DISRESPECT AND ABUSE OF WOMEN DURING PREGNANCY AND THE EFFECTS ON THE UTILIZATION OF ANTE NATAL CARE SERVICES: A CASE OF JARAMOGI OGINGA ODINGA TEACHING AND REFERRAL HOSPITAL IN KISUMU COUNTY

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DECLARATION

This project paper is my original work and has not been presented for examination in any other university.

Signature. Date ____________________

Judith Kibuye

This project paper has been submitted for examination with my approval as the university supervisor.

Signature. ____________________ Date ______________

Dr. Dalmas Omia

DEDICATION

To all the women who have lost their lives while giving life and the providers who strive to give safe and dignified care …!

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Abstract

Disrespect and Abuse during pregnancy is a gross violation of human and women's rights and constitutes gender-based violence. D&A has received attention globally with studies confirming its effects on maternal and neonatal mortality. However, these works have not addressed D&A during antenatal care (ANC) services as a possible contributor to poor ANC attendance ultimately leading to unskilled birth attendance. Increasing the proportion of women delivering in facility consequently remains a challenge necessitating effort to change the status quo. The study was conducted in JOOTRH, in Kisumu County in Kenya, in the month of April 2019. The study employed cross-sectional survey to establish the different forms of D&A and their impact on ANC uptake. For quantitative data 111 women were interviewed using a structured questionnaire. Further, 4 providers and 6 women participated in Key informant interview and case narratives respectively. The most common forms of D&A in the health facility are long delays before being attended, discrimination based on age, ethnicity, health or socio-economic status, lack of necessary supplies at the facility, use of harsh or rude language by the service providers and poor physical condition of facilities. D&A then leads to miscarriages and general negative pregnancy outcomes resulting in increased exposure to unskilled care and high maternal mortality rates. To deal with D&A, expectant women change health facilities, report to the authorities, seek counselling services, avoid starting ANC early and reduce frequency of visit to the health facility or avoid ANC services all together. D&A during childbearing is highly prevalent in JOOTRH. The findings indicate that the situation is contributed to largely by fatigue brought about by high workload and lack of necessary supplies and equipment a consequence of unmatched investment in health care by the county government in the era of increased demand for service due to free service brought about by UHC. If D&A is not taken seriously, maternal and neonatal mortality rate that has plagued Kenya remains a mirage. The study recommends the training of providers to treat the service users in ways that encourage them to seek skilled care.

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List of Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Care
CHANGE	Centre for Health and Gender Equality
CRR	Centre for Reproductive Rights
CS	Cesarean Section
D&A	Disrespect and Abuse
EDD	Expected date of delivery
FIDA	Federation of Women Lawyers
GBV	Gender based violence
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
JOOTRH	Jaramogi Oginga Odinga Teaching and Referral Hospital
KEMSA	Kenya Medical Supplies Authority
KII	Key informant interview
KNH	Kenyatta National Hospital
KPC	Known positive client
MDG	Millennium Development Goal
MOH	Ministry of Health
NACOSTI	National Commission for Science, Technology and Innovation
NCPD	National Council for Population and Development
PMTCT	Prevention of Mother-to-Child Transmission
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendants
UHC	Universal Health Care
UN	United Nations
USAID	United States Agency for International Development
VAW	Violence against Women
VCT	Voluntary Counselling and Testing

UHC	Universal Health Care
WHO	World Health Organization

CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Violence against women (VAW) is a worldwide problem occurring in many contexts and assumes different forms, like verbal, physical force, coercion, or life-threatening deprivation, directed at an individual woman or girl. It manifests in the form of physical, sexual, emotional and economic contexts (UN Women, 2013). Violence against women is of concern as it results in physical or psychological harm, humiliation or arbitrary deprivation of liberty, and perpetuates female subordination (The World Bank, 1994). According to Jewkes and Penn-Kekana (2015), such violence stems from structural gender inequality, that is, women's subordinate position in society as compared to men. Violence against women can be a relational vulnerability embedded in highly asymmetrical social [and professional] relations and the associated dependencies (Kabeer, 2014). Although underreported and comparatively less in number, violence can also be perpetrated against men depending on the context including intimate partner violence or during armed conflict. Disrespect and Abuse of women can be defined as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified." (Freedman, et al, 2014)

Doku et al (2012) report that ante-natal care (ANC) offers pregnant women an opportunity to access preventive care, and presents a viable option for women to be screened for potential risks during pregnancy or delivery, as well as any opportunities for treatment and health education. This is because interventions regarding risky behavior & lifestyle during pregnancy, nutritional advice including the benefits of breastfeeding, among other services of importance to both mother and child, are available during ANC services through to child delivery. All these services offered, therefore, help in reducing maternal and neonatal mortality and morbidity. Besides, it is reported

by Kipronoh (2009) that a mother's health has a direct bearing on the health of her newborn and about 15% of all pregnant women experience life threatening complications as a result of pregnancy. This, therefore, calls for early examination for signs of chronic and infectious conditions such as malaria, human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), preeclampsia, anemia, heart diseases, diabetes, malnutrition and tuberculosis (TB), which are capable of negatively affecting the outcome of pregnancy hence require immediate treatment, monitoring and follow-up throughout this critical period (Kipronoh, 2009: 25)

Women may suffer violence during pregnancy and child birth commonly referred to as obstetric violence or disrespect and abuse {D&A} (World Health Organization, 2015). In Kenya, this form of violence manifests itself as psychological, emotional, physical and even sexual abuse among women. GIRE (n.d.) states that this kind of violence occurs both in public and private medical practice in the course of provision of health care services related to pregnancy, childbirth, and the post-partum period. Such violence, from a broader perspective, has the possibility of creating fear, among other things, and may, therefore, influence behavior that could cause some women to choose not to visit facilities for professional ANC services.

There is a broad range of D&A including: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers and health system conditions and constraints (Bohren et al, 2015:7). This kind of violence is often perpetrated by the facility staff attending to the women (McMahon et al, 2014) Furthermore, D&A is reported to negatively impact birth outcomes (Asefa & Bekele, 2015) resulting in serious health implications since D&A may also affect the utilization of ANC services.

Media reports in Kenya have pointed out some extreme cases of D&A at childbirth. Examples include, a pregnant woman who was neglected and deliberately left to deliver on the floor, the woman was then accused and beaten for making the floor dirty following her delivery. In addition to that, a woman in Nyeri Referral Hospital was reported to have lost her baby after giving birth while standing (Daily Nation, 2016). She also narrated how the nurses at the facility ignored her plea for help.

The aforementioned incidences of maltreatment of pregnant women in medical facilities may dissuade many women from utilizing facility services during pregnancy and other critical periods when their lives could be in danger, thereby cutting the important continuum of care. Nursing moms of premature babies have not been spared similar ordeals. Most recently, Federation of Women Lawyers (FIDA, 2018), in a statement to media houses, condemned a bizarre incident where nursing mothers of premature babies complained of rape as they moved between different floors to go and breastfeed their babies who were in the nursery at Kenyatta National Hospital (KNH). This has the potential of seriously discouraging women from seeking professional care for fear of being attacked in the same manner.

Different forms of D&A have also been reported in other countries. Diaz-Tello (2016) suggests that women in the United States experience significant pressure and loss of autonomy in maternity care. Similarly, in Mexico, a study by Castro and Erviti (2003) revealed that violations of women's reproductive rights during childbirth exist. In Hungary, extreme D&A led to the formation of women's association for birth rights culminating in protests in 4 Hungarian cities in 2016, to advocate for maternity care that respects women's fundamental rights (EMMA, 2016). Additionally, expectant women in Cambodia do not always receive humane, professional, supportive and respectful treatment from skilled birth attendants (Ith, Dawson & Homer, 2013).

Similar findings were reported by McMahon et al, (2014) who not only found that women experience unpleasant births but also acknowledged the importance of respectful care as vital to addressing the goal to improve maternal health. The fact that women desire to experience respectful care is a pointer that they could easily ignore using health facilities due to abuse by care providers. McMahon et al, (2014), in their study in Tanzania, reported that many women were observed to experience D&A during childbirth while a study in Ghana also suggests that even midwifery students are perpetrators of D&A and blame the vice on their professional socialization (Moyer, Adongo, Aboringo, Hodgson & Engmann, 2014). In Kenya, a study conducted by Population Council on D&A at Childbirth in 2014 across 13 health facilities reported that 20% of women had experienced some form of D&A in those facilities (Abuya, et al, 2015a). This perhaps is the reason why utilization of Traditional Birth Attendants (TBAs) still thrives in Kenya despite campaigns to have women utilize professional facility-based services.

While examining the completed Millennium Development Goals (MDGs), the Centre for Health and Gender Equality (CHANGE) alluded to the fact that of the eight MDGs, reducing maternal mortality was the goal that was furthest from being met. One of the reasons attributed to this dismal outlook is the fact that women are not getting the quality of care they need (CHANGE, 2015). Further, it was noted that the six major factors that impede progress on maternal health are D&A, unsafe abortions, underlying health conditions, unmet need for family planning, weak health systems, and human rights violations (CHANGE, 2015:7). From these findings, it can be surmised that D&A is one of the factors contributing to failure to curb maternal mortality, hence a contributing factor in the failure to realize the MDGs and if not mitigated, could lead to nonrealization of the SDGs.

Challenges are immense and Ratcliffe et al, (2016) confirm that there is mounting evidence to show that D&A may not only undermine women's trust in the healthcare system but also deter them from seeking facility-based care for delivery and hence the need to focus on the quality of care as a critical part of the efforts to improve maternal and neonatal health. While good ANC experiences increase the chance of using a skilled attendant at birth and contribute to good health through the entire life circle, inadequate ANC breaks a critical link in the continuum of care, affecting both women and babies (Lincetto, Mothebesome-Anoh, Gomez & Munjanja, 2006). Moreover, Rockers, Wilson, Mbaruku and Kruk (2009) opine that the quality of care during ANC visits influences women's decisions about whether or not to deliver at a facility. D&A is, therefore, recognized both as an indicator of poor quality of care and as an obstacle to obtaining the desired maternal health. While D&A is recognized as a major impediment to good maternal health care outcome during both pregnancy and childbirth, most of the studies done (Abuya et al, 2015; Bohren et al, 2015; Freedman & Kruk 2015) done have focused mostly on investigating this problem during facility delivery and not during ANC services. The studies are, therefore, limited in explaining D&A in the course of accessing ANC services and as possible hindrances to facility-based deliveries or utilization of ANC services. This study at Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH), therefore, sought to fill this gap.

1.2 Problem Statement

Reduction of maternal and neonatal mortality continues to be a challenge to attaining global social and economic development and the Sustainable Development Goals (SDGs) (Kipronoh (2009). For the seven-year period between 2007 and 2014, the Kenya Demographic and Health Survey (KDHS) reported maternal mortality rate at 362 deaths per 100,000 live births, with a confidence interval of 254-471 (KDHS, 2014: 8).

Kenya is among the 10 countries that comprise 58% of the global maternal deaths with the average maternal mortality ratio estimated to be 510 deaths per 100,000 live births in 2015 with Kisumu County reporting a higher maternal death ratio than the national average at 587 per 100,000 births (National Council for Population and Development (NCPD et al, 2015).

Ante-natal care service is not just an entry point to safe delivery and postnatal care, it enhances recognition and mitigation of health problems or diseases directly related to pregnancy known to contribute to unfavorable outcomes (Kipronoh, 2009). Doku et al, (2012) concur that ANC services offer pregnant women an opportunity to access preventive care and the recommended screening for potential risks during pregnancy and delivery, not forgetting opportunities for interventions on nutritional and behavioral issues during this critical period. The authors in their studies employed a standardized approach to investigate the association between poor ANC visits and neonatal mortality and found a positive correlation of 55% lower risk of neonatal mortality among pregnant women who achieved the WHO recommended number of ANC in all the regions studied, e.g., Asia, Africa (Doku et al, 2012)

The fear for D&A during facility delivery according to Abuya et al, (2015a) leads to low skilled birth attendance and hence a likely contributor to Kenya's sustained high maternal [and neonatal] mortality rate. D&A clearly contributes to women's deprivation yet despite this understanding, few studies have looked at the effects of D&A on ANC. Besides being a gross human rights violation for expectant women, D&A during facility attendance may translate to either poor ANC attendance or decisions not to use facilities for childbirth despite seeking ANC services in the early stages of pregnancy, or much worse, failure to seek ANC care all together. D&A, therefore, hinders the realization of some key Sustainable Development Goals (SDGs) like poverty reduction, gender equality and health and well-being.

Previous studies on D&A have been carried out on women during facility childbirth leaving out the accounts of women seeking ANC services. For instance, a study by Warren, Njue, Ndwiga and Abuya (2017) focused on investigating the manifestations and drivers of D&A during childbirth in Kenya. Furthermore, Family Care International (FCI, 2013) conducted a study in a rural community investigating care seeking tendencies of families in the areas of preparations for delivery, care during delivery, obstetric emergency and postpartum period. However, this study did not investigate issues surrounding D&A during ANC. Similarly, concerns around ANC services were notably not included in a study by Centre for Reproductive Rights and Federation of Women Lawyers (CRR & FIDA, 2007) who highlighted the flaws in reproductive healthcare focusing on family planning, childbirth and restrictive abortion laws. Issues with ANC services have been highlighted by Besett (2010). Findings from this study indicated that mothers viewed ANC services as deficient and were thus, dissatisfied with the perceived quality of care offered during their ANC visits. Mason et al (2015) studied barriers and facilitators to ANC and delivery care in western Kenya. Though the target of these studies were women seeking ANC services, Besett (2010) focused on normalization of pregnancy symptoms in the USA while Mason et al (2015) focused on the general barriers and facilitators to ANC in Western Kenya hence the effects of D&A still remains largely understudied.

Consequently, minimal attention has been given to investigating the nature, effects and coping strategies with D&A among mothers seeking ANC services. If the issues of D&A in ANC services are not studied and effectively addressed, some consequences such as increased maternal and related infant mortality will persist. In order to address the identified gaps, this study was guided by the following research questions:

1. What is the nature of D&A among women seeking ANC services at JOOTRH?

2. What are some of the effects of D&A on women seeking ANC services at JOOTRH?
3. What are the coping mechanisms adopted by women seeking ANC services at JOOTRH in response to D&A?

1.3 Objectives of the Study

1.3.1 Overall Objective

To assess the effects of D&A on women seeking ANC services at JOOTRH

1.3.2 Specific Objectives

1. To identify the nature of D&A among women seeking ANC services at JOOTRH.
2. To establish the effects of D&A by women seeking ANC services at JOOTRH.
3. To identify the coping mechanisms adopted by women seeking ANC services at JOOTRH in response to D&A

1.4 Assumptions of the Study

1. Women seeking ANC services at JOOTRH experience different forms of D&A such as delay harsh language, stigma and discrimination, non-consented medical examinations and breaches of confidentiality among others.
2. The effects of D&A on women include miscarriage and pregnancy complications
3. Women cope with D&A through delaying first ANC attendance, resorting to the services of traditional birth attendants, reporting to the relevant authorities or rationalizing the behaviors of the providers among others.

1.5 Justification of the Study

The purpose of this study was to examine the effects of D&A on the utilization of ANC services. While D&A during childbirth had been identified and studied by key organizations like Population Council, Federation of Women Lawyers FIDA-K and Centre of Reproductive Rights (CRR) among others, its effects on the utilization of ANC services had not been the focus of that attention. This is despite D&A breaking the important continuum of care that women should benefit from during pregnancy. Findings from this study have the potential of informing hospital

management practices and policy; on strengthening health system in provision of quality of care, increased uptake of ANC services and improved maternal health outcomes.

1.6 Scope and Limitations of the Study

The study focused on expectant women aged between 15–49 years seeking ANC services in JOOTRH, a public teaching and referral hospital. Specifically, the study focused on the nature of D&A during ANC services; the effects of D&A on women seeking ANC services and the coping mechanisms adopted by women experiencing D&A were addressed.

Considering the sensitivity of the study regarding the possibility of victimization of participants, the researcher ensured complete anonymity and confidentiality; during data collection all the interviewees were sought consent and further the interviews were conducted in private room within the hospital to ensure confidentiality. In addition to that, all the participants were given pseudo names to conceal their identity during analysis.

1.7 Definition of Key Terms

Antenatal care: Care given to a pregnant woman from the time of conception to the onset of labor.

Coping mechanisms: Refers to coping mechanism is something a person does to deal with a difficult situation. In this study, coping mechanism is what the expectant women do to manage the effects of disrespect and abuse when meted on them.

Discrimination: The unequal treatment of persons or groups of persons based on their gender or economic, social, health, education or marital status.

Disrespect and abuse - The interactions with facility providers and/or hospital conditions that are viewed to be humiliating or undignified. In this study, D&A refers to the humiliating and undignified experiences of women seeking ANC services.

Experience –. In this context experience means the D&A encounter expectant women undergo in the hands of health care providers as they seek professional maternity services.

Human rights-based approach: This means giving people greater opportunities to participate in shaping the decisions that impact on their human rights. It also means increasing the ability of

those with responsibility for fulfilling rights to recognize and know how to respect those rights, and make sure they can be held to account.

Maternal mortality: Maternal deaths due to pregnancy and childbirth complications.

Mothers: Women of reproductive age seeking services at ante-natal clinics during pregnancy.

Providers*:* Health staff at JOOTRH serving in ANC at the time of study or have served in the last one year preceding the study and available for interview.

Quality of care: Care provided according to standards and national guidelines, based on Evidence-Based Medicine, and meeting client needs.

Violence against women (VAW): The verbal abuse, physical force, coercion, or life-threatening deprivation directed at an individual woman or girl. In this study, VAW is the physical, psychological, verbal and any other form of discrimination that is meted on expectant women as they seek ANC services in health facilities.

Woman: An adult human female. In this study, women are all females aged 15-49 years who are seeking ANC services.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This Chapter reviews the literature relevant to the experiences of women seeking ANC services with D&A. The literature is reviewed using the following headings: The history of Disrespect and Abuse, typology of D&A, prevalence of D&A, the effects of D&A; the experiences women on D&A, and the coping mechanisms adopted by women experiencing D&A. The section, finally, discusses the theoretical frameworks that guided the study.

2.2 Disrespect and Abuse

Ratcliffe (2013) suggests that there is no operational definition of respectful maternity care and the phenomenon is, therefore, mostly defined in the absence of respectful care hence D&A of patients. Similarly, Freedman et al, (2014) concur and suggest that even though evidence on the typology and prevalence of D&A is very essential for effective programmes, policy and advocacy, there is no definition in the existing literature to use in studying its prevalence. Disrespect and Abuse is defined by Freedman et al, (2014) as interactions or facility conditions that are deemed to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified. Further, in an attempt to develop a framework for identifying challenges to maternal healthcare in Argentina, Vacaflor, (2016) used the term obstetric violence which could be used interchangeably with D&A and which, in the researcher's view, defines the problem more comprehensively, i.e. "(v)iolence exercised by health personnel on the body and reproductive processes of pregnant women, expressed through dehumanized treatment, medicalization abuse, and the conversion of natural processes into pathological ones..." (Vacaflor, 2016:66). However, Freedman et al, (2014) suggests that legal definitions do not resolve the definitional problems and, therefore, adopt the definition of D&A according to WHO (2014) i.e. interactions or facility conditions that local consensus deem to be humiliating or undignified, and

those interactions or conditions that are experienced as or intended to be humiliating or undignified. It is noteworthy though, that this definition is applicable to the problem only during childbirth and leaves out the important period of ANC services. Freedman and Kruk (2014) add the importance of taking note that even the absence of D&A does not translate to equal respect, respectfulness, quality of care and that women-centered care needs a prioritized conscious effort by care providers and the health systems.

2.2.1 Typology of Disrespect and Abuse

As illustrated by Bohren et al,(2015), the general typology of D&A comprise seven broad themes including: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints. They further break the typologies and classify them as first order, second order and third order as shown in the Table 2.1:

Table 2.1: Thematic Typology of Mistreatment of Women in Childbirth

Third order	Second order	First order
Physical abuse	Use of force	Women beaten, slapped, kicked, or pinched during Delivery
	Physical restraint	Women physically restrained to the bed or gagged during delivery
Sexual abuse	Sexual abuse	Sexual abuse or rape
Verbal abuse	Harsh language	Harsh or rude language
		Judgmental or accusatory comments
	Threats and blaming	Threats of withholding treatment or poor outcomes
		Blaming of poor outcomes
Stigma and Discrimination	Discrimination based on socio-demographic	Discrimination based on age
		Discrimination based on ethnicity, race or religion

Third order	Second order	First order
	characteristics	Discrimination based on socio-economic status
	Discrimination based on medical conditions	Discrimination based on HIV status
Failure to meet professional standards of care	Lack of informed consent and confidentiality	Lack of informed consent process
		Breaches of confidentiality
	Physical examinations and procedures	Painful vaginal exams
		Refusal to provide pain relief
		Performance of non-consented surgical operations
	Neglect and abandonment	Neglect, abandonment, or long delays
		Skilled attendant absent at the time of delivery
Poor rapport between women and providers	Ineffective communication	Poor communication
		Dismissal of women's concerns
		Language and interpretation issues
		Poor staff attitudes
	Lack of supportive care	Lack of supportive care from health workers
		Denial or lack of birth companions
	Loss of autonomy	Women treated as passive participants during childbirth
		Denial of food, fluids, or mobility
		Lack of respect for women's preferred birth positions
		Denial of safe traditional practices
		Objectification of women
		Detainment in facilities
		Women treated as passive participants during childbirth
Health system conditions and constraints	Lack of resources	Physical condition of facilities
		Staffing constraints
		Staffing shortages

Third order	Second order	First order
		Supply constraints
		Lack of privacy
	Lack of policies	Lack of redress
	Facility culture	Bribery and extortion
		Unclear fee structures
		Unreasonable requests of women by health workers

Source: Bohren et al, (2015)

In a post child-birth exit survey of 641 women, Abuya et al, (2015a) found that D&A is perpetuated by health workers and other facility staff. Further, a systematic review of fourteen studies conducted in Nigeria by Ishola, Owolabi and Filippi (2017) corroborates this and suggests that D&A was mostly reported as perpetrated by facility staff in their systematic review of fourteen studies conducted in Nigeria. Sadler et al, (2016) also report that D&A can occur when women interact with the providers or simply by the systemic failures at the facilities. The evidence, therefore, confirms that D&A is very likely to occur during any stage of pregnancy, including childbirth and ANC services and a typology for D&A during ANC services should be looked into. However, even though the typology by Bohren et al, (2015) is based on evidence synthesis from a study conducted on women during childbirth, it has aspects which can be applied to women during ANC services.

Misago et al, (2001) noted that the 1970s and 1980s saw the inception of humanization of childbirth movement in Brazil which was aimed at promoting respectful maternity care. Ratcliffe (2013) further suggests that the movement only lost its spotlight in the late 1990s and early 2000s having realized many of the principles of the movement and the concept of respectful care. Regarding the history of quality of care as a human rights need, Miller and Lalonde (2015) acknowledge that it was after the 1994 International Conference on Population and Development

in Cairo, Egypt, that the quality of care was first framed in a human rights perspective and the rights of girls and women were strengthened in the context of reproductive health and health care. This human rights lens was, however, perceived to have failed not only to focus on D&A during childbirth but also to establish a link between adverse maternal health outcomes to abusive practices and the poor quality of care (Miller & Lalonde, 2015). The authors further note that it was not until the year 2000 that women's rights to dignity and respect in childbirth became acknowledged in Latin America where, following a Birth Humanization Conference in Brazil, the Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN) was founded.

The term D&A was introduced and conceptualized in the year 2010 (Ishola et al, 2017). The same study, however, suggests that research related to this subject has been going on for many years and supports the assertion that although D&A has been in existence for a while, it had not, until recently, received much attention (Ishola et al, 2017).

Hodges (2009) suggests that despite the presence of many caring and supportive physicians and hospital staff in the USA, anyone involved with birthing women had come across a form of abuse directed at women giving birth in hospitals, hence D&A. In 2012, it was reported that a woman sued the Southern General Hospital in Glasgow, United Kingdom, where she had gone to deliver her third baby and the hospital admitted to bullying her into taking precautionary antibiotics that she did not want or need (The Guardian, 2012). Vedam et al, (2017) cite a qualitative study of women's experiences of hospital-based birth by Baker et al, (2005) that reported that over half of British women interviewed commented on the negative attitudes and behaviors of mid-wives.

Patel (2013) confirms that the prevalence of D&A in India is better illustrated by a young doctor, who on finishing his internship in a hospital, equated giving birth in a public hospital in India to

third degree torture in jails (Patel, 2013). In Pakistan, D&A is reported to be highly prevalent although under-recognized by women (Azhar, et al, 2017)

A systematic review (Ishola et al, 2017) suggests that D&A during childbirth occurs frequently in Nigeria and takes many forms with non-dignified care being the most common. Kruk, Paczkowski, Mbaruku, Pinho and Galea (2009) conducted a discrete choice experiment in two hospitals in rural Tanzania where previously only a third of women would deliver in health facilities to find out the preferred place of delivery. Of the six facility attributes looked into such as distance from hospital, cost, type of provider, provider attitude, drugs and equipment, availability of free transport, the study revealed that the most important attribute to the patients was respectful attitude and availability of drugs and medical equipment, an indication of the presence of D&A.

Abuya et al, (2015b) in a baseline study measured the effect of a package of interventions to reduce D&A by women during facility childbirth in 13 hospitals using an exit survey. The findings revealed that 20% of the women reported a form of D&A within the 13 hospitals studied. Ratcliffe (2013) notes that even though D&A is a global issue affecting both developed and developing countries, there is no accurate estimate of its global prevalence

All this evidence suggests that D&A is prevalent and could be one of the major contributing factors to low facility-based delivery. However, all the literature indicates that even the history and prevalence of D&A mostly covers the problem during childbirth.

McMahon et al, (2014) report that women view D&A as being caused by overworked providers who are, as a result, unable to provide the required ideal care. Reader and Gillespie (2013) in a review of literature around neglect of patients in hospital, found that both proximal (mostly high workload) and distal (mostly organizational management) were responsible for the prevalence of

D&A. This could be attributed to structural violence and perhaps the reasons for D&A in many Kenyan hospitals where the patient/provider ratio is very high.

2.3 Prevalence of Disrespect and Abuse

2.3.1 Experiences of Women with Disrespect and Abuse

McMahon et al, (2014) in their study in Tanzania narrate how a woman experienced neglect that exposed her child to danger. A woman in Nyeri Level 5 Hospital experienced neglect, making her deliver her baby while standing (Daily Nation, 2016). CRR & FIDA (2007) reported in their study that a woman reported that the provider used on her an unsterilized pair of scissors previously used on another patient. In the same study, a woman experienced neglect after the doctor left for the day and the available nurse told her she would not help her until the head of the baby came out and had to be helped to deliver her baby by a fellow patient CRR & FIDA (2007) after which the nurse asked the woman who had just delivered to get off the bed and clean the bed herself. Some women are neglected while about to deliver and end up delivering their babies on the floor (McMahon et al, 2014). A woman in Bungoma, Kenya, was physically assaulted by a nurse after calling for help in vain, causing her to deliver on the floor (Centre for Reproductive Rights, 2018).

McMahon et al, (2014 report that some women experience discrimination at the hands of the health care providers just because of their refusal to bribe or due to their economic status. They report in their study of cases where healthcare providers solicited for bribes from the women in order for them to be treated with speed as their situation demanded. Another case is seen where a woman had been informed of the required amount for the service provided but the cost was increased by the cashier and the woman was further threatened with detainment if she did not pay the amount (McMahon et al, 2014). Medicalization of childbirth including some unnecessary interventions, is also experienced by women (Manning & Schaaf, 2017).

2.3.2 Normalization of Disrespect and Abuse

Extant studies suggest that D&A has been normalized and accepted by both women and the providers. For example, a study by the Kenya Ministry of Health in March 2017 revealed that women justify D&A as a necessity in enhancing the safety of the mothers with the facility providers in the same study also agreeing that D&A is necessary, justified and that it guarantees women cooperation and focus on the birth process. For example, the providers alleged that slapping the women encourages them to push when they have to (The Standard, 2017). This is the same case in South Africa where patients perceived the poor treatment as an inseparable part of the procedure in clinics (Jewkes, Abraham & Mvo, 1998). The said normalization is evident and was manifested during their study in the manner women apologetically confessed to having been treated with care (Jewkes et al, 1998). The authors note that even though women reported neglect as one of the most distressing part of their hospital experience, few women, including those who delivered without the help of a nurse saw the neglect for what it truly is. Manning and Schaaf (2017) suggest that in many cases, the reason women view D&A as normal is because D&A is so common that the women often expect it to happen. Freedman et al, (2014) corroborate this and add that even in cases where some behaviour is viewed by the women as disrespectful, the providers would not agree to view it as disrespectful.

McMahon et al, (2014) suggest that a majority of women, but not their partners rationalize that workers were not giving ideal care due to the work load. This suggests that the men are more knowledgeable on what to expect in terms of quality care. Additionally, the authors reported that a woman who participated in their study said she delivered alone but rather than feel frustrated or angry she could only empathize with the working conditions of the workers. Moronkola et al, (2007) suggest that women who were unaware of their rights and had never been treated

respectfully during maternity care often see D&A as the norm. Even though some women and providers agree on the necessity for slapping to save the babies life hence normalization, Warren et al, (2017) stresses the need to call abuse for what it is.

Sadler et al, (2016) suggest that it is wrong to assume that women fully understand their options and are always able to make a choice regarding their health, hence the little knowledge on D&A. Perhaps the lack of knowledge calls for awareness creation among women on the need to understand their options and their healthcare rights. This normalization of D&A could be an indication of high prevalence downplayed by the lack of knowledge. D&A is not just as a violation of women's rights but also as a phenomenon that should be nonexistent. The lack of knowledge on the part of the women is a clear impediment to the fight against D&A and a contributing factor to the perpetuation of this form of violence against women.

2.4 Effects of Disrespect and Abuse

Miller and Lalonde (2015) investigated the global epidemic of D&A and found that there is a link between D&A and negative birth outcomes whether directly or indirectly.

2.4.2.1 Direct Effects

Disrespect and Abuse affects birth outcomes, for example, when a woman is ignored or abandoned while in labor or during delivery leading to negative birth outcomes(Miller & Lalonde, 2015). In their study conducted in the Dominican Republic a woman went through neglect in a facility where she was for over 24 before any check-up was done on her, and thereafter was found to have a raptured uterus and her baby's heartbeats were missing (Miller & Lalonde, 2015). World Health Organization (2016) agrees that neglecting women could make women suffer life-threatening and yet avoidable complications and constitutes a violation of trust between patients and the health care providers. In their study in Tanzania a nurse neglected a patient, responded late

and consequently had to hold the baby without the help of gloves which is potential health hazard for the baby (McMahon et al, 2014). Neglect is recognized to have the possibility of negatively impacting the health of either the mother, her newborn or both by preventing timely or proper diagnosis and/or treatment of complications (Asefa & Bekele, 2015; Manning & Schaaf, 2017). Over medicalization of childbirth including some unnecessary interventions contribute to morbidity and mortality (Manning and Schaaf, 2017). Raj et al, (2017) reported that women who reported D&A during pregnancy were likely to have complications during childbirth and in the postpartum period. A study by Center for Reproductive Rights ; Federation of Women Lawyers--Kenya (2007) reported that a woman reported to have tested HIV positive after delivery while the husband was negative, attributing her new status to the use of unsterilized scissors which had been used on another patient during her last delivery.

Additionally, there are other health outcomes of concern like adverse mental health effects over and above other poor physical outcomes (Manning & Schaaf, 2017). Such mental effects can result in fear of childbirth, influence sexuality and the desire to have children, generate lifelong feelings of guilt and grief and even trigger memories of sexual assault, if any, in some women (Manning & Schaaf, 2017). Other forms of D&A such as lack of autonomy during childbirth has also been reported to disempower women reducing them to a state of passivity hence disabling them from being active participants in the birthing process (Warren et al, 2017).

In a study where 98% of the study participants had delivered in a facility and were attended to by skilled health care personnel, Miller and Lalonde (2015) found that maternal mortality was still high, a factor that was attributed to D&A. This is further explained by (Warren et al, 2017: 12) who noted that treatments of discrimination in a particular facility often led to the stigmatized and discriminated women bypassing the nearest facilities leading to potential morbidities and

mortalities associated with delays during self-referrals. Moreover, cases where a woman's identification card is withheld until the bill is settled indicates the woman in question is unable to seek further care or other social services where necessary.

The effects of D&A can only be underscored. Poor ANC care could lead to complications and even death and the ripple effect is that the lack of trust arising from D&A during ANC services could dissuade women from seeking skilled attendance. In order to address [maternal and] neo-natal mortality it is extremely important to increase ANC coverage and attendance (Doku et al, 2012). This perhaps is achievable if the matter of D&A is conclusively addressed.

Most of this evidence derived from studies conducted during childbirth point to the fact that D&A directly affects women negatively and therefore a hindrance to the effort of reducing maternal mortality. There was need, therefore, to look into the likely effects of D&A during ANC services.

2.4.2.2. Indirect Effects of Disrespect and Abuse

While examining the global epidemic of D&A during childbirth, Miller and Lalonde (2015) reported that indirect effects may occur in cases where women who have previously experienced D&A in past deliveries, avoid future use of facilities, even if they suspect complications. Asefa et al, (2018) confirm this in their study of service providers, with most of the respondents (79.6%) agreeing that lack of respectful care discourages pregnant women from coming to health facilities for delivery. As corroborated by Kipronoh (2009), despite high utilization of ANC in Kenya, ANC has not adequately influenced the use of skilled personnel at delivery.

Indirect effect is also reported in cases of inadequate facility infrastructure by McMahon et al,(2014) while exploring the experiences of, and responses to disrespectful maternity care and abuse during childbirth as likely to foster demoralizing atmosphere for both providers and patients.

The authors' further report that D&A could not only make patients lack the necessary trust in a facility but also view health facilities as inhospitable. Similarly, patients who perceive interrogations on their cultural practices and use of herbal medications as criticism of their social status by providers, are likely to be demoralized to use facility services in their present or subsequent deliveries, thus increasing the number of births by non-skilled personnel (Ishola et al, 2017; Manning and Schaaf 2017; McMahon et al, 2014). Women's experiences at the health facilities and their perceptions of quality of care in health facilities also influence their care seeking tendencies for their expected newborns and children (Manning and Schaaf, 2017). CRR; FIDA (2007) study confirms this and adds that the negative effects may have long lasting effects. In a study on the violations of women's human rights in Kenya health facilities, a woman narrated how her experience made her resolve to never bear another child, and that when she 'accidently' got pregnant later, she chose to deliver at home (CRR; FIDA, 2007). It is no wonder that the same study reports that TBAs still deliver 28% of babies while relatives and friends assist in 22% of births at home and only 42% of deliveries happen in the care of a health professional.

WHO (2015) also recognizes that D&A constitutes a violation of trust between women and their health care providers hence a powerful disincentive for women to seek and use maternal health care services. This is not good for the health of any nation and is likely to contribute to the high morbidity and mortality rate in both the infants/children and their mothers.

2.5 Coping Mechanisms for Disrespect and Abuse

Women have been reported to employ different measures to deal with D&A and these have been grouped into non-confrontational and confrontational coping mechanisms.

2.5.1 Non-Confrontational Measures

Non-confrontational measures include resigning oneself to the experience, returning home, rejecting facilities altogether or bypassing bad facilities and/or bad providers (McMahon et al, 2014:13). The authors further found that women and providers have accepted D&A as a part of the bargain. Jewkes and Penn-Kekana (2015) report that even when the women in their study were made to wait for long periods as a punishment because they had not booked earlier as required by the hospital, they simply accepted it as a form of punishment for their 'wrong doing'.

In order to overcome D&A men, especially, pay providers to ensure they look after their wives(Warren et al, 2017) and the willingness of the women patients to pay bribe has also been reported by McMahon et al, (2014) adding that D&A also means that women were treated according to their social status in society. Thus, a woman's delay in seeking care in facilities is not always an oversight but often a well-calculated move probably to avoid the D&A likely to be experienced in hospital (McMahon et al, 2014).

Delivering on the floor is another coping mechanism noted by McMahon et al,(2014) who reports that when unattended, the women feel it is better to leave the bed and give birth on the floor to prevent the baby from falling down to the ground.

Another coping mechanism by women, according to McMahon et al, (2014), is that of bypassing a provider within the same facility, something the women do cautiously for fear of its potential backlash, and this was the same case with lodging an official complaint. Others move to a different facility or stop seeking skilled care altogether and further discourage other women not to seek services but instead resort to seeking services of TBAs. CRR & FIDA (2007) report that an 18-year-old pregnant girl was so terrified of delivering in a hospital that she ran away. That while

waiting in the theatre she realized that the woman attended to before her had died while undergoing an operation.

2.5.2 Confrontational Measures

McMahon et al,(2014) note that women are rarely confrontational though they only fear confronting the nurses for fear of retaliation during later visits. The same study also notes that the women were uncertain about what precisely to do to effectively address abuse and hence they thank the providers even when they were supposed to be complaining. McMahon et al,(2014) also posit that women fear complaining to higher levels fearing the facilities could be closed affecting their access to care. While women easily rationalize some aspects of D&A saying the workers are overworked and the like, men were reported in McMahon et al,(2014) to get violent and beat up the providers.

2.6 Theoretical Framework

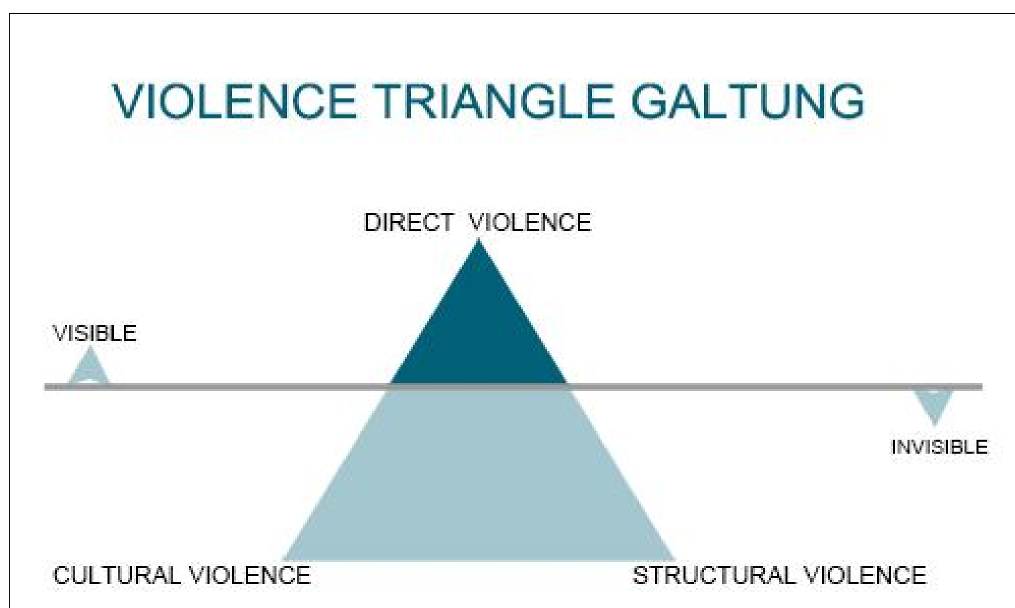
This study used the cultural violence theory by Galtung (1990) and mitigated by the human based rights approach to health. The theory brought out how cultural violence normalizes and perpetuates direct and structural violence. The human rights-based approach to health showed how to mitigate the problem. In this context, it is the institutional culture that

2.6.1 Cultural Violence

Galtung (1990) defines violence as the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible and asserts that the threat of violence is also violence. He divides violence into three forms: direct, structural and cultural. Whereas direct violence involves a face-to-face altercation of physical assault, structural violence, according to Galtung (1990), is not perpetrated by an individual but hidden to a large extent in structures e.g. schools, hospitals and workplaces (Galtung, 2008). He

adds that structural violence manifests itself in the unequal distribution of power and, as a result, unequal opportunities. Galtung equips that structural violence is equal to social injustice and is, indeed, social injustice (Galtung, 2008). Cultural violence on the other hand are those aspects of culture that legitimizes the use of direct and/or structural violence. They are those aspects of culture re-acquired through socialization.

The three types of violence are related in a triangular fashion. Cultural and structural violence are located towards the base of the triangle and are usually invisible and forming the ground from which pro-violence social structures spring. The structures, according to Galtung, may include health systems, the focus of this study. At the top of the violence triangle is the direct violence which is most visible and supported by the other two types of violence as shown in figure 2.1.



Source: Violence, peace and peace research (1969)
Figure 2.1: Violence Triangle (Galtung, 2008)

2.6.1.1 Relevance of the Theory

Violence theory was used to understand some of the types of D&A experienced by women during ANC services in the facility. Direct violence manifests itself in physical, sexual and verbal abuse

perpetrated on women by health care workers. A woman who is being scolded, verbally abused, stigmatized and discriminated against either because of their physical, health or socio-economic status is also experiencing direct violence. Structural violence, which is the institutional culture was the focus of this study.

Structural violence, on the other hand, is visible in the poor and inadequate facilities, lack of medication, and lack of equipment in the facilities, which is very common in the health facilities used by childbearing women. Poor supervision of facilities, for example, could lead to poor forecasting of supplies further leaving the few resources to be accessed by the highest bidder leading to bribery or high charges for medicine which would otherwise be free and thereby denying those with no money access to essential and lifesaving services (Galtung, 2008). This would make some women bypass certain facilities or simply resort to TBAs or worse still not seek any help. The end result is the sustained maternal morbidity and mortality. This means that expectant women unable to access ANC or services in a facility because of one reason or the other, are experiencing a form of violence.

Galtung further adds that cultural violence makes direct and structural violence seem normal, right and justifiable as seen in the normalization of D&A (Galtung, 2008). This is applicable to this study as our culture prohibits the questioning and complaining to those in authority, and more specifically to health providers who are viewed as all-knowing. This also hinders reporting and not only legitimizes D&A but also perpetuates and makes it seem right and justifiable, leading to the normalization of D&A by both health care workers and the victims of D&A. Most women view D&A as a normal part of their hospital visit to the extent that even when they are neglected, they do not see the neglect for what it is. Besides, women have also been socialized to believe that pregnancy is normal, not a sickness and even seeking ANC services may not be necessary (Bohren

et al, 2014). D&A makes it worse and reinforces their belief that they can safely give birth at home alone or seek the services of TBAs. This cultural violence is also the reason health providers strongly believe that the use of direct violence is justifiable and is supposed to help the women do the right thing i.e. push the baby when they have to (CRR, 2018; The Standard, 2017)

2.6.2 Human Rights Based Approach

A human rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and, operationally, directed to promoting and protecting human rights. It seeks to analyze inequalities which lie at the heart of development problems and redress discriminatory practices and unjust distributions of power that impede development (WHO, 2017:13).

2.6.2.1 Human Rights Based Approach to Health

A human rights-based approach to health is a people-centered approach which requires that the root causes of ill health and the impediments to enjoyment of health and well-being are remedied through inclusive education, access to information and gender equality (WHO, 2017: 13). WHO further adds that a human rights-based approach requires delivery of health care through systems, and in a manner, compatible with the norms and standards of human rights paying attention to gender and age-sensitive participation in health decision-making, among other things (WHO, 2017:13).

2.6.2.2Maternity Care and Human Rights

Addressing maternal care needs through the human rights-based approach also ensures attention is paid to the fundamental human rights principles of dignity, autonomy, equality and safety. Human rights-based approach to health is a possible means of addressing D&A in hospitals because it

would mean that if achieved, all women would enjoy these standards and also get satisfaction from the health facilities leading to more women utilizing health care facilities.

The Universal Rights of Childbearing Women (The Respectful Maternity Care Charter) launched by the White Ribbon Alliance is a move to demonstrate the link between human rights in maternal health focusing on the interpersonal aspects of care received by women seeking maternity services. The Alliance sets out the following seven rights of childbearing women: freedom from harm and ill treatment; information, informed consent, and refusal and respect of choices and preferences, including the right to a companion of choice whenever possible; confidentiality and privacy; dignity and respect; equality, freedom from discrimination and equitable care; timely health care and the highest attainable level of health; and liberty, autonomy, self-determination and freedom from coercion (White Ribbon Alliance, 2011)

2.7 Conceptual Framework

This conceptual framework shown in fig 2.1 illustrates the relationship between the dependent and independent variables identified for this study.

It shows how D&A or the fear of D&A which manifests itself in discrimination, rude or harsh language, long waiting hours, the lack of informed consent and poor facility infrastructure may lead to women choosing to deliver at home, delays the first ANC service visit, affects the number of subsequent visits and also leads to change of mind on facility for delivery. That would mean that they miss some of the interventions necessary during pregnancy like screening for health risks, interventions relating to nutrition and behavioural issues like alcohol consumption during pregnancy and other preventive care. The intervening variables could involve awareness creation, teaching women about their rights, improving HIV testing disclosure, strengthening universal

health care. These would ensure the women get the services they need to enhance their well-being and experience during ANC services.

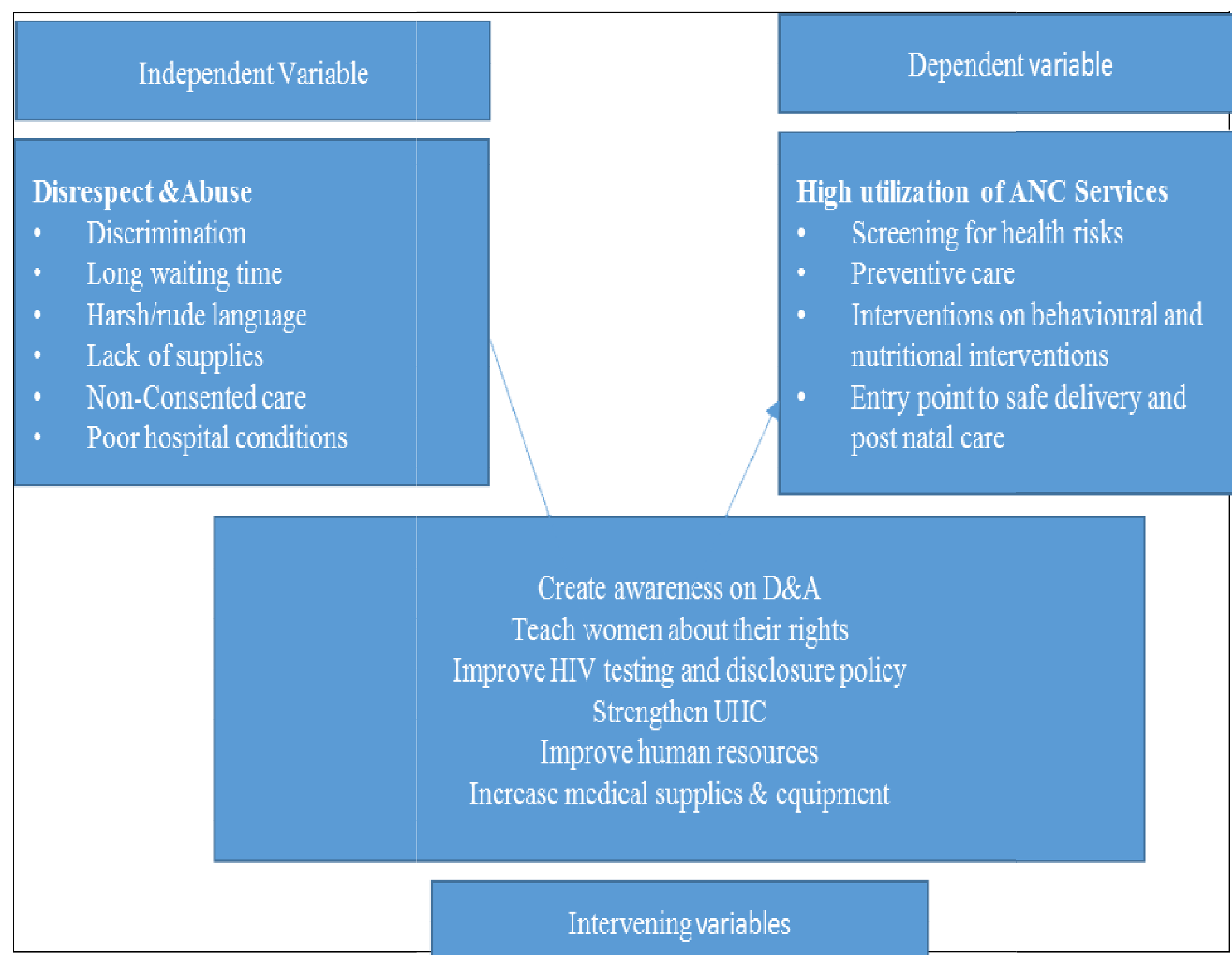


Figure 2.2: Conceptual Framework

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This Chapter describes the methodology used in this study. It describes the research site, research design, study population, sample population and sampling procedure. It also describes the data collection and analysis methods. The chapter concludes with a discussion of the ethical considerations that the researcher observed.

3.2 Research Site

This study employed descriptive cross-sectional study design. Cross-sectional design was useful because it's cost effecting and can be used to study the association between variables (Setia, 2016). The study used a mixed method approach hence both quantitative and qualitative methods of collecting data; namely, structured questionnaire, case study and key informant interviews.

The study was conducted in JOOTRH in Kisumu County (Figure 3.1) below. JOOTRH has a very high catchment area with about 28 expectant women seeking ANC services daily, close to 800 monthly and 9600 annually. Its maternity is well capacitated, with about 60 beds for maternity, 20 for labor and 60 beds for newborn (Kisumu, 2012). Jaramogi Oginga Odinga Teaching and Referral Hospital was purposively selected as the study location because it is the largest teaching and referral hospital in the region and serves 10 counties in the Western Kenya region. It is also situated in Kisumu County, which is one of the counties in Kenya with maternal mortality rate above the national average of 597 per 100,000 live births (National Council for Population and Development, 2015). The high maternal mortality rate has often been blamed on poor access to; and low utilization of skilled birth attendance during pregnancy, childbirth, and the postnatal period; and delays in seeking skilled care among other factors (NCPD et al, 2015).

Figure 3.1: Map showing the study site - Jaramogi Oginga Odinga Teaching and Referral Hospital

3.4 Study Population and Unit of Analysis

The study population comprised all expectant women aged between 15-49 years old seeking ANC services at JOOTRH. The unit of analysis was be the individual expectant woman. The study population was obtained from a sampling frame based on an inclusion criterion adopted for the study where individuals were expectant women 15-49 years old. Women below 18 years who were not accompanied by an adult who could give consent on their behalf were excluded from the study. This study involved administration of structured questionnaire to sampled expectant women seeking ANC services at JOOTRH, case narratives with expectant women who hinted to having experienced D&A and Key Informant Interviews with providers and an employee of a reproductive rights organization embedded at JOOTRH in Kisumu County was also done.

By the end of the study, total of 111 structured questionnaires had been administered to the women seeking ANC services; six case narratives and four key informant interviews targeting 2 ANC nurses, ANC nurse administrator and an employee of reproductive health rights organization embedded at JOOTRH ANC. All these were done over a period of one month from 15th April, 2019.

3.5 Sample Size and Sampling Procedure

The minimum sample for the quantitative phase was calculated such that it was representative of the population and was statistically significant so that results could be inferred. The minimum representative sample is a factor of population size, error margin, and the desired confidence level (Krejcie and Morgan, 1970). Thus, given 450, the total number of women attending ANC services at JOOTRH in a given month, a desired confidence level of 95% and a target margin of error of 5%, the sample size calculation formula yielded a minimum sample size of 110. Participants for the survey were therefore 111 expectant women aged 15-49.

3.6 Data Collection Methods

3.6.1 Quantitative Data Collection

3.6.1.1 Structured Questionnaire

Structured questionnaire was preferred because it is cheap and efficient (Bryman, 2012) Further it is useful in the collection of information on quality of life research (Cheung, 2014). To ensure confidentiality the questionnaires were administered in a private room at the ANC clinic at JOOTRH. Willing participants who satisfied the selection criteria were requested to participate and signed the consent form (appendix III). The structured questionnaires were used to find out the effects of the different forms D&A such as physical abuse, stigma and discrimination, verbal abuse, poor provider attitude including lack of rapport between women and providers; experienced

by women during ANC services on the uptake of ANC services as well as its effects and coping mechanisms in response to D&A.

3.6.2 Qualitative Data Collection

3.6.2.1 Case Narratives and Key Informant Interviews

Qualitative interviews which comprised key informants and case narratives (Appendix IV and V) were used to collect data from some respondents. Case narratives and Key Informant Interviews (KIIs) were used to capture the experiences, effects as well as the coping mechanisms employed by women to manage D&A. Case study was conducted with six (6) women in their early pregnancies, while KIIs was conducted with four (4) hospital employees including one employee of a reproductive health rights organization embedded at JOOTRH. The case narrative participants were selected purposively based on their experiences of different forms of D&A and their ability to share such experiences, the effects and coping mechanism adopted by women. To ensure confidentiality, the interviews were conducted in a private room within the hospital. Some interviews were audio-recorded while others were not. This is because some of the interviewees feared for the confidentiality of the data necessitating the researcher to take notes.

3.6.4 Secondary Sources

Development of the proposal involved information obtained from books, articles, peer-reviewed articles, journals, the internet, reports, newspapers, blog posts and other relevant documents touching on D&A of women during pregnancy and childbirth. Source from Population Council were particularly useful throughout. Bohren et al, (2015) work was also useful in enriching the research.

3.7 Data Processing and Analysis

3.7.1 Quantitative Data

Quantitative data was collected by the researcher and research assistant using structured questionnaire to examine the effects of D&A on women and its effects on the uptake of ANC services at the facility level. Data was entered into MS Excel and later transferred in a comma separated values file to STATA version 12(Stata Cop, college station, Texas, USA) for analysis. Descriptive analysis was conducted and presented in tables and graphs where appropriate. Comparison between groups and different forms of abuse was done using chi-square test for various categorical variables. Logistic model was used to determine the effect for key indicators adjusting for age, education and marital status.

3.7.2 Qualitative Data

Qualitative interviews were taped or handwritten, the audios and notes were then translated into English where appropriate, transcribed and typed into word document. Quality assurance was enhanced through notes taken during the interview for further consideration. To enhance internal validity, triangulation through comparing different actors was done. Data analysis was reflective; it included annotation of transcripts, development of thematic framework and then coded progressive categorization of issues based on inductive and deductive using NVIVO 12 (QSR international). Themes were further modified through development charts to examine more issues from the data. During the final analysis, a trustworthiness check was enhanced by balancing use of quotes by respondent type and examining whether the responses are based on probes or the main question. Finally, the interpretive judgements were based on the understanding of the specific context and field observations.

3.8 Ethical Considerations

A research permit was obtained from NACOSTI (NACOSTI/P/19/26722/27979) and Jaramogi Oginga Odinga Teaching and Referral Hospital Ethical Review Committee reference no. ERC.IB/Vol.3/6. During the actual data collection process, the research aim was explained to all participants as appropriate, and their informed consent obtained. Measures to protect the identity of participants during and after data collection were made. For example, in the case study and Key informant interviews recording are not shared, transcripts were anonymized by use of pseudo names to avoid linking the information to a particular actor.

There were a few risks involved with conducting the study. During the recruitment of participants for KII and case study, women were asked several sensitive questions which have been considered intrusive and too personal. Careful steps were taken to minimize potential discomfort to the participants' such as pre-tested tools among small group of women with similar characteristics of the study population to identify potentially negative consequences and modify them accordingly. For confidentiality, interviews were conducted in private settings, and ample time was allowed for data collection to ensure that privacy and confidentiality was guaranteed. Consequently, a respondent who required immediate intervention had her case referred to the administration.

The benefits to the study were made clear to the participants. For example, they were informed that there were no immediate or direct benefits to respondents for participating in the study. However, respondents were made aware of the overall benefit of participating in the study, that is, that the information gathered may be used in policy formulation or improvement towards the issue of D&A.

CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter discusses the data analysis and findings of the study.

4.1.1 Demographic Characteristics of the Study Participants

Survey sampled and successfully interviewed 111 women seeking ANC services at JOOTRH. The demographic features of individuals are known to influence decision making in various spheres of life. In this study the focus was to determine the effect of D&A on ANC. Among the study variables were age, education of level, religion, marital and employment status of respondents. Pregnancy and birth history of the study participants was also investigated.

On respondents age, slightly fewer than 70% of these ANC clients were aged 23 to 32 years and in their prime age of giving birth. In this study, ANC is perceived to be critical in ensuring the safety and health of the mother and baby. Their utilization of ANC services is therefore important to this age group and the study wanted to determine if D&A is prevalent and how this affects the uptake of this service. Equally important is that some mothers are in late ages of reproduction. From reproductive health studies ages beyond 40 years are at risk of pregnancy complications (Dieti et al, 2015) and requires very close attention and care. Therefore, any aspect that creates a barrier to get ANC services would be perceived in this study to endanger the lives of such mothers and their babies.

About half 75 (68%) had schooled beyond primary level of education.. The level of education was significant for this study because educated women mostly know their rights, and education is also key in the decisions the women make as well as helping the women to articulate issues. The implication is that most of the women who attended ANC had basic education which could

provide a launching pad for healthy reproductive health practices in line with the countries policy. Blanchard & Lurie (2004), observe that negative perception of the patient care relationship leads to suboptimal care. Accordingly, the patients who feel that they were disrespected were unlikely to adhere to the doctor's instructions and were likely to put off needed care. In relation to this study, the women confirmed that one of the strategies they would employ when they feel disrespected is to skip some ANC visits.

Finally, it was established that 53% were employed (self-employed and employed. Though it is important to note that 42% reported not being engaged in any economic activity. Economic status was significant for this study because there is evidence that women perceived to be poor are likely to be treated disrespectfully (Amnesty International 2009). It is also an important variable in determining the respondents' abilities to afford services that are paid for. The consequence is that most of the women are not economically empowered and perhaps when faced with D&A in a public hospital where the services are free, they may not even think of trying a different facility where they are required to pay. A study by FCI (2013) in Kenya reported that money keeps women away from getting skilled care. Consequently, such women may abandon skilled care completely and seek the services of TBAs who they viewed to be friendly, or just stay at home.

Slightly more than half (55%) were protestant while slightly 78% were married. While one key informant alleged that most of the women from their records are single, the findings of this study revealed the majority are married. If true most women are single, then this points out to stigma about single pregnant women. Previous studies also show that married women are required to get permission from their husbands to visit the facilities, often leading to delays in seeking help (USAID, 2010). Table 4.1 reflects the full range of demographic and economic characteristics measure.

Table 4.1: Socio-demographic and Economic Characteristics of Mothers

Socio Demographic and economic Characteristics of mothers:	Women (n=111)	Proportion (%)
Age (in years):		
18-22	19	17
23-27	42	38
28-32	33	30
33-37	17	15
Highest level of Education attained:		
Primary	36	32
Secondary	51	46
Tertiary	24	22
Religion		
Protestant	61	55
Catholic	30	27
Islam	6	5
Traditional religion	13	12
Current Marital Status:		
Single	24	22
Ever Married	87	78
Current Employment Status:*		
Employed	22	20
Self employed	36	33
Unemployed	46	42
Others	6	5

Women interviewed, n=110

4.2.4 Pregnancy and Birth History

The pregnancy and birth history of these mothers were also explored. This was important in seeing the perspectives, attitude and knowledge of mothers regarding ANC services. The findings that revealed that slightly more 50% of the ANC clients had between 2 and 4 pregnancies in the past. There is a perceived association between multiparous and exposure to prior ANC education

hence knowledgeability and the expectation to take their visits seriously. The contrary is, however, true from key informants who report that the multiparous have a know it all attitude and start their first ANC visits late.

About birth history, 30% had experienced a live birth before while slightly more than half (50%) had experienced still birth or abortion. About 87% of the them had delivered in a health facility while about 14% delivered at home alone or with the help of a TBA.

Table 4.2: Pregnancy, Birth and Health History of the Women Sampled

Pregnancy, birth and health history:	Women (n=111)	Proportion (%)
Type of birth:*		
Live Birth	33	30
Still Birth	56	51
Other	21	19
Place of delivery:*		
Public Facility	35	32
Private Facility	60	55
Home alone	13	12
Help of TBA	2	2

***Women interviewed, n=111**

4.2 Nature of Disrespect and Abuse among Women Seeking ANC Services at JOOTRH

The survey results (Table 4.3) show that 98% of all the ANC clients in the study had experienced some form of disrespect and abuse. The five most common forms of disrespect and abuses reported were: long delays before being attended to (81%), discrimination based on age, ethnicity, health or socio-economic status (37%), lack of necessary supplies at the facility (22%), use of harsh or rude language by the service providers (20%) and poor physical condition of facilities in the hospital (19%). The other forms of Disrespect and Abuse by the proportion of ANC clients who reported them are enumerated in table 4.3. Experiencing harsh language or verbal abuse from a service provider was associated to the age of women interviewed with χ^2 (3) =9.815 and a p

value of 0.020. 72% of the younger women reported having experienced this kind of Disrespect and Abuse compared to younger ones. Associated to extortion or unclear hospital fees was employment status of the women interviewed (χ^2 (3)=8.148, p=0.043). In terms of the nature of the association, women aged 23-27 years were 5 (1.048 – 23.864) times more likely to report an episode of harsh language or verbal abuse compared to those aged 18-22 years. Those who had completed at least college level of education were 5.768 (1.264-26.321) times more likely to report long delays in the queues before getting served compared to those with at most primary level of education.

Table 4.3: Forms of Disrespect and Abuse Experienced by Women Attending ANC at JOOTRH

While attending ANC services, has witnessed or experienced:	**Women (n=111)**	**%**	***P values***		
			Age	Educ	Marital Status
Discrimination based on age/ethnicity/health/socio-economic status	41	37	0.649	0.516	0.913
Harsh or rude language	22	20	0.006	0.203	0.915
Being blamed by nurse/doctor for an outcome	8	7	0.355	0.790	0.750
Lack of informed consent for test and other procedures	7	6	0.228	0.228	0.431
Breaches of confidentiality/privacy	5	5	0.06	0.749	0.454
Request for bribes/ Extortion or unclear hospital fees	4	4	0.404	0.280	0.632
Sexual abuse/harassment	1	1	0.424	0.368	0.955
Dismissal of concerns	11	10	0.741	0.080	0.600
Lack of necessary supplies at the facility	24	22	0.630	0.080	0.600
Long delays before being attended to	90	81	0.546	0.036	0.855
Poor physical condition of facilities in the hospital	21	19	0.241	0.295	0.119
Threats of withholding treatment	4	4	0.661	0.523	0.973
Other	8	7	-	-	-

4.2.1 Long Delays

The findings revealed that 90 (81%) of the respondents complained of delays before being attended, for instance, A mother had this to say:

"*I stayed in hospital from 11:a.m. to 5 p.m. without being seen. Apart from coming for clinic, I was feeling sick, I usually have high blood pressure. At 5 while waiting, they just closed and told those of us on the line to come the following day.*" (CN2).

Another mother also reported that:

"*I came here before 8 and by 1:00p.m., I had not been seen."(CN5)*

As captured from the quote, expectant mothers have to wait for long hours irrespective of their condition and sometimes leave the hospital without being attended to, pointing to neglect. Worse still, the health workers are not courteous enough to explain the reasons of delay. This seems to leave the mothers dejected which could serve as a discouragement for attending ANC.

In relation to this study, findings from the demographic data reveal that most of the women eke out a living on self-employment running small businesses. Spending most of their day at the facility may therefore leave the mothers with no time to tend to their businesses. Such businesses may suffer and deny them the much-needed source of income including transport to use for their next visit. According to Mackian (n.t.d.) women find it difficult to attend to maternal health care due to many factors including traveling long distances [lack of transport] coupled with long waiting hours. The authors argue that without social support from a wider social network for childcare or household duties while they are away, they may decide not to seek medical services even if it is necessary. The delay in being attended may therefore dissuade the women from seeking ANC services or lead to women skipping some ANC services. The ripple effect is that such action may lead to them being reprimanded by the providers making them stop altogether. It could also translate to mother's delaying their first ANC visits in subsequent pregnancies. The negative effects of long waiting hours is therefore, colossal, and could in the end result in detectable, preventable and treatable ailments associated with pregnancy passing unnoticed (Ewunetie,

Meselu, Simeneh & Meteku, 2018) putting the lives of the women and their unborn children to great danger. While agreeing with the concerns of the mothers, a key informant stated that:

> *"Waiting time is an issue. We recently did an exit interview of patients everywhere for UHC but the waiting time is always long because services are free. Waiting time is also long because we do review meetings with nurses before we start serving the mothers. The number of nursing students we have are also many hence a problem." (KII 1)*

As can be seen from the quote the health service providers acknowledge the long waiting hours at the facility though at the same time seems to blame universal health care responsible for free health care, review meetings as well as the number of students as factors that justify long waiting hours. This seems to suggest that there is little that can be done to change the status quo since Kenya is striving to implement a policy decision that is, universal health care. Further, the reviews are a normal practice in any health care as is training in a teaching hospital. The attitude portrayed by the health workers seems to prejudice those who seek free medical services, which reflects negatively on the health workers. While free medical service may attract an influx of women to ANC services, it does not mean that the services cannot be planned and organized and thus reduce waiting time. Furthermore, the main reason for free medical services is to increase access to health care service. That the increased access can be blamed in any way to the UHC policy is contradictory because the review is standard practice and training is mandatory being a teaching hospital hence both are standing orders of practice. The feeling that they interfere with the ANC services seems to remove the blame from the providers and the facility and suggests that there is nothing that can be done about the delay. There is need to check the waiting hours in facilities where UHC has not been implemented in order to confirm or refute this claim.

Moreover, although the providers blame the long waiting hours on the influx of women and multiple duties performed by the nurses, findings from the field observation revealed that the providers commence ANC services late. For example, one morning by 7:45a.m, about 30 or so

mothers had already assembled but the providers were not on site yet. An hour later at 8:45 a.m., no services had commenced, and a nurse passed around and one of the mothers asked when they would start attending to them and she simply said, "*soon*". More women added their voices to the complaint about the delay at which point the provider shouted back simply stating "*we are doing our best*." Arguably, starting work late contributes to long waiting hours and could also lead to disorganization of the service provider. Lateness and employee disruptions affect time-sensitive areas of the job, such as customer service. Accordingly, tardiness disrupts routine and may throw employees off, of the line therefore negatively affecting productivity. This means tardy health service workers are likely to offer poor service in addition to keeping the health seekers waiting long. All these could translate to the underutilization of ANC services thereby cutting the range of care services that the expectant women really need in order to lower maternal and neonatal mortality rates that has been bedeviling the county. This points to the structural violence as pointed out by Galtung.

The findings are consistent with those of Ganle, Parker, Fitzpatrick and Otipiri (2014) where they reported that delays in being given services and overcrowding was a common occurrence for women seeking ANC services in Ghana. However, in their case, the delay and influx in numbers was blamed on the lack of a booking system that saw women just walk in. In this study however, a booking system is in place, though one is simply given the next date and must be early if they want to be attended to early. Despite the booking system at JOOTRH, the influx was also blamed on referrals from other sub-county hospitals. Being a referral hospital, such referrals should be expected and with proper planning the mothers can be seen without them staying for too long at the facility.

The KII also stated that the delay is caused because of the dual role of ANC clinic as a service point for the mothers as well as a teaching clinic. This confirms what Behruzi et al, (2010) reported about the interruption of care by midwifes when the trainees are present in the birthing room. It is the view of the researcher that the lack of planning is to blame and not the mere fact that this is a teaching hospital. Further, the shortage of nurses was also associated with the long delays being experienced by the mothers in hospital as illustrated below:

> *"We have only one nurse per booth. The nurses are overworked and cannot even take a bathroom break because the patients complain whenever they leave their booths." (KII3)*

As captured in the above quote, the providers blame the shortage of staff at the facility for the delay. Indeed, the shortage is so bad that the providers don't even take health breaks lest the mothers complain. This confirms McMahon et al, (2014) report on the study of women in Tanzania where they sought to find out the experiences of disrespectful maternity and found that D&A was sometimes blamed on the few providers being overworked. Further, Reader and Gillespie (2013) in their study confirm that high workloads and staff burnout can lead to patient neglect. They further note that such high workloads easily lead to staff shifting their beliefs on the acceptability of risk and quality of care to manage the workloads (Reader & Gillespie, 2013). Though the providers should focus on the lifesaving services that they offer this important group of women, it is important for their wellbeing to be also addressed.

4.2.2 Discrimination Based on Ethnicity/Age/Education/Health

A total of 41 respondents, (37%) faced problems with discrimination based on ethnicity/ age/ education/ health. Discrimination was also mentioned as a problem by a key informant nurse who stated that;

> "*Discrimination is possibly encountered by mothers and mostly at the registration desk…maybe about 30% of mothers face discrimination." (KII1).*

As illustrated in the quote, a key informant admitted that discrimination is a common occurrence at the facility. The informant even gave a rough percentage on his opinion on the prevalence of discrimination placing discrimination to occur in about 30% of the mothers attending ANC services. Another key informant stated that underage adolescent mothers were also likely to be discriminated against as captured below: -

"Discrimination is common among young underage mothers coming for services." (KII1)

As captured in the above quote, the underage/adolescent mothers have a higher likelihood of being discriminated against based on their age. This resonates with the works of McMahon et al, (2014) qualitative study on experiences of and responses to disrespectful maternity care and abuse during childbirth with women and men in Morogoro Region, Tanzania. They found that discrimination is a generally common occurrence during the whole period of pregnancy through to childbirth.

Discrimination or perceived discrimination has a host of negative effects on health seeking behavior that puts the victim or perceiver at risk. According to Housmann et al, (2011) in their study on the Impact of Perceived Discrimination in Healthcare on Patient-Provider Communication, one mechanism by which perceived discrimination is hypothesized to affect health is by inhibiting patients' engagement with the healthcare system. Accordingly, individuals who feel discriminated may delay or fail to seek health services as well as avoid using preventive services. In addition, individuals who feel discriminated do not trust the health care providers and may fail to adhere to the instructions of the providers (Blanchard & Lurie (2001). In this study discrimination was found to be a major abuse at JOOTRH which means that there could be many women who put their lives and that of their unborn children at risk due to the vice. ANC offers important preventive services to the mother and the unborn child but if the service users feel devalued, they may not go for the services. The suboptimal use of ANC services poses a big challenge to the realization of SDG 3 and could lead to substituting to alternative birth practices that seem to increase mortality at birth in Kenya. It could also lead to irregular ANC attendance

among the women. Abbas, Rabeea, Hafiz and Ahmed (2017) confirm in their cross-sectional study on the effects of irregular antenatal care attendance in primiparas on the perinatal outcomes that women with irregular ANC attendance are more prone to complications like preeclampsia, eclampsia, anemia, low birth weight, pre-term birth and even still birth. Discrimination or perceived discrimination should be dealt with to improve ANC utilization and thus improving the pregnancy outcomes for mothers.

4.2.3 Harsh or Rude Language

Harsh and rude language was reported to have been experienced by 22 (20%) as shown in table 4.3. two mothers said of harsh language or rudeness that:

> *"One time I heard a provider shout at a mother attending ANC services "you give birth like a rat; do you know there is family planning?" (*CN1)

> *"You go to the wrong room nasty words are thrown at you just for missing a room*. (CN3)"

One key informant when asked the manifestations of D&A during ANC services at the facility agreed with the mothers and acknowledged that:

> "*Rude and harsh language is sometimes used on mothers attending ANC services."(KII1)*

While agreeing with the colleagues that harsh or rude language is sometimes used, one provider tried to justify the use of such language and stated categorically that:

> "*There are some mistakes that make us not laugh with them…*" (KII2).

As can be seen from the above quotes, mothers are compared to rats and subjected to hostilities for flimsy reasons as missing a room earmarked for a service. Further, a key informant acknowledges the presence of harsh and rude language, though an attempt is made to justify why such attitudes are prevalent, blaming the ANC mothers for literally asking for such treatment. This points to a general poor provider attitude towards the women which could easily lead to the mothers feeling the facility environment is hostile making them feel dejected and want to keep off. Roberts et al, (2015) confirms in their study in Malawi that patient-provider relationship attitude and support had

a huge impact on ANC utilization. The mother being compared to rats can easily decide that she does not want such humiliation and not go back to hospital. This therefore means that this kind of rude language has the potential of making the mothers want to keep off the facilities. For this category of women who need screening for potential health risks that may pose problems to their lives during pregnancy or birth, this should not happen. Consequently, this kind of poor patient-provider attitude has the potential of endangering the lives of women.

4.2.4 Lack of Necessary Supplies

Regarding the availability of supplies like medicine at the hospital, 24(22%) noticed that there were no medications. The following key informants agreed and stated that

> "*Because of UHC, sometimes there is no medication. Partners help with equipment but not medication."(KII4)*

> "*UHC has compromised the quality of care. Sometimes we don't even have gloves to wear as we examine the ANC mothers."* (KII3)

> **"***Kenya Medical Supplies Authority (KEMSA) system should be strengthened they never give hospitals everything they order for because they don't have everything."(KII4)*

Kenya Medical Supplies Authority (KEMSA) is a state corporation under the Ministry of Health established in 2013 with a mission to provide reliable, affordable and quality health products and supply chain solutions to improve healthcare in Kenya and beyond. KEMSA is clearly not up to its documented mandate going by the key informant's assertion that the hospital can never get what they order. Since KEMSA is a function of devolved government, it is important for both the national and county governments to ensure that the authority is well equipped.

As observed in the quotes, again the service providers acknowledge the existence of D&A and admit to the lack of necessary supplies at the facility. The failure to have and use basic and necessary items like gloves when examining women is indeed a gross violation of the basic health and safety requirement. WHO recommends that the providers should wear gloves for any contact

with patients, even if a patient seems healthy and has no signs of any germs. Tucker and Spear (2006) asserts that the lack of supplies which was termed as operational failures in hospitals wastes a lot of time during service provision with the potential of contributing to delayed service delivery. Again, Linceto et al, (n.d) found that antepartum still birth accounts for two-thirds of still births and can be blamed on both maternal infections and pregnancy complications. The lack of necessary supplies like gloves, therefore, put the health of mothers in jeopardy.

This is also another area the KIIs spoke strongly about, blaming UHC for the low supplies of necessary medications at the facility. Even though it may be true, UHC as a policy is to increase access to health and cannot be blamed hence is an attempt to normalize D&A during ANC by the providers.

However, proper planning and resources allocation should ensure all patients have their needs met in the facilities they visit and the UHC policy should therefore, be re-evaluated and strengthened.

It must be noted that the TBAs have neither medications nor equipment and are still valued by the women. When it turns out that the mothers are sure that the lack of necessary supplies in the facilities is the norm, the women may lack conviction to visit these facilities sending them to the ready hands of the TBAs as an alternative despite the findings that some maternal deaths are blamed on such services. This is perhaps the reason Kruk et al, (2009) who studied maternal cases in Tanzania found the lack of necessary supplies was a form of D&A in the facilities they studied and emphasized on the importance of having the necessary supplies and equipment.

4.2.5 Non-Consented Care

Majority of the respondents said that the hospital did ask their consent, the other 7(6%) had instances where their consent wasn't sought. Despite the majority reporting that their consent was duly sought before some procedures and tests, two key informants agree with each other on consent and stated that:

“*Unconsent is rampant; the nurses always assume the patients understand (KII4).*

“*I cannot deny that sometimes we don’t ask them for consent. This happens especially when they are attended to by students or new staff.”(KII1).*

A mother in addressing the issue of consent on HIV testing lamented that:

“*I went to that VCT which they force us with, I was also unhappy with many other things so I told them to do whatever they want to do but they should not ask me anything, and I did not talk even as they did the test and I just left the room.*” (CN6).

Asked whether there was a protocol for the patients to sign when giving consent, two key informants confirmed there was no protocol for the mothers to sign and that consent was sought verbally.

As observed in the quotes, both the service providers and the women (to a small extent) acknowledge the existence of non-consented care. The mother in this quote paints a picture of forced HIV testing at the facility and adds that she was already dissatisfied and unhappy with some aspects of care at the facility. Even though she claims she did not talk, I guess her initial conversation stating that they should not engage her verbally but simply do whatever they wanted to do was assumed as consent and the test was duly done.

While it is acknowledged that there is no protocol to sign by mothers while giving consent, a key informant states clearly that non-consented care is rampant and duly apportions the blame for it to students and new staff. This is yet another instance where there is normalization of D&A by the providers, by blaming the students and new staff. While students are learning, they must adhere to the code of conduct provided at the facility. The same is the case with new staff who practice requirements demand should go through proper induction which includes briefing on what is expected of them. Some of the mothers are probably also unaware of their right to always give consent in writing and assume the sporadic verbal consent sought is the norm.

The findings resonate with Gamlin and Holmes (2018) study on the preventable perinatal deaths as they reported that the mothers were often subjected to routine procedures, they had not given

consent to, or of which they were unaware. Because of such treatment, the study reported that some mothers chose not to deliver in hospital out of fear. Further, Bowser and Hill (2010) in their systematic review confirm that the absence of consent protocol is common and was believed to result in unnecessary episiotomies and cesareans. In this study too, it is emerging that non-consented care could be rampant. While there is need to educate the mothers about their rights, providers including trainees must also seek informed consent of the mothers for any procedures as stipulated in the 4th edition of the code of professional conduct and discipline for health workers (2012). However, the code has grey areas as it simply lists that implicit or explicit consent should be asked without being categorical whether consent should be in writing or not. The issue of consent should be looked into and clarity made on how it should be done.

4.2.6 Confidentiality, Withholding of Treatment, Addressing of Concerns and Blaming for Outcomes.

Only 5 (5%) said they found issues with the confidentiality as information they wouldn't have liked to get out slipped. However, as one mother noted:

> "*I think they breach confidentiality. It may not be easy though, to know if confidentiality is breached, they may be breaching it but we may not know*" (CN5).

From the above quote, while this is a good sign that there is no outright breach of confidentiality, the quote points to a lack of trust by the women on the providers alluding to lack of confidence on the health system. Kujawski et al, (2015) reported in their study that D&A is not just a deterrent to facility delivery but also lowers the confidence of women in the health system. Ratcliffe (2013) also points to D&A as undermining women's trust in the health care system. The lack of confidence obviously affects utilization and therefore, a danger to the health of women.

Regarding withholding of treatment, those who answered yes (4%), mostly referred to threats to withhold treatment and not the actual act. For example, a mother who was admitted and requested to go home since she was not on any treatment stated that:

> "*I was on contraceptives, but I conceived so my EDD is not known. Recently, I did an ultrasound which revealed I am 35 weeks. At one time I was booked for theatre then again, I was told to wait for labour and yet I am a CS person. One doctor said he doesn't know the number of weeks I am and when I reminded him about the ultrasound, he said he doesn't believe in ultrasound. I am admitted here and not actually being treated and yet my children, including a 2-year-old are home alone. I requested them to let me go home and they told me I would have to sign so that should there be complications due to my insistence, I would not be attended to if I return*." (CN6)

Though there is no protocol to sign while conducting invasive investigations like HIV testing at the ANC clinic, it is interesting to note that suddenly the mother is told of this requirement as a way to make her comply. She was told that after signing, she would not be taken back if she left and later need to go back for treatment. Coupled by the fact that she had minors fending for themselves in her absence, she was quite stressed up that the best the providers would have done is to explain to her in detail why it was necessary to keep her in hospital. Such a woman could in the future, with similar instruction of admission from providers perhaps even choose to disregard such instructions.

For this case, the researcher informed the hospital administrator in charge of quality to look into her case so that she would be informed about the available treatment options. According to her, just being monitored was not enough to keep her in hospital without active treatment. She looked worried and stressed something that could compromised her health further.

Regarding dismissal of concerns, only 11 (10%) reported their concerns were dismissed. Two mothers corroborate dismissal of concerns and explain:

> *"When you complain to the female nurses, they tell you they are experienced women who have given birth many times and they know what you are saying is not a serious problem."(CN5)*

"I came for regular visit, but I was also having stomach cramps. They said they suspected threatened abortion but advised that I go and have bed rest. That night, I came back to hospital with severe cramps. I was sent for ultrasound and told it is nothing serious I should go back home and rest.". (CN4)

From the captured quotes, one woman is told that what she is experiencing is normal, poses no danger to her and has been experienced by the female nurses who are also mothers who believe they can confirm that it is not serious. CN5 was instructed to get bed rest and was only attended to on her third visit to the hospital ending up losing the pregnancy. The case of Serena Williams whose pulmonary embolism concern was initially dismissed only to become a reality is a case in point (Harvard health publishing, 2011) since it was noted to be a serious condition with the possibility of killing her. Dismissal of concerns poses a great threat to the health of women and their unborn babies.

4.3.7 Level of Satisfaction with Components of Care

From the survey, the ANC clients interviewed expressed satisfaction with various components of care. Specifically, 45% were at the least satisfied with waiting time before being seen, 87% considered the friendliness of service providers at the hospital satisfactory at the very least, 86% were at least considering the treatment by the service provider satisfactory, about 90% considered the confidentiality of the information they shared, consent sought on necessary tests & procedures and the time taken by provider to provide information at least satisfactory. For 85% and 95% of those interviewed, the fact that time was given by provider to ask & answer questions and the tests and services were provided in a private room were satisfactory as table 4.4

Table 4.4: Level of Satisfaction of ANC Clients at JOOTRH with Various Components of Care

During ANC visits with this pregnancy, rating of specific components of care:	V. Satisfied	Satisfied	Dissatisfied	V. Dissatisfied
Waiting time before being seen:	11 (10%)	39 (35%)	47 (42%)	14 (13%)
Friendly service providers at the hospital:	11 (10%)	86 (77%)	13 (12%)	1 (1%)
Respectful treatment by provider:	23 (21%)	83 (75%)	5 (5%)	
Confidentiality of the information shared:	15 (14%)	84 (76%)	11 (10%)	1 (1%)
Time taken by provider to provide information:	22 (20%)	78 (70%)	9 (8%)	2 (2%)
Time given by provider to ask & answer questions:	12 (11%)	82 (74%)	16 (14%)	1 (1%)
Tests and services provided in a private room:	24 (22%)	81 (73%)	6 (5%)	
Consent sought on necessary tests & procedures:	26 (24%)	72 (66%)	10 (9%)	1 (1%)

As shown in the above table, the mothers are overwhelmingly satisfied with most components of care investigated pointing to satisfaction with the quality of services sought. Except for the waiting time which has remained to be a cause for discontent, the other components of care are viewed in positive light. One mother posed regarding waiting time: -

"Let them not even greet us, they should just attend to us as fast as possible." (CN5)

Again, some of the mothers are not willing to question the quality because they are not paying for the services after all. A mother had this to say:

"The services are free; surely can one complain. We should just be thankful." (CN3)

As captured in the quote, some mothers are not willing to question quality of care for the reason that the services are free. This points out to an aspect of normalization of D&A during ANC services by the mothers. USAID (2010) confirms that the normalization, from their study on facility childbirth was because most women have never known quality and are not aware of their own patient rights. It is surprising, however, that contrary to what the patients report regarding quality, the providers disagree with the mothers and acknowledged that the quality was wanting.

"The quality of service is not good in my opinion. This UHC has compromised the quality of care that we give. The women are more hence the long waiting hours. They also ask for extra services and complain if their requests are not granted." (KII1)

It is evident from the quote that the key informant acknowledges that the quality is not good but blaming the poor quality on UHC. Kisumu is one of the pilot counties for UHC having been launched in December 2018. Since the launch of UHC, JOOTRH is reported to have witnessed an influx of patients, ANC seekers included. While some of the mothers are happy that the services are free and seem not to care much about the quality, it is surprising the providers acknowledge the poor quality of care. They also report that UHC contributes to the high workload that they have to endure. The findings conflict with those of Ganle et al, (2014) where the nurses praised the quality they offered, and the women believed the quality was substandard. It may be important for the mothers to know that the lack of essential supplies and care is a fundamental violation of their right whether the services are free or not. Moreover, UHC is to ensure not only access to health care but also adequate health resources in a timely manner. In this study, both provider and the women have normalized D&A. The implication of normalizing the bad quality is that the services continue to be poor thus compromising the health of the mothers.

4.3.7 Factors Influencing Disrespect and Abuse

From the case narratives with clients and interviews with key informants, several factors emerged to influence D&A at the facility. These factors are in three broader categories namely: client related factors, service provider related factors and health facility related factors. The client related factors include age, socio economic status of clients, late start of ANC services and lack of sensitivity to the pressure that health care workers face. The study revealed that adolescent mothers were more at risk of abuse and discrimination at the facility due to their lack of experience with procedures at the facility especially when they visit for the first time. Older women were

reported to understand the procedures hence find it somewhat easier to navigate through different procedures. A case in point is the reluctance to go for the recommended HIV testing during the first ANC for young women especially when they are not yet ready to know their HIV status.

> "*Adolescent mums they fear, and they don't want to be examined, especially HIV. And first visit, if one comes in the afternoon, they are turned away. They also don't give the full information*." KII 2

> *"Some young people say we make noise because they get pregnant early, it has already happened so not need of making noise."* KII 1

Due to UHC, services are free at the facility increasing demand for the ANC services at the facility in light of unmatched service provider number. This builds pressure on the part of service providers while creating a perception of neglect on the part of clients. Also due to low social status of the clients that this arrangement attracts, it creates a perception of lack of alternative making the ANC clients endure discrimination, mistreatment and abuses meted on them at the facility.

> *"I came back here because this is the biggest referral hospital, where else do I go? I really hope it will be better this time."* (CS 4)

Service provider related factors which include poor provider attitude, poor communication between provider and clients, and heavy provider workload were also reported by the mothers. The mothers hinted to the high number the providers have to see through they still lamented the poor attitude and rapport. Health facility related factors include poor hygiene conditions, the lack of drugs and other necessary supplies. For example, the women mentioned incidences when the only outpatient toilet in the facility was either overflowing or locked for hygiene issues and lack of medication.

4.3 Effects of Disrespect and Abuse Experienced by ANC Clients at JOOTRH

The research found out that 70% of the clients that D&A at the health facility resulted to poor health of mother and baby and stress and mental health problems. Out of the women sampled,

reports of high mortality rates were associated with the age of ANC clients interviewed, the statistics of the data is reported in Table 4.5. out of those interviewed, there was a high correlation between those who felt that D&A could lead to high maternal mortality χ^2 (6) =12.965, p =0.044. Likewise, reports of stress and mental health problems as effects of D&A was associated with religion and employment status of the women interviewed at χ^2 (8)=21.689, p=0.006 and χ^2 (6)=13.920, p=0.031 respectively. Perceived hostile environment for patients as an effect of D&A was associated with religion (χ^2 (8)=17.009, p=0.030). Demoralizing atmosphere for providers was associated with religion (χ^2 (8) =19.928, p=0.011) while women in employment mentioned that that getting infections at the facility was a possibility (χ^2 (6) =14.587, p=0.024). Though there were no specific mention of how these effects relate to the various D&A that women experienced at the health facility. Also mentioned were trigger of bad memories for expectant women, high mortality rates among women during antenatal period or immediately after delivery as well as lack of trust among others as table 4.5 shows.

Table 4.6: Perceived Effects of Disrespect and Abuse among ANC Clients in JOOTRH

Perceived effects of D&A	**Women (n=111)**	**%**	***P Values***		
			Religion	Employment	Age
Life threatening complications:	81	73	0.000	0.000	0.000
Poor health of mother and baby:	78	70	0.000	0.000	0.000
Stress and mental health problems:	82	74	0.006	0.031	0.000
Trigger bad memories for expectant women:	48	43	0.000	0.000	0.000
Women getting infections in facility:	17	15	0.000	0.024	0.000
High maternal mortality:	61	55	0.000	0.000	0.044
Hostile environment for patients:	52	47	0.030	0.000	0.000
Demoralizing atmosphere for providers:	44	40	0.011	0.000	0.000
Lack of trust and fear in future pregnancies:	63	57	0.000	0.000	0.000

0.000* values > 0.001, *p=0.05*

The survey explored further how the different forms of D&A could affect women attending ANC. The findings showed that among the five most common forms of D&A reported to have been experienced by the respondents, long delays before being attended to could lead to discontinuation of ANC and total avoidance of ANC by expectant women according to 39% and 32% of the ANC clients interviewed respectively. Discrimination based on age, ethnicity, health or socio-economic status led to discontinuation of ANC and total avoidance of ANC by expectant women according to 18% and 33% of those interviewed respectively. Lack of necessary supplies at the facility led to discontinuation of ANC and total avoidance of ANC by expectant women according to 24% and 50% of those interviewed respectively. Use of harsh or rude language by the service providers led to discontinuation of ANC and total avoidance of ANC by expectant women according to 22% and 49% of those interviewed respectively, Lack of redress for the complains raised or forwarded led to discontinuation of ANC and total avoidance of ANC by expectant women according to 50% and 47% respectively. Other Disrespect and Abuses that that affects ANC attendance are shown in table 4.6.

Table 4.7: Effects of Disrespect and Abuse on Attendance of ANC by Clients at JOOTRH

Forms of Disrespect and Abuse on ANC attendance:	**Leads to discontinuation of ANC**	**Leads to no ANC attendance at all**
Discrimination based on age/ethnicity/health/socio-economic status:	20 (18%)	37 (33%)
Harsh or rude language:	24 (22%)	54 (49%)
Being blamed by nurse/doctor for an outcome:	6 (5%)	15 (14%)
Lack of informed consent for test and other procedures:	6 (5%)	13 (12%)
Breaches of confidentiality/privacy:	8 (7%)	13 (12%)
Request for bribes:	9 (8%)	9 (8%)
Extortion or unclear hospital fees:	2 (2%)	8 (7%)
Sexual abuse/harassment:	7 (6%)	12 (11%)
Dismissal of concerns:	6 (5%)	21 (19%)
Judgmental or accusatory comments:	8 (7%)	45 (41%)
Lack of necessary supplies at the facility:	27 (24%)	56 (50%)
Long delays before being attended to:	43 (39%)	36 (32%)

Poor physical condition of facilities in the hospital:	28 (25%)	9 (8%)
Threats of withholding treatment:	5 (5%)	6 (5%)
Lack of redress when complains are forwarded:	56 (50%)	52 (47%)

From the key informant interviews, it emerged that a number of effects are associated with Disrespect and Abuses meted on the clients at JOOTRH. These include: Increase in undesirable health outcomes such as maternal mortality and miscarriage where quality of the healthcare is compromised by either delay in seeking care due to fear of Disrespect and Abuse, delay in provision of care either due to lack of appropriate medical equipment, know how or sheer neglect on the part of the service provider, lack of full disclosure of information necessary for appropriate care as a result of fear of lack of confidentiality on the part of the service provider among other reasons as experienced by one of the case narratives in the study. There is also increased risk of none compliance to the recommended treatment by the clients especially where they are discriminated or abused in a way that makes them feel demeaned. This arises from fear of having a similar destabilizing experience. There is also increased possibility of utilization of alternative healthcare such as visits to the traditional birth attendants for antenatal care and delivery services. This is because they believe they receive respectful maternal care from these sources unlike in the health facility. It also makes those that cannot se TBAs to seek healthcare elsewhere which may come at a cost since they may be forced to travel long distances or seek services in more costly private health facilities thereby straining their resources further as well as increasing their health risk.

> *"If I lose a pregnancy because of negligence, I would not come again*." CN 5

> "*They don't complete the schedule…TBAs are many, and they are a factor in high maternal deaths. They cheat the patients that they are nurses, so the patients go to their houses in Manyatta*". KII 2

> *"They don't come back when you make noise at them. If I know I would be insulted, I would better not go to the clinic if that's what I get. I can even go to the TBAs*." KII 1

Discrimination or perceived discrimination has a host of negative effects on health seeking behavior that puts the victim or perceiver at risk. According to Housmann et al, (2011) in their study on the Impact of Perceived Discrimination in Healthcare on Patient-Provider Communication, one mechanism by which perceived discrimination is hypothesized to affect health is by inhibiting patients' engagement with the healthcare system. Accordingly, individuals who feel discriminated may delay or fail to seek health services as well as avoid using preventive services. In addition, individuals who feel discriminated do not trust the health care providers and may fail to adhere to the instructions of the providers (Blanchard & Lurie (2001).

ANC offers important preventive services to the mother and the unborn child but if the service users feel devalued, they may not go for the services. The suboptimal use of ANC services poses a big challenge to the realization of SDG 3 and could lead to substituting to alternative birth practices that seem to increase mortality at birth in Kenya. It could also lead to irregular ANC attendance among the women something that several case narratives as well as service providers interviewed in the study confirmed. This reality is further confirmed in a study by Kujawski et al, (2015) as well as Roberts et al, (2015) who reported that D&A is not just a deterrent to facility delivery but also lowers the confidence of women in the health system. Ratcliffe (2013) also points to D&A undermining women's trust in the health care system. The lack of confidence obviously affects utilization and therefore a danger to the health of women.

The fear for D&A during facility delivery according to Abuya et al, (2015a) and Bekele (2015) leads to low skilled birth attendance and hence a likely contributor to Kenya's sustained high maternal [and neonatal] mortality rate. Further, it is reported that the fear of being mistreated by

nurses who the mothers stated 'do not take care of the patients' led to some fear making the women opt for TBAs (CRR & FIDA (K), 2007).

The effects of the D&A to the women interviewed were comparable to what Abbas, Rabeea, Hafiz and Ahmed (2017) found in their cross-sectional study on the effects of irregular antenatal care attendance in primiparas on the perinatal outcomes. These were that with irregular ANC attendance, women are more prone to complications like preeclampsia, eclampsia, anemia, low birth weight, pre-term birth and even still birth further confirming the need to deal with perceived D&A as a way of improving ANC utilization and ultimately, improving the pregnancy outcomes for mothers.

Long distances to the health facility as well as long waiting hours at the facility lead to delay in clients being attended to and may therefore dissuade the women from seeking ANC services or lead to women skipping some ANC services. The ripple effect is that such action may lead to them being reprimanded by the providers making them stop altogether. It could also translate to mother's delaying their first ANC visits in subsequent pregnancies. The negative effects of long waiting hours is therefore, colossal, and could in the end result in detectable, preventable and treatable ailments associated with pregnancy passing unnoticed (Ewunetie, Meselu, Simeneh & Meteku, 2018) putting the lives of the women and their unborn children to great danger. This compromises the realization of the health policy that focusses on improving health services.

When it turns out that the mothers are sure that the lack of necessary supplies in the facilities is the norm, the women may lack conviction to visit these facilities sending them to the ready hands of the TBAs as an alternative despite the findings that some maternal deaths are blamed on such services. This is perhaps the reason Kruk et al, (2009) who studied maternal cases in Tanzania

found it was a form of D&A in the facilities they studied and emphasized on the importance of having the necessary supplies and equipment.

The study also suggests that both provider and the women have normalized D&A as the providers want to blame UHC while the mothers see D&A as the norm, hence a non-issue. The implication of normalizing the bad quality is that the services continue to be substandard thus compromising the health of the mothers. USAID (2010) confirms that the normalization during facility childbirth was because most women have never known quality and are not aware of their own patient rights. It is surprising, however, that contrary to what the patients report regarding quality, the providers' views on the quality of care they provide contradicts the mothers. While some of the mothers are happy that the services are free and seem not to care much about the quality, the providers acknowledge the poor quality of care which they attribute to the high work load brought about by UHC which beats the purpose of UHC which has both access and quality at the heart of it. The fact that women are satisfied with the services while service providers acknowledge the services to be substandard conflicts with the study of Ganle et al, (2014) where the nurses praised the quality they offered, and the women believed the quality was below standards.

The findings confirm what Miller and Lalonde (2015) reported in their study that D&A could lead to serious complications for the mother and baby thus negatively impacting the health of either or both if there is no timely diagnosis and/or treatment of complications (Asefa & Bekele, 2015; Manning and Schaaf, 2017). Ganle et al, (2014) in their study reiterate that pregnancy and childbirth are indeed dangerous hence care and close monitoring is advised every step of the way. It is therefore clear that D&A can lead to life threatening complications for both mother and the foetus. Clearly, D&A is fatal and one of the contributing factors to high maternal mortality rate according to CHANGE, 2015; Warren et al, 2017; Miller & Lalonde, 2015 & Raj et al, (2017).

Consequently, if it is not addressed conclusively then the chances of realizing SDG 3 remain a mirage. Further, evidence suggests that D&A during maternity care negatively affect maternal health outcome leading to high mortality rates according to maternal health and respectful care factsheet (2014). This is because D&A potentially affects skilled birth and ANC attendance which consequently affects the health of the women in question. For maternal mortality to be reduced further, D&A must be reduced to increase access to skilled attendance.

Also, from the study, it emerges that women exposed to D&A experience anxiety as well as stress during their pregnancy something that Manning & Schaaf, (2017) also confirmed in their study to have the potential to lead to mental health problems for the woman. They also observe that such stress can result in fear of childbirth, influence sexuality and the desire to have children, generate lifelong feelings of guilt and grief and even trigger memories of sexual assault, if any, in some women. The stress is further confirmed by Lareya and Wolke (2012) to have negative effects on the foetus by increasing their risk to victimization by peers later on in life. It is clear that D&A has effects for both the foetus the mother and should be eliminated in its entirety if we are to boast a healthy future nation.

4.4 Coping Mechanisms Employed by ANC Clients at JOOTRH

The third objective of this established some of the coping mechanisms employed by clients who ever experienced various forms of discrimination at the health facility used. The most common approach was to change the health facility (64%), reporting to the authorities (48%), seeking counselling services and avoiding ANC services (26%) among others as table 4.7 shows. Delay in seeking first ANC services in later pregnancy as a coping mechanism was associated with age of the women interviewed in the study as majority of the younger women (χ^2 (3)=9.169, p=0.027) stated they would delay seeking ANC. Reporting to authorities in case one is discriminated against

or abused was associated with employment status (χ^2 (3)=8.151, p=0.043). Majority of those who reported addressing D&A experiences by reporting to the authorities were in employment. Clients aged 23-27 years were 0.096 (0.012-0.789) less likely to report delay in seeking ANC services when they experience D&A compared to those aged 18-22 years.

Table 4.8: Strategies Used by ANC Clients at JOOTRH in case of Mistreatment during ANC visits

Steps taken when mistreated during ANC visits:	Women (n=111)	%	*P Values*		
			Age	Employment	Marital Status
Avoid going for ANC services:	29	26	0.000	0.000	0.000
Report to authorities:	53	48	0.000	0.043	0.000
Seek counselling services:	45	41	0.000	0.000	0.000
Go to traditional birth attendant:	7	6	0.000	0.000	0.000
Confront the provider:	20	18	0.000	0.000	0.000
Skip some ANC visits:	16	14	0.000	0.000	0.000
Pay a bribe:	2	2	0.000	0.000	0.000
Delay 1st ANC visit services in later pregnancy:	27	24	0.027	0.000	0.000
Change the facility being used for further facility	71	64	0.000	0.000	0.000
Other:	12	11	0.000	0.009	0.001

These findings show that the mothers would seek alternative ways irrespective of their risk to the mother and the infant, surrender to the health care provider even when the clients knows what the procedure entails and doesn't agree with it, reporting to the facility management even when they are sure nothing much would become of it, delays in starting ANC as well as reduced number of contact with the service providers in the subsequent ANC visits.

> *"I will never come back here. I would rather go to a dispensary. There are many hospitals, I will not come here again."* CN 4

> *"When patients talk to doctors, they get an attitude. They keep saying daktari told me this and this".* KII 1

The study highlights that women would stop coming for these important services when they are questioned or reprimanded or experience neglectful care. This is something that Jewkes et al, (1998) also established in South Africa where mothers were unreasonably subjected to very early morning visits to enable them book for delivery with some stopping attending ANC services until they were in labor thus endangering their lives. While the key informants said they don't have a system of tracking patients to know how often they attend the services, they reported that the women do miss some services. Some even stop coming altogether, and the providers assume that perhaps they have transferred to a different facility. Unfortunately, the study found that some women still consider unskilled services from the TBAs as alternatives when they have such experiences. The other coping mechanisms mentioned were bribing themselves out of the hands of a specific service provider and late start of ANC services at the facility. The findings confirm those McMahon et al, (2014) where they stated that a woman's delay in seeking care in facilities and also skipping of services is often a well-calculated perhaps to avoid the D&A further confirming D&A as a deterrent to skilled attendance even during ANC services.

4.4.1 Maternal Knowledge and Experiences while Seeking ANC Services

The sampled ANC clients' understanding of various aspects of access and utilization of ANC was also explored through the survey. To begin with, it was established that all the women had started accessing ANC or had visited the health facility of the material day for their first ANC visit. Of these, 87% (97) had started their ANC at JOOTRH and the remaining 13% (14) had started their ANC in health facilities situated elsewhere. In terms of knowledge of period (in months) after conception that a woman is supposed to start her ANC visits, 32% of the women reported that the ideal time should be one month while about 45% mentioned at least 3 months as figure 4.1 shows.

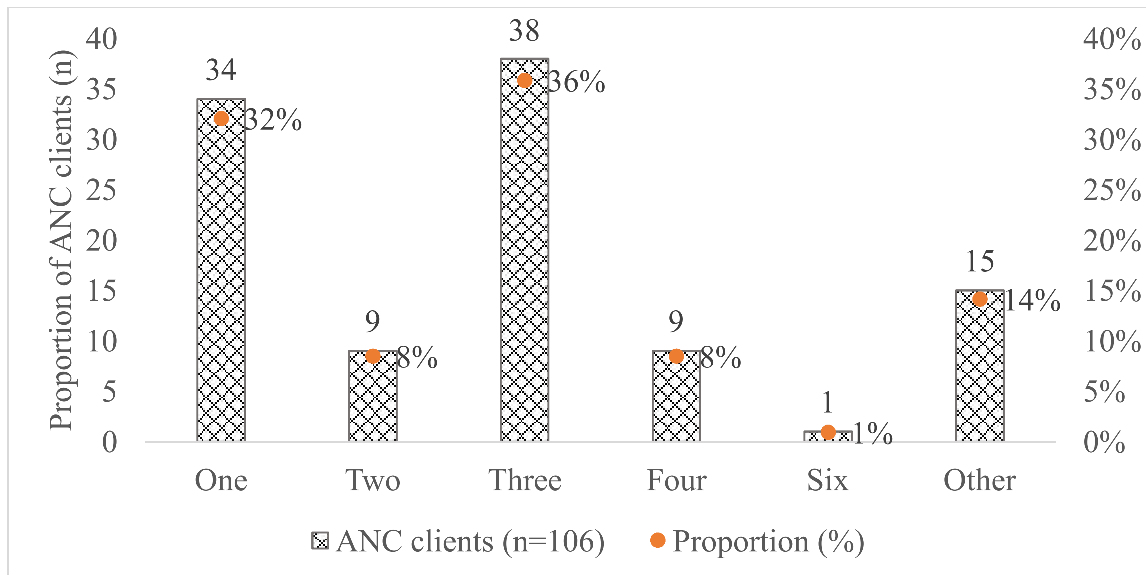
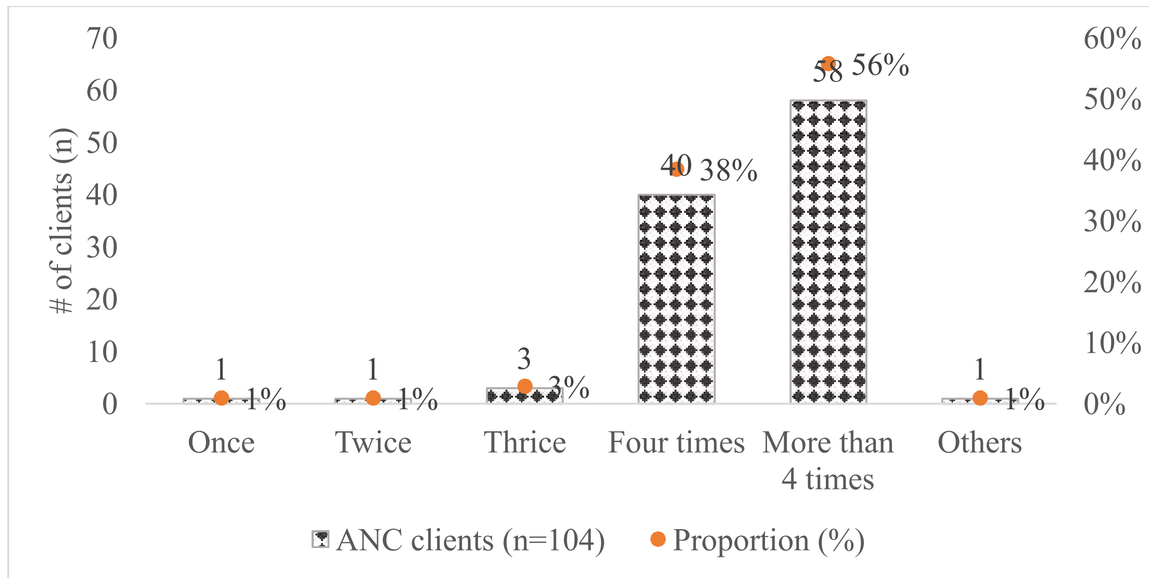


Figure 4.1: Perceived period (in months) before a pregnant woman first visits an ANC clinic (n=106)

In terms of recommended number of ANC visits an expectant woman should make before delivery, only 4% mentioned less than 4 times which is below the WHO recommendations for focused ANC attendance of 4 times during pregnancy WHO, 2015). 38% of the mothers mentioned 4 times and 56% mentioned more than 4 times as figure 4.2 shows. All of the ANC clients interviewed considered ANC important to expectant women like themselves with about 94% of them considering it very important.

Figure 4.2: Frequency ANC attendance of ANC services for pregnant women (n=104)



In terms of the factors that influenced decision on ideal place for delivery, 108 clients responded. Of these, 78% considered cleanliness and affordability of the treatment or service to be very important while 79% considered functionality of the hospital equipment for the procedures recommended and good supply of medicine as very important. Friendliness of the staff was very important for 81% of the ANC clients interviewed while knowledgeability of the service provider and the possibility of them choosing the service provider were very important for 68% and 51% of the clients interviewed in the survey as table 4.8 shows.

Table 4.9: Extent to which specific factors influence decision making for ANC clients on where to seek ANC services

Factors that influence decision on ideal place for ANC services:	Very Important	Important	Not Important
Cleanliness:	86 (78%)	24 (22%)	
Working hospital equipment:	88 (79%)	23 (21%)	
Knowledgeable provider:	75 (68%)	35 (32%)	1 (1%)
Good supply of medicines:	88 (79%)	23 (21%)	
Affordable cost of treatment:*108	84 (78%)	24 (22%)	
Ability to choose the provider:**110	56 (51%)	47 (43%)	7 (6%)
Friendly staff at the hospital:***109	88 (81%)	21 (19%)	

n=108, **n=110 and ***n=109

It is evident from the findings that the service providers acknowledge D&A on those they perceive to be underage and should not get pregnant. This confirms USAID (2010) findings that provider prejudice lead to young girls being scolded for being too young to get pregnant. Incidentally, this is the group that needs ANC most because of their age and the development stage in which they are in. Combs-Orme (1993) observe that adolescent pregnancy involves additional risk for adverse outcomes characterized with three major indicators of poor pregnancy outcome which are, pregnancy complications, low birth weight, and infant mortality. WHO (2004) on the other hand, observe that anemia is prevalent in adolescent mothers who are also at risk of contracting HIV/ Aids? This has the implication that the adolescents or young mothers need close medical observation for successful delivery.

However, hostility from the service providers only serves to discourage them from seeking the important services. This compromises their health and could create negative attitude about the ANC that could stay on even in their adult lives. Further scolding them rather than create awareness could lead to non-adherence to instructions of the service provider. Negative comment

could also lead to guilt feelings that may prevent them from seeking assistance from the elders. Therefore, rather than scold the young to be mothers, the health service providers should be more concerned with their health which is their core duty rather than issues of morality which is not in their realm of service. The same adolescent mothers were also reported to be very impatient when it came to waiting time. The waiting time is apparently a concern to many, and they are being blamed just because they are able to voice their concerns regarding the long waiting time. They were also reported to take advantage of the coupling call by often bringing different partners during their ANC visits.

It is also clear that multiparous maybe start ANC late to get the book. This book is a necessity when one wants to utilize the facility for delivery. Some of these women as seen in the demographics believe they have experience and can even deliver on their own, and the same attitude is being employed during ANC services. The findings confirm what Ewunetie et al, (2018) reported in their study on delay on first ANC visit by the same class of women. They found that out of 40.7% of participants in their study who were multiparous visited ANC clinic were for the first time after 16 weeks and not the recommended 12 weeks of gestation. This should be addressed as pregnancy complications knows no experience. They should be educated on the benefits of early ANC visits as well as the acceptable minimum number of ANC visits in a pregnancy, which is important for a good outcome. It is important to point out to the mothers the importance of early ANC initiation.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

5.1.1 Nature of Disrespect and Abuse among Women Seeking ANC Services

The study finds that D&A is common among most ANC mothers at JOOTRH. This is in the form of long delays before being attended to, discrimination (based on age, ethnicity, health or socio-economic status), lack of necessary supplies at the facility, use of harsh or rude language by the service providers and poor physical conditions of facilities in the hospital. Compared to socio-economic demographics, the study found that women who have at least college education are more likely to state experiencing long delays in the queues compared to those with primary level of education and below. Age, socio economic status of clients, high workload for service providers, increased demand for free services due UHC, lack of essential equipment and supplies are some of the contributing factors to D&A in the facility.

5.1.2 Effects of Disrespect and Abuse Experienced by ANC Clients

Disrespect and Abuse at the health facility results into an increase in undesirable health outcomes for mother and baby. Some of the outcomes include miscarriage and stress related issues which ultimately lead to high maternal and neonatal mortality where quality of the healthcare is characterized by either delay in seeking care due to D&A or simply the fear of D&A. Delay in provision of care is either due to lack of appropriate medical equipment, know how or sheer neglect on the part of the service provider, lack of full disclosure of information necessary for appropriate care as a result of fear or lack of confidentiality on the part of the service provider among other reasons were mentioned by mothers who participated in the case narratives.. There is also increased risk of none compliance with the recommended treatment by the clients especially

where they are discriminated or abused in a way that makes them feel demeaned. This arises from fear of having a similar experience.

There is also increased possibility of utilization of alternatives like visits the TBAs for antenatal care and delivery services. This is because the mothers believe they receive respectful maternal care from these TBAs unlike in the health facility. Other mothers' resort to changing facilities, something which may come at a cost. For example, resorting to private clinics could mean the women abandoning skilled care altogether, or having to travel to travel long distances increasing their health risk of complications if urgent help is needed.

Reports of high mortality rates are associated with the age of ANC clients while those of stress and mental health problems was associated with religion and employment status of the women. Perceived hostile environment for patients as an effect of D&A was associated with religion; demoralizing atmosphere for providers was associated with religion while women getting infections at the facility was associated with employment status.

5.1.3 Copying Mechanisms Employed by ANC Clients

Some of the most common coping mechanism likely to be employed by women at the health facility are change of health facility to a different one, reporting to the authorities, seeking counselling services and avoiding ANC services. Delay in seeking first ANC services in later pregnancy was also mentioned as a coping mechanism and associated with age of the women interviewed in the study as majority of the younger women reported that they would delay their first ANC visit in subsequent pregnancies. However, clients aged 23-27 years are less likely to report delay in seeking ANC services when they experience D&A compared to those aged 18-22 years. Reporting to authorities in case one is discriminated against or abused was associated with

employment status of the women as majority of those who stated they would address D&A experiences by reporting to the authorities were in employment.

5.2 Conclusions

It emerges from the study that D&A is very prevalent among expectant women seeking ANC services at JOOTRH. It is common to the extent that it has been normalized by both clients and health care providers. It is however contradictory that government program such as UHC whose goal is to make available quality healthcare for all, is perceived as a contributing factor. UHC program has resulted to increased demand for health services that is not matched with additional investment in human resources for health as well as investment in essential medical equipment and commodities increasing the risk of compromised quality health care. Staff welfare is also not a priority in this program leading to increased risk of burn out and fatigue which is further manifested in the perceived mishandling of clients.

5.3 Study Limitations

The study has several limitations. D&A as measure is subjective but since the goal of the study was to improve utilization of ANC, the perceptions of the mothers were very important during the analysis. The study did not involve the male companions who were seen accompanying their spouses to find out their perception on D&A during ANC services. The fact that the interviews were done within the facility affected the findings as most doubted the confidentiality hence fearing victimization. The small percentages of respondents for example 37% who faced problems with discrimination, 20% for those who faced harsh and rude language and those who experienced the availability of supplies like medicine 22% could be higher than reported. However, time and resource constraints, was a hinderance. Further, having taken some time to wait for services, the case narrative participants were not willing to wait longer, making the interviews very short. They

were also willing to participate on a different day other than the clinic day only if they were facilitated with an allowance and transport.

5.4 Recommendations

5.4.1 Recommendations for Practice

1. In order to improve the services for the mothers, it may be necessary to have the nursing students distributed to other sub county hospitals within the county to ease the work of the ANC nurses.
2. All health care providers attending to expectant women should be trained on the ethical healthcare provision and patient centered service. They should also be taught the general need to treat the women in a way that encourages the mothers to seek skilled care. They should further be enlightened on the importance of the quality of care to the women to help build mutual understanding on the needs of both providers and the mothers.

5.4.2 Recommendations for Policy

Consent for HIV test is asked for verbally and is perceived by the women as something they have to do. Since many women gave the fear for HIV testing as the possible reason why some women do not seek ANC services, it may be necessary to relook into the HIV and disclosure implementation policy regarding the issue of consent and as a possible hindrance to the utilization of ANC services.

5.4.3 Recommendations for Further Research

Given the limitations of the study regarding the interviews which were done within the hospital premise, the researcher recommends the recruitment of participants to be done in hospital while the administration of the questionnaires and interviews are done out of the hospital. The small percentages of respondents for example 37% who faced problems with discrimination, 20% for

those who faced harsh and rude language and those who experienced the availability of supplies like medicine 22% could be higher than reported.

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Appendices

Appendix I
Consent Form

Investigator: Judith Kibuye.

Introduction

I am **Judith Kibuye** from the Institute of Anthropology, Gender and African Studies, University of Nairobi. I am conducting a study on **THE EFFECTS OF DISRESPECT AND ABUSE OF WOMEN DURING PREGNANCY ON ANC UPTAKE: A CASE OF JARAMOGI OGINGA ODINGA TEACHING AND REFERRAL HOSPITAL IN KISUMU COUNTY**

Purpose: The study seeks to assess the effects of D&A on women seeking Ante Natal Care (ANC) services at the Jaramogi Oginga Odinga Teaching and Referral Hospital, Kisumu County. D&A includes physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and healthcare providers and health system conditions and constraints including lack of medicine, lack of necessary hospital equipment and failure to maintain proper hygiene.

Procedure: If you agree to participate in the study, a structured interview will be administered by the researcher or her research assistants. The nature of the questions will be about the nature and effects of D&A as well as the coping mechanisms employed by women seeking ANC services. There are also questions on your demographic characteristics. Confidentiality will be strictly maintained.

Risks/Discomfort: There is no risk in participating in this study. However, you may experience some discomfort due to the personal nature of the questions, but this will be asked in private and your confidentiality will be maintained at all times.

Benefits: There will be no direct benefit in participating in the study but in case you have any questions the investigator will readily assist you. The study will help in determining the effects of Disrespect and Abuse on women seeking ANC services at the Jaramogi Oginga Odinga Teaching and Referral Hospital in Kisumu County. This will help understand the challenges faced by the women while seeking ANC services and the findings could be used to formulate or review existing policy to improve maternal and neonatal health outcomes.

Confidentiality: Your confidentiality will be maintained at all times. There shall be no mention of names or identifiers in the report or publications which may arise from the study.

Compensation: There will be no compensation for your participation in the study.

Voluntariness: Participation in the study is voluntary. If you choose not to participate, you will not be compelled to. You will also be free to withdraw from the study at any time. However, I humbly request your full cooperation.

Persons to contact: If you have any questions regarding the study, you can contact Judith Kibuye through telephone number 0722442859. You may also contact the JOOTH/ERC/254722453219 or 057-2020801/3/321.

Your participation in the study will be highly appreciated.

I________________________Tel No. _____________________ hereby voluntarily consent to participate in the study. I acknowledge that a thorough explanation of the nature of the study has been given to me by Ms.____________________________________. I clearly understand that my participation is completely voluntary.

Signature____Date_______________________

Signature of Reseacher/Assistant_____________________Date________________________

Appendix II

Structured Questionnaire

SECTION A: MATERNAL CHARACTERISTICS

1. Age (Years):
   18-22 [ ] 23-27 [ ] 28-32 [ ] 33-37[ ] 38-42[ ] 43-48[ ] 49[ ]

2. What is the highest level of schooling you completed? Below primary [ ] Primary [ ] Secondary [ ] College/University [ ] none [ ]

3. What is your religion? Protestant [ ] Catholic [ ] Islam [ ] Traditional Religion [ ] other specify………………..

4. Are you currently living with a partner? Yes [ ] No[ ] What is your current legal marital status? Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ]

5. Which of the following best describes your employment status? Employed [ ] Self-employed [ ] none [ ] others (specify) ……………..

6. In total how many times have you been pregnant? ___ Times. What were the outcome? Live birth [_] Still birth [_] other (specify)___________________

7. Where did you deliver during your last pregnancy? Public facility [ ] Private facility [ ] Home alone [ ] Help of TBA [ ] Others (specify) _______________________________

SECTION B: QUESTIONS ON KNOWLEDGE OF ANC SERVICES:

8. How important is ANC services to expectant women? Very Important [ ] Important [ ] Less Important [ ] Not Important [ ]

9. In your opinion, at how many months should a pregnant woman first visit an ANC clinic? 1 month [ ] 2 months [ ] 3 months [ ]

10. How many times in total should pregnant women attend ANC services? Once [ ] Twice [ ] Thrice [ ] Four times [ ] More than four times [ ]

QUESTIONS RELATED TO THE NATURE OF D&A EXPERIENCED

11. While attending ANC services, have you witnessed or experienced any of the following?

Discrimination based on age/ethnicity/health/socio-economic status [ ]
Harsh or rude language [ ]
Being blamed by nurse/doctor for an outcome [ ]
Lack of informed consent for test and other procedures [ ]
Breaches of confidentiality/privacy [ ]
Request for bribes [ ]
Extortion or unclear hospital fees [ ]

Sexual abuse/harassment [ ]
Dismissal of concerns [ ]
Lack of necessary Supplies at the facility [ ]
Long delays before being attended to [ ]
Poor Physical condition of facilities in facility [ ]
Threats of withholding treatment [ ]
Lack of redress when complaints are forwarded [ ]

Any other form of D&A experienced? --

12. Below is a list of things that might influence your decision about your ideal place for ANC services. Please tick appropriately. VI Very Important, I=Important, NI= Not important

	VI	I	NI
Cleanliness			
Working hospital equipment			
Knowledgeable provider			
Good supply of medicines			
Affordable cost of treatment			
Ability to choose the provider			
Friendly staff at the hospital			

SECTION C: QUESTIONS RELATING TO THE EFFECTS OF D&A EXPERIENCED

13. Do you think D&A could lead to the following? Multiple answers accepted

	Yes	Undecided	No
Life threatening complications			
Poor health of mother and baby			
Stress and mental health problems			
Trigger bad memories for expectant women			
Women getting infections in facility			
High maternal mortality			
Hostile environment for patients			
Demoralizing atmosphere for providers			
Lack of trust and fear in future pregnancies			

Any other effects of D&A experienced? ---

SECTION D: QUESTIONS RELATING TO THE COPING MECHANISMS EMPLOYED

14. Which of the following steps would you consider taking in case you feel mistreated during ANC visits? Multiple response allowed.

Avoid going for ANC services	
Report to authorities	
Seek counselling services	
Go to traditional birth attendant	
Confront the provider	
Skip some ANC visits	
Pay a bribe	
Delay in seeking first ANC services in later pregnancy	
Change the facility being used even for a farther facility	

15 Where did you start your ANC service? JOOTRH [ ] Other [ ]
If not in this facility, why did you change to JOOTRH?

____

16. If here, are there reasons that make you wish to discontinue seeking ANC services here? Please choose as many as possible from the list below

Discrimination based on age/ethnicity/health/socio-economic status [ ]
Harsh or rude language [ ]
Being blamed by nurse/doctor for an outcome [ ]
Lack of informed consent for tests and procedures [ ]
Breaches of confidentiality/privacy [ ]
Request for bribes [ ]
Extortion or unclear hospital fees [ ]
Sexual abuse/harassment [ ]
Dismissal of concerns [ ]
Judgmental or accusatory comments [ ]
Lack of necessary Supplies at the facility [ ]
Long delays before being attended to [ ]
Poor physical conditions in facility [ ]
Threats of withholding treatment [ ]
Lack of redress when complaints are forwarded [ ]

Any other reason? ---

17. Do you think there is a good reason why some women don't seek ANC services at all?

----

18. What should be done to improve the quality of ANC services in this facility?

____

Appendix III:
Case Narrative guide

1. Tell me about what you experienced.
2. How did you feel about the experience?
3. How did that affect you?
4. What did you do about it?
5. How do you cope with such treatment?...
6. If reported, what was done about it?
7. If not reported, why did not report?
8. What should be done to improve the quality of ANC services?
9. What could be done encourage women to seek ANC services?
10. What in your opinion could be done to eliminate the problem of D&A?
11. If you had money, would you come for services here.

Appendix IV:
Consent for Key Informants

Thank you for agreeing to do this interview. The study seeks to assess the nature and effects of D&A on women seeking Ante Natal Care (ANC) services at the Jaramogi Oginga Odinga Teaching and Referral Hospital, Kisumu County. Further the researcher would like to recommendations on interventions to mitigate D&A. Disrespect and Abuse includes physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and healthcare providers and health system conditions and constraints including lack of medicine, lack of necessary hospital equipment and failure to maintain proper hygiene.

The purpose of the interview is to learn more about any experiences in this area of D&A and also get to know your challenges and recommendations which may improve service for the women seeking ANC services.
Everything you tell me is confidential. If you want me to protect your privacy, I will not connect your name with anything you say.
At any time during this interview, let me know if you have any questions or if you don't want to answer some questions.
I hope that the outcome of this research will make things better for the workers as well as the patients. Is it okay if I audiotape this interview?

- What is your position?
- What major responsibilities do you have in your current position
- How long have you been here?

Persons to contact: If you have any questions regarding the study, you can contact Judith Kibuye through telephone number 0722442859. You may also contact the JOOTH/ERC/254722453219 or 057-2020801/3/321.
Your participation in the study will be highly appreciated.
I_________________________Tel No. ______________________ hereby voluntarily consent to participate in the study. I acknowledge that a thorough explanation of the nature of the study has been given to me by Ms.______________________________________. I clearly understand that my participation is completely voluntary.
Signature____Date________________________
Signature of Reseacher/Assistant______________________Date_________________________

Appendix V
Key Informant Interview Guide

Hospital administrator
Nature of D&A

Can you give me an overview of the ANC attendance, the quality of care at the facility and the issue of D&A in your perspective?

What cadres of health workers were involved in these incidences?

In your experience, how common or rare are incidences such as these?

In your opinion, what factors led to or enabled this disrespect and abuse to occur? Prompt: patient characteristics (age, tribe, education, lack of companion, etc), provider characteristics (prejudice, job dissatisfaction, stress, lack of time, etc), facility factors (poor management, lack of standards, lack of accountability, and lack of supervision), policy factors (guidelines, laws, accountability, etc).

Are you happy the work conditions for the Nurses handling ANC patients?

What do you think about the availability of equipment and necessary supplies for the women visiting the hospital for ANC services?

What is the nurse/patient ratio and how does that affect the workload and the efficiency of the nurses attending to ANC

Effects of D&A

How did the subject of the complaint react about the complain?

How did the treatment affect the patient (probe visible and invisible including)?

D&A causes women to skip ANC services or delay first attendance. In your opinion, would this affect the maternal and neonatal health outcomes?

Coping Mechanisms employed

Does the hospital have mechanism for reporting cases of D&A?

Would you know if the women who have complained before continue seeking ANC services?

Are there mechanisms to find out if women who complain continue coming for the ANC services?

Interventions:

Regarding the interventions aimed towards reducing the incidences of D&A…do you have any success stories? If you were to redo the interventions, what would you change?
Any suggestions to improve the general ANC attendance and the quality of care?

Employee of Reproductive health organization

The nature of D&A
There have been a lot of complaints from expectant women mostly in public hospitals of unfriendly treatment in facilities around the country. Have you received any complaints or witnessed patients being mistreated by the provider during ANC attendance and what is the nature of such mistreatment?

In your opinion, what factors enable this disrespect and abuse to occur? Prompt: patient characteristics (age, ethnicity, education, lack of companion, etc), provider characteristics (prejudice, job dissatisfaction, stress, lack of time, etc), facility factors (poor management, lack of standards, lack of accountability, lack of supervision),

What do most people feel about the way expectant women are treated in hospitals? Is that how you feel too?

Effects of D&A

Coping Mechanisms employed by women
Patient empowerment and community engagement is believed to help mitigate the issue of D&A. Do you think this is true? What is your organization doing to empower patients and engage the other stakeholders?

Hospital infrastructure:
How would you rate the hospital infrastructure in terms of necessary supplies and equipment that the women attending ANC services need?

Intervention

Could you tell me about work, if any that the county government has done or is currently doing related to D&A)? *Prompt: the work and location,*

Have you or your organization ever worked on an intervention aimed at reducing the incidences of D&A? If No, have you heard of the Respectful maternity care; the universal rights of childbearing women?
Has your organization ever been involved in ensuring the quality of health worker education? (Nurse/County health officer

Are there any ways of getting feedback from the patients and what is done with the feedback?

Hospital ANC Nurse

How would you rate the work conditions including workload in this facility? Other than attending to the women on a working day, are there other duties that you have to perform?
On average, at what month do they start their ANC attendance?

How is the rate of ANC attendance by the expectant women? By this I mean their ability to honour their appointments. If not good, what in your opinion would be the reason for skipping appointments

Can you take me through the processes that women follow when they come to a facility to for ANC services? Prompt: registration, payment, who's allowed/not, etc.

During these processes, do you think there is a chance of them experiencing any form of D&A?

If so, what exactly did this D&A consist of? Prompt: 7 categories of D&A: Physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, detention

How many women do you attend to on a single day? Is this too much or it is manageable for you? If not do you think this could contribute to the low quality of service that the women complain about?

Are there specific set of procedures and tests that the women have to undergo during their ANC visits? Do you seek their consent for each and every procedure and test? Have there been cases of women complaining about some of the procedures

Have you heard of the Respectful maternity care; the universal rights of childbearing women? Do you think as a facility you comply to this charter?

Do you like the work you do?

How would you rate the general treatment of women during their ANC services in line with the respectful maternity care?

What challenges do you encounter as you do your work? Do you have everything you need to facilitate the smooth running of your work?

What do you think about your work environment?

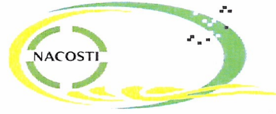
Can you talk me through the process that women would go through when they come to a facility for ANC services? Prompt: registration, Lab, who's allowed/not, etc.

Do you think there are some patient characteristics that frustrate you as you do your work? Age, education, impatient ones

Are there factors that hinder you from giving the quality of care you would want to give?

Appendix VI

Ethical Clearance letters



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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2241349,3310571,2219420
Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/19/26722/27979**

Date: **6th February, 2019**

Judith Auma Kibuye
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "***Disrespect and abuse of women during pregnancy and its effects on the utilization of antenatal care services: A case of Jaramogi Oginga Odinga Teaching and Referral Hospital in Kisumu County***" I am pleased to inform you that you have been authorized to undertake research in **Kisumu County** for the period ending **5th February, 2020.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Director of Health Services, Kisumu County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Kisumu County.

Ethical Clearance: JOOTRH

Telegrams: "MEDICAL", Kisumu
Telephone: 057-2020801/2020803/2020321
Fax: 057-2024337
E-mail: ercjootrh@gmail.com
When replying please quote

Ref: ERC.IB/VOL.3/6

JARAMOGI OGINGA ODINGA TEACHING & REFERRAL HOSPITAL
P.O. BOX 849
KISUMU

Date 12th April, 2019

Judith Auma Kibuye

Dear Judith,

RE: FORMAL APPROVAL OF THE PROTOCOL STUDY ENTITILED:- ***"DISRESPECT AND ABUSE OF WOMEN DURING PREGNANCY AND ITS EFFECTS ON THE UTILIZATION OF ANTENATAL CARE SERVICES: A CASE OF JARAMOGI OGINGA ODINGA TEACHING AND REFERRAL HOSPITAL IN KISUMU COUNTY"***

The JOOTRH ERC reviewed your protocol and found it ethically satisfactory. You are therefore permitted to commence your study immediately. Note that this approval is granted for a period of one year (w.e.f. 12TH April, 2019 to 12th April, 2020 If it is necessary to proceed with this research beyond approved period, you will be required to apply for further extension to the committee.

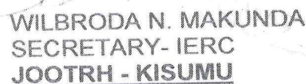
Also note that you will be required to notify the committee of any protocol amendment(s), serious or unexpected outcomes related to the conduct of the study or termination for any reason.

In case the study site is JOOTRH, kindly report to the Chief Executive Officer before commencement of data collection.

Finally, note that you will also be required to share the findings of the study in both hard and soft copies upon completion.

The JOOTRH – IERC takes this opportunity to thank you for choosing the Institution and wishes you the best in your future endeavours.

Yours sincerely,



WILBRODA N. MAKUNDA
SECRETARY- IERC
JOOTRH - KISUMU

Appendix VII
Authority to Collect Data

COUNTY GOVERNMENT OF KISUMU
DEPARTMENT OF HEALTH

Telephone: 057-2020801/2020803/2020321
Fax: 057-2024337
E-mail: medsuptnpgh@yahoo.com
ceo@jaramogireferral.go.ke
Website: www.jaramogireferral.go.ke
When replying please quote
GEN/21A/V
Ref: ....

JARAMOGI OGINGA ODINGA TEACHING &
REFERRAL HOSPITAL
P.O. BOX 849-40100
KISUMU

15TH APRIL, 2019
Date ....

Judith Auma Kibuye
KISUMU

RE: PERMISSION TO COLLECT DATA

Following approval of protocol titled "Disrespect and abuse of women during pregnancy and its effects on the utilization of antenatal care services in Jaramogi Oginga Odinga Teaching and Referral Hospital", you are hereby permitted to proceed with the activity.

Thank you.

DR. OKOTH PETER.,
CHIEF EXECUTIVE OFFICER,
JOOTRH – KISUMU.