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Attitudes and behaviour of Health Care Workers toward women during childbirth in Zambia

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A mini-thesis submitted in partial fulfillment of the requirements for the degree of Master in Public Health at the School of Public Health, University of the Western Cape

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GLOSSARY OF ACRONYMS AND ABBREVIATIONS

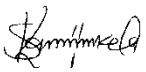
DHD	District Health Director
HIV	Human Immunodeficiency Virus
IRB	Institutional Review Board
MoH	Ministry of Health
RMC	Respectful Maternity Care
SAMRC	South African Medical Research Council
SPSS	Statistical Package for Social Science
WHO	World Health Organization
WCA	Women of Childbearing Age

KEYWORDS

- Respectful maternity care
- Women's rights
- Health services
- Confidentiality
- Dignity
- Informed consent
- Childbirth
- Perinatal period
- Safe motherhood
- Zambia

DECLARATION

I, Kanonkela Shindon, declare that this thesis, entitled, **"Attitudes and behaviour of Health Care Workers toward women during childbirth in Zambia"** is all my work, and through complete references, all the sources quoted and used have been appropriately acknowledged in this research study. I further affirm that this research study has not been submitted anywhere for any other degree save for this one.



Researcher's signature

22/10/2021
Date

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DEDICATION

I sincerely dedicate this thesis to all family members who accommodated and supported me during this study in one way or another. Above all, may God get all the honour and glory for this milestone of my life.

ABSTRACT

Background: In recent years, the Chipata district has been making progress in promoting Respectful Maternity Care (RMC) implementation, with great emphasis on its underlying principles of ethics and psycho-sociocultural aspects as critical ingredients of care. RMC approach is individual-oriented and is based solely on the understanding of ethics and respect for human rights. Additionally, this approach utilizes evidence-based practices that recognize the needs and preferences of women and that of their newborns. Unfortunately, disrespectful and abusive care during childbirth has been found to discourage women from having their babies delivered by qualified health care workers, a practice that is essential in reducing maternal and neonatal mortalities. However, lacking are studies in the Chipata district that describe the prevalence of disrespectful and abusive maternity care.

Aim: This study aimed to assess the magnitude and patterns of disrespectful and abusive care among health care workers toward women during childbirth in Chipata district, Zambia.

Methodology: This cross-sectional analytical study utilised a quantitative method using face-to-face structured questionnaires with postnatal mothers. Statistical Package for Social Sciences (SPSS) software version 25 was used to analyze both descriptive and analytical data. The magnitude of disrespect and abuse was measured in reference to the seven categories of disrespect and abuse and their respective verification criteria as exemplified in the RMC Charter.

Results: Of the 243 mothers enrolled in the study, at least 19% experienced some form of disrespect and abuse during childbirth. Those at risk of mistreatment were younger and less educated women, which signified inequalities in how providers treated women during childbirth. Non-consented care [27%], non-dignified care [33%], and detention in facilities [38%] were frequently reported by all the women. Primary determinants of non-dignified care were level of education [$\alpha = 0.05$, $\chi2(3) = 17.61$, $p < .001$,], and status of employment [$\alpha = 0.05$, $\chi2(2) = 6.55$, $p = .038$]. On the other hand, employment status was also associated with physical abuse [$\alpha = 0.05$, $\chi2(2) = 6.73$, $p = .035$]. There were no apparent associations between disrespectful and abusive care and some socio-demographic characteristics such as age, parity, marital status, and Human Immunodeficiency Virus (HIV) status.

Conclusion: The magnitude and patterns of disrespect and abuse highlighted in this study represent a blatant violation of childbearing human rights, devoid of psycho-sociocultural consideration. Woman-centered care should be promoted and provided in a culturally appropriate and respectful manner. This can only be achieved when care providers adhere to the ethics and dictates of RMC. The study has shown that awareness of RMC by both mothers and providers is key in revitalizing the provider-client relationship during delivery. This will largely contribute to the betterment of the childbearing experience and reduce the mistreatment and its associated preventable maternal and neonatal mortalities.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

Maternal mortality is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site (intra or extrauterine) of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Alkema *et al.*, 2016). Maternal mortality raises a lot of concerns because it usually occurs [99%] among women who are poor and marginalized and is almost always manageable or preventable (McMillian, 2012). The leading causes of maternal mortality are haemorrhages, hypertensive disorders (eclampsia), sepsis, unsafe abortion, and obstructed labour. Evidence, however, shows that these conditions can be managed and prevented if skilled birth attendants and healthcare facilities with adequate infrastructure and supplies are available (Prata *et al.*, 2010). In 2019, Zambia recorded a high number of maternal and perinatal deaths, which prompted the Zambian President to declare maternal and perinatal mortality as a public health emergency (Kalobwe, 2019). This declaration coincided with both the Health Ministry's plan to strengthen RMC and the 2017 – 2021 National Health Strategic Plan (NHSP), which also focuses on the reduction of maternal deaths to less than 100 per 100 000 live births and infant deaths to less than 15 per 1000 live births by 2021 (Ministry of Health, 2017).

Several interventions to prevent these deaths were put in place by the Zambian Ministry of Health (MoH) and included improved and well-coordinated referral systems, improved access and expansion of maternal and neonatal health services such as Emergency Obstetric and Neonatal Care (EmONC), expanded use of Family Planning for birth spacing, criminalization of early marriages, and increasing the number of skilled birth attendants, especially midwives (Ratcliffe, 2013; Tunçalp *et al.*, 2015). While these interventions are appropriate, less attention was given to RMC and the quality of rapport that should be promoted before and during delivery between mothers and health care providers (Abuya *et al.*, 2015). Safe motherhood should not only focus on the prevention of infant and maternal mortality but also incorporate women's fundamental human rights (Bowser and Hill, 2010; Solnes Miltenburg *et al.*, 2018). During childbirth, the experiences of women with health care providers can motivate and empower or leave lifelong emotional trauma and pain (Koblinsky *et al.*, 2016).

According to the Zambia Demographic Health Survey (ZDHS), 83.8% of births in Zambia take place in a health facility, of which 80.4% are assisted by skilled health workers (ZSA, MOH and ICF, 2019). In light of this, the government of Zambia seeks to strengthen respectful maternity care to not only increase institutional deliveries but also as a conduit for improved delivery of maternal and child health services. Lack of respectful care from providers may lead to frustration of mothers with a diminished likelihood of seeking maternity care services in the future. Health care providers' attitudes and behaviour can influence women's perception of maternal health care services either positively or negatively (Orpin *et al.*, 2018; O'Connor, McGowan and Jolivet, 2019). It can be concluded from the above that disrespectful and abusive care affects the utilization of maternal health services at all levels of care, thus compromising the achievement of Sustainable Development Goal number three.

1.2 Problem statement

Pregnancy and childbirth bring untold happiness to the lives of women and their families, evidenced by a deeper sense of personal and social significance. Supporting women during and after delivery is, therefore, essential for their well-being and that of their newborns. However, evidence in Zambia suggests that health care providers rarely provide respectful care explicitly due to the normalization of abuse and mistreatment during childbirth (Smith *et al.*, 2020). Care during birth should take into account the aspect of basic human rights, namely; "the right to the highest attainable standard of health, the rights to respect, dignity, confidentiality, information, and informed consent; and freedom from discrimination and all forms of ill-treatment" (Azhar, Oyebode and Masud, 2018; Ayoubi *et al.*, 2020). It is believed that women who encounter disrespectful and abusive maternity care during delivery are not likely to seek health care or deliver in the same health facility in the future (Mulenga *et al.*, 2018). These women will instead deliver at home and increase the chances of maternal and neonatal complications (Sacks, 2017; Sacks *et al.*, 2017; Wassihun and Zeleke, 2018). Disrespectful and abusive maternity care during childbirth presents in many forms or patterns and includes; "physical abuse, non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific attributes, abandonment or denial of care, and detention in facilities" (White Ribbon Alliance and RMC Advisory Council, 2011). These vices discourage women from seeking care in health facilities. Assessing the availability or lack of respectful maternity care among women

during childbirth is, therefore, important for monitoring the quality of care provided by health care workers during the perinatal period (Denny, 2018; Morton and Simkin, 2019). Despite the overwhelming evidence of these practices in many health facilities and their negative impact on the global goal of reducing maternal mortality, no studies have been done in Chipata district to uncover the extent of disrespectful and abusive care against women during childbirth. This study, therefore, seeks to assess the magnitude and patterns of disrespect and abuse that women experience during childbirth.

1.3 Purpose of the study

This study will facilitate a greater understanding of RMC and increase women's awareness of RMC rights, needs, and opinions on their health and the health services available to them. Having a specific focus on facility-based birth will encourage them to demand change from decision-makers and health care providers. It will further contribute to the development of effective strategies to combat abusive and disrespectful care in many health care facilities as well as barriers to RMC. Above all, this study will provide a ground for holding communities and the maternal health care system accountable to RMC rights and align women's rightful privilege to high-quality maternal care during childbirth with international community standards of human rights. Lastly, this study will contribute to the rise in institutional deliveries as more women will be willing to deliver from health facilities without fearing unwarranted mistreatment from health care providers.

1.4 Outline of the Mini-thesis

Section	Scope
Chapter 1	Introduces the thesis, provides the background to the research, problem statement, and discusses the aim and objectives of the study.
Chapter 2	Reviews the relevant literature on the research topic from appropriate authors, journals, newspapers, and other related studies.
Chapter 3	Presents the methodology that was used in this research.
Chapter 4	This chapter gives a detailed report of the study findings.
Chapter 5	This chapter provides a detailed discussion of the study findings.
Chapter 6	This chapter summarizes the study and offers recommendations based on the study findings

CHAPTER TWO: LITERATURE REVIEW

This literature review will focus on the following themes; the burden of disrespect and abuse during childbirth, underlying causes of disrespect and abuse during childbirth, its effects, and the strategies or interventions used around the world to lessen or prevent disrespect and abuse of women during labour and delivery.

2. 1 Overview of disrespectful and abusive maternity care

Respectful maternity care is a "universal human right that is due to every childbearing woman in every health system around the world, which demonstrates the legitimate place of maternal health rights in the broader context of human rights" (Windau-Melmer, 2013). The importance attached to the life of women and their universal right to dignified care has motivated several studies that have been done from different perspectives locally and internationally to uncover issues surrounding disrespect and abuse of women during childbirth (Denny, 2018).

2.1.1 The burden of disrespectful and abusive care during childbirth

Focusing on the status of RMC in Zambia and the world over, studies have demonstrated that disrespectful and abusive care against women is very prevalent during childbirth in most parts of the world, with some reporting prevalence of as high as 91.7%. Amongst the most commonly reported abuses during delivery include culturally inappropriate care (75.2%), not allowing the client to ask questions (75.9%), healthcare provider's inability to introduce themselves (80.0%), not obtaining consent before any procedure (63.8%) and inability to use curtains or visual barriers to protect the client (81.7%) (Okafor, Ugwu and Obi, 2015; Atai *et al.*, 2018; Denny, 2018; Mulenga *et al.*, 2018; Nyirenda *et al.*, 2018; Baranowska *et al.*, 2019; Bekele, Bayou and Garedew, 2020; Sacks and Peca, 2020; Smith *et al.*, 2020).

Evidence suggests that most women experience physical abuse from service providers during delivery and are not accorded a chance to choose their preferred position during birth which is tantamount to non-dignified care (Ratcliffe *et al.*, 2016a; Azhar, Oyebode and Masud, 2018; Betron *et al.*, 2018; Solnes Miltenburg *et al.*, 2018; Giordano and Surita, 2019). Other critical issues highlighted in the above studies include women being left unattended during labour and delivery, the service provider not responding to women's needs timeously, and women being detained in the health facility. The findings further suggest that women's right to confidentiality

and privacy are not respected, and on average, close to 31% of women are not dignified during delivery and are discriminated against based on specific attributes (Nyirenda *et al.*, 2018). In another study that explored the evidence for disrespect and abuse in facility-based childbirth, seven types or forms of disrespect and abuse that women encounter during labour were described, repeatedly occurring from indirect disrespect and humiliation to explicit violence (Bowser and Hill, 2010). This view is also supported by Reis *et al*. (2012), in a survey report focusing on country-specific experience on respectful maternity care, which identified critical areas of disrespect and abuse with their associated factors. These areas were associated with the policy, standards of practice in health care facilities and societies, health care management, infrastructure and resources, ethics and culture, skills, attitudes, and knowledge (Reis *et al.*, 2012; Rosen *et al.*, 2015).

Furthermore, in-depth interviews with postpartum women in a study that focused on "developing a tool to measure women's perception of respectful maternity care in public health facilities" revealed the prevalence of specific forms of abuse and disrespect. Women reported physical abuse, and non-consented care was so frequently observed that it was normal for any procedures to be carried out without obtaining consent from mothers. Non-dignified care such as yelling at women for making noises due to labour pains and not attending antenatal care services was also reported (Sheferaw, Mengesha and Wase, 2016; Sheferaw *et al*., 2017).

2.1.2 Underlying causes of disrespect and abuse during childbirth

To successfully direct appropriate interventions towards promoting respectful maternity care, we must identify and target the specific causes and underlying factors for disrespect and abuse. In their landscape analysis, Bowser and Hill recognize several factors responsible for disrespect and abuse during childbirth. These factors can be categorized into "individual and community, provider, facility, and national systems' factors" using an ecological framework model (Bowser and Hill, 2010; Ratcliffe, 2013). The framework below (Figure 1) presents an ecological model of interrelated concentric circles to demonstrate the relationships between personal and systems-level factors that influence the delivery of respectful maternity care. Respectful Maternity Care is affected by various systems, including individual and community beliefs and behaviours, provider training and attitudes, facility subsystems, and the central government health system and policies. Each of these system-level factors is complex and is similarly influenced by the other systems

surrounding it (Ratcliffe, 2013). It is, therefore, essential to consider the broader context of various levels when designing and selecting RMC interventions for them to be appropriate for any given setting as none exists in a silo.

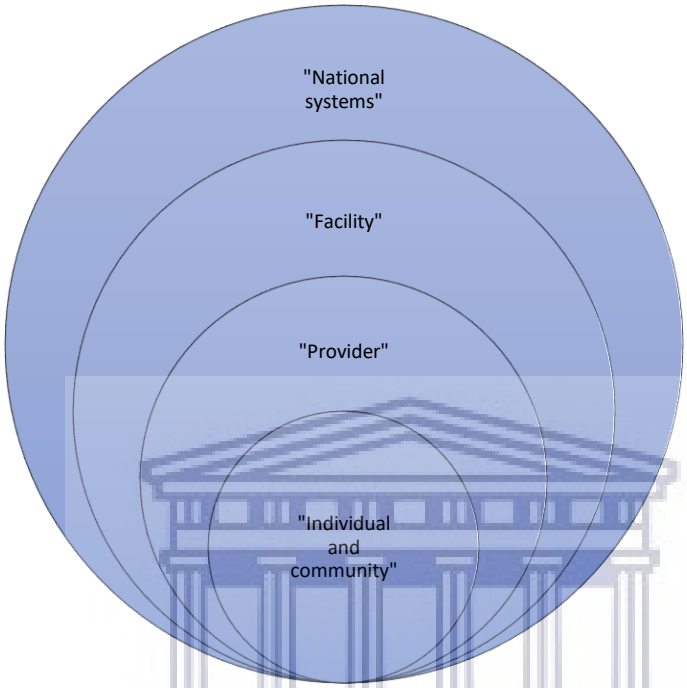

Figure 1: Framework of risk factors for disrespect and abuse during childbirth (Adapted from Ratcliffe, 2013)

As shown in the figure above, individuals and communities are at the center of the framework. Disrespectful and abusive care in this category is associated with inadequate community engagement and oversight, financial challenges, lack of autonomy and empowerment of women, and the normalization of mistreatment during childbirth (Díaz *et al.*, 2002; Bangser *et al.*, 2011; Warren *et al.*, 2012). At the provider level, risk factors may include provider prejudice based on specific attributes such as the client's age. This creates a disconnection between delivering staff and mothers that deliberately overemphasizes medical treatment without regard for interpersonal care, thus increasing the chances of disrespectful and abusive provider practices (Jewkes, Abrahams and Mvo, 1998; Matthews *et al.*, 2010; Leape *et al.*, 2012a). This level also encompasses provider status and respect, poor working conditions due to weak health systems, lack of professional growth opportunities, and shortages of health care personnel (D'Oliveira *et al.*, 2002; Leape *et al.*, 2012b).

At the facility level, disrespectful and abusive care is associated with aspects of management and supervision such as incompetent leadership and supervision for respectful maternity care. Other factors include inadequate accountability procedures and mechanisms such as client complaint boxes, incident reports, or client charters which are the basis for holding providers accountable for the quality of care they provide; and poor infrastructure, inadequate supplies, and shortage of care providers that can significantly contribute to disrespect and abuse (D'Oliveira *et al.*, 2002; Miller *et al.*, 2003; Leape *et al.*, 2012b). Lastly, national systems are the last level of the ecological model. This includes health systems, laws, and policies. Lack of existence or enforcement of these laws and policies in promoting adherence to ethical and human rights principles plays a role in the normalization of disrespect and abuse during childbirth (Fathalla, 2006; White Ribbon Alliance, 2011).

2.1.3 Effects of disrespectful and abusive care during childbirth

In a landscape report, it was noted that among the problems that women have concealed under the veil of silence during childbirth that has significantly impacted the willingness of women to seek out high-quality maternity care is disrespectful and abusive care by providers (Bowser and Hill, 2010; Orpin *et al.*, 2018; Orpin, Puthussery and Burden, 2019). This view is supported by another study conducted in Zambia, which focused on women's childbirth experiences. This study also observed that disrespectful and abusive care during delivery plays a role in maternal mortality (Kwaleyela, Greatrex-White and Walsh, 2019; ZSA, MOH and ICF, 2019). The study further suggested that until Zambian women are provided with maternity care that embraces both physical and psychological dimensions of childbirth, high levels of maternal mortality will continue. The mistreatment of women by providers has also been recognized in some studies as having contributed to reduced institutional deliveries and, inversely, an increase in home deliveries, a practice that is responsible for high maternal mortality in many developing countries (Maimbolwa, 2004; Ratcliffe *et al.*, 2016; O'Connor, McGowan and Jolivet, 2019). Disrespectful and abusive care during delivery also constitutes an abuse of women's rights to life, self-determination, bodily integrity, and freedom from discrimination and may severely disturb women's mental health and create fear of childbirth (Lukasse *et al.*, 2015; Lokugamage and Pathberiya, 2017). Lastly, there is an erosion of trust and satisfaction in the health care system and providers, resulting in poor service delivery, which puts both the mother and her child at risk (Kowalewski, Jahn and Kimatta, 2000;

Kujawski *et al.*, 2015; Shakibazadeh *et al.*, 2018).

2.1.4 Interventions against disrespectful and abusive care during childbirth

Several studies have addressed the interventions against disrespectful and abusive care during childbirth. These interventions are wide-ranging and include individual/community interventions, provider-centered, facility-focused, and national systems interventions. Evidence suggests that through communication, individual/community interventions such as women's groups increase women's knowledge of their rights by creating a strong voice for accountability (Okafor, Ugwu and Obi, 2015; Kassa and Husen, 2019; Sacks and Peca, 2020). Further, provider-centered interventions emphasize improved staff attitudes and treatment of patients for better outcomes. Evidence suggests that if providers are fully aware of the rights of others across multiple dimensions, they will exhibit the highest levels of empathy for all the mothers under their care, and this will consequently improve their interpersonal relationships (Wassihun and Zeleke, 2018).

Additionally, interventions that are focused on the facility include making childbirth programs more humane by providing targeted personnel training and improved access to health information systems on the one hand (Misago *et al.*, 2001). On the other hand, interventions that focus on national systems include laws and policies that emphasize protection of women's rights to RMC that should be delivered on time whilst promoting, protecting and respecting human rights (Miller *et al.*, 2016). These interventions have the potential to improve respectful maternity care.

In conclusion, this chapter has reviewed relevant literature on Respectful Maternity Care provided to women during childbirth from global, regional and national perspectives. It has further explored the policies, guidelines and laws that promote the establishment and proper delivery of RMC in both developed and underdeveloped countries. Lastly, it examined the burden, underlying causes, effects and interventions against disrespectful and abusive care during childbirth. Based on this literature review, political commitment, adequate resources within the healthcare system, and the attitudes of health care workers emerged as significant factors that impact the delivery of appropriate RMC.

CHAPTER THREE: METHODOLOGY

Research methodology is "an approach used to conduct research systematically and includes the precise steps of the study from conceptualisation to detailed methods of data collection, analysis, and discussion" (Struwig and Stead, 2013; Creswell, 2014). In this chapter, the research approach, design, and methods that were used to address the research objectives are described. This chapter provides the setting, study design, population and sampling, data collection, data analysis, and ethical considerations.

3.1 Study Aim and Objectives

This study aimed to assess the magnitude and patterns of disrespectful and abusive care among health care providers towards women during childbirth.

3.1.1 Objectives

1. To determine the magnitude of disrespect and abuse experienced by women during childbirth.
2. To describe the patterns of disrespect and abuse against women during childbirth.
3. To determine factors associated with disrespectful and abusive care during childbirth.

3.2 Study design

This was a cross-sectional analytical study that utilised a quantitative method. Cross-sectional studies serve many purposes and can be utilised in studies that involve the assessment of disease prevalence, attitudes, or knowledge among patients and health care personnel (Creswell, 2014). The method's appropriateness in this study lies in the fact that it sought to assess and quantify the magnitude and patterns of disrespect and abuse that women experience during childbirth, thus, giving a representative picture of this behaviour and its prevalence at a point in time (Robson and McCartan, 2016).

3.3 Study setting and population

Chipata district lies about 570 km east of Lusaka, Zambia's capital city, with 288,451 people (Central Statistical Office, 2019). The setting for this study was the health centres, both rural and urban, within Chipata district, and included; 26 health centres and 3 hospitals. The health services provided in these health facilities include preventive, curative, promotive, and rehabilitative services. These health facilities offer services such as antenatal, postnatal, family planning, youth-

friendly health services and cross border initiatives, among others. Most of these health facilities (i.e., health centres, health posts, and hospitals) conduct deliveries and have at least one qualified medical practitioner who attends to mothers during childbirth.

Furthermore, these health facilities are divided into five zones with an estimated 63,461 women of reproductive age, from whom 15,577 pregnancies and 15,000 deliveries are expected per year (Chipata District Health Office, 2019). These health facilities have different catchment populations based on their locality and population density. The study sites only included health facilities that conduct deliveries in the district. The study population was the postnatal mothers aged 18 – 49 years who are residents of Chipata and delivered in health facilities within four weeks before data collection.

3.4 Inclusion and exclusion Criteria

The inclusion criteria included women of childbearing age (18 – 49 years) who had a normal delivery in the health facility and were less than thirty days post-delivery (women who gave birth between 15 February and 15 March 2021) before data collection. These women were residents of the Chipata district regardless of their geographical locations. Women who delivered under a high-cost plan or were attended to by private health care providers and/or underwent special procedures during delivery were excluded from the study.

3.5 Sampling and sample size

The Chipata district under the Ministry of Health is divided into five zones with approximately six health facilities per zone. These zones were treated as clusters, and a multistage cluster sampling strategy was used with the aid of a simple random sampling method. The sampling stages included: zone stage (primary unit where three zones were randomly selected), facility stage (secondary unit where three health facilities were randomly selected from each zone), and participant stage (tertiary unit where the appropriate number of participants was randomly selected from the nine health facilities to make up the sample size). The sample size was calculated with the help of Epi Info StaCalc for “sample size and power” under the population survey. The projected expected deliveries for the Chipata district for 2020 was about 15000, out of which 80%, according to Zambia Demographic Health Survey (2019), were expected to be assisted by skilled health care providers. Therefore, given that: N (Number of expected deliveries for women of childbearing age

(WCA) was 15000, the expected frequency was 80%, an acceptable margin of error was 5%, cluster sampling design effect was 1, and clusters were 9 (based on the nine health facilities from where the participants were drawn), the sample size came to 243. In order to account for the lost data and those who could not provide answers to some sections of the questionnaire, I increased the sample to 270. Each health facility, therefore, contributed 30 participants to the overall sample size.

3.6 Data collection and processing

Data collection was conducted during the period of the COVID-19 pandemic. We, therefore, observed all public health measures that the Zambian government had put in place based on the World Health Organization (WHO) recommendations. These measures included social distancing, the mandatory wearing of face masks, and frequent washing of hands or hand sanitising (World Health Organization, 2020). One-to-one interviews were conducted using structured questionnaires, which made it easier to collect large amounts of information from a large sample of people in a quicker, cheaper, and efficient way. These interviews took place in private rooms and open spaces where social distance (1 meter) and privacy were guaranteed. The questionnaire was formulated based on the RMC Charter, a guide for advocating for RMC (Windau-Melmer, 2013). Nine research assistants who were trained and oriented on the protocol and data collection procedures collected data from participants who were enrolled through their consent from all the study sites. The training involved reviewing the questionnaire with them carefully and modifying it where it was necessary. Health Care Workers were not included among Research Assistants/interviewers due to conflict of interests. Excluding them was done to prevent biases that might be introduced into the study due to their dominant position in the health care system. Preference was therefore given to school leavers and non-health workers.

Pretesting of the questionnaire was done with five people from all study sites before the actual data collection to identify unanticipated problems and put possible solutions in place. It included reviewing and checking for completeness of fields, inconsistencies in responses, and how well skip patterns were working. Data collection protocols included the following:

- An introductory letter to participants regarding the nature of the study and the study purpose,
- A script for interviewers to create a trustworthy relationship with participants during the study,

- Instructions for recruiting and enrolling participants in the study,
- Instructions on the administration of the questionnaire, especially that there were multiple data collectors/interviewers,
- Ways that interviewers should handle challenging encounters with participants,
- Ensuring data entry quality checks by checking several records against the completed survey instrument for accuracy,
- Double-entry of data to prevent and eliminate errors.

3.7 Data Analysis

The collected data were checked, coded, cleaned, and analysed using SPSS version 25. Univariate descriptive analyses were used to summarise the findings. All predictor variables, which included age, education level, employment status, HIV status (self-reported), and parity, were summarised using frequencies. Key outcome variables included "physical abuse, non-consented care, non-confidential care, non-dignified care including verbal abuse, discrimination based on specific attributes, abandonment or denial of care and detention in facilities". Chi-square ($\chi 2$), a non-parametric statistic test, was used to provide information on the significance of the observed differences between variables and provided detailed information on exactly which predictor variable(s) accounted for any discrepancies found in the categories of disrespect and abuse. Cramer's V test was only used to measure the statistical strength of the observed differences between variables. Thus, a Chi-square test of independence was conducted to examine whether disrespectful and abusive care was significantly associated with some socio-demographic characteristics of participants.

3.7.1 Measures and scoring

3.7.1.1 Outcome variables

Disrespectful and abusive care during childbirth was the main outcome variable in this study, based on indicators classified under the seven behavioural and attitudinal categories (Table 1). An 'overall count of values within cases' was constructed by adding the scores for relevant items in each category of disrespect and abuse to be able to affirm whether or not there was abuse during childbirth. All "positive" items were rephrased to "negative" and coded for consistency where '0' referred to 'experienced abuse' and '1' to 'not abused'. This meant that the total scores of halves

or more for each category affirmed the presence of abuse (Table 1). The same procedure was repeated for the 'individual categories' for each type of behaviour.

3.7.1.2 Predictor variables

Several variables were considered as factors that may be associated with disrespect and abuse during childbirth. These included age, parity, marital, education, employment, and HIV status.

Table 1: **Scoring for disrespectful and abusive care**

CATEGORY OF DISRESPECT AND ABUSE	ITEMS OF THE QUESTIONNAIRE	MEASURE OF ABUSE
Physical abuse	9, 10, 11, 12, and 13	3 or more affirmative responses
Non-consented care	14, 15, 16, 17, 18, 19, 20, and 21	4 or more affirmative responses
Non-confidential care	22, 23, 24, and 25	2 or more affirmative responses
Non-dignified care (including verbal abuse)	26, 27, 28, and 29	2 or more affirmative responses
Discrimination based on specific attributes	30 and 31	1 or more affirmative responses
Abandonment or denial of care	32, 33, 34, and 35	2 or more affirmative responses
Detention in facilities	36 and 37	1 or more affirmative responses

3.8 Validity

Robson and McCartan (2016) suggest several ways of ensuring validity in a study. To prevent selection biases, I obtained a representative sample using a multistage cluster sampling strategy with the aid of the simple random sampling method in which every participant stood an equal chance of being included. I also ensured that participants correctly satisfied the inclusion and exclusion criteria and adjusted for factors that might affect the outcomes, such as age. I also recognised the degree to which the results might apply only to specific groups or particular circumstances. To eliminate or minimise possible measurement biases, pretesting the questionnaire was done to ensure that it measured what it was meant to measure. Furthermore, data collectors (Research Assistants/Interviewers) were thoroughly trained and oriented to the tool and the procedures to not inadvertently introduce errors into the study (Creswell, 2014; Robson

and McCartan, 2016). Lastly, data was thoroughly double-checked during and after collection and during entry and analysis for accuracy.

3.9 Reliability

The researcher ensured the reliability of the study by using the questionnaire correctly and consistently so much that if it were used by a different observer on the same client, the results would still be the same (Creswell, 2014). Questions were also phrased and asked similarly across all participants. To ensure internal consistency, the questionnaires were sent out at the same time, thus, preventing confounding variables, and were carefully devised in such a way that respondents answered the same for each part or questions that were designed to measure the same thing. Questions that intended to reflect the same concept were carefully formulated so that if you randomly split the results into two halves, there was still a strong correlation between the two sets of results (Robson and McCartan, 2016). In addition, to identify any disparity in the instrument and ensure consistency, the principal investigator reassessed 5% of the questionnaires and compared the outcome.

3.10 Generalizability

Generalization refers to "the extent the findings of a study hold for variation of populations and settings" (Creswell, 2014). The findings of this study applied to this study's population only. However, it is hoped that the findings may be replicated in similar settings within and outside the district.

3.11 Ethical consideration

The Biomedical Research Ethics Committee of the University of Western Cape approved the proposal and provided ethical clearance. Since this research was conducted in Zambia, local ethical clearance from an Institutional Review Board (IRB) was also needed. Ethics clearance was, therefore, obtained from Eres Converge IRB. Permission for data collection was sought from the District Health Director (DHD) in charge of the study setting. Participants in this study were informed that participation was voluntary and was at liberty to refuse or discontinue participation at any stage without any consequence. We obtained written informed consent from all participants and assured them of the confidentiality of their individual information. All the information collected in this study will be safely and securely stored for five years, and only then will it be

destroyed. To protect participants' identities, names were replaced with study identification numbers.

Furthermore, some participants might have described disrespectful incidences linked to a health care provider, and their identity might readily be ascertained or associated with the information. To ensure the protection and confidentiality of the identity of such a health care provider, only the research team and other authorized individuals had access to the data at all times. Additionally, it was anticipated that the research would not harm the participants. There were no instances that required any form of support to any participant arising from their involvement in this research. However, all the study sites had medical staff and psychosocial counsellors who were ready to assist if needed.

CHAPTER FOUR: FINDINGS

This chapter presents the findings of this study that drew on relevant extracts from the Respectful Maternity Care Charter, a policy perspective that legitimizes maternal health rights within the broader context of human rights. Seven types or forms of disrespect and abuse, as highlighted and reported by Bowser and Hill (2010) in their landscape analysis, were used to assess the magnitude and patterns of disrespect and abuse endured by women at the time of delivery in the clinics and hospitals. The categories of disrespect and abuse used included "physical abuse, non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific attributes, abandonment or denial of care and detention in facilities" (see Table 2).

Table 2: **Categories of disrespect and abuse, with examples from Browser and Hill (2010)**

	Category of Disrespect and Abuse	**Corresponding Right**
1	Physical abuse	Freedom from harm and ill-treatment
2	Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
3	Non-confidential care	Confidentiality, privacy
4	Non-dignified care (including verbal abuse)	Dignity, respect
5	Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
6	Abandonment or denial of care	Right to timely healthcare and the highest attainable level of health
7	Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

4.1 Demographic characteristics

The study successfully administered 243 questionnaires, and they were all completed, resulting in a 100% response rate.

Table 3: **Demographics of study participants (n-243)**

Variable	*Number (n=243)*	*%*
Age		
18-24 years	110	45.3
25-34 years	97	39.9
35-44 years	31	12.8
45-49 years	5	2.1
Parity		
1	74	30.5
2	77	31.7
3	48	19.8
4+	44	18.1
Marital status		
Never married	46	18.9
Living together	5	2.1
Married	176	72.4
Divorced/ Separated	14	5.8
Widowed	2	0.8
Education Levels		
Never been to school	10	4.1
Primary	86	35.4
Secondary	130	53.5
Tertiary	17	7.0
Employment		
Employed	33	13.6
Self-employed	74	30.5
No employment at all	136	56.0
HIV status		
Positive	32	13.2
Negative	178	73.3
Does not know	12	4.9
Cannot share	21	8.6

Table 3 above shows that the most frequently observed age category was 18-24 years (*n* = 110, 45.3%), and for parity, it was two (*n* = 77, 31.7%). The majority of the participants were married (*n* = 176, 72.4%). The most frequently observed education category was secondary schooling (*n* = 130, 53.5%), while for employment, many reported being unemployed (*n* = 136, 56.0%). Many participants reported being HIV negative (*n* = 178, 73.3%) when asked about their status.

4.2 Magnitude of disrespect and abuse

Women were asked about their experiences during childbirth concerning each of the categories of disrespect and abuse using the performance standards of respectful maternal care indicators. The findings were as follows:

4.2.1 Physical abuse

In this category, women recalled the rough treatment they received from labour and delivering staff. The 7% in the pie chart below constitutes the overall percentage of women who reported being physically abused during childbirth by health care providers in different ways, as shown in Table 3.

Figure 2: Distribution of women that experienced physical abuse from health providers

Table 4: **Types of physical abuse women experienced from health providers (n=243)**

The provider demonstrated care in a cultural way		
	Frequency	Percent
No	65	26.7
Yes	178	73.3
The provider talked positively about pain and provided relief as necessary		
	Frequency	Percent
No	29	11.9
Yes	214	88.1
The provider used physical force or abrasive behaviour		
	Frequency	Percent
No	225	92.6
Yes	18	7.4
The provider physically restrained you during labour		
	Frequency	Percent
No	161	66.3
Yes	82	33.7
The provider denied you food or fluid in labour when it was not medically necessary		
	Frequency	Percent
No	195	80.2
Yes	48	19.8

Based on Table 4 above, 26.7% of women affirmed that the health provider did not demonstrate caring culturally; 11.9% of the women were not talked to about pain, and pain relief was not provided. Additionally, 7.4% of women agreed that the provider used physical force or abrasive behaviour; 33.7% of participants agreed that the provider physically restrained them during childbirth, and 19.8% indicated that they were denied food or fluid in labour when it was not medically necessary.

4.2.2 Non-consented care

In this category, women recalled and confirmed that they did not give consent to the care that they received from health care providers during childbirth. The overall results, as shown in Figure 3 below, indicates that 27% of all participants received non-consented care from the service provider in various ways, as described in Table 5.

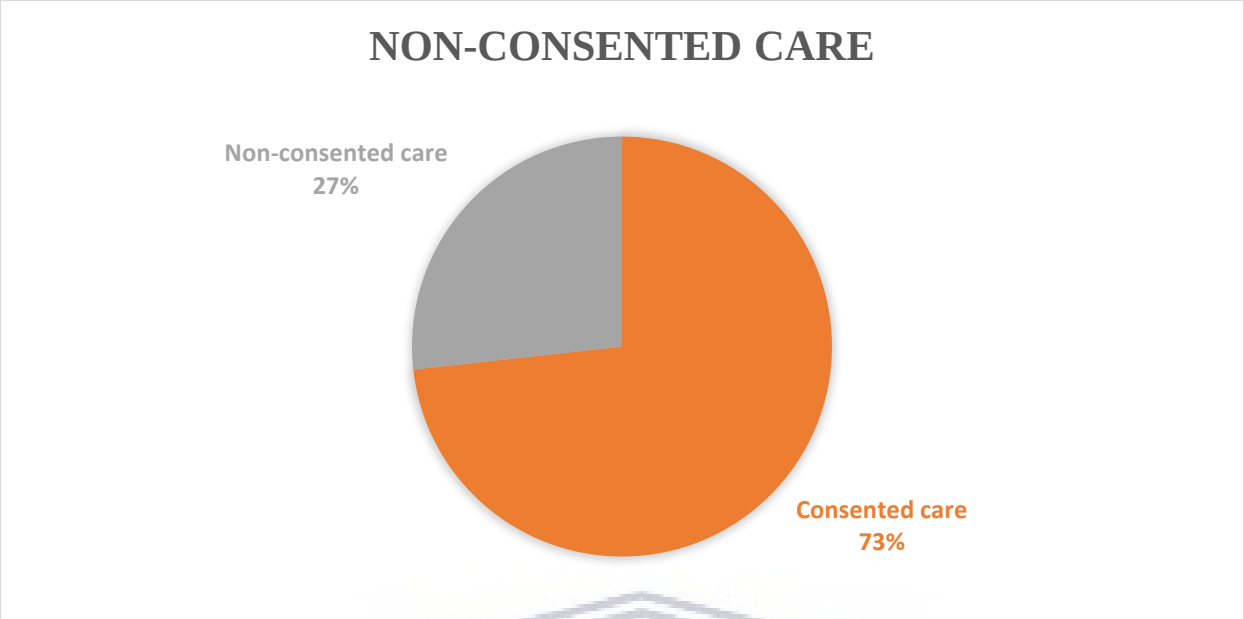

Figure 3: Distribution of women that experienced non-consented care from health providers

The frequency of non-consented care was as demonstrated in the table below.

***Table 5:* Types of non-consented care women experienced from health providers (n=243)**

The provider introduced him/herself		
	Frequency	Percent
No	71	29.2
Yes	172	70.8
The provider encouraged you and/or your companion to ask questions		
	Frequency	Percent
No	44	18.1
Yes	199	81.9
The provider allowed you to move about and assume the position of choice during birth		
	Frequency	Percent
No	149	61.3
Yes	94	38.7
The provider encouraged your companion to stay with you whenever possible		
	Frequency	Percent
No	116	47.7
Yes	127	52.3

The provider obtained consent before any procedure		
	Frequency	Percent
No	114	46.9
Yes	129	53.1
The provider explained what was being done and what to expect throughout		
	Frequency	Percent
No	63	25.9
Yes	180	74.1
The provider responded to questions with promptness and politeness		
	Frequency	Percent
No	45	18.5
Yes	198	81.5
The provider gave periodic updates on the status and progress of the labour		
	Frequency	Percent
No	59	24.3
Yes	184	75.7

As shown in Table 5, it is evident that 29.2% of women did not know the kind of providers they were dealing with during childbirth due to lack of introduction. In addition, 18.1% of participants and their companions were not encouraged to ask questions; 61.3% of participants were not allowed to move about and assume their preferred position during birth. In addition, 47.7% of women agreed that their companion was not encouraged to stay with them whenever possible; 46.9% of participants affirmed that the provider did not obtain consent or permission before conducting procedures. Furthermore, 25.9% did not receive an explanation about what was being done and what to expect throughout childbirth. About 18.5% of women were not given responses to questions with promptness and politeness by providers, and about 24.3% were not updated periodically on the status and progress of labour.

4.2.3 Non-confidential care

This category refers to a lack of privacy due to the absence of curtains or other visual barriers to protect the woman during examinations and how personal information, including files, was kept. Overall, about 12% of participants received non-confidential care, as shown in Figure 4. The forms of non-confidential care that the women received are further explained in Table 6.

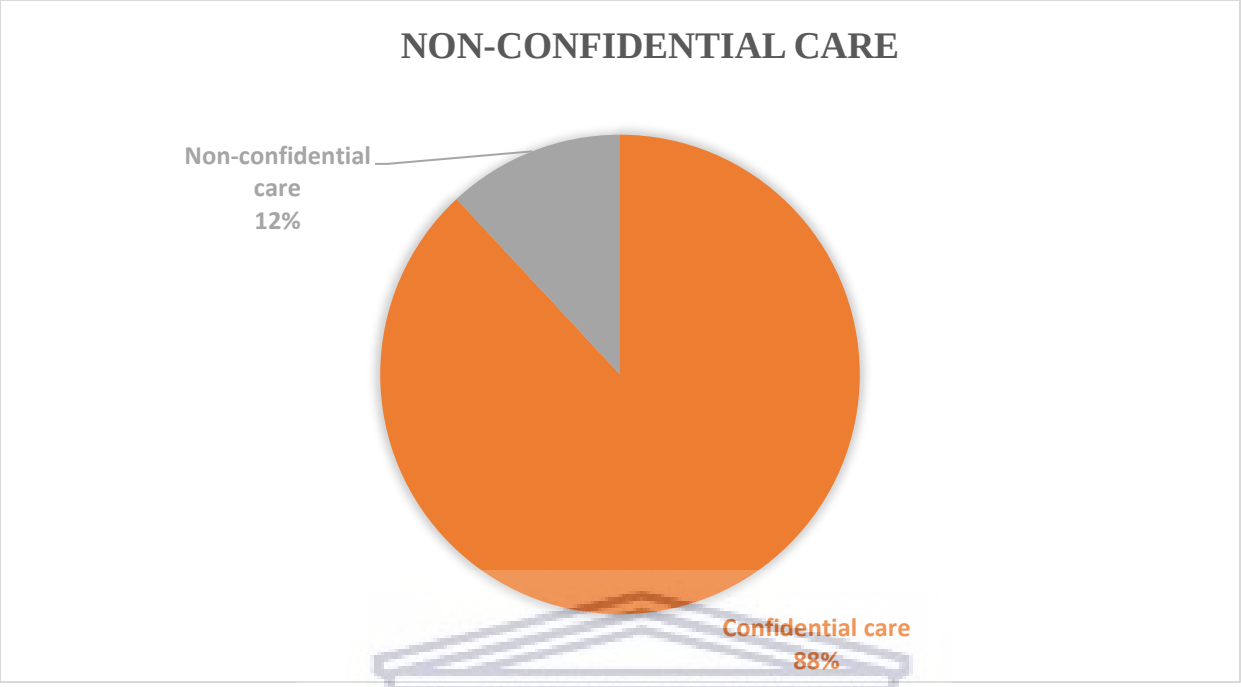

Figure 4: Distribution of women that experienced non-confidential care from health providers

Table 6: **Types of non-confidential care women experienced from health providers (n=243)**

The provider offered appropriate drapes or covering to protect your privacy		
	Frequency	Percent
No	53	21.8
Yes	190	78.2
The provider used curtains or other visual barriers to protect you during exams		
	Frequency	Percent
No	32	13.2
Yes	211	86.8
The client's medical files were stored in a place with limited access		
	Frequency	Percent
No	219	90.1
Yes	24	9.9
The provider shared sensitive information (status, medical history) in a way that other people could hear		
	Frequency	Percent
No	210	86.4
Yes	33	13.6

Table 6 above clearly shows that 21.8% of women were not offered appropriate drapes or covering to protect their privacy during childbirth, while 13.2% agreed that curtains or other visual barriers were not used to protect them during exams. Further, files for about 9.9% of mothers were not stored in a place with limited access; and about 13.6% had their sensitive personal information (status or medical history) shared by service providers in a way that other people could hear.

4.2.4 Non-dignified care, including verbal abuse

This category shows the nature of the interaction between the client and delivering staff. It also demonstrates how the service provider communicated with the client during childbirth. As shown in Figure 5 below, approximately 33.3% of women received non-dignified care during delivery, as explained in detail in Table 7.

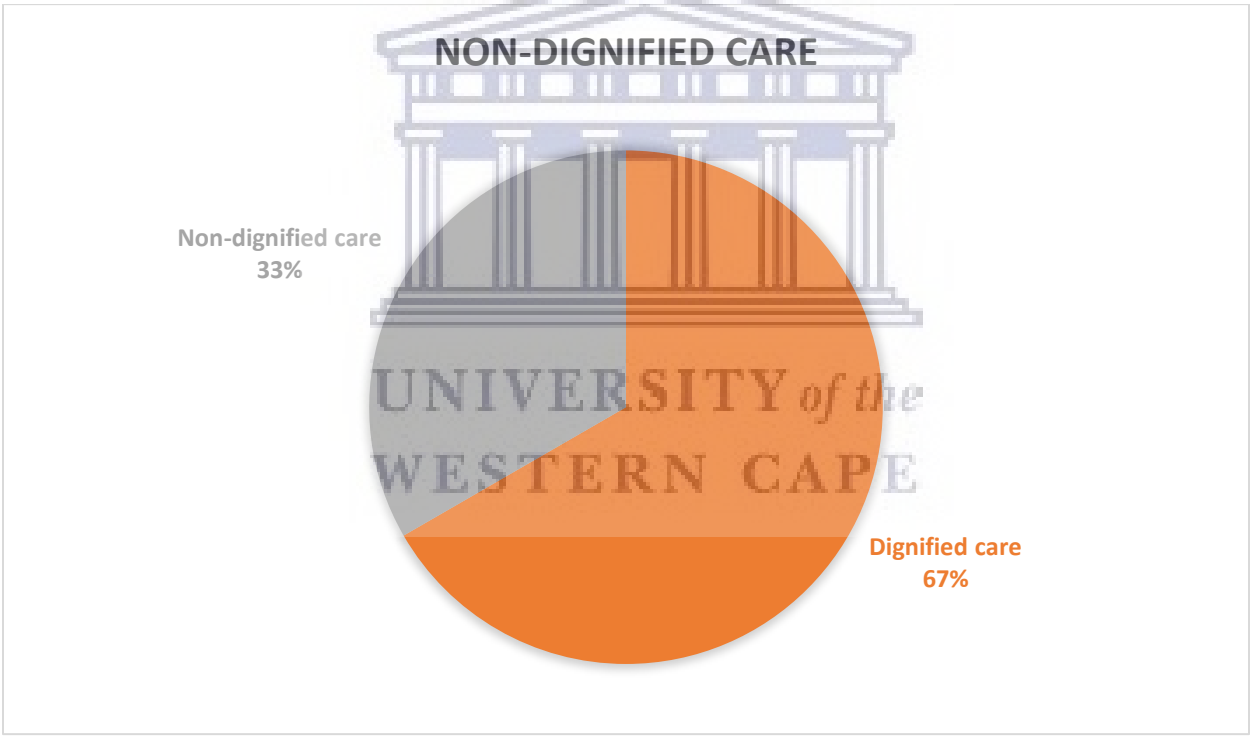

Figure 5: Distribution of women that experienced non-dignified care from health providers

The frequency of non-dignified care is depicted in the table below.

Table 7: **Types of non-dignified care women experienced from health providers (n=243)**

The provider addressed the client by name		
	Frequency	Percent
No	78	32.1
Yes	165	67.9
The provider spoke politely to the client and/or companion		
	Frequency	Percent
No	49	20.2
Yes	194	79.8
The provider allowed the client and/or companion to observe cultural practices.		
	Frequency	Percent
No	153	63
Yes	90	37
The provider insulted, intimidated, threatened, or coerced the client and/or companion.		
	Frequency	Percent
No	220	90.5
Yes	23	9.5

Table 7 above shows that 32.1% of women were not addressed by their names; 20.2% and/or their companion were not spoken to politely; 63% and/or their companion were not allowed to observe their cultural practices; and about 9.5% and/or their companion were insulted, intimidated, threatened or coerced during childbirth.

4.2.5 Discrimination based on specific attributes

This category was based on the client's admission of being discriminated against, including the provider's use of language that the client did not understand. Overall, about 4% of women were discriminated against based on specific attributes, as shown in Figure 6 and explained in Table 8.

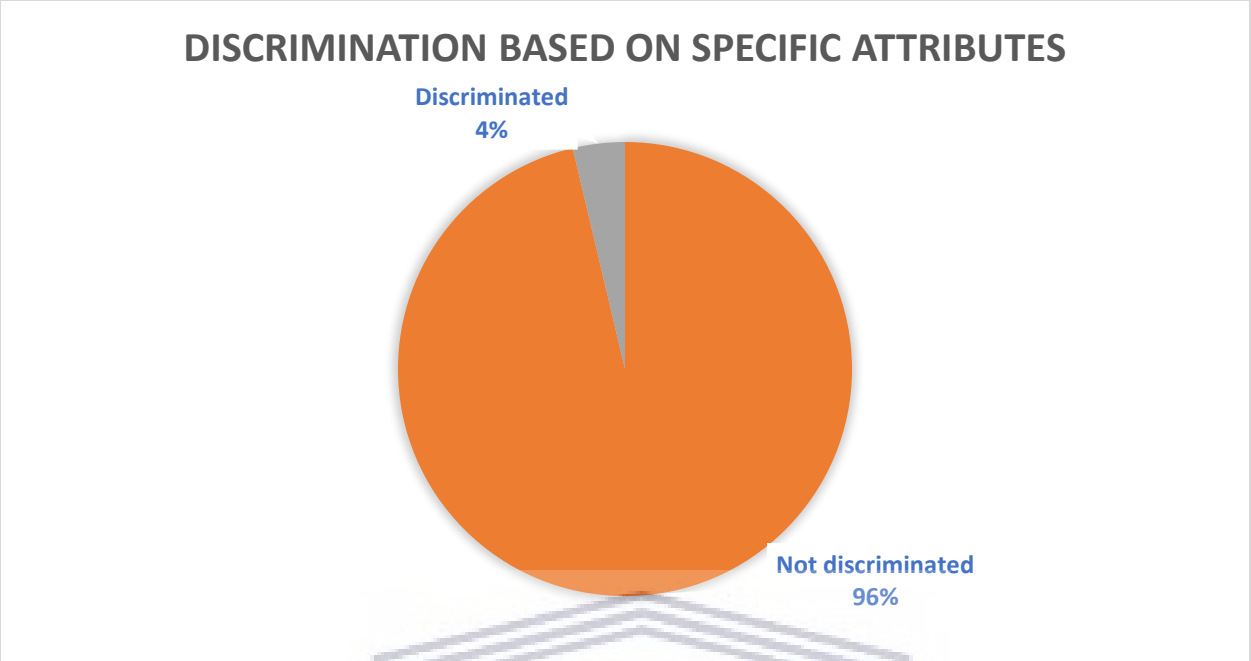

Figure 6: Distribution of women that were discriminated against based on specific attributes

The frequency of discrimination based on specific attributes was as depicted in the table below.

Table 8: **Types of discrimination that women experienced from health providers based on specific attributes (n=243)**

The provider discriminated against the client from the rest of admitted women because of her tribe, education status, economic situation, or any other attribute.		
	Frequency	Percent
No	241	99.2
Yes	2	0.8
The provider spoke to the client in a language that she could understand.		
	Frequency	Percent
No	8	3.3
Yes	235	96.7

As depicted in Table 8 above, a few (0.8%) women felt that they were discriminated against based on tribe, education status, economic situation, and about 3.3% were not communicated to, using the language that they could easily understand.

4.2.6 Abandonment or denial of care

This category was based on the client's admission of being neglected in one way or another during childbirth. Overall results in Figure 7 indicate that approximately 10% of women were abandoned or denied care during delivery, and this is further described in Table 9.

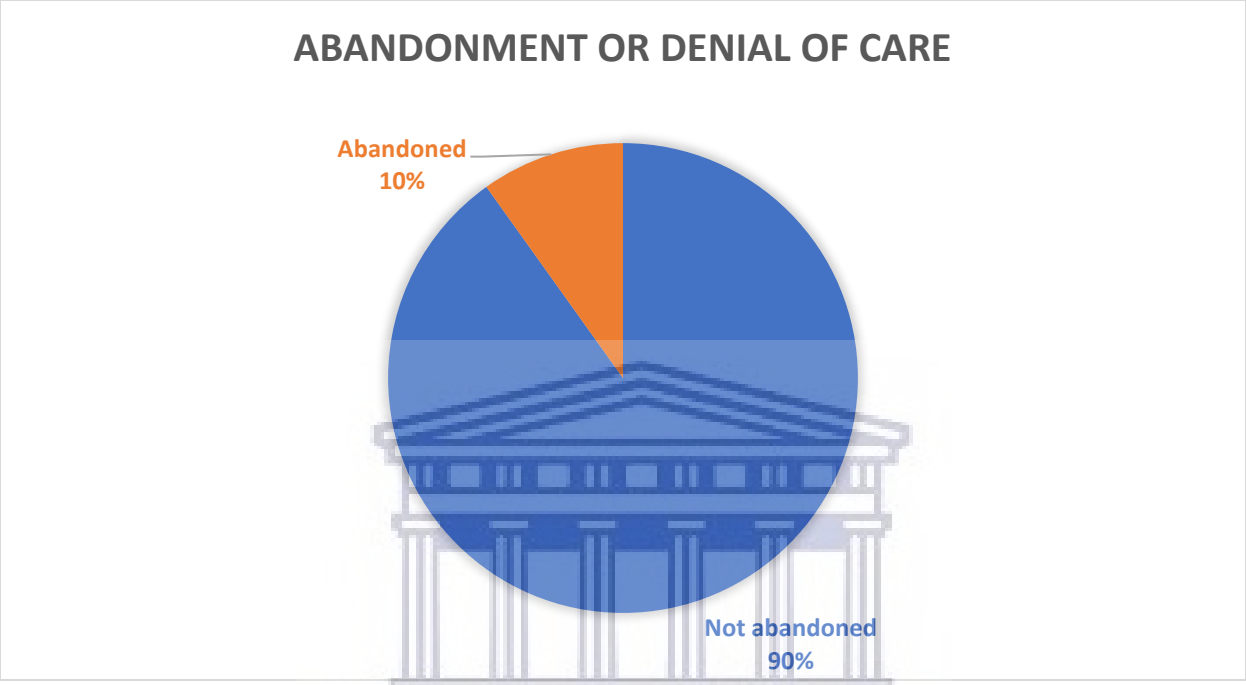

Figure 7: Distribution of women that were abandoned or denied care by care providers

The frequency of abandonment or denial of care was as depicted in the table below.

Table 9: **Types of abandonment or denial of care women experienced from health providers (n=243)**

The provider left the client alone or unattended to during labour		
	Frequency	Percent
No	217	89.3
Yes	26	10.7
You gave birth by yourself, or other patients assisted you to deliver.		
	Frequency	Percent
No	226	93
Yes	17	7
The provider did not respond to your needs in a timely way.		
	Frequency	Percent
No	194	79.8
Yes	49	20.2

The provider encouraged you to call him/her if you needed his/her service.		
	Frequency	Percent
No	36	14.8
Yes	207	85.2

From Table 9 above, it is evident that 10.7% were left alone or unattended during labour; 7.0% gave birth by themselves, or other patients assisted them to deliver. Approximately 20.2% of women affirmed that providers did not respond to their needs in a timely way, and about 14.8% of women agreed that they were not encouraged to call for help when they needed it from their providers.

4.2.7 Detention in facilities

This category was based on the client's admission that they were kept in the health facility unnecessarily long without any medical rationale. The overall results shown in Figure 8 indicate that 38% of women were detained in facilities even though it was not medically necessary. Details of this detention are given in Table 10.

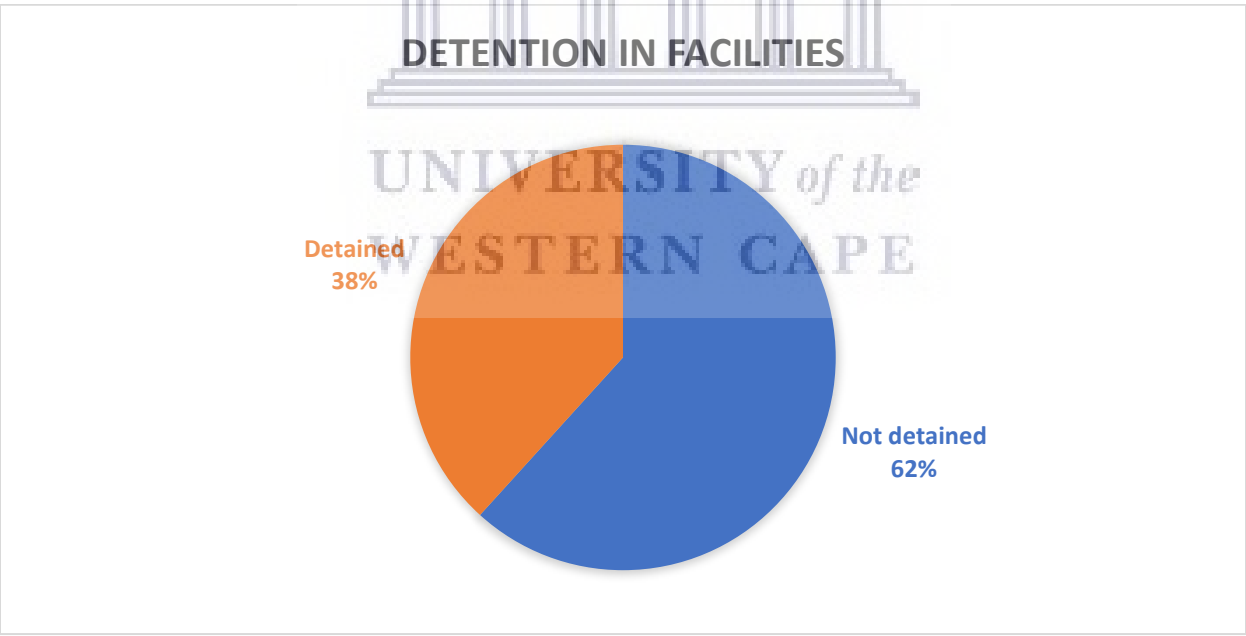

Figure 8: Distribution of women that were detained in facilities after delivery

The frequency of detainment in facilities is as depicted in the table below.

Table 10: **Types of detainment women experienced in facilities from health providers (n=243)**

The provider stopped you from leaving the facility when you so wished for no reason.		
	Frequency	Percent
No	156	64.2
Yes	87	35.8
The provider detained and stopped the client from leaving the facility for failure to pay.		
	Frequency	Percent
No	227	93.4
Yes	16	6.6

Table 10 above shows that 35.8% of women were stopped from leaving the facility when they wished for no reason, whereas 6.6% were detained and prevented from leaving the facility because of failure to pay.

4.3 Factors associated with disrespectful and abusive care during childbirth

Chi-square ($\chi 2$), a non-parametric statistic test, also called a distribution-free test, was used to provide information not only on the significance of the observed differences but also provided detailed information on exactly which categories accounted for any differences found (McHugh, 2013). Cramer's V test, on the other hand, was used to measure the statistical strength of the observed differences (see Tables 11 and 12 below).

Table 11: **Association between non-dignified care and socio-demographic characteristics of participants**

Socio-demographic characteristics	Categories	Total count	Non-dignified care				χ^2	P-value	Cramer's V test
			Yes		No				
			Count	%	Count	%			
Age	18 - 24 yrs	110	36	32.7%	74	67.3%	4.319	0.229	0.133
	25 - 34 yrs	97	37	38.1%	60	61.9%			
	35 - 44 yrs	31	8	25.8%	23	74.3%			
	45 - 49 yrs	5	0	0.0%	5	100.0%			
Marital status	Never Married	46	16	34.8%	30	65.2%	1.191	0.88	0.07
	Living together	5	2	40.0%	3	60.0%			
	Married	176	58	33.0%	118	67.0%			
	Divorced/ Separated	14	5	35.7%	9	64.3%			
	Widowed	2	0	0.0%	2	100.0%			
Education	Never been to school	10	4	40.0%	6	60.0%	17.609	**0.001**	0.269
	Primary	86	14	16.3%	72	83.7%			
	Secondary	130	55	42.3%	75	57.7%			
	Tertiary	17	8	47.1%	9	52.9%			
Employment	Employed	33	14	42.4%	19	57.6%	6.549	**0.038**	0.164
	Self-employed	74	31	41.9%	43	58.1%			
	No employment	136	36	26.5%	100	73.5%			
HIV status	Positive	32	17	53.1%	15	46.9%	6.574	0.087	0.164
	Negative	178	54	30.3%	124	69.7%			
	Does not know	12	4	33.3%	8	66.7%			
	Cannot share	21	6	28.6%	15	71.4%			
Parity	1	74	28	37.8%	46	62.2%	3.315	0.346	0.117
	2	77	28	36.4%	49	63.6%			
	3	48	15	31.3%	33	68.8%			
	4+	44	10	22.7%	34	77.3%			

Table 12: **Association between physical abuse and socio-demographic characteristics of participants**

Socio-demographic characteristics	Categories	Total count	Physical abuse				χ^2	P-value	Cramer's V test
			Yes		No				
			Count	%	Count	%			
Age	18 - 24 yrs	110	6	5.5%	104	94.5%	1.018	0.797	0.065
	25 - 34 yrs	97	8	8.2%	89	91.8%			
	35 - 44 yrs	31	2	6.5%	29	93.5%			
	45 - 49 yrs	5	0	0.0%	5	100.0%			
Marital status	Never Married	46	3	6.5%	43	93.5%	1.665	0.797	0.083
	Living together	5	0	0.0%	5	100.0%			
	Married	176	13	7.4%	163	92.6%			
	Divorced/ Separated	14	0	0.0%	14	100.0%			
	Widowed	2	0	0.0%	2	100.0%			
Education	Never been to school	10	1	10.0%	9	90.0%	0.985	0.805	0.064
	Primary	86	4	4.7%	82	95.3%			
	Secondary	130	10	7.7%	120	92.3%			
	Tertiary	17	1	5.9%	16	94.1%			
Employment	Employed	33	4	12.1%	29	87.9%	**6.729**	**0.035**	**0.166**
	Self-employed	74	8	10.8%	66	89.2%			
	No employment	136	4	2.9%	132	97.1%			
HIV status	Positive	32	2	6.3%	30	93.8%	2.924	0.403	0.11
	Negative	178	11	6.2%	167	93.8%			
	Does not know	12	0	0.0%	12	100.0%			
	Cannot share	21	3	14.3%	18	85.7%			
Parity	1	74	2	2.7%	72	97.3%	2.842	0.417	0.108
	2	77	7	9.1%	70	90.9%			
	3	48	4	8.3%	44	91.7%			
	4+	44	3	6.8%	41	93.2%			

Note: the highlighted rows indicate that the Chi-square statistic is significant at the 0.05 level

As can be seen above (Tables 11 and 12), a Chi-square test of independence was conducted to examine whether or not disrespectful and abusive care was significantly associated with some socio-demographic characteristics of participants. Out of all the socio-demographic characteristics that were considered in this study, only employment and education showed some significant relationships with some categories of disrespect and abuse, in particular, non-dignified care and physical abuse (Tables 11 and 12). Employment status and level of education satisfied the

assumption of adequate cell size and were strongly linked to disrespectful and abusive care during childbirth. The rest were dropped because of the violation of the assumption of adequate cell size, which "requires all cells to have expected values greater than zero and 80% of cells to have expected values of at least five" (McHugh, 2013), and in each case, the p-value was > 0.05.

4.3.1 Non-dignified care and Education level

The results of the Chi-square test of independence were significant based on an alpha value of 0.05, $\chi 2(3) = 17.61$, $p < .001$, suggesting that Education and Non-dignified care were associated with one another, and this relationship was strong, based on Phi and Cramer's V test of; 0.269, $p < .001$.

4.3.2 Non-dignified care and Employment status

The results of the Chi-square test of independence were significant based on an alpha value of 0.05, $\chi 2(2) = 6.55$, $p = .038$, suggesting that Employment and Non-dignified care were related to one another, and this relationship was also strong based on Phi and Cramer's V test of; 0.164, $p < .038$.

4.3.3 Physical abuse and Employment status

The results of the Chi-square test were significant based on an alpha value of 0.05, $\chi 2(2) = 6.73$, $p = .035$, suggesting that Employment and Physical abuse were associated with one another, and this relationship was also strong based on Phi and Cramer's V test of; 0.166, $p < .035$.

4.4 Patterns of disrespect and abuse observed

From the results above, the following patterns of disrespectful and abusive maternity care were revealed with varying degrees of magnitude;

1. Physical abuse
2. Non-consented care
3. Non-confidential care
4. Non-dignified care, including verbal abuse
5. Discrimination based on specific attributes
6. Abandonment or denial of care, and;
7. Detention in facilities

CHAPTER FIVE: DISCUSSION OF FINDINGS

Mistreatment of women during childbirth violates women's basic rights and is not a new phenomenon. This study aimed to assess the magnitude and patterns of disrespectful and abusive care among health care providers towards women who attend public health facilities during childbirth. The discussion will cover demographic characteristics, the magnitude of disrespect and abuse, patterns of disrespect and abuse, and factors associated with disrespectful and abusive care during childbirth in light of this study.

5.1 Discussion

In this study, several significant findings were observed. The most frequently observed category of participants was between 18 and 24 years (n = 110, 45%). This category was more likely to report abuse during childbirth due to inadequate experience in issues relating to labour and delivery, an observation that several studies have documented both in developed and developing countries (Lusambili *et al.*, 2020; Pemde, 2019; Habib *et al.*, 2020). This finding, unfortunately, gives a worrying picture of the quality of care that women are subjected to during childbirth at the hands of care providers. This finding also parallels the disrespect and abuse that has been reported among women in other countries (Wassihun *et al.*, 2018; Rosen *et al.*, 2015; Sando *et al.*, 2016; Bohren *et al.*, 2017; Vedam *et al.*, 2019). Interestingly, this group represents the majority of the sexually active population (Pettifor *et al.*, 2005; Mabaso *et al.*, 2018) which incidentally is not only the most reproductive age group but also vulnerable to disrespectful and abusive care during childbirth (Habib *et al.*, 2020). A scenario that, if not fought with every available intervention, may undo all the successes that Zambia has achieved in the fight against maternal and neonatal mortality (ZSA, MOH and ICF, 2019).

This study has further demonstrated that disrespectful and abusive care is a reality that is still common in the Chipata district with varying magnitude and occurs to women mostly during childbirth. The most commonly reported incidents included; non-consented care, non-dignified care, and detention in facilities. Of all women interviewed in this study, 19% reported experiencing at least one or more forms of disrespect and abuse during childbirth, with the frequency rising to 38% as in the case of detention in health facilities. This resembles findings reported in similar studies conducted in Tanzania and Kenya, which reported a prevalence of 19.5% and 20% respectively (Kruk *et al*., 2014; Bohren *et al.*, 2015). This interestingly contrasts sharply with the

study conducted in South-Eastern Nigeria, Enugu, which reported a staggering prevalence of 98%, suggesting a possible regionalized or culturally linked disrespectful and abusive care (Okafor, Ugwu and Obi, 2015). The author, therefore, suggests that this variation in findings is not surprising, as it may depend on how disrespect and abuse are conceptualized and measured (perceived or observed) across different settings.

5.1.1 Physical and verbal abuse

Physical abuse corresponds to the right to freedom from harm and ill-treatment during childbirth (Bowser and Hill, 2010). Remarkably, this study observed both physical and verbal abuses of women during birth [7%], an observation that has also been reported in a study of similar nature despite varying magnitudes but between 5% and 10% (Mesenburg *et al.*, 2018). As in this study, a community survey also highlighted that physical and verbal abuse with younger, less educated women are more common because of judgements made by healthcare providers about their age and engagement in sexual activity. This suggests that inequalities exist in how women are treated during childbirth (Maya *et al.*, 2018). Other studies (Abuya *et al.*, 2015; Ratcliffe *et al.*, 2016b; Kruk *et al.*, 2018) have also recorded proportionately similar findings though seemingly less significant than those found in this study due to the reported likelihood of rising awareness of litigation among care providers. Underreporting is also possible if this behaviour is accepted as usual and not considered a violation of women's rights (Abuya *et al.*, 2015) or if specific questions about these situations were not asked by the researchers (Kumbani *et al.*, 2013). The author, therefore, suggests that the differences in findings may be due to differences in settings, research methodology, or perhaps, knowledge of RMC by participants.

Additionally, midwives and doctors, in a qualitative research study, also found that 41·6% of women had experiences of physical and verbal abuse as a punishment for non-cooperation during delivery. Providers, however, justified the act as a way of ensuring a good outcome for their babies, which is still unacceptable (Bohren *et al.*, 2016; Balde *et al.*, 2017). They further justified this act as having been necessitated by stressors influencing provider behaviour such as unavailability of resources and clinical skills to manage childbirth and complications. From the above studies and others (Babalola and Fatusi, 2009; Sando *et al.*, 2016), it can be deduced that physical and verbal abuse is still of great concern among women during childbirth. As in this study, it comes in different forms, such as pinching and slapping, shouting, yelling, insults and derogatory remarks,

which may harm women's self-confidence and future utilization of facility-based care. Failure to push during labour, young age, and inability to bring all items required for the birthing process has been cited as potential triggers for mistreatment, also echoing previous studies which were done in other areas (Crissman *et al.*, 2013; Moyer *et al.*, 2017; Rominski *et al.*, 2017). Nonetheless, there is no question that the problem is a common one with a range of associated factors and may indicate a lack of respect for or awareness of RMC among labour and delivering staff or vice versa.

5.1.2 Non-consented/ Non-confidential care

Respectively, non-confidential and non-consented care correspond to the women's right to confidentiality and privacy, the right to information, informed consent and refusal, and respect for choices and preferences, including the right to the companionship of choice wherever possible. This study reported 27% for non-consented and 12% for non-confidential care. This is a clear and unacceptable breach of the code of ethics in healthcare practice. The violation of non-consented and non-confidential care included: 1) asking clients private questions publicly, 2) nurses examining clients without a screen, 3) mothers giving birth in public view, 4) performing procedures without informing clients or getting permission from them, 5) lack of involvement of mothers in their care coupled with impromptu and impolite responses to their questions. Similar to these findings, violations of women's right to information [72%], confidential care [69%], and consented care [81%] were also noted in a study in Pakistan (Hameed and Avan, 2018). As much as these observations differed in magnitude and are re-echoed in other studies (Jansen *et al.*, 2013; Asefa and Bekele, 2015; Bohren *et al.*, 2016; Khosla *et al.*, 2016), they are still in conflict with medical ethics and protocols. Protocols demand care providers involve mothers in their care, guarantee the confidentiality of care, and give periodic updates on the status and progress of labour, including any potential risks from any procedure to get their consent. It is my considered view that the variation in findings could be due to the differences in both the culture of participants and the composition of professionals responsible for labour wards.

These behaviours may be more common due to the provider's lack of understanding of women's rights and consideration of such behaviours as usual (Kruske *et al.*, 2013; Freedman and Kruk, 2014; Bohren *et al.*, 2016). Regarding non-confidential care in facility-based settings, a large number of healthcare professionals and the presence of trainee students have been reported to reinforce the lack of privacy (Behruzi *et al.*, 2011; Balde *et al.*, 2017b). Furthermore, non-

consented care due to absence or inadequate information about the care and procedures was less reported in some studies, resulting in litigations and increasing awareness of disrespectful and abusive care among healthcare providers (Ijadunola *et al.*, 2019). It is the considered view of this researcher that most of these women regard the delivery of a healthy baby as the most crucial end goal of pregnancy; hence, they are willing to accept any spectrum of disrespect and abuse.

5.1.3 Non-dignified care/ Discrimination based on specific attributes

Non-dignified care corresponds to the woman's right to dignity and respect, whereas being discriminated against based on specific attributes is associated with the woman's right to equality, freedom from discrimination, and equitable care. This study reported non-dignified care [33%] and discrimination [4%] based on specific attributes. These results are more extreme than those documented in studies conducted in the Varanasi district of Northern India and the Enugu district of Southeastern of Nigeria, which reported non-dignified care of [19.3%] and [29.6%] respectively (Okafor, Ugwu and Obi, 2015; Bhattacharya and Sundari Ravindran, 2018). The observed difference in findings may be attributed to variations in the study settings and sociocultural differences. This study discovered that women were given non-dignified care and were discriminated against based on specific socio-economic, demographic, and maternal factors. These findings are consistent with those reported in a South African study (Oosthuizen *et al.*, 2017), which also observed that women's age, education, language, and distance to the health facility reinforced the disrespect and abuse that women experience during childbirth.

Other attributes like belonging to a particular group of people (tribe), as in the case of 'scheduled caste', in India, has also been associated with inferior care and discrimination against women belonging to such groups during childbirth (Mitra, 2008; Sudhinaraset *et al.*, 2016; Chattopadhyay, 2018). Researchers have further suggested that because these women are less empowered, health care providers are more likely to mistreat them and think that they can still get off scot-free (Sudhinaraset *et al.*, 2016). Interestingly, discrimination, cultural insensitivity, and undignified care during facility-based childbirth have also been reported in higher-income countries (Hodges, 2009; Goer, 2010). These findings suggest that this behaviour is widespread and affects all income levels of women with varying magnitudes.

5.1.4 Abandonment or denial of care/ Detention in facilities

Abandonment or denial of care corresponds to the woman's right to timely health care and the highest attainable level of health, whereas detention in facilities corresponds to the woman's right to liberty, autonomy, self-determination, and freedom from coercion. The current study reported abandonment [10%] or denial of care and detention [38%] in health facilities. Regarding detention, it was mainly related to providers stopping mothers from leaving health facilities for no reason, when they so wished, and partly for failure to pay in the minority of cases. Abandonment, on the other hand, was primarily due to an impromptu response to women's needs and partly due to providers leaving women alone or unattended during labour. This is consistent with a study in southwest Nigeria, which reported 6% of mothers being left unattended to or denied appropriate care, which related to lack of encouragement during childbirth and detainment on account of failure to pay for services (Ijadunola *et al.*, 2019). This practice is unacceptable and has been condemned as far as facility-based delivery is concerned (World Health Organization, 2016) because a woman should never be abandoned during labour or confined thereafter, against her will. Maternity care in Zambia is free, but due to health care challenges across the country, women are told during childbirth to provide gloves, disinfectants, and other items to facilitate labour. Thus, detainment arises when there is a failure to provide these items, especially in rural areas. Surprisingly, a study in Ethiopia found no reports of inappropriate demands for payment from midwives or detention due to inability to pay. In addition, there were relatively rare cases of abandonment and denial of care compared to a study in Sub-Saharan Africa (Abuya *et al.*, 2015). This might be explained by differences in infrastructural and staffing levels, underreporting, possibly due to seeing the behaviour as acceptable and not as a violation of women's rights, or how the incident was conceptualized and measured by the researchers (Kumbani *et al.*, 2013; Abuya *et al.*, 2015; Sando *et al.*, 2016)

5.1.5 Factors associated with disrespectful and abusive care during childbirth

Studies around the world have shown that women's rights during childbirth are violated in different ways based on age, parity, marital status, level of education, employment status, HIV status, and other demographic characteristics (Bowser and Hill, 2010; Bohren *et al.*, 2015; Ijadunola *et al.*, 2019). However, of all these characteristics, only the level of education and employment status showed significant associations with disrespectful and abusive care during

childbirth in this study. Non-dignified care and level of education showed the strongest relationship [$\alpha = 0.05$, $\chi 2(3) = 17.61$, $p < .001$,]. Others were non-dignified care and employment status, physical abuse, and employment status. This is consistent with various studies that have also reported these power imbalances as being responsible for perpetuating and thereby, normalizing disrespectful and abusive care during childbirth (Onah *et al.*, 2006; Abuya *et al.*, 2015; Ishola, Owolabi and Filippi, 2017; Kruk *et al.*, 2018). It can be argued further that education and employment empower women and increase their expectations of not only the quality of health care but also the behaviour befitting a provider. This self-confidence and awareness of their rights reduce the power imbalance between them and providers. Thus, there is a reduced likelihood of being mistreated during childbirth. Employment, on the other hand, empowers a woman financially. This makes it easy for her to adequately prepare for her delivery to fulfil all antenatal requirements, which may trigger mistreatment during childbirth if not met satisfactorily. It is, therefore, evidently true that the level of education and employment status are closely associated with disrespect and abuse during childbirth. This, however, may not be the case in all contexts, as some studies have demonstrated otherwise (Hameed and Avan, 2018) and may warrant further investigation.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study has highlighted the reality of disrespectful and abusive care among health care workers toward women during childbirth in Chipata, Zambia. It has further emphasized several factors as enablers for the disrespect and abuse of women. It is against this background that we cannot overemphasize the importance of bettering maternity care services, humanizing women's care during childbirth, and empowerment of health care providers with knowledge of women's childbearing rights. In resource-limited settings such as Zambia, disrespect and abuse of women during childbirth defeats the fight against high maternal and neonatal mortality rates and consequently undermines efforts to attain the sustainable development goal of good health and well-being through the pledge to leave no one behind. Respectful maternity care is critical in improving the quality of care and reducing inequalities in the provision of health care services. My considered view is that these findings will inform policies, programmes and services and guarantee memorable and positive childbirth experiences if supported by a well-functioning health care system and motivated healthcare providers.

6.2 Key findings

Of the 243 mothers enrolled in the study, at least 19% experienced some form of disrespect and abuse during childbirth. Those at risk were younger and less educated women, signifying inequalities in how providers treated women during childbirth. Non-consented care [27%], non-dignified care [33%], and detention in facilities [38%] were frequently reported by all the women. Primary determinants of non-dignified care were level of education [$\alpha = 0.05$, $\chi2(3) = 17.61$, $p < .001$,], and status of employment [$\alpha = 0.05$, $\chi2(2) = 6.55$, $p = .038$]. On the other hand, employment status was also implicated in physical abuse [$\alpha = 0.05$, $\chi2(2) = 6.73$, $p = .035$]. There were no apparent associations between disrespectful and abusive care and some socio-demographic characteristics such as age, parity, marital status, and HIV status.

6.3 Limitation of the study

While this study provides some insights into the magnitude and patterns of disrespectful and abusive care that women experience during childbirth at the hands of health care providers, it only relied on self-reporting, time-specific experiences of women who delivered in the health facilities.

The findings may be limited to this setting. However, the researcher hopes that the results are replicable in similar settings within and outside the district in Zambia.

6.4 Recommendations

This study has suggested several interventions that can address the violation of women's rights during childbirth. A clear understanding of enablers to these violations is essential in ensuring that appropriate interventions are put in place to curtail the mistreatment of women during delivery. The following are recommendations made:

6.4.1 Education recommendations

i) There is a need to incorporate respectful maternity care (RMC) charter lessons in antenatal care to increase the awareness of women's childbearing rights and help them develop a sense of entitlement to high-quality health care devoid of abuse and disrespect during childbirth.

ii) Service providers in all settings should be made aware of the RMC charter, and mechanisms should be devised for implementation and supportive supervision to ensure woman-centered and culturally appropriate care.

iii) At the community level, deliberate sensitization programs on the RMC charter, and other rights targeting women of childbearing age, should be implemented to promote awareness of their childbearing rights, thereby reducing the likelihood of mistreatment during childbirth.

6.4.2 Practice recommendations

i) Health facility administrators should ensure improvement in the quality of labour and delivery environment for mothers, such as visual barriers for privacy the introduction of care standards for providers to monitor their adherence to RMC practice, including strengthening accountability through legal redress.

ii) There is a need for community participation in promoting RMC using traditional leaders or community representatives through clinics or hospital health management committees to facilitate dialogue on issues relating to RMC during childbirth.

6.4.3 Research recommendations

i) Further research is required, which should employ a mixed-methods approach to explore other reasons behind disrespectful and abusive care during childbirth other than socio-demographic characteristics and should also involve providers. This will enhance our understanding of social dynamics that drive disrespect and abuse of women during delivery and help find lasting solutions to this problem. Nevertheless, the suggested recommendations should not await more research findings but should be implemented as soon as possible; otherwise, women will continue to sacrifice their dignity during childbirth and may be discouraged from delivering in health facilities in future.

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APPENDICES

UNIVERSITY of the WESTERN CAPE

60 YEARS of hope, action & knowledge

12 October 2020

Mr S Kanonkela
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM20/8/14

Project Title: Attitudes and behaviour of Health Care Workers towards women during childbirth in Zambia

Approval Period: 12 October 2020 – 12 October 2023

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

Permission to conduct the study must be submitted to BMREC for record-keeping.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
Republic of South Africa
Tel: +27 21 959 4111
Email: research-ethics@uwc.ac.za

NHREC Registration Number: BMREC-130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

ERES CONVERGE

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I.R.B. No. 00005948
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23rd November, 2020.

Ref. No. 2020-Oct-015

The Principal Investigator
Mr. Kanokela Shindon,
University of Western Cape,
Private Bag X 17, Bellville 7535,
SOUTH AFRICA.

Dear Mr. Shindon,

RE: ATTITUDES AND BEHAVIOUR OF HEALTH CARE WORKERS TOWARDS WOMEN DURING CHILDBIRTH IN CHIPATA DISTRICT, ZAMBIA.

Reference is made to your protocol resubmission dated 20th November, 2020. The IRB resolved to approve this study and your participation as Principal Investigator for a period of one year.

Review Type	**Ordinary**	Approval No. **2020-OCT-015**
Approval and Expiry Date	Approval Date: 23rd November, 2020	Expiry Date: 22nd November,2021
Protocol Version and Date	Version - Nil.	22nd November,2021
Information Sheet, Consent Forms and Dates	• English, Chewa.	22nd November,2021
Consent form ID and Date	Version - Nil	22nd November,2021
Recruitment Materials	Nil	22nd November,2021
Other Study Documents	Questionnaires.	22nd November,2021
Number of participants approved for study	-	22nd November,2021

Specific conditions will apply to this approval. As Principal Investigator it is your responsibility to ensure that the contents of this letter are adhered to. If these are not adhered to, the approval may be suspended. Should the study be suspended, study sponsors and other regulatory authorities will be informed.

Conditions of Approval

- No participant may be involved in any study procedure prior to the study approval or after the expiration date.
- All unanticipated or Serious Adverse Events (SAEs) must be reported to the IRB within 5 days.
- All protocol modifications must be IRB approved prior to implementation unless they are intended to reduce risk (but must still be reported for approval). Modifications will include any change of investigator/s or site address.
- All protocol deviations must be reported to the IRB within 5 working days.
- All recruitment materials must be approved by the IRB prior to being used.
- Principal investigators are responsible for initiating Continuing Review proceedings. Documents must be received by the IRB at least 30 days before the expiry date. This is for the purpose of facilitating the review process. Any documents received less than 30 days before expiry will be labelled "late submissions" and will incur a penalty.
- Every 6 (six) months a progress report form supplied by ERES IRB must be filled in and submitted to us.
- A reprint of this letter shall be done at a fee.

Should you have any questions regarding anything indicated in this letter, please do not hesitate to get in touch with us at the above indicated address.

On behalf of ERES Converge IRB, we would like to wish you all the success as you carry out your study.

Yours faithfully,
ERES CONVERGE IRB

Dr. Jason Mwanza
Dip. Clin. Med. Sc., BA., M.Soc., PhD
CHAIRPERSON

The University of the Western Cape
Private Bag X 17,
Bellville 7535,
South Africa

Tel: +27 21-959 2809,
E-mail: soph-comm@uwc.ac.za

3RD March, 2021.

The District Health Director
Chipata District Health Office,
Po Box 510023,
Chipata.

Dear Sir/Madam,

REF: PERMISSION TO UNDERTAKE A RESEARCH STUDY AND COLLECT DATA

I am an MPH student at the University of the Western Cape, South Africa. In partial fulfilment of the Masters of Public Health degree, I am required to carry out a mini-thesis research study. My research project is titled "Attitudes and behaviour of Health Care Workers toward women during childbirth" in Chipata district of Zambia.

The study is trying to assess the magnitude and patterns of disrespect and abuse that the women experience during child birth. It is hoped that this study will facilitate a greater understanding of Respectful Maternity Care (RMC). Moreover, this study will increase women's awareness of their RMC rights, needs, and opinions on their health and the health services available to them. It is hoped that once women are aware, they will be encouraged to demand change from both decision-makers and health care providers.

I, therefore, write to ask for permission to conduct this work in your health facilities. Your positive response to this request will be highly appreciated.

Yours Faithfully,

Kanonkela shindon (Mr.)

Telephone: 021-62 22129
Fax: 021-62 -221298

in Reply Please Quote
No.: "

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

CHIPATA DISTRICT HEALTH OFFICE
P.O. BOX 511205
CHIPATA

9th March 2021

Kanonkela Shindon (Mr.).
University of the Western Cape,
Private Bag X 17,
Bellville 7535,
South Africa.
E-mail: soph-comm@uwc.ac.za

Dear Sir,

REF: PERMISSION TO UNDERTAKE A RESEARCH STUDY AND COLLECT DATA - YOURSELF.

Reference is made to your letter dated 3rd March, 2021, in which you requested permission to undertake a research study and collect data from the following health facilities based in Chipata district; Kapata, Gondar, Namseche, Mchini, Magwero, Chipungo, Madzimoyo, Walela and Chikando.

We have no objection to your request for you to successfully undertake your study. You are also advised to use the said data strictly for academic purposes.

Furthermore, we will be happy to receive a copy of your final report. I wish you the best in your studies.

Yours faithfully

Dr Charles Fanaka
District Health Director.
CHIPATA

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
09 MAR 2021
DISTRICT HEALTH DIRECTOR
P.O BOX 511205, CHIPATA .

All correspondences should be addressed to the District Health Director

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

PARTICIPANT INFORMATION SHEET

Project Title: **Attitudes and behaviour of Health Care Workers toward women during childbirth in Zambia**

What is this study about?

This is a "research project being conducted by Kanonkela Shindon from the University of the Western Cape, South Africa. We would like to talk to you about your experience in the health facility during labor and delivery of your youngest child. First, I will explain more about the study. The study is trying to assess the magnitude and patterns of disrespect and abuse that women experience during child birth. You have been randomly chosen and being asked to take part in this research project because you have given birth in the past 30 days, and your opinions will be needed in ensuring that this study achieves its intended purpose. Before you decide whether or not you wish to take part in this research, you should read the information provided below carefully. Take time to ask questions, do not feel rushed or under any obligation to make a hasty judgement. You should clearly understand the benefits of participating in this study so that you can make a decision that is right for you from an informed" mind.

Purpose of the research

This study will facilitate a greater understanding of Respectful Maternity Care (RMC). Moreover, this study increases women's awareness of their RMC rights, needs, and opinions on their health and the health services available to them. It is hoped that once women are aware, they will be encouraged to demand change from both decision-makers and health care providers.

What will I be asked to do if I agree to participate?

If you agree to take part in the study, you will be asked to respond to some questions about your opinions and experiences relating to daily life, reproductive health, and use of health services. You will be talked to in a private room at the health facility or in your home in privacy. You will be asked questions, and your responses will be recorded in the questionnaire. Nobody else will be present, except you and the interviewer who shall also assist in filling in the questionnaire. The interview will not take more than 60 minutes, and we will not contact you at any later time for further participation.

Would my participation in this study be kept confidential?

The researchers undertake to "protect your identity and the nature of your contribution. To ensure your anonymity, the questionnaires will not contain information that may personally identify you. Only an identification code will be used to link your responses to your identity, and only the research team will have access to the identification key. To ensure your confidentiality, we will not write down your name or other information that could identify you at any time. We will not share any study records or notes with anyone outside of the research team. We shall keep all records of your participation, including a signed consent form which we shall need from you should you agree to participate in this research study, locked away at all times. We will destroy the questionnaires and consent forms five years after the research is completed. The results of the study will be put into a report, and we will share these results with those working on this project, but we will not identify you in anything we write or share about the study. We will keep the information you share and may use it in the future, but no one will know the information comes from you. All files will be protected by a password on the computer. If someone approaches us to find out what we are talking about, we will stop talking until they leave. You do not have to answer any question that you do not feel comfortable with, and you may choose to leave the discussion at any time". You also do not have to tell anyone that you are taking part in the study if you don't want to.

What are the risks of this research?

This research will "explore your experience with health care providers during facility-based delivery, which can be a sensitive topic. There may be some risks from participating in this research study because all human interactions and talking about self or others carry some number of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention".

What are the benefits of this research?

This research is not designed to help you personally, but the results may help in improving facility-based deliveries in Zambia through improved awareness of women's RMC rights.

Do I have to be in this research and may I stop participating at any time?

Your "participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time, for whatever reason without having to justify your decision and without any negative impact on you or lose any benefits to which you otherwise qualify".

What if I have questions?

This research is being conducted by **Kanonkela Shindon** under the School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact:

Kanonkela Shindon (Principal Investigator).
C/O St Francis Hospital,
P/B 11,
Katete, Zambia.

Mobile phone: +260976223297
Email: kshindon265@gmail.com

OR

The Chairperson.
RES CONVERGE IRB,
33 Joseph Mwilwa Road,
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LUSAKA.

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E-mail: eresconverge@yahoo.co.uk

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
Head of Department: School of Public Health
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ulehmann@uwc.ac.za

Prof Anthea Rhoda
Dean: Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee.

Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
Bellville
7535
Tel: 021 959 4111
e-mail: research-ethics@uwc.ac.za

REFERENCE NUMBER: **BM20/8/14**

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PARTICIPANT INFORMATION SHEET - CHEWA

Mutu wa kafuku-fuku: **Macitidwe ndi mkhalidwe wa anyachito a za umoyo kwa azimai pa nthawi yo beleka mu Zambia.**

Kodi kafuku-fuku uyu unena zotani?

Iyi nchito ya kafuku-fuka icitidwa ndi Kanonkela Shindon wo cokera pa Univesiti ya Western Cape ku South Africa. Tifuna tilankhule nanu pa zinthu zomwe munapitamo ku cipatala pa nthawi yo beleka maka panthawi yomwe munabeleka mwana wunu wamg'ono. Coyamba, ndi za masulila za kafuku-fuku uyu. Kafuku-fuku uyu uyesa kupeza muyeso wake wankhaza ndi kusapasidwa ulemu kumene azimai a pitamo pa nthawi yo beleka. Inu mwasakidwa pa anthu ambiri-mbiri ndipo muphephedwa kuti mutengeko mbali ku kafuku-fuku uyu cifukwa inu mwa beleka m'masiku makumi atatu apitawa, ndipo ndigaliro yanu izafunikila pakuonetsetsa kuti kafuku-fuku uyu ukwanilitsa colinga cace. Musanapange ciganizo cakuti mutengeko mbali kapena ai ku kafuku-fuku uyu, muyenera kuwerenga mosamala fundo zomwe zapatsidwa pasipa. Tengani nthawi kufusa mafunso, osamva kuti ndinu ofulumitsidwa kapena kuti pali cithu cina cimene cizapangitsa kuti mupange mfundo yoipa. Muyenera kumvetsetsa mofikapo za ubwino otengako mbali ku kafuku-fuku uyu kotero kuti mupange sankho yabwino yocokela mukudziwa.

Cholinga cha kafuku-fuku

Kafuku-fuku uyu uzapereka kumvetsetsa kwa kukulu pa nkhani yakasamalidwe kaulemu ka azimai apakati. Kafuku-fuku aka kazapereka ciziwitso kwa azimai pankhani ya zaufulu za kasamalidwe ka azimai ali ndi pathupi, zofunikira zao ndi maganizo yayo pa zaumoyo ndi zinchito

zoperekedwa kuchokera kucipatala zowasamalira. Ndiciyembekezo cathu kuti ngati azimai adziwa za ufulu wao, azaphemba kusintha kuchokera kuopanga malamulo ndi owasamalira kucipatala.

Kodi ndidzaphephedwa kucita ciani ngati ndabvomera kutengako mbali?

Ngati inu mwabvomera kutengako mbali ku kafuku-fuku aka, mudzaphephedwa kuyankha mafunso maka kupereka ganizo lanu ndi zimene unu mwapitamo mu umoyo wa tsiku ndi tsiku, umoyo wa za ubereki ndi zinchito zomwe zipezeka m'cipatala. Muzayankhulidwa mukacipinda komata kucipatala kapena kunyumba kwanu mwapadela. Muzafunsidwa mafunso ndipo mayankho yanu yazalembedwa mcipepala. Palibe azapezekapo, ndimwe, ndi-ofufuza cabe. Kukambirana kwathu sikuzapyola pa mphindi makumi asunu ndi imodzi ndipo simuzaitanidwa panthawi ina yace kuti mukatengeko mbali.

Kodi kugwapo kwanga mukafuku-fuku uyu kuzasungidwa mwacisinsi?

Wocita kafuku-fuku uwu alonjeza kuteteza inu kuti musaziwike ndi mbali ya nchito imene inu muzagwapo. Pakuonesetsa kuti musadziwike, cipepala cha kafuku-fuku sicidzankhala ndi zofunsa za dzina lanu. Komabe manambala azizidikiro azasewezesedwa kugwiraniza zoyankha zanu ndi inu. Okhawo akafuku-fuku ndiwo adzakhala ndi fungulo ya zizindikiro. Pakuonetsetsa kuti cisinsi canu cisungidwa, sitidzalemba dzina lanu kapena ciliconse cosonyeza kuti ndinu panthawi ili yonse. Sitidzaonetsa mapepala anu a kafuku-fuku kwa wina aliyense koma okhawo otengako mbali mukafuku-fuku aka. Tidzasunga mapepala yanu yakutengako mbali pamodzi ndi pepala yomwe inu muzasindikizapo limene tidzafuna kucokera kwa inu ngati mwabvomera kutengako mbali ku kafuku-fuku uyu. Mapepala awa adzakhala yokhomeledwa nthawi zonse. Tizaononga mapepala yakafuku-fuku aka pakapita zaka zisanu ngati nchito yakafuku-fuku yamalizidwa. Zotulukamo za kafuku-fuku uyu zidzalembedwa mu pepala lothera ndipo zotuluka za kafuku-fuku zidzagawidwa kwa anthu amene asewezerapo. Ife sitizakubvumbutsani pa zonse zimene tilemba kapena zimene tigawana za kafuku-fuku uyu. Tizasunga zimene inu muzagawana nafe ndipo tizatha kudzisewenzetsa msogolo koma palibe yemwe azadziwa kuti zimenezi zinacokera kwa inu. Zolemba zonse zidzatetezedwa ndi zo bisika za pa kompyuta. Ngati wina abwera kuzafufuza zomwe tilankhulana, ife tidzaima kukambilana kufikira atapita. Ndinu omasuka kuleka kuyakha mafunso ngati sizinakukondweletseni ndipo ndinu omasuka kusankha kuleka kukambirana kwathu nthawi iriyonse. Ndipo inu Muli ndi danga losabvumbulutsa kwa wina ali yense kuti muli kutengako mbali mukafuku-fuku uyu ngati inu mufuna.

Kodi zoopsya za kafuku-fuku uyu ndi zotani?

Kafuku-fuku aka kazaonetsa poyera zimene inu mukumana nazo ndi anamwino pa nthawi ya kubeleka m'cipatala, nkhani imene siyakhulidwa kwa mbiri. Kungakhale zoopsya pakutengako mbali mukafuku-fuku uyu cifukwa kulakhulana ndi kunena za iwe mwini kapena za ene kuli ndi zoopsya zace. Koma ife tidzayesa kucepetsa zoopsya zimenezi ndi kucita zithu mofulumira ngati inu mukumana ndi zinthu zomwe zingathe kucotsa mtendere wanu, za maganizo kapena zina zace pa nthawi inu mutengako mbali mukafuku-fuku uyu. Ngati zabvuta, muzatumizidwa ku a katswiri kuti mukapeze nthandizo lokwana.

Kodi zokoma za kafuku-fuku aka ndi zotani?

Kafuku-fuku aka sikanapangidwa kuti kakathandize inu, koma zotulukamo zace zingathe kuthandiza kupititsa patsogolo ubeleki wocitikira mzipatala za mu Zambia kupitira mukuziwitsa azimai bwino za ufulu wao waubeleki.

Kodi ndiyenera kupezeka mukafuku-fuku aka ndipo ndingathe kucoka m'kutengako mbali nthawi ina iri yonse?

Kutengako mbali kwanu mukafuku-fuku aka ndikozipereka kwanu cabe. Inu mutha kusankha kusatengako mbali. Ngati mwasankha kutengako mbali mukafuku-fuku aka, mutha kuleka nthawi iri yonse pacifukwa ciri conse popanda kunena cifukwaco ndipo popanda zotulukamo zoipa kwa inu kapena kutaya malipilo yena yaliyonse yamene inu muyenere kukhala nayo.

Nanga ngati ndiri ndi mafunso?

Aka kafuku-fuku kacitidwa ndi Kanonkela Shindon wo phunzira pa sukulu ya Univeziti ya Western Cape. Ngati muli nao mafunso kulingana ndi kafuku-fuku aka, conde tumilami ku:

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Ngati muli nao mafunso ena kulingana ndi kafuku fuku aka ndi ufulu wanu ngati wotengako mbali, kapena mufuna kudziwitsa bvuto limene mwapeza kulingana ndi kafuku-fuku aka, conde, tumilani ku:

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Kafuku-fuku aka kabvomerezedwa ndi bungwe la Univesiti la Western Cape.

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REFERENCE NUMBER: **BM20/8/14**

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PARTICIPANT CONSENT FORM

Title of Research Project: Attitudes and behaviour of Health Care Workers toward women during childbirth in Zambia.

The "study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits".

Participant's name…….

Participant's signature…….

Date……

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PARTICIPANT CONSENT FORM - CHEWA

Mutu wa kafuku-fuku: Macitidwe ndi mkhalidwe wa anyachito a za umoyo kwa azimai pa nthawi yo beleka mu Zambia.

Kafuku-fuku aka kamasulidwa kwa ine m'cilakhulo cimene ndi mvetsetsa. Mafunso anga kulingana ndi kafuku-fuku yayankhidwa. Ndi mvetsetsa zocitika mkutengako mbali ndipo ndibvomera kutengako mbali mwakusankha kwanga ndipo mwaufulu. Ndimvetsetsa kuti sindizabvumbulusidwa kwa wina aliyese. Ndiziwa kuti ndingathe kusiya m'kutengako mbali ku kafuku-fuku aka ponda kubvumbulutsa cifukwa, ndipo popanda mantha ya zotulukamo zoipa kapena kutaya malipiro.

Participant's name…….

Participant's signature…….

Date……

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QUESTIONNAIRE

Health Facility Name _____
Facility ID: _____
Client ID _ _
Date __ __/ __ __/ __ __ (DD/MM/YY)

Section I: Demographic data

Today I'd like to talk to you about the care you received during your recent delivery at the health facility. To start, let me first learn a little about you.

Question	Answer choices	Data Entry
1. How old are you?	__ __ 1. 18 – 24 years 2. 25 – 34 years 3. 35 – 44 years 4. 45 – 49 years	 **1** **2** **3** **4**
2. How many children do you have? (Children you have given birth to)	*Select one* 1. 1 2. 2 3. 3 4. 4+	 **1** **2** **3** **4**
3. What is your marital status?	1. Never Married 2. Living together 3. Married 4. Divorced / Separated 5. Widowed	**1** **2** **3** **4** **5**
4. What is the highest level of your education?	1. Never been to school 2. Primary 3. Secondary 4. Tertiary	**1** **2** **3** **4**
5. What is your employment status?	1. Employed 2. Self-employed 3. No employment at all	**1** **2** **3**
6. What is your HIV status?	1. Positive 2. Negative 3. Does not know 4. Cannot share	**1** **2** **3** **4**

Section II: Labour and delivery experience

Each of the questions below relate to your recent experience during labor and delivery. Please respond whether you agree or disagree with each statement.

"Freedom from harm and ill treatment (Physical abuse)"		
Question	**Answer choices**	**Data Entry**
7. At what facility did you deliver your youngest baby?	__	**1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** **12**
8. Who was the main person that delivered your baby?	1. Doctor. 2. Nurse. 3. Midwife. 4. Other. 5. Do not know.	**1** **2** **3** **4** **5**
9. The service provider demonstrated caring in a cultural way (you were encouraged to express your views freely, even when they differed from service providers' views).	1. Agree. 0. Disagree.	**1** **0**
10. The service provider talked positively about pain relief and provided comfort/pain-relief as necessary.	1. Agree. 0. Disagree.	**1** **0**
11. The service provider used physical force or abrasive behaviour (e.g. slapping, intimidation, shouting).	0. Agree. 1. Disagree.	**0** **1**
12. The service provider physically restrained you during labour.	0. Agree. 1. Disagree.	**0** **1**
13. The service provider denied you food or fluid in labour when it was not medically necessary.	0. Agree. 1. Disagree.	**0** **1**

"Right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice wherever possible (Non-consented care)"

Question	Answer choices	Data Entry
14. The service provider introduced him/herself.	1. Agree 0. Disagree	**1** **0**
15. The service provider encouraged you and/or your companion to ask questions.	1. Agree 0. Disagree	**1** **0**
16. The service provider allowed you to move about and assume the position of choice during birth.	1. Agree 0. Disagree	**1** **0**
17. The service provider encouraged your companion to stay with you whenever possible.	1. Agree 0. Disagree	**1** **0**
18. The service provider obtained consent or permission prior to any procedure.	1. Agree 0. Disagree	**1** **0**
19. The service provider explained what was being done and what to expect throughout.	1. Agree 0. Disagree	**1** **0**
20. The service provider responded to questions with promptness and politeness.	1. Agree 0. Disagree	**1** **0**
21. The service provider gave periodic updates on the status and progress of labour.	1. Agree 0. Disagree	**1** **0**

"Confidentiality, privacy (Non-confidential care)"

Question	Answer choices	Data Entry
22. The service provider offered appropriate drapes or covering to protect your privacy.	1. Agree. 0. Disagree.	**1** **0**
23. The service provider used curtains or other visual barriers to protect you during exams.	1. Agree. 0. Disagree.	**1** **0**
24. Your medical files were stored in a place with limited access.	1. Agree. 0. Disagree.	**1** **0**

25. The service provider shared sensitive information, such as your status or medical history, in a way that other people could hear.	0. Agree. 1. Disagree.	**0** **1**

"Dignity, respect (Non-dignified care including verbal abuse)"

Question	Answer choices	Data Entry
26. The service provider addressed you by your name.	1. Agree. 0. Disagree.	**1** **0**
27. The service provider spoke politely to you and/or companion.	1. Agree. 0. Disagree.	**1** **0**
28. The service provider allowed you and/or companion to observe your cultural practices (e.g., "during labour, women from some cultures avoid moving too much; some stay lying down, some prefer to sit or squat. In some cultures, the father does not attend the birth but the mother or mother in-law").	1. Agree. 0. Disagree.	**1** **0**
29. The service provider insulted, intimidated, threatened or coerced you and/or your companion.	0. Agree. 1. Disagree.	**0** **1**

"Equality, freedom from discrimination, equitable care (Discrimination based on specific attributes)"

Question	Answer choices	Data Entry
30. The service provider discriminated you from the rest of admitted women because of your tribe, education status, economic situation or any other attribute.	0. Agree. 1. Disagree.	**0** **1**
31. The service provider spoke to you in a language that you could easily understand.	1. Agree. 0. Disagree.	**1** **0**

"Right to timely health care and to the highest attainable level of health (Abandonment or denial of care)"

Question	Answer choices	Data Entry
32. The service provider left you alone or unattended to you during labour.	0. Agree. 1. Disagree.	**0** **1**
33. You gave birth by yourself, or other patients assisted you to deliver.	0. Agree. 1. Disagree.	**0** **1**
34. The service provider did not respond to your needs in a timely way.	0. Agree. 1. Disagree.	**0** **1**
35. The service provider encouraged you to call him/her if you needed her service.	1. Agree. 0. Disagree.	**1** **0**

"Liberty, autonomy, self-determination, and freedom from coercion (Detention in facilities)"

Question	Answer choices	Data Entry
36. The service provider stopped you from leaving the facility when you so wished for no reason.	0. Agree. 1. Disagree.	**0** 1
37. The service provider detained and stopped you from leaving the facility for failure to pay.	0. Agree. 1. Disagree.	**0** **1**

Section III: Follow up care and future health service

Each of the statements below relate to your follow up care after delivery and future health services during labor and delivery. Please respond with yes or no to each statement.

Questions	Answer choices	Data entry
38. Have you returned to any health facility since giving birth?	0. Yes 1. No **If yes, continue to question 39** **If no, skip to question 40**	**0** **1**
If yes, please tell me which of these services you returned for and whether you returned to this facility or another one.		**0 = Yes** **1 = No**
39. If **YES**, did you return to the same health facility, and for which health service?	__ Same health facility for postnatal and/or other health care services.	**0**
	__ Different health facility for postnatal and/or other health care services.	**1**
	__ No applicable (If answer to question 38, is No).	**2**
40. If **NO**, what are your reasons for not returning to the health facility?	__ Have not sought health care services yet.	**0**
	__ Did not like the care I received during my last delivery.	**1**
	__ Not applicable (If the answer to question 38, is Yes).	**2**
41. Would you return to the same facility for future delivery?	0. Yes 1. No	**0** **1**