1% (n=30) of those with secondary and tertiary education were disrespected and abused (Table 4.1)

Table 4.1: *Socio-demographic Profile of Respondents*

Characteristic	Frequency	Experienced Disrespect and Abuse	
		Yes	No
Age			
20 and below	31 (14.9)	22 (14.8)	9 (15.5)
21-31	115 (55.6)	82 (55)	33 (56.8)
32-42	56 (27.1)	40 (26.8)	16 (27.5)
43-53	5 (2.4)	5 (3.4)	0 (00.0)
Total	**207 (100)**	**149 (100)**	**58 (100)**
Marital Status			
Married	183 (88.4)	133 (89.3)	50 (86.2)
Single	16 (7.7)	9 (6.0)	7 (12.1)
Separated	8 (3.9)	7 (4.7)	1 (0.01)
Total	**207 (100)**	**149 (100)**	**58 (100)**
Level of Education			
No formal education	1 (0.5)	1 (6.7)	0 (00.0)
Primary education	163 (79.1)	118 (79.2)	45 (78.9)
Secondary education	36 (17.5)	26 (17.4)	10 (17.5)
Tertiary education	6 (2.9)	4 (2.7)	2 (0.04)
Total	**206 (100)**	**149 (100)**	**57 (100)**
Occupation			
Housewife	29 (14.0)	22 (14.8)	7 (12.1)
Farmer	131 (63.3)	90 (60.4)	41 (70.7)
Casual worker	41 (19.8)	34 (22.8)	7 (12.1)
Employed	6 (2.9)	3 (2.0)	3 (5.2)
Total	**207 (100)**	**149 (100)**	**58 (100)**
Monthly Income			
< 3000	129 (62.3)	98 (65.8)	31 (53.4)
3001-6000	53 (25.6)	34 (22.8)	19 (32.8)
6001-9000	9 (4.3)	5 (3.3)	4 (6.9)
9001-12000	6 (2.9)	4 (2.7)	2 (3.4)
> 12000	10 (4.8)	8 (5.4)	2 (3.4)
Total	**207**	**149 (100)**	**58 (100)**

Note : Figures are reported in the format: Frequency(Percentage)

As for the family and delivery characteristics, 32.4% (n=67) of the women had two children, 35.3% (n=73) had at least one child delivered at home, while 63.8 % (n=129) delivered all their children in a health facility. Majority of the women 94.6% (n=196) accessed childbirth services from public health facilities within Meru county as shown in table 4.2.

Table 4.2: *Number of Children and Place of Delivery*

Characteristic	Frequency(n)	Percent (%)
Number of Children		
One	58	28.0
Two	67	32.4
Three	40	19.3
Four	25	12.1
Five	6	2.9
Six	8	3.9
Seven	3	1.4
Total	**207**	**100**
Children Delivered at Home		
None	129	63.8
One	44	21.7
Two	21	10.4
Three	6	2.9
Four	1	0.5
Five	1	0.5
Total	**202**	**100**
Children Delivered in Hospital		
all of them	132	64.1
One	26	12.6
Two	30	14.5
Three	14	6.8
Four	2	1.0
Five	1	0.5
Total	**206**	**100**
Type of Facility Delivered		
Public	196	94.6
Private	10	5.4
Total	**206**	**100**

4.4 Prevalence of Disrespect and Abuse during Childbirth

Out of the 207 respondents interviewed, 71.9% (n=149) reported having experienced at least one form of Disrespect and Abuse during Childbirth while only 28.1% (n=58) did not experience any

form of D&A. The women were asked to state the specific types of abuse they experienced based on the six categories as suggested by Bowser & Hill (2010). Majority of the women 67.1% (n=139) had un-consented procedures with 38.2 % (n=79) of the women being given un-consented episiotomies, 55.6% (n=115) un-consented vaginal examinations while 31.4% (n=65) had the episiotomies sutured without their consent as shown in table 4.3.

A total of 41.5% (n=86) of the women reported having been physically abused with 28.5% (n=59) having had their episiotomies and tares sutured or repaired without pain killers, 27.5% (n=57) of the women reported having been beaten, slapped or pinched when giving birth. This was corroborated by one woman, who said "…as she was assisting me to give birth she bit me with scissors and told me to behave" (IIR8, Personal Communication. August 31st, 2015). Another woman also experienced similar abuse and put it thus;

"Yeeees… the beating is always there! I was beaten by a male nurse and I felt very bad" (IIR16, Personal communication. August 31st , 2015).

The women who reported non-dignified care were 53.1% (n=110) with 38.6 % (n=80) and 35.7% (n=74) of the women reported having been blamed, intimidated during childbirth and threatened with caesarean delivery for shouting and screaming in pain respectively. Other forms of non-dignified care included; being left naked after giving birth 1% (n=2), being scolded, shouted at and called stupid 37.2% (n=77) and receiving slanderous remarks as one woman put it;

> Every time I was in terrible pain I would call her. She told me she was not the one who made me pregnant so she was not going to be gentle with me. I refused to be stitched down there but she forced me and said no man-not even my husband-would make love to me if left that way (IIR3, Personal communication. September 2nd , 2015).

The health care workers in the maternity appeared indifferent to the suffering of the laboring women and even appeared to add to the suffering by verbal abuse and slanderous remarks. In some cases the laboring women were threatened with beatings if they did not do what the health care workers expected as put across by one woman who experienced this cruelty:

> …She told me I stop disturbing her and that she was not my husband. She said I will go to disturb my husband and that I should give birth nicely. Then she told me that if I continued she will beat me. I pleaded with her not to beat me (IIR1, Personal Communication. September 2nd , 2015)

Some of the remarks made by the health workers had sexual undertones and they appeared to suggest that the woman enjoyed the sexual act and now should persevere the suffering. One woman who experienced it puts it thus; "I am not your husband. When your husband was making you pregnant you felt good and enjoyed now you are here disturbing us" (IIR11, Personal communication. September 2nd , 2015).

During the process of childbirth women are naked and thus care should be provided in private and only staff assisting in childbirth should be present. This was not the case as 30.9 % (n=64) of women underwent vaginal examination witnessed by many people who were not involved in the care while 29.5 % (n=61) of the women delivered in front of many people not involved in care. The women felt helpless and ashamed as one woman says; "When I was through giving birth, I saw four students staring at me and I felt very bad in my heart because I did not expect to find them there"(IIR13, Personal communication. September 2nd , 2015).

In the maternity units, 66.7 % (n=138) of the women experienced abandonment and neglect of care. For instance, 72.9 % (n=151) were denied companionship of their husbands or relatives during labor and delivery a time when such companionship is needed the most.

Despite the fact that the women were in a maternity manned by qualified staff, 25.1 % (n=52) of the women were not attended during the second stage of labor and many gave birth on their own. A woman describes her ordeal; "…The nurse chased me and told me to go and walk outside so that the baby can come down quickly. As I was walking outside the maternity I almost delivered on the floor" (IIR6, Personal communication. September 2nd, 2015). A woman who was also in labor describes what she observed;

> I saw some women giving birth all by themselves and that time the 'doctors' are in the office talking. When you call them, they tell you to go they are coming but they don't come (IIR13, Personal communication. September 2nd, 2015).

In some cases, there was complete failure to intervene even when medically indicated. This was reported by 14.9 % (n=30) of the women. In one case the woman who was carrying a new born baby describes what almost cost her life;

> …When I gave birth I was cut down there but they did not stitch me. Instead I was told to take my baby and I go where women who have just given birth go. On the way I bled so much until I fainted and fell down. That is when another 'doctor' picked me, took me back stitched and infused me (IIR5, Personal communication. September 2nd, 2015)

Non-confidential care was experienced by 14.5% (n=30) of the women with 14.5% (n=30) being provided with care without privacy, while 1.4% (n=3) had their medical history disclosed to third parties without their involvement. In 1% (n=2) age of the woman was disclosed without her consent.

The expectant women also faced discrimination in the provision of care with 8.2 % (n=17) experiencing it. Most women 7.7% (n=16) reported discrimination on the basis of social. The women felt that they were discriminated in service provision because they looked like they were poor or like they did not have money. A woman describes what she experienced; "Those women who have money are looked after well. I delivered outside the hospital while those are given beds inside the maternity" (IIR17, Personal communication. September 3rd , 2015).

Some women in labor claimed not to have been given tea or milk after delivery and yet this is supposed to available to every woman after birth. Instead, the nurses gave the tea, milk or porridge to women selectively as put across by one woman;

> …The woman who looked well to do and had money was well looked after
> but when I gave birth I asked for water to bath and drink but they refused
> and told me to wait for my husband in the morning (IIR3, Personal communication. August 31st, 2015)

Table 4.3*: Prevalence of specific types of Disrespect and Abuse*

Category (Bold) and Specific types of Abuse (N=207)	Experienced D&A	
	Yes n (%)	No n (%)
Un-consented Procedures	**139 (67.1)**	**68 (32.9)**
Episiotomy	79 (38.2)	128 (61.8)
Augmentation of labor	34 (16.4)	173 (83.6)
Shaving of pubic hair	15 (7.2)	192 (92.8)
Sterilization/Family planning	1 (0.5)	206 (99.5)
Caesarean delivery	1 (0.5)	206 (99.5)
Blood transfusion	0 (0.0)	0 (0.0)
Vaginal examination	115 (55.6)	92 (44.4)
Suturing episiotomy	65 (31.4)	142 (68.6)
Physical Abuse	**86 (41.5)**	**121 (58.5)**
Restrained/Tied during labor	33 (15.9)	174 (84.1)
Episiotomy given/sutured without analgesia	59 (28.5)	148 (71.5)
Beaten, Slapped or Pinched	57 (27.5)	150 (72.5)
Touched breast, buttocks private parts in a sexual way	0 (0.0)	0 (0.0)
Un-consented sexual intercourse	0 (0.0)	0 (0.0)
Frequent, Rough Vaginal exams	2 (1.0)	205 (99.0)
Non-dignified care	**110 (53.1)**	**97 (46.9)**
Blamed or intimidated during childbirth	80 (38.6)	127 (61.4)
Threatened with CS to discourage from shouting in pain	74 (35.7)	133 (64.3)
Received slanderous remarks from health worker	74 (35.7)	133 (64.3)
Scolded, shouted at or called stupid	77 (37.2)	130 (62.8)
Vaginal examination watched by many people	64 (30.9)	143 (69.1)
Giving birth in front of many people	61 (29.5)	146 (70.5)
Left naked after giving birth	2 (1.0)	205 (99.0)
Abandonment & Neglect of care	**138 (66.7)**	**69 (33.3)**
Denied companionship of the husband or close relative	151(72.9)	56 (27.1)
Left unattended during second stage of labor	52 (25.1)	155 (74.9)
Birth attendant failed to intervene when medically indicated	31(14.9)	176 (85.1)
Not granted requested attention because staff was exhausted	8 (3.9)	199 (96.1)
Non-confidential care	**30 (14.5)**	177 (85.5)
Age disclosure without consent	2 (1.0)	205 (99.1)
Provision of care without privacy	30 (14.5)	177 (85.5)
Medical history disclosure without consent	3 (1.4)	204 (98.6)
Disclosure of HIV status without consent	0 (0.0)	207 (100)
Discrimination in Provision of care	**17 (8.2)**	**190 (91.8)**
Denial of needed attention because of ethnic origin	1 (0.5)	206 (99.5)
Denial of needed service because of low social class	16 (7.7)	191 (92.3)
Denial of care because of teenage (< 18 yrs)	0 (0.0)	207 (100)
Denied services because of being HIV positive	0 (0.0)	207 (100)

Note 1: A woman may experience more than one form of Disrespect and Abuse during childbirth.
Note 2: Figures are expressed in the format : Frequency (Percentage)

4.5 Relationship between Socio-demographic Characteristics and Disrespect and Abuse

The association of maternal socio-demographic characteristics and experience of any form of Disrespect and Abuse during facility based delivery was examined. A respondent who experienced any D&A among the seven categories according to Bowser and Hill (2010) was considered to have been abused and disrespected. The relationship was determined using Odds ratio (OR) and 95% confidence interval and significance level of p=0.05. The null hypothesis was; There is no relationship between maternal socio-demographic characteristics and Disrespect and Abuse or the OR is one (OR=1). The computed Odds Ratios for all the variables included 1 at 95% CI ($p > 0.05$, $\alpha=0.05$) as illustrated in table 4.4.

The null hypothesis was therefore accepted and hence there was no statistically significant association between the socio-demographic variables and disrespect and abuse during facility based delivery in Uringu Division Meru County.

Table 4.4: Association between socio-demographic characteristics and D&A

Socio-demographic Variable	Disrespected & Abused During Childbirth		Odds Ratio (95% CI) OR(LL,UL)	*P* Value
	Yes	No		
Age in Years (Reference group 20 years and below)				
20 and below	22	9		
21-31	82	33	1.03 (0.42, 2.49)	0.947
32-42	40	16	1.04 (0.40, 7.30)	0.959
43-53	5	0	1.66 (0.52, 54)	0.679
Total	149	58	207	
Marital Status(Reference group Married)				
Married	133	50		
Single	9	7	0.48 (0.16, 1.42)	0.187
Separated	7	1	2.63 (0.31, 22.38)	0.381
Total	149	58	207	
Education level (Reference group Tertiary education)				
No formal education	1	1	0.5(0.02, 12.89)	0.689
Primary education	118	45	1.32(0.23, 7.45)	0.766
Secondary education	26	10	1.3 (0.21, 8.23)	0.793
Tertiary education	4	2		
Total	149	58	207	
Occupation (Reference group Employed)				
Housewife	22	7	3.14 (0.51, 19.20)	0.217
Farmer	90	41	2.20 (0.41, 11.86)	0.364
Casual worker	34	7	4.86 (0.81, 29.20)	0.083
Employed	3	3		
Total	149	58	207	
Monthly income (Reference group Income >12000)				
< 3000	98	31	0.79 (0.16, 3.92)	0.785
3001-6000	34	19	0.45 (0.09, 2.27)	0.336
6001-9000	5	4	0.31 (0.04, 2.39)	0.265
9001-12000	4	2	0.50 (0.05, 4.98)	0.566
> 12000	8	2		
Total	149	58	207	

Note : The Confidence Interval is reported in the format; Odds Ratio(Lower Limit, Upper Limit)

4.6 Disrespect and Abuse and Intent to use Services

The relationship between the experience of any form of Disrespect and abuse during facility based deliveries and the intention to use maternity services again was examined. Intention to use maternity services was determined by asking the women whether they would deliver in a hospital in case they became pregnant. The relationship between the variables was determined using Pearson's Chi-Square test. The null hypothesis was that there was no difference in the intention to use maternity service between those who experienced any form of D&A and those who did not. The obtained Chi-square was 9.097 and the p value (0.004) was less than the significance level (0.05) as shown in table 4.5. The null hypothesis was therefore rejected meaning there is a relationship between Disrespect and Abuse during Childbirth and the intention to use maternity services in Uringu Division.

Table 4.5: Relationship between D&A and intent to use service

		Deliver in Hospital Again		
		No	Yes	Total
Experienced D&A	No	0	58	58
	Yes	21	128	149
	Total	21	186	207

Note: the minimum expected value is 5.88
Pearson Chi-Square =9.097, Two tailed sig(p=0.04)

The data was disaggregated into the six categories of disrespect and abuse and hypothesis tested. There was statistically significant relationship between non-consented care and intent to use maternity services (X^2 =7.260, p=0.010, α=0.05). There was a significant relationship between those that reported discrimination in service provision and intent to use maternity services again (Fishers X^2 =7.542, p=0.018, α=0.05).

There was no statistically significant relationship between un-consented procedures, Physical abuse, abandonment and neglect of care, non-confidential care and intention to use maternity services in Uringu Division (Table 4.6)

Table 4.6: Relationship between Disrespect and Abuse and Intent to use Maternity services

Category of D&A		Deliver in Hospital		X^2	d.f	*p* value
		No	Yes			
Un-consented Procedures	No	5	63	0.866	1	0.465
	Yes	16	123			
Physical abuse	No	10	111	1.130	1	0.352
	Yes	11	75			
Non-dignified care	No	4	93	7.260	1	0.010
	Yes	17	93			
Abandonment and Neglect of care	No	3	66	3.816	1	0.054
	Yes	18	120			
Non-Confidential care	No	18	159	0.001*	1	1.000
	Yes	3	27			
Discrimination in provision of care	No	16	174	7.542*	1	0.018
	Yes	5	12			

*The expected values in 25% of the cells were less than 5 and hence Fishers exact test was done
d.f : degrees of freedom for a 2 by 2 contingency table.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

This chapter will involve the discussion of the major findings of the research in accordance with the specific objectives and the research questions. A conclusion will also be made based on the findings and thereafter recommendations for further action will be included.

5.1.1 Prevalence of Disrespect and Abuse

According to this study 71.9 % of all women interviewed experienced a form of disrespect and abuse during their most recent facility delivery. This is in sharp contrast to the findings of Abuya et al., (2015). According to their study, 28% of women in a sample followed into the community reported having experienced at least one type of Disrespect and Abuse during hospital delivery. However, 18% of the same women had reported any form of D&A when exiting the hospital. The difference may be due to courtesy bias where women do not want to negatively evaluate health workers while they still need their services. In Uringu the women had delivered within the last five years and they had little or no courtesy bias hence the high prevalence.

5.1.2 The Types of Disrespect and Abuse reported

According to this study, non-dignified care appears to be a common manifestation of Disrespect and abuse during childbirth in Uringu Division. It included women being intimidated during labor, verbal abuse and slanderous remarks. One woman reported her experience as follows; "…I was screaming in pain and they told me if I don't follow their rules I should leave immediately" (IIR17, Personal communication. September 3rd , 2015).

All the abuses were geared towards exerting medical power and control over the laboring female body (Foucault, 2003). The health workers never empathized with the laboring women instead they blamed them of having brought the suffering by having sex with their husbands.

In some cases medical procedures were done in full view of medical students. In 31 %(n=64) of women vaginal examination was observed by students while 30 %(n=61) of the women had their deliveries observed by students without consent. This way, the women were stripped off their social being and were treated as objects subjected to scientific inquiry. This is the cardinal characteristic of the Foucauldian clinical gaze.

In labor wards some procedures that included invasion of a woman's privacy were done without prior consent or explanation. The procedures included repairing of episiotomies & tares and vaginal examinations. Approximately 38.2 % (n=79) of the women only realized that they had been cut on their vagina when they felt extremely painful because no pain killer was used even though procedure protocols included use of local anesthetics. The abuse took a different turn when the health care workers beat, slapped and pinched the helpless and suffering mothers as one of them put it; "…as she was assisting me to give birth she bit me with scissors and told me to behave"(IIR8, Personal communication. August 31st , 2015).

The direct violence meted on laboring women reveals deep seated bitterness towards the system and the only way the health care workers could express their displeasure is through acts of violence on the women and this is in accordance to Galtung's theory of violence (Galtung, 2008). Structural violence was also experienced by the women in that those that appeared well to do were well looked after and even given preferential treatment as summed up one of the respondents; "Those women who have money are looked after well. I delivered outside the hospital while those were given beds inside the maternity" (IIR17, Personal communication.

September 2nd , 2015). This is suggestive of corrupt practices where health workers demand cash in exchanges of otherwise free maternity services. Corruption theme also appeared in Abuya et al.(2015) where multiparous women were 5 times more likely to be asked for bribes compared to newly delivered mothers.

The women went to the hospital to get the much needed care. Instead some experienced abandonment of care. For instance 72.9% (n=151) of the women were denied birth companions and yet this is the time such company is most needed. Additionally they were left to labor alone and worse still, 25.1 % (n=52) of the women gave birth without the assistance of the health care workers. This can be viewed as failed surveillance according to the principles of foucauldian panopticon where laboring bodies are supposed to be regularly monitored so that any danger to the mother and the unborn is arrested on time. In some cases failure to intervene when medically indicated led to injuries and almost to deaths as one woman says;

> …After cutting the cord, the students forgot to tie the cord on the baby.
>
> My baby was bleeding and there was blood all over the baby's abdomen.
>
> I told them and they tied the cord and pleaded with me not to tell the in-
>
> charge (IIR6, personal communication. August 31st , 2015).

The many injuries or harms reported in the maternity units are a confirmation of Illich's thesis of clinical iatrogenesis where the women suffer and get injuries, infections or even deaths in the hands of the health care workers (Illich, 1976).

Out of all the 148 women who experienced Disrespect and Abuse during childbirth, majority 86.5 % (n=128) would still deliver in the hospital again if ever they conceived again. The women therefore experience D&A and take as a normal experience. This is because the D&A is so common such that it has become a routine practice in the maternity units. The women therefore tend to take it as part of their socially constructed reality and in accordance with Gidden's

structuration theory (Ritzer, 1996). This normalization of Disrespect and abuse leads to the continuity of the practice and its underreporting. No efforts to rectify the situations are therefore instituted.

5.1.3 Socio-demographic Characteristics and Disrespect and Abuse

The association between the respondent's characteristics of age, marital status, monthly income and level of education was examined. There was no statistically significant difference in prevalence of D&A across the various socio-demographic variables. Similar findings were reported in a study conducted in Enugu Nigeria by Okafor et al., 2015). However, these findings are in contrast to those of a study by Abuya et al (2015) in Kenya. According to their study married women were less likely to be detained for lack of payment and were also twice as likely to be neglected compared to single women. The lack of association between demographic characteristics and D&A in the current study may be because of homogeneity in the sample since it was derived from the same community as was the case with the Nigerian study.

5.1.4 Disrespect and Abuse and intent to use Services

In Uringu Division, there is a statistically significant relationship between Disrespect& Abuse during childbirth and intent to use maternity services (X^2 =9.097, p=0.04, α=0.05). All the women who did not experience any form of D&A had the intent of delivering in the hospital again, while 14% (n=21) of those who experienced D&A had no intention of using the service again. One of the women put it as follows;

> …Aiiiii! There were many students. I felt ashamed as four of them were looking at me as I gave birth and I was completely naked. Even when I was being stitched they were still looking. When I came back home I told my husband

when I get another pregnancy I will not give birth in that hospital (IIR10, Personal communication, September 2nd , 2015).

On disaggregation into the six categories, significant relationship was found between non-dignified care, discrimination in service provision and intent to use maternity services again. Perhaps inhumane acts like verbal abuse, slanderous remarks and exposing women's bodies strip women of their femininity so much such that they may not want to use the maternity services again. Discrimination on the basis of social class and bribery may also dissuade women from using maternity services since they may feel unwanted and violated.

Women seek help from the health workers expecting care, comfort and human companionship and this is because labor and delivery is a period of pain, emotional and physical trauma. Instead of getting solace they are disrespected and abused by the very people who were supposed to provide comfort. This is the reason for instance women in a Tanzanian discrete choice experiment chose provider attitude as the most important factor to consider when choosing a health center where to deliver (Kruk et al., 2009). Similar findings have been reported in Morogoro Tanzania where lack of compassion, verbal abuse and failure to intervene drive women to deliver at home(Mcmahon et al., 2014)

5.2 Study Conclusion

The study has revealed that Disrespect and Abuse of women during childbirth has a high prevalence in Uringu division Meru county since 71.9 % (n=149) of all women interviewed experienced at least one form. The specific types of D&A varied from woman to woman, but the most prevalent were; being denied companionship during birth, vaginal examinations done without consent or explanation, being blamed and intimidated during birth, episiotomies given without consent, and shouting & scolding in that order.

There was no statistically significant association between socio-demographic variables and Disrespect and Abuse during childbirth in Uringu Division. However, there was a statistically significant relationship between Disrespect and Abuse during childbirth and intent to use maternity services again. Women who experienced D&A are less likely to intend to deliver in a health facility as compared to those who did experience D&A.

5.3 Recommendations

1. The ministry of health Meru county, Non- governmental organizations dealing with maternal child health in Meru county should immediately embark on programs to lower the unacceptably high prevalence of Disrespect and Abuse during child birth in Uringu Division Meru County.

2. The Kenya National human rights Commission should establish reporting mechanisms where women report their D&A experiences as they exit the health institutions. In some cases the Commission should institute litigation against the health workers as some forms of D&A constitute crime and are a violation of women's reproductive rights.

3. Professional associations like Nursing Council of Kenya (NCK) and Kenya Medical Dentists Pharmacist Board (KMDPB) should investigate and institute disciplinary action against members found to have disrespected and abused women during childbirth in Uringu Division.

4. An aggressive public health education campaign should be carried out by the county government of Meru and civil societies to educate women that it is not normal to be abused and disrespected and that it is their right to receive quality care devoid of any form of abuse.

5. The study was carried out in a Division in Meru County. A larger nationally representative study is needed in order to understand national burden of D&A and its correlates.

References

Abuya, T., Warren, C. E., Miller, N., Njuki, R., Ndwiga, C., Maranga, A., … Bellows, B. (2015). Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. *PLOS ONE*, *49*, 1–13. doi:10.1371/journal.pone.0123606

Ambruoso, L. D., Abbey, M., & Hussein, J. (2005). Please understand when I cry out in pain□: women ' s accounts of maternity services during labour and delivery in Ghana. *BMC Public Health*, *11*, 1–11. doi:10.1186/1471-2458-5-140

Asefa, A., & Bekele, D. (2015). Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa , Ethiopia. *Reproductive Health*, *12*(33), 1–9. doi:10.1186/s12978-015-0024-9

Berger, P. L., & Luckman, T. (1966). *The Social Construction of Reality:A Treatise in the Sociology of Knowledge* (First., p. 249). London: Penguin Books. Retrieved from http://perflensburg.se/Berger social-construction-of-reality.pdf

Bohren, M. a, Hunter, E. C., Munthe-Kaas, H. M., Souza, J., Vogel, J. P., & Gülmezoglu, a. (2014). Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. *Reproductive Health*, *11*, 71. doi:10.1186/1742-4755-11-71

Bowser, D., & Hill, K. (2010). *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis* (pp. 1–57). Retrieved from http://wordpress.sph.harvard.edu/mhtf-2/wp-content/uploads/sites/32/2014/08/RespectfulCareatBirth9-20-101Final.pdf

Brüggemann, A. J. (2012). *Toward an Understanding of Abuse in Health Care – A Female Patient Perspective*. Linkoping. Retrieved from http://www.diva-portal.org/smash/get/diva2:540481/FULLTEXT01.pdf

Brüggemann, A. J., & Swahnberg, K. (2013). What contributes to abuse in health care□? A grounded theory of female patients ' stories. *International Journal of Nursing Studies*, *3*(50), 404–412. Retrieved from http://www.diva-portal.org/smash/get/diva2:612367/FULLTEXT02.pdf

Bryman, A. (2008). *Social research Methods* (Third., p. 748). Oxford.New York.Aukland.Cape Town.Dar es salaam.Hongkong.Toronto: OXFORD UNIVERSITY PRESS.

Bryman, A., & Cramer, D. (2009). *Quantitative Data Analysis with SPSS 14,15 & 16□: A Guide for Social Scientists* (p. 381). London.New york: Routledge Taylor& Francis Group.

Centre for Reproductive Rights, & Federation of Women Lawyers-Kenya. (2007). *Failure to Deliver: Violation of Womens Human Rights in Kenyan Health Facilities* (p. 105). Nairobi. Retrieved from http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf

Crowe, S., Utley, M., Costello, a, & Pagel, C. (2012). How many births in sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015? *BMC Pregnancy and Childbirth*, *12*(1), 4. doi:10.1186/1471-2393-12-4

D'Oliviera, L., Diniz, G., & Schraiber, B. (2002). Violence against women in health-care institutions: an emerging problem. *The Lancet*, *359*, 1681–1685. Retrieved from http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673602085926.pdf?id=caasZZO7M1a_mcgaTW-Nu

Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2006). *Listening to Mothers II* (p. 118). New York. Retrieved from http://www.childbirthconnection.org/pdfs/LTMII_report.pdf

Foucault, M. (2003). *The Birth of the Clinic:An archeology of Medical Perception* (p. 223). London and New York: Routledge Taylor Francis Group (Fisrt Published in 1963).

Foucault, M. (2003). *The Birth of The Clinic:An Archeology of Medical Perception* (p. 226). London: Routledge. Retrieved from http://home.ku.edu.tr/~mbaker/CSHS503/FoucaultClinic.pdf

Freedman, L., & Kruk, E. (2014). Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. *The Lancet*, *384*(9948), e42–e44. doi:10.1016/S0140-6736(14)60859-X

Gage, H., Hart, J., Crow, R., Hampson, S., Kimber, A., Storey, L., & Thomas, H. (2002). The measurement of satisfaction with healthcare: implications for practice from a systematic review of the Literature, *6*(32). Retrieved from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCsQFjAB&url=http://www.researchgate.net/profile/Jo_Hart/publication/10609002_The_measurement_of_satisfaction_with_healthcare_implications_for_practice_from_a_systematic_review_of_the_lit

Galtung, J. (2008). Cultural Violence. *Journal of Peace Research*, *27*(3), 291–305. Retrieved from http://www2.kobe-u.ac.jp/~alexroni/IPD 2014 readings/IPD 2014_2/Cultural Violence (Galtung).pdf

Goer, H. (2011). Cruelty in Maternity Wards: Fifty Years Later. *The Journal of Perinatal Education*, *19*(3), 33–42. doi:10.1624/105812410X514413

Hodges, S. (2009). Abuse in Hospital-Based Birth Settings? *The Journal of Perinatal Education*, *18*(4), 8–11. doi:10.1624/105812409X474663

Hogan, M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M., … Foundation, M. G. (2008). Maternal mortality for 181 countries , 1980 – 2008□: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet*, *375*(9726), 1609–1623. doi:10.1016/S0140-6736(10)60518-1

Human Rights Watch. (2011). *"Stop Making Excuses": Accountability for Maternal Health Care in South Africa* (p. 73). New York.Belgium.London.Paris.Washington DC.Parktown. Retrieved from http://www.hrw.org/sites/default/files/reports/sawrd0811webwcover.pdf

Illich, I. (n.d.). *Medical Nemesis: The expropriation of Health* (p. 36). New York: PANTHEON BOOKS. Retrieved from http://www.columbia.edu/itc/hs/pubhealth/rosner/g8965/client_edit/readings/week_2/illich.pdf

Illich, I. (1976). *Medical Nemesis: The expropriation of Health*. New York: Pantheon Books. Retrieved from http://www.ratical.org/ratville/AoS/MedicalNemesis.pdf

Kenya National Bureau of Statistics. (2008). Kenya Demographic and Health Survey 2008-09.

Kitui, J., Lewis, S., & Davey, G. (2013). Factors influencing place of delivery for women in Kenya□: an analysis of the Kenya demographic and health survey , 2008 / 2009. *BMC Pregnancy and Childbirth*, *13*(1), 1. doi:10.1186/1471-2393-13-40

KNBS. (2010). *2009 Kenya Population and Housing Census Vol 1A Population distribution by administrative units*.

Kruger, L. M., & Schoombee, C. (2010). The other side of caring□: abuse in a South African maternity ward. *Journal of Reproductive and Infant Psychology*, *28*(1), 84–101. doi:10.1080/02646830903294979

Kruk, M. E., Paczkowski, M., Mbaruku, G., De Pinho, H., & Galea, S. (2009). Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. *American Journal of Public Health*, *99*(9), 1666–1672. doi:10.2105/AJPH.2008.146209

Kruk, M., Kujawski, S., Mbaruk, G., Ramsy, K., Moyo, W., & Freedman, L. (2014). Disrespectful and abusive treatment during facility based delivery in Tanzania:A Facility and Community Survey. *Health Policy and Planning*, *30*(4). doi:10.1093/heapol/czu079

Kumbani, L., Bjune, G., Chirwa, E., Malata, A., & Odland, J. Ø. (2013). Why some women fail to give birth at health facilities□: a qualitative study of women ' s perceptions of perinatal care from rural Southern Malawi. *Reproductive Health Journal*, *10*(9), 1–12. doi:10.1186/1742-4755-10-9

Mcmahon, S. A., George, A. S., Chebet, J. J., Mosha, I. H., Mpembeni, R. N. M., & Winch, P. J. (2014). 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 and Childbirth*, *14*(1), 1–13. doi:10.1186/1471-2393-14-268

Merian webster. (2015). *Merriam Webster.com*. Retrieved from http://www.merriam-webster.com/dictionary/abuse

Merriam Webster. (2015). *Merriam Webster*. Retrieved from http://www.merriam-webster.com/dictionary/disrespect

National council for Population and Development. (2013). *KENYA POPULATION SITUATION ANALYSIS*. Retrieved from http://countryoffice.unfpa.org/kenya/drive/FINALPSAREPORT.pdf

Okafor, I. I., Ugwu, E. O., & Obi, S. N. (2015). Disrespect and abuse during facility-based childbirth in a low-income country. *International Journal of Gynecology & Obstetrics*, *128*(2), 110–113. doi:10.1016/j.ijgo.2014.08.015

Population Council. (2014). *Confronting Disrespect and Abuse during Childbirth in Kenya* (p. 2). Nairobi. Retrieved from http://www.popcouncil.org/uploads/pdfs/2014RH_HeshimaBrief.pdf

Pylypa, J. (1998). Power and Bodily Practice : Applying the Work of Foucault to an Anthropology of the Body. *Arizona Anthropologist*, *13*, 21–36. Retrieved from https://arizona.openrepository.com/arizona/bitstream/10150/110194/1/azu_gn1_a785_n13_21_36_w-ocr.pdf

Rest, J. (1986). *Moral development: Advances in research and theory*. New York: Praeger.

Ritzer, G. (1996). *Sociological Theory* (Fourth., p. 653). New York. St.Louis.San Fransisco.Aukland...Toronto: McGraw-Hill.

Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A. B., Daniels, J., … Alkema, L. (2014). Global causes of maternal death: A WHO systematic analysis. *The Lancet Global Health*, *2*. doi:10.1016/S2214-109X(14)70227-X

Schroll, A.-M., Kjærgaard, H., & Midtgaard, J. (2013). Encountering abuse in health care; lifetime experiences in postnatal women - a qualitative study. *BMC Pregnancy and Childbirth*, *13*, 74. doi:10.1186/1471-2393-13-74

Swahnberg, K., Schei, B., Hilden, M., Halmesmaki, E., Sidenius, K., Steingrimsdottir, T., & Wijma, B. (2007). Patients' experiences of abuse in health care:a Nordic study on prevalence and associated factors in gynaecological patients. *Acta Obstetricia et Gynaecologica*, *86*, 349–356. Retrieved from https://www.researchgate.net/publication/6443534_Patients'_experiences_of_abuse_in_health_care_a_Nordic_study_on_prevalence_and_associated_factors_in_gynecological_patients

United Nations International Childrens Education Fund. (2013). UNICEF Data:Monitoring the situation of Children and women. Retrieved February 25, 2015, from http://data.unicef.org/maternal-health/delivery-care

Waldenström, U., Hildingsson, I., Rubertsson, C., & Rådestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth*, *31*(March), 17–27. doi:10.1111/j.0730-7659.2004.0270.x

World Health Organization. (2014a). *The prevention and elimination of disrespect and abuse during facility-based childbirth WHO statement* (p. 4). Retrieved from http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1

World Health Organization. (2014b). *Trends in Maternal Mortality : 1990 to 2013 Executive Summary* (p. 68). Geneva. Retrieved from http://apps.who.int/iris/bitstream/10665/112697/1/WHO_RHR_14.13_eng.pdf?ua=1

World Health Organization. (2014c). WHO Media Centre. Retrieved February 25, 2014, from http://www.who.int/mediacentre/factsheets/fs348/en/

APPENDIX 1: Study Questionnaire

Serial No._____

Disrespect and Abuse Of Women During Facility Based Delivery and Its Effects on Intent to Use Maternity Services in Uringu Division Meru County

Study Questionnaire

INTRODUCTION

This questionnaire is about the disrespectful and abusive experiences that women go through during the process of giving birth in the hospital. As such you may be asked questions that are private and involve the reproductive system. However, utmost confidentiality will be observed and will the results will be used for research purposes only.

Participation in the research is voluntary and you can withdraw after beginning if uncomfortable. Since this research is for advancement of knowledge only, no monetary motivation is available but the researcher greatly appreciates your participation.

INSTRUCTIONS

1. Answer all the questions honestly
2. Do not write your name anywhere on the questionnaire
3. Filing the questionnaire will take approximately 35 minutes

CONSENT

Please tick in the appropriate box below

1. I have agreed to participate in the study voluntarily ☐
2. I decline to participate in the study ☐

FOR THE RESEARCH ASSISTANT

Ask the respondent the following questions;

1. Do you have a child aged 5 years and below? 1. Yes 0. No
2. Was your child delivered in a health facility within Meru county 1. Yes 0. No

If the answer to both questions is yes, then proceed and administer the questionnaire otherwise stop

Section I: Socio-Demographic Data

1. What your age in years? (*Circle the correct answer*)

    1. Below 20
    2. 21-31
    3. 32-42
    4. 43-53
    5. Other (Specify)_____

2. What is your marital status? (*Circle the correct answer*)

    1. Married
    2. Single
    3. Divorced
    4. Separated
    5. Windowed
    6. Other (Specify)_____

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

    1. No formal education
    2. Primary education
    3. Secondary education
    4. Tertiary education

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

    1. A housewife
    2. A Farmer
    3. Casual worker
    4. Employed
    5. Any Other (Specify)_____

5. How many children do you have? (*Circle the correct answer*)

    1. One
    2. Two
    3. Three
    4. Four
    5. Five
    6. Six

6. How many children have you delivered at home*?(circle the correct answer*)

    1. All of them
    2. None
    3. One
    4. Two
    5. Three
    6. Four

7. What is your household's average monthly income from all sources in Ksh?

1. Below 3,000
2. 3001-6000
3. 6,001-9000
4. 9,001-12000
5. Above 12000

8. How many children have you delivered in a health facility?(*Circle the correct answer*)

1. All of them
2. None
3. One
4. Two
5. Three
6. Four

9. In what type of health facility did you deliver?

1. Public hospital

2. Private hospital

Section II: Experiences of Disrespect and Abuse During Childbirth

(For all the questions below circle the correct answer)

1. **During facility delivery did you undergo the following procedures without your consent?**

An Episiotomy	1.	Yes	0.	No
Augmentation of labor	1.	Yes	0.	No
Shaving of pubic hair	1.	Yes	0.	No
Sterilization	1.	Yes	0.	No
Caesarean delivery	1.	Yes	0.	No
Blood transfusion	1.	Yes	0.	No
Vaginal examination	1.	Yes	0.	No
Suturing an episiotomy or tare	1.	Yes	0.	No

2. **During facility based delivery did you experience the following types of physical abuse?**

Restrained or tied down during labor	1.	Yes	0.	No		
Episiotomy given or sutured without anesthesia	1.	Yes	0.	No		
Beaten, Slapped, or Pinched	1.	Yes	0.	No		
Touched breast, buttocks or private parts in a sexual way			0.	Yes	2.	No
Had sexual intercourse without consent	1.	Yes	0.	No		
Frequent, rough unnecessary vaginal examinations	1.	Yes	0.	No		

3. During facility based delivery did you experience the following types of non-dignified care?

Blamed or intimidated during childbirth	1.	Yes	0.	No
Threatened with cesarean section to discourage from shouting in pain	1.	Yes	0.	No
Received slanderous remarks from health worker	1.	Yes	0.	No
Scolded shouted at or called stupid	1.	Yes	0.	No
vaginal examination watched by many people	1.	Yes	0.	No
Giving birth in front of many people	1.	Yes	0.	No
Left naked for long after giving birth	1.	Yes	0.	No

4. During facility based delivery did you experience the following types of abandonment/neglect of care?

Denied companionship of the husband or close relative	1.	Yes	0.	No
Left unattended during the second stage of labor	1.	Yes	0.	No
Birth attendant failed to intervene when medically indicated	1.	Yes	0.	No
Not granted requested attention because staff was exhausted	1.	Yes	0.	No

5. During facility based delivery did you experience the following types of non-confidential care?

Age disclosure without consent	1.	Yes	0.	No
Provision of care without privacy	1.	Yes	0.	No
Medical history disclosure without consent	1.	Yes	0.	No
Disclosure of HIV status without consent	1.	Yes	0.	No

6. During facility based delivery did you experience the following types of detention?

Discharge postponed until hospital bills are paid	1.	Yes	0.	No
Detained in the hospital until infants bill is paid	1.	Yes	0.	No

7. During facility based delivery did you experience discrimination based on following attributes?

Denial of needed attention because of ethnic origin	1.	Yes	0.	No
Denial of needed attention because of low social class	1.	Yes	0.	No
Denial of needed attention because of teenage (< 18 yrs)	1.	Yes	0.	No
Denial of need attention because of being HIV positive	1.	Yes	0.	No

<u>For use by research assistant</u>

8. Did the respondent experience any form of D&A during most recent facility based delivery? (***Circle the appropriate answer***)

1. Yes 0. No

9. Considering what you experienced during your most recent delivery in the hospital, will you give birth in the hospital again?

1. Yes 0. No

10. Would you advice a relative, a close friend or a neighbor who is expectant to give birth in a health facility?

1. Yes 0. No

Appendix ii: In-depth Interview Guide

Serial No._____

Disrespect and Abuse of Women during Facility Based Delivery and Its Effect on Intent to use Maternity Services in Uringu Division Meru County

In-Depth Interview Guide

Introduction

This questionnaire is about the disrespectful and abusive experiences that women go through during the process of giving birth in the hospital. As such you may be asked questions that are private and involve birth experiences and the reproductive system. However, utmost confidentiality will be observed and the results will be used for research purposes only.

Participation in the research is voluntary and you can withdraw after beginning if uncomfortable. Since this research is for advancement of knowledge only, no monetary motivation is available but the researcher greatly appreciates your participation.

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 35 minutes
4. Every bit of the interview should be clearly tape recorded.

Consent

Please tick in the appropriate box below

I have agreed to participate in the study voluntarily ☐

decline to participate in the study ☐

Experience of Childbirth

1. During your most recent childbirth in hospital how was your experience?
2. During labor was a relative or spouse allowed to stay with you? Did you request someone to be allowed to stay with you?
3. Is there anything done during labor that made you unhappy ?(Probe on vaginal examinations, abandonment, Privacy)
4. Please describe your experience during second stage/Childbirth (Probe on position, instructions, encouragement, episiotomy)

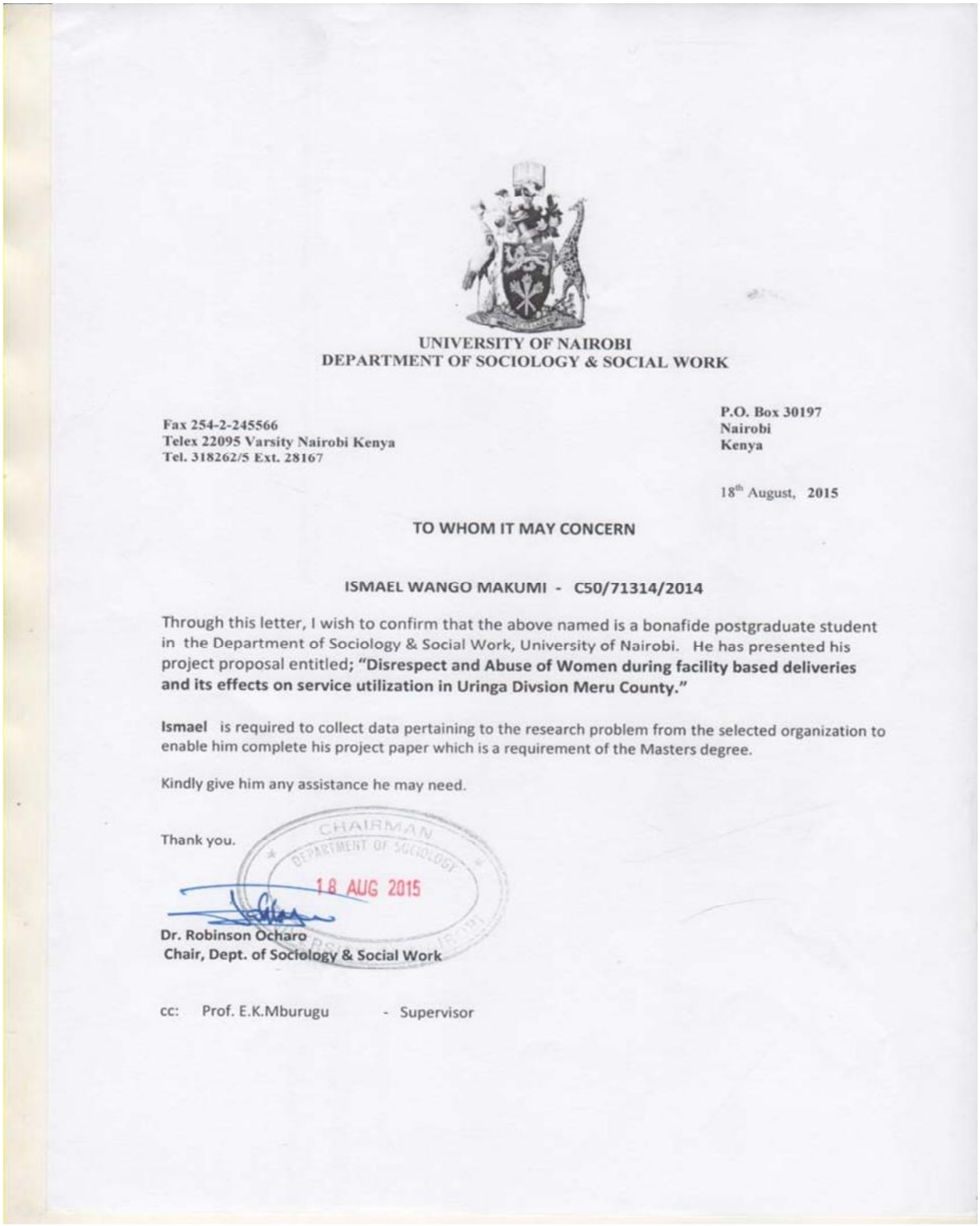
5. During your entire stay in maternity were you physically or verbally abused? (please explain, probe on; inappropriate touching, slapping, pinching and shoving)

_____

Ask the client whether there is anything she would like to add. If none, then thank the interviewee and end the interview.

_____

Appendix iii Department letter of authorization



UNIVERSITY OF NAIROBI
DEPARTMENT OF SOCIOLOGY & SOCIAL WORK

Fax 254-2-245566
Telex 22095 Varsity Nairobi Kenya
Tel. 318262/5 Ext. 28167

P.O. Box 30197
Nairobi
Kenya

18th August, 2015

TO WHOM IT MAY CONCERN

ISMAEL WANGO MAKUMI - C50/71314/2014

Through this letter, I wish to confirm that the above named is a bonafide postgraduate student in the Department of Sociology & Social Work, University of Nairobi. He has presented his project proposal entitled; **"Disrespect and Abuse of Women during facility based deliveries and its effects on service utilization in Uringa Divsion Meru County."**

Ismael is required to collect data pertaining to the research problem from the selected organization to enable him complete his project paper which is a requirement of the Masters degree.

Kindly give him any assistance he may need.

Thank you.

CHAIRMAN DEPARTMENT OF SOCIOLOGY
18 AUG 2015

Dr. Robinson Ocharo
Chair, Dept. of Sociology & Social Work

cc: Prof. E.K.Mburugu - Supervisor

Appendix iv Research Project Work Plan

March to Oct 2015

ACTIVITY	BY	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT
Research conception & Topic formulation	**1,2**	■							
Chapter one preparation	**1,2**		■						
Proposal development & Review	**1,2**			■	■	■			
Data Collection	**1,3,4**						■		
Data analysis	**1,2**						■		
Project report preparation	**1,2**							■	
Project defense	**1,2**							■	
Corrections and Presentation of final research project report	**1,2**								■

Key

1 Researcher
2 Research project supervisor
3 Research assistants
4 Area Chief/Headman

Appendix v Research Project Budget

BUDGET ITEM	**UNIT COST(Ksh)**	**QUANTITY**	**TOTAL(Ksh)**
1. Stationery			
Biro Pens	20	10	200
Clipboards	100	5	500
Tape recorder hire	500/day	4	2000
Printing			
Chapter 1	5/page	20 pgs*3 copies	300
Chapter 1&2	5/page	60pgs*1	300
Draft Proposal	5/Page	65*1	325
Final Proposal	5/page	65*5	325
Structured Questionnaires	5/page	5*3*250	3750
In-depth Questionnaires	5/page	5*2*20	200
Draft Project	5/page	75*1	375
Photocopy			
Final Proposal	2/page	65*1	130
Final Project	2/page	75*3	450
Sub-Total 1			**8855**
2. Manpower			
Research Assistants	500/day	4*4	8000
Chief/Headman	500/day	2*4	4000
Sub-Total 2			**12000**
3. Transport			
Research Assistants	200/day	4*4	3200
Researcher(Nairobi-Meru-Nairobi)	2000	2	4000
Researcher accommodation	2000	6	12000
Sub-Total 3			**19200**
Total 1			**36,105**
10 % Contingency			3,610.50
GRAND TOTAL			**43,665.50**