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BARRIERS TO RESPECTFUL MATERNITY CARE in the year 2020 IN RUWA, GOROMONZI DISTRICT, MASHONALAND EAST, ZIMBABWE,

BY

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Abstract

Respectful maternity care (RMC), is the care given to all women in a way that maintain their dignity, give them privacy and confidentiality, so that they are free from harm and not be mistreated, as this enables them to have informed choices, and they continuously support when they are in labour and delivering their child. Respectful maternity care is a very important strategy for improving quality and utilization of maternity care. However, to access good care during labour and childbirth in health care facilities might not guarantee good quality of care because of non-respectful and undignified care, which will be a barrier to access care during intra-partum period. The aim of this study was to assess the factors associated with RMC during childbirth in Ruwa, Goromonzi District, Zimbabwe in the year 2020. The seven categories or ways of disrespect and abuse and the rights of women when they are giving birth were used as a guide in this study. The study was an analytical cross-sectional design. This study was done at Ruwa Poly clinic, Goromonzi District in Mashonaland East, Zimbabwe. The study population were all women from 15 years of age and above who were attending to Ruwa clinic and who had a normal vaginal delivery in 2020. The population included the nurses and midwives working at Ruwa Clinic, in the department of maternity. Data was collected using interviewer administered questionnaires. Epi Infor 7.2.4 was used to enter data and data was analysed using Stata 13. Ways of disrespect and abuse (D&A) at Ruwa Clinic included: abandonment (65%), non-consented care (29.3%), undignified care (27.2%), being physical abused (13.3%), being discriminated (13.3), detention for non-payment of funds (6.6%), and non-confidential care (3.3%). Of the participants 32 (53.3%) were not knowledgeable on the rights of women when in labour. An increase of one year in age of women decreased the odds of non-dignified care of staff being impolite and was statistically significant with p-value = 0.031. An additional one more pregnancy and one more hour of the duration of labour increased the odds of staff not explaining the labour process to the women and was statistically significant with p-value = 0.019. Disrespectful maternity may be barriers to access quality RMC in Ruwa, Goromonzi District. Therefore, strengthening interventions is important to adopt and implement good policies, which promotes respectful and non-abusive maternity care in Ruwa.

Key words: Respectful Maternity care, Disrespect and Abuse, rights of women during childbirth.

Declaration

I declare that this dissertation is my original work except for where sources have been cited and acknowledged. The work has never been submitted, nor will it be submitted to another university for award of a degree.

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List of Acronyms and Abbreviations

ANA	American Nurses Association
ANC	Antenatal care
D&A	Disrespect and Abuse
DHS	Demographic Health Survey
LMIC	Low to Medium Income Countries
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
PMR	Perinatal Mortality Rate
RMC	Respectful Maternity Care
SDG	Sustainable Development Goals
UNFPA	United Nations Population Fund
WHO	World Health Organisation
WRA	White Ribbon Alliance
ZDHS	Zimbabwe Demographic and Health Survey

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CHAPTER 1 INTRODUCTION

1.1 Introduction

Respectful maternity care (RMC) is the quality care given to all women during delivery of their new babies in a way which will maintain their confidentiality, dignity, and privacy, ensuring that they are free from harm and being mistreated, which will enable them to have an informed decision and will be continuously supported when in labour (World Health Organization [WHO], 2018). The pillars of RMC are the healthcare workers, but quite often they disrespect or abuse women who are pregnant. Other healthcare like catering staff, cleaners, and the hospital security guards sometimes can be perpetrators of disrespect to pregnant women (Rawdon, 2014). These employees are the gatekeepers, but sometimes cause suffering to the women.

The health care system is affected by poor respectful maternity and this affect the health system including the reproductive health policies, and yet the RMC is not enforced in the system (Rawdon, 2014). To improve quality of care RMC is an important way of improving care and uptake of maternity care services. It is seen as a universal human right which bound the principles of ethics and the respect for women's state of mind, dignity, decisions and what they prefer (Moridi, Pazandeh, Hajian, and Potrata 2020). The White Ribbon Alliance and the Safe Motherhood also called for enhancing the promotion of respectful person-centred care in both reproductive health as we work towards to achieve the Sustainable Development Goals.

It is recognising that disrespectful maternity care is a barrier for women to get required health services. Thus, the WHO developed a statement "The prevention and

elimination of disrespect and abuse during facility-based childbirth" and recently came up with a guide to standards for improving the quality maternal and newborn care in the health care system (Webber, Chirangi, & Magatti, 2018). Lack of respectful maternity care during labour and delivery is increasingly being recognized as a sign of poor quality of care and as an obstacle to receiving the maternal and newborn health Sustainable Development Goals (SDGs) (Pitter, Latibeaudiere, Rae, and Owens, 2017).

1.2 Background to the study

Worldwide, about 140 million births happen every year. An estimated 303,000 maternal deaths, which occurred worldwide in 2015, a bigger percentage (99%) was, recorded in low and medium income countries (LMICs). In Zimbabwe, the Demographic Health Survey (DHS) (2015) found that the maternal mortality was at 651 deaths per every 100, 000 live births.

More than a third of maternal deaths and a proportion of the pregnancy-related which are life-threatening, are caused by complications that occur during labour or childbirth and immediate postpartum period, usually as result a of obstructed labour, postpartum haemorrhage, or sepsis. Approximately 50% of all stillbirths and about a quarter of all neonatal deaths are because of the complications that happen during labour and delivery (WHO, 2018).

In view of the above complications, it is of great importance to improve the quality of care around the time of birth, especially in LMICs, as it has been identified as the most impactful approach for reducing stillbirths, maternal and new-born deaths. This negative aspect can influence women's decision not to use health care facilities in

time or completely abandon it in their present or subsequent deliveries. It is therefore crucial to know what forms of disrespect and abuse exist and how to prevent them, and better meet women's emotional, physical, socio-cultural, and psychological needs to aim high quality maternity care.

Pregnant women have been educated on the importance of giving birth in health facilities, so that they will be able to access trained health professional and can be referred on time when the need for transfer arises. Furthermore, accessing maternity care services may not mean good quality maternity care because of disrespectful and undignified care by health care staff, which will eventually be a barrier to receive intra-partum services (Ishola, Owolabi, and Filippi, 2017). As indicated in the WHO, (2017) framework, to improve the quality of care for those women who are in labour, there should be a recognition of experienced care, which should be important as well as like clinical care provided to achieve the good person-centred outcomes.

Disrespectful care during child delivery infringes on the basic principles of women's rights and violates the activities in the health care delivery system to provide supportive care and healing. Different theories have been developed to define and categorize D&A. Bowser and Hill (2010) analyzed and categorized disrespectful and abusive care into seven types: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities.

The terms "disrespect and abuse" or "mistreatment" relating to childbirth were introduced and were conceptualized in the year 2010 and 2015 respectively, and the research in relation to the subject has been going on in different countries for many

years. These studies believes that D&A of women in labour has been in existence for a while and these practices infringes on the basic principles of women's rights yet it has got little programmatic attention (Ishola et al., 2017).

Recent research studies worldwide, show an increase in the number of cases of complaints on D&A by health professionals at the hospitals or clinic facilities, and mainly complaining of the midwives' and nurse's attitudes. Some studies done in Nigeria by Ishola et. al, (2017) showed the presence of D&A ranging from 11% to 71%. When a women receives poor treatment during the time of childbirth it will contribute to the poor health outcomes, which might significantly lead to the increase in maternal and neonatal mortality and morbidity.

Tsomondo, Chihava, Kasu and Mugadza (2017) also said that, even though efforts by the responsible personnel to implement RMC worldwide for better mother and new-born positive outcomes, D&A have been reported on worldwide. Also according to a research done by WHO, (2019) in selected 4 African countries shows that more than one 33% of women do experience disrespectful care during labour and delivery in health care facilities.

A Zimbabwean article (The Zimbabwean: A voice for the Voiceless, 2014), revealed that pregnant women were being mistreated, and these women would opt to be delivered by a traditional midwife, were there will be treated well with dignity and when there is a foreseen complication they will then go to the health facility. Dodzo (2018) assert that D&A is a problem in Zimbabwe and also said women`s human rights were being violated in health facilities whilst women are giving birth by nurses and midwives, non-dignified and physical abuse were reported mostly.

The millennium development goal (MDG) number 5 previously targeted to reduce maternal deaths by 75% by the year 2015, and this target was not achieved because there is still need for unrestricted access to high-quality emergency obstetric care to reduce the high risk of dying in pregnancy, which is still present in the low-resource countries. Reducing the high risk of mortality during childbirth in low-resource countries is the new target in the sustainable development goal (SDG) number 3, targeting to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 (Guzha et al., 2018).

It is noted that the lifetime risk of a women to dye from pregnancy-related complications is 1 in 4,700 in the developed world, while the lifetime risk of an African woman dying from pregnancy related complications is 1 in 39 (United Nations Population Fund [UNFPA], 2013). Zimbabwe has been battling to reduce its Maternal Mortality Rate (MMR) and Perinatal Mortality Rate (PMR) so as to meet the global targets despite the high skilled attendance birth rate of less than 70 maternal deaths per 100 000 and reduce neonatal mortality to at least as low as 12 per 1,000 live births (United Nations [UN], 2020). Maternal Mortality Rate (MMR) declined from 960 per 100,000 live births in 2010-2011 to 651 per 100,000 live births in 2015. This progress did not, however, enable Zimbabwe to meet its health-related MDGs. SDG 3 aims at reducing the global maternal mortality ratio to less than 70 per 100,000 live births.

It was noted that, although Zimbabwe's maternal deaths have been declining, the MMR is still high (651 deaths per 100 000 live births, ZDHS 2015, 421 death per 100 000 live births, MICS 2018). The MMR is still high, above the Zimbabwe's 2020 target of 326 maternal deaths per 100 000 live births (UNFPA, 2016). The

Perinatal mortality has increased from 29 deaths per 1000 live births to 32 deaths per 1000 live births (MICS 2014; MICS 2019).

Studies done recently, show a rise in the number of complaints on D&A by healthcare workers at healthcare facilities. Studies done in Nigeria by Ishola et. al, (2017) showed that the frequency of D&A was high ranging from 11% to 71%. In Tanzania, the prevalence was 15% in post-partum and 70% in community follow-up (Sando et al., 2016). Abuya et. al, (2015) conducted a study in Kenya and reported that 20% of women experienced D&A. Siraj, Teka, & Hebo (2019) did a study in Southwest Ethiopia which show a prevalence of 91.7% of D&A during facility-based childbirth.

In order to improve maternity services, there is need to monitor and improve the quality of care women get in different obstetric units (Guzha et al., 2018). There was acknowledgement that the provision and experience of care were critical elements that may affect service utilisation and health outcomes for the mother and new-born (Tsomondo et al., 2017). Thus, the need to improve obstetric care in health facilities as this will help to prevent maternal and neonatal morbidity and mortality.

1.3 Problem Statement

Promoting respectful care at childbirth is important to improve quality of care hence improve maternity outcomes. RMC issues are poorly documented in Zimbabwe, however some studies done have shown that D&A of women during child delivery is a problem in Zimbabwe (Dodzo, 2018). At Ruwa clinic, they conduct about 791 deliveries annually. Many of these women have at time complained of D&A during childbirth, though nothing is documented, this was said by the Environmental Health

Officer of Ruwa Local Board and the Sister in Charge of Ruwa Clinic, when the researcher visited Ruwa Clinic.

Disrespectful and abusive treatment of women during child delivery in health care facilities by health care providers have been the talk in the community, and the media continue to report these complaints. It is crucial to explore the current situation on disrespect and abuse of women during childbirth in Zimbabwe in order to understand its nature and extent, contributing factors and consequences, and propose solutions to improve quality maternity care hence improve the MMR and PMR. This study seeks to explore the RMC and provide a detailed knowledge of the D&A faced by women during maternity care in Zimbabwe.

1.4 Objectives of the study

1.4.1 Broad Objective

The broad objective of this research was to:

Determine the factors associated with respectful maternity care during childbirth in Ruwa, Goromonzi District, Zimbabwe in the year 2020.

1.4.2 Specific Objectives

The specific objectives of this research were to:

1. Determine the socio-demographic characteristics of pregnant women associated with disrespect and abuse of women during childbirth in Ruwa, Goromonzi District in the year 2020.

2. Identify the types of abuse women are facing during childbirth in Ruwa, Goromonzi District in the year 2020.

3. Establish the drivers of disrespect and abuse of women during childbirth by nurses and midwives at Ruwa Clinic, Goromonzi District in the year 2020.

4. Determine health care service factors in the maternity department associated with disrespect and abuse of women during childbirth at Ruwa clinic, Goromonzi District, in the year 2020.

1.5 Research Questions

1. What are the socio-demographic characteristics of pregnant women associated with disrespect and abuse of women during childbirth in Ruwa in the year 2020?

2. What are the types of abuse pregnant women are facing during childbirth at Ruwa clinic, 2020?

3. What are the drivers of disrespect and abuse of women during childbirth at Ruwa Clinic, Goromonzi District, 2020?

4. What are the healthcare services factors associated with disrespect and abuse of women during childbirth at Ruwa Clinic, Goromonzi District?

1.6 Significance of the study

It is crucial to know what forms of disrespect and abuse exist, to understand its nature and extent, contributing factors and consequences in order to propose solutions. An in-depth knowledge and more clarity on what respectful maternity care really is would assist both the health care giver and the women to have a mutual understanding of respectful maternity. The study helps to highlight the importance of the need for caregivers to honour the women's rights in a culture sensitive manner. Women would have a better awareness of their rights under care in maternity units. Detailed knowledge of RMC helps improve the quality of maternity care and improve the maternity and perinatal outcomes.

1.7 Delimitation of the study

The study was conducted in Ruwa town, Goromonzi District in Mashonaland East, it was carried out over a period of four months. The study was focusing on women of childbearing age from the age of 15years to 49 years of age, attending Ruwa Clinic, as well as nurses and midwives working in maternity department at Ruwa clinic. The study was looking on the factors associated with respectful maternity care and the prevalence of disrespect abuse of women during childbirth in Ruwa Goromonzi District. The field of study is health.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

This chapter provides insights into literature review on RMC and D&A of women by health care workers during childbirth. Available literature was searched to place the current study in the context of previous studies done in related fields. This chapter reviews literature on respect maternity care as researched by different authors, and a conceptual framework was developed. It looks on the background of respectful maternity care and various aspects, which include, types of abuse women are facing during childbirth, possible factors that lead to disrespect and abuse, socio-demographic characteristics associated with RMC, and healthcare service factors associated with RMC.

World Health Organisation, (2018) defines respectful maternity care as the care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth. Respectful Maternity Care improves women's experience of labour and childbirth and addresses health issues. Maternal care, dignified care and respect have been seen to be key issues of maternal health service satisfaction (Srivastava, Avan, Rajbangshi, & Bhattacharyya, 2015).

World Health Organisation states that RMC is a universal human right that is supposed to be given to every child-bearing woman in every health system in which the maternity care is expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights. In support of the human rights,

there are several conventions on women's human rights. An example is Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979, which include realization of women's reproductive health, sexual health and reproductive rights. The Convention obligates government to condemn all forms of discrimination against women (Khan, 1999).

White Ribbon Alliance (2011) calls together the Global Respectful Maternity Care Council with a broad group of stakeholders representing research, clinical, human rights and advocacy perspectives. The WRA and the Global Respectful maternity care Council developed the Respectful Maternity Care Charter and the Universal Rights of women and newly born child, which clearly shows the rights of women and new-borns when receiving maternity care in a healthcare facility.

Respectful Maternity Care must be taken into consideration as a critical component for providing good-quality care for women and infants within the health facility. Creative approaches need to be established to incorporate RMC into maternal quality of care enhancement efforts and neonatal care programmes (Shakibazadeh et al., 2017).

Freedman et. al, (2014) defines disrespect and abuse (D&A) during childbirth as an interaction or conditions that local consensus seems to be humiliating or undignified, and those interactions or conditions that are experienced as undignified. Disrespect and abuse can be a barrier to safe motherhood and can contribute to the two of the three deadly delays a woman can face during labour, which are not recognizing the signs of an emergency and seeking care; and not receiving adequate and appropriate treatment.

Improving access to health facilities will not save women if they are not willing or allowed to go to facilities or forced to endure abuse if they do. If a woman does not feel safe and respected when she first visits a maternity centre, she is less likely to attend her antenatal care appointments or come to a health facility when in labour, which increases her risk of both pregnancy-related morbidity and mortality (Barlett, 2015).

The World Health Organization (WHO) has defined quality of care and prepared a framework for providing optimum care for mothers and new-born around the time of pregnancy, delivery and postpartum because they realized that adequate care in this period contributes maximally to saving lives (Ijadunola et al., 2019). World Health Organisation, (2015), characterised quality of care definition, which include safety, effective, timely, efficient, equitable and people centred in delivering health care.

2.2 Theoretical framework

The factors associated with respectful maternity care during childbirth, and the disrespectful and abusive experiences women are facing during labour and delivery may be defined by social-ecological model. It is the model for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviours. The social ecological model states that health is affected by the interaction between the characteristics of the individual, the community, and the environment that includes the physical, social, and political components (Kilanowski, 2017).

Sallis, Owen and Fisher (2008) postulates that people are part of a social system and their interactions with the environment influence their health outcomes. Orpin (as cited in McLeroy et al., 1988) highlight five levels that are likely to influence health

outcome: individual, interpersonal, community, organisational and policy levels. A person's history factors such as age, attitude, understanding and behaviour are components of the individual level that influence the possibility of being a victim or perpetrator of violence (Krug et al., 2002). The interpersonal level comprises of the social influence from an individual's family, friends, neighbours and workgroups within the social system (McLeroy et al., 1988).

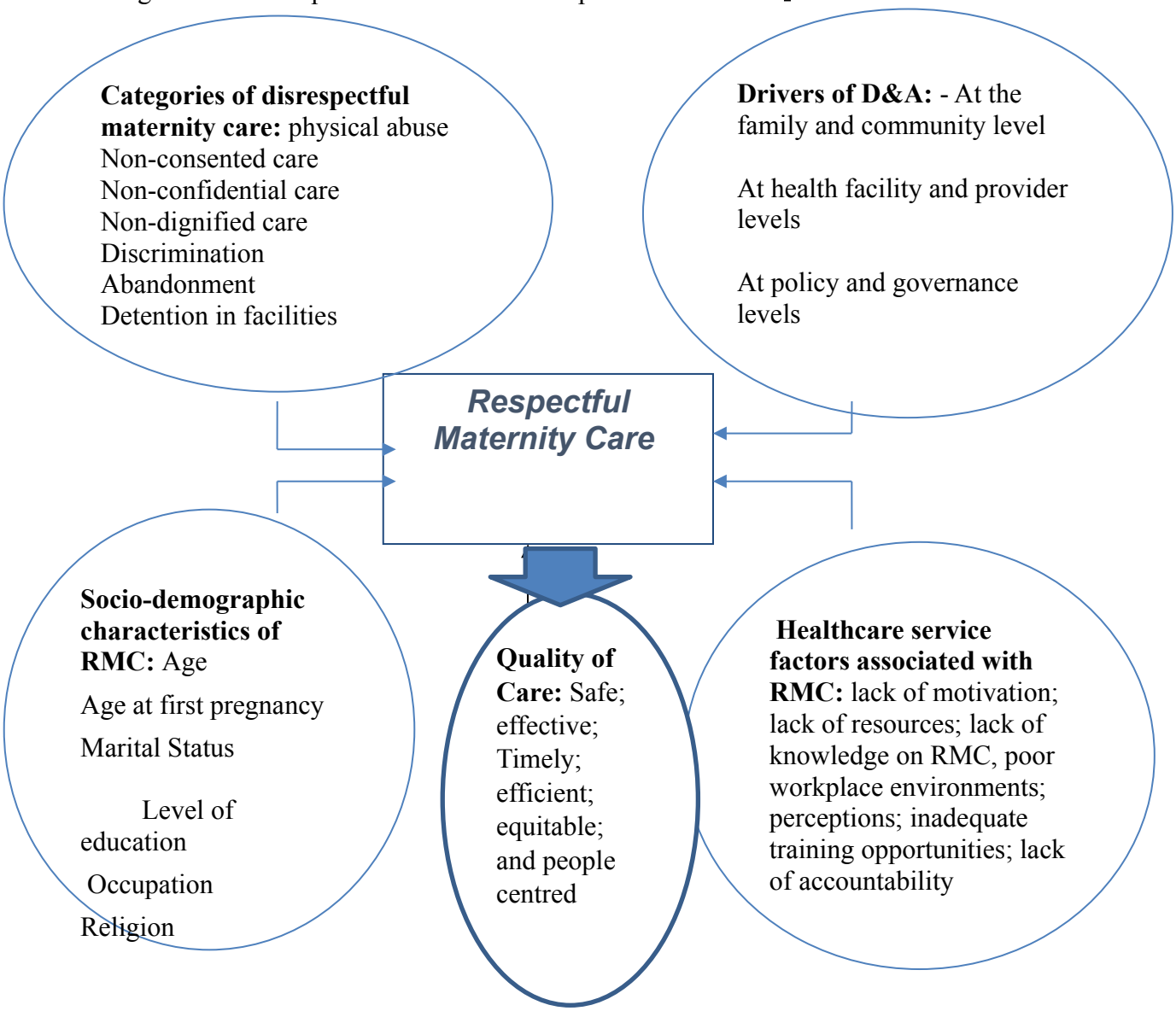
The organisational, also known as the institutional level comprises of elements such as communication networks, culture and structure of an organisation, and management styles. The approach to implementing interventions at organisational levels can involve the development of incentive programmes and process consultation. The community-level comprises of social and health services and informal and formal leadership practices. The goal of community-based interventions is to increase health services and empower disadvantaged people. The public policy level consists of legislation, taxes, policies and regulatory agencies, political change and media campaigns (McLeroy et al., 1988). The use of literature from different literature reviewed and the review of the above model helped in the construction of the following conceptual framework.

2.2.1 The conceptual Framework for Respectful Maternity Care

The conceptual framework of RMC was constructed from the literature review. When the socio-demographic characteristics, drivers of D&A, categories of D&A, rights for childbearing women and healthcare service factors has been established and addressed then RMC is achieved by the healthcare workers caring for the women in labour. Respectful Maternity Care (RMC) then result to the improvement of quality maternity care (Barlett, 2015: Browser and Hill, 2010: WHO, 2016: WHO,

2019: White F e, 2011). The conceptual framework helps to establish the factors associated with respectful maternity care and development of the data collection tools.

Figure 2.1: Conceptual Framework developed from literature



2.3 Relevance of theoretical framework to the study

The above concepts and their relatedness are described below as reported and viewed by various authors.

2.3.1 Types or Categories of disrespect and abuse

It occurs in all societies, but is particularly prevalent in low- and middle-income countries where there is only minimal accountability in the health systems and health facilities are poorly resourced. Prevalence rates for any kind of violence against women are notoriously difficult to determine due to a lack of documentation and societal norms that tolerate abuse against women. World Health Organisation did a research in four African countries which showed that more than one-third of women (approximately 35%) experience mistreatment during childbirth in health facilities (WHO, 2019).

There are seven categories of disrespectful maternity care that have been highlighted by Browser and Hill (2010), on the analysis of disrespect and abuse are: physical and verbal abuse, non-consented clinical care, non-dignified care, discrimination, non-confidential care, abandonment and detainment in a health facility. These may be due to behavioural and structural factors.

All women have a universal human right to be respected and cared for during pregnancy, childbirth, and thereafter.

2.3.1.1. Universal human right of pregnant women

Various literature have reported physical abuse, abusive language, rudeness, intimidation, scolding, lack of empathy, lack of privacy, unconsented care, neglect and detention in facility for failure to pay by the health care providers. This will mean that multiple human rights principles are being violated in particular the right of every woman to be treated with respect for their dignity.

The WRA, (2011) launched The Respectful Maternity Care Charter: the Universal Rights of Childbearing Women. The articles of the charter for RMC were given as every woman having a right to: be free from harm and ill treatment; information,

informed consent and refusal, respected for her choices and preferences including the choice of a birth companion; privacy and confidentiality; be treated with dignity and respect; equality, freedom from discrimination and equitable care; health care and to the highest attainable level of health liberty, autonomy and self-determination; and freedom from coercion (WRA, 2011: Browser and Hill, 2010). Table 2.1 shows the categories of disrespect and abuse and the universal rights which corresponds.

Table 2.1: The categories of disrespect and abuse and the universal rights which corresponds adopted from Bowser and Hill (2010)

Categories of Disrespect and abuse	**Categories of Corresponding Rights**
Physical abuse	Freedom from harm and ill treatment
Non-consented care	Right to information, informed consent and refusal and respect for choices and preferences, including the right to companionship of choice wherever possible
Non-confidential care	Confidentiality, privacy
Non-dignified care (including verbal abuse)	Dignity, respect
Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
Abandonment or denial of care	Right to timely health care and to the highest attainable level of health
Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

2.3.2 Possible drivers of D&A of women during childbirth

Drivers of D&A to women during childbirth may include at policy and governance levels, at health facility and provider levels and at the individual and community level.

2.3.3 Possible drivers of D&A at individual and community level

A study done by Warren, Njue, Ndwiga. and Abuya, (2017) revealed that lack of knowledge by women on their rights and the kind of treatment to expect from health care workers are drivers to D&A.

Low socio-economic status was seen as drivers to D&A, for instance the poor are easily identified by their mode of dress and their inability to pay and are often discriminated or abandoned when seeking delivery services (Warren et al., 2017). WRA, (2015) identified the following as drivers to D&A: sociocultural factors, imbalanced gender power dynamics, healthcare providers seen as authority figures, limited understanding of women's health rights, illiteracy, misinformation and lack of information, and non-prioritisation of healthcare needs. The role of community advocacy groups, professional associations and government in promoting awareness of the concepts of RMC should be strengthened.

2.3.4 Possible drivers of D&A at health facility and provider levels

These include limited understanding of clients' rights, inadequate infrastructure leading to poor working environment, staff shortages leading to high stress and poor quality of care, lack of basic knowledge and inappropriate task-shifting, poor supervision, lack of professional support, lack of standards and quality-of-care guidelines (WRA, 2015).

A study done by Afulani et. al,(2020) showed that the main reason health professionals gave for undignified care and physical abuse was that they do it in order to save the baby when the woman was not cooperative. Women were not following their instructions for instance to expose their perineum, to push, examination refusal, screamed too much, wanted to deliver on the floor, could become impatient or insisted to being seen to ahead of the other persons, or were disrespectful to the healthcare providers were described as difficult. Women having their first pregnancy were viewed as likely to be difficult, and were the ones likely to be disrespected and abused by health professionals (Afulani et al., 2020).

Jolly, Aminu, Mgawadere, & Broek (2019) highlighted deficiencies in knowledge regarding RMC and the rights to both women receiving maternity care and trained healthcare providers providing the care. They went on to say that, there is a need to be more proactive to promote the rights of women as stated in the RMC Charter.

2.3.5 Possible drivers of D&A at policy and governance levels

White Ribbon Alliance, (2015) identified non-realisation of international conventions, lack of transparency and accountability for policymakers, insufficient funding for maternal healthcare, and insufficient reporting and/or monitoring and evaluation of services as drivers to D&A at governance levels. Poor supervision of facilities, poor supply of drugs, and supplies, and lack of equipment also leads to D&A.

2.3.6 Socio-demographic characteristics associated with RMC

Studies have reviewed that socio-demographic factors such as one's age, marital status, highest level of education, person's of residence, employment status, one's

religion are associated with RMC. Labour and delivery experience is influenced by the views and expectations of the coming birth, health information given by healthcare providers and interpersonal communication between the midwife and client (Henriksen, Grimsrud, Schei, & Lukasse, 2017). The experience of positive care by women during childbirth, including respect, non-discriminatory care, addressing the women's rights, communication and emotional support, is particularly important to mothers. Bryanton, Gagnon, Johnston, & Hatem, (2008) postulates that, positive experiences have been associated with age, parity, prenatal education, expectations, social status, being informed, experience of feeling in control, method of delivery, medications, experience of support from caregivers and partners, length of labour and the birth situation.

Warren et. al, (2017) found that women reported some of the physical abusive actions, such as being pushed and being beaten during child delivery. The women have seen as the actions to be helpful to them and the younger ones felt that being beaten was acceptable because it was to ensure their cooperation and be attentive to the labour process. A study done by Lerberg, Sundby, Jammeh, & Fretheim, (2014) revealed that Women in low resource settings, continue to report disrespect and verbal abuse from midwives and other care providers, which deter them from giving birth in hospital.

2.3.7 Healthcare service factors associated with RMC

There are a multitude of factors that lead to disrespect and abuse of women during childbirth. Barlett (2015) revealed these factors as, gender norms and values; power and status relationships; lack of motivation to practice RMC; poor workplace environments; perceptions of health workers in society and the media; inadequate

training opportunities; and pervasive lack of accountability for disrespect at both local and national level

Health systems in crisis need support to effectively implement and sustain respectful maternity care practices, and this includes addressing the rights and needs of both clients and health workers. Health workers, women, and their families need to know the rights of a woman seeking maternity care and health sectors must address the needs of their health workforces (Barlett, 2015).

Webber, Chirangi, & Magatti, (2018) reviewed that insufficient supplies and inadequate staffing are other common concerns, which likely contribute to negative staff attitudes, as well as working understaffed or without the equipment and medication needed to perform their jobs will make attitude improvements among health care providers unlikely to be sustained.

Pitter, Latibeaudiere, Rae, and Owens, (2017), said the using the framework for quality maternal and newborn care falls within the midwifery practice. They went on to say, they should therefore raise awareness and agitate civil society demand for RMC rights, mobilize communities to hold local leaders and service providers accountable for RMC rights and secure commitment at the national level to in cooperate RMC as the standard of care.

As frontline workers, midwives have a crucial role to play in the healthcare delivery system and to achieve its maternal goals. Furthermore, midwives are usually women in that regard they should ensure that women, newborn babies and families receive sensitive care with dignity, compassion, and kindness in a safe environment (Pitter et al., 2017) .

Barlett, (2015) stated that, to sustain respectful maternity care, health sectors should provide health workers with, safe working conditions and reasonable working hours, policies that mandate health workers are treated with respect by other staff and clients, support from their managers and ministries of health, training on cultural sensitivity and continual education on evidence-based practices. Mentors who model respectful maternal care, adequately resourced facilities, and physical and psychosocial support to combat stress and fatigue. Afulani et. al, (2020) revealed that provider attitude can be accredited by stress, lack of motivation, ignorance, lack of training or just being human, and some providers are rude and arrogant.

As local governments find to improve services, they will need to address training, compensation, and retention of suitable numbers of health care providers to ensure positive work attitudes, in addition to providing these providers with the necessary tools to exercise their skills, including medications to give their patients (Webber et al., 2018).Morgan (2015) argued that a suitable definition of woman-centred care is missing, he reviewed that woman-centred care has the following characteristics: non-demanding relationship, informed decision and woman centred care.

Respectful maternity care is vital in attaining the Sustainable Development Goals in order to reduce maternal mortality to 70/100 000 by 2030. This is only possible with better use of skilled birth attendants and health institutional deliveries in the non-appearance of disrespect and abuse. The care delivered should be patient-centred, accessible, reasonable in well-resourced delivery facilities, with skilled, pleasing and are well motivated staff (Tsomondo et al., 2017). Policy makers need to put policies in place to support respectful maternity care in terms of infrastructure, resources and supportive supervision and accountability.

Health systems should organise for and have sufficient human and material resources, a favourable working environment for the workers and patients (Tsomondo et al., 2017). Poor infrastructure and insufficient supplies and medications hinder the provision of RMC.

A study done in Kenya by Afulani et. al, (2020) revealed that occasionally it is difficult to maintain women's confidentiality and privacy because of the open environment of the labour wards, which were too small for the number of women in labour, and non-existence of privacy screens.

At the health-facility level, there is a need for measures to ensure that skilled birth attendants can deliver well organized, effective, and uninterrupted maternity care. These include supportive supervision, motivations, training, suitable physical infrastructure, and sufficient human resources. Healthcare providers may also benefit from the more clear inclusion of RMC actions in pre-service and postgraduate teaching, although the effectiveness of teaching to improve RMC has not been precisely established (Shakibazadeh et al., 2017).

At the level of health-system, the formation and integration of values and standards relating to RMC should be considered. This will require the development and validation of RMC-related indicators that along with the policy, cultural, and financial implications are adequately responsive to RMC-related improvements. Policymakers should safeguard the improvement and integration of inscribed, up-to-date values and standards for RMC that clearly describe goals, working strategies, and monitoring mechanisms. Policymakers should also be conscious that shifts in health-system infrastructure (e.g. increasing assignments) could interrupt implementation; thus, any infrastructural variations need close monitoring to

guarantee the feasibility and the sustainability of RMC actions (Shakibazadeh et al., 2017).

Some health care personnel might not have enough knowledge on RMC. A study done by Webber et. al, (2018) showed that the health care workers after workshops attendance, that the excellent health care services they presented was lacking and many of them stated that their approaches towards their women clients were problematic.

2.4 Summary

Respectful maternity care is necessary. It is achievable, and it is everybody's responsibility. Every woman has the right to the highest achievable standard of health, which includes dignified and respectful care. Disrespect and abuse should be prevented and eliminated throughout childbirth, to reduce mortality and morbidity of the women and the new-born babies. The chapter focused on review of literature related to respectful maternity care. The literature reviewed by researcher, noted that there is no research, which has been done on barriers to RMC and the on the prevalence of disrespect and abuse of women during labour in Goromonzi District, Zimbabwe.

CHAPTER 3 METHODOLOGY

3.1 Introduction

In this chapter, the researcher presents a description of how the research was carried out. According to Jharotia (2015), the methodology section is very important because it tells how the researcher is planning to tackle the research problem, and it will provide the work plan and describe the activities necessary for the completion of the project.

The topics covered in this chapter include, research design and its appropriateness, the definition of the target population and sample, sampling techniques, research instruments, data collection procedures, and data presentation, analysis and interpretation. The chapter also looks on reliability of the research instrument and validity and ethical considerations.

3.2 The Research Design and its appropriateness

Research design is considered as the structure of a project, it is a plan of the proposed research work (Akhtar, 2016). An analytical cross-sectional study design was used, as it reflect the situations and factors associated with respectful maternity care among women during childbirth at Ruwa clinic, Goromonzi District in the year 2020. The chosen research design allowed the researcher to get a “snapshot” of the disrespectful and abusive maternity care the women are facing from the midwives during childbirth at Ruwa clinic. The analytical study design helped the researcher to analyse the presents of D&A and its associated factors. It was also chosen as it is easy, quick, cheap and less time consuming.

3.3 Study setting and rationale for selection

The study was carried out at Ruwa Poly clinic, Goromonzi District in Mashonaland East, Zimbabwe. It is situated 24 kilometres from the Harare Central Business District (CBD) in Ruwa town, Goromonzi District. The clinic was conveniently selected as it is the biggest clinic in Ruwa which provides maternity services to the Ruwa residents. It has been found out that most of the women who would have delivered at the clinic occasionally complain about the disrespectful and abusive care they get at the clinic. Be that as it may, at Ruwa clinic there is a lack of comprehensive documentation of D&A experienced by women during childbirth, specifically its nature, forms, causes, and prevalence, and in so knowing these, disrespect and abuse can be eliminated.

3.4 Study Population

The targeted population was all women aged 15 years to 49 years who attended Ruwa clinic and had a normal delivery in the year 2020. In the study period January to December 2020 a total of 720 women delivered at Ruwa Poly clinic according to the delivery records at Ruwa clinic.

The study population also included health care workers who worked at Ruwa Poly Clinic, and comprised of midwives and nurses working in Maternity department. There were a total of six midwives and one general nurse who worked in maternity department during study period.

3.4.1 Inclusion criteria

Women aged 15 years to 49 years who had delivered at Ruwa Clinic, Goromonzi District in the year 2020, and coming for postnatal care who had given consent to be part of the study were included. Women who would have delivered before arrival at

the clinic were also included. All health care workers that comprised of midwives and nurses who had worked at Ruwa Clinic maternity department for at least 6 months were also included. The nurses and midwives were targeted, as they are the ones that are much involved in the patient's care.

3.4.2 Exclusion criteria

Women who did not deliver at Ruwa Clinic and those who did not deliver in the year 2020 were excluded. Teenagers below the age of 15 years were also excluded. Any women who was suffering from a mental illness and who had a stillbirth were also excluded. Health care workers who had less than six months working experience at Ruwa Clinic, and any health worker who was not a registered general nurse or midwife were also excluded.

3.5 Sample Size and Sampling procedure

3.5.1 Sample size calculation

Using Dobson`s formula - $n = Z^2 p (1-p)/\Delta^2$ where: n = sample size, Z= 1.645using a 90% confidence interval, p= 0.67 proportion of participants who reported having experienced with D&A, 1-p= 0.33 proportion of women who did not experience D&A basing on a cross-sectional study on prevalence of disrespect and abuse of women during childbirth and associated factors in Bahir Dar town, Ethopia in 2018 by Wassihun, Deribe, Worede, & Gultie (2018), Δ=absolute precision 10%. The calculated sample size was 60 for the women who are going to be recruited into the study.

A census was done on the health care workers whereby every nurse and midwife with more than six months working in maternity department was recruited into the study. 5 midwives and 1 nurse were recruited into the study.

3.5.2 Sampling Procedure

The researcher used the purposive sampling technique whereby women and health care workers were selected according to the needs of the study provided in-depth information relevant to the study. All applicants who did not meet the profile were excluded from the study. Purposive sampling was used as it aimed at identifying and recruiting participants that possessed some characteristics which were necessary to achieve the research objectives and allows researcher to gain an in-depth understanding of the phenomenon under study (Patton, 2015). Purposive sampling enabled for the identification and recruitment of women, nurses, and midwives who provided in-depth information relevant to answer the stated research questions.

The researcher calculated 60 participants as the required sample size using Dobson's formula as shown paragraph 3.5.1, thus, a total number of 60 participants were recruited. Interviews were conducted at Ruwa clinic on the women who had delivered at the clinic and those who delivered before reaching the facility, in 2020. The study participants were recruited into the study during their postnatal care visit and were required to give their written informed consent to participate in the study. The average number of women that came for postnatal care per day at the clinic was around 15 therefore purposive sampling was done as mothers came into the postnatal clinic. Every women who possessed the characteristics was interviewed with a target of 10 interviews per day.

All the nurses and midwives who had more than six months working experiences at Ruwa clinic maternity department were interviewed until the target sample size was achieved.

3.6 Data Collection Instruments

Questionnaires were prepared after reviewing literature related to RMC. Questionnaires were used as they were easy and cheap to administer. They also allowed uniformity in responding to questions as it was administered in written form and the instructions and questions were standardised. Data on socio-demographic characteristics associated with RMC, types of abuse women are facing during childbirth, and healthcare service factors associated with RMC was collected from the study participants using questionnaire. The data was used to understand the factors associated with RMC.

A questionnaire was also used to collect data from the nurses and midwives working in maternity department at Ruwa clinic. The interview questions were formulated basing on the reviewed literature reviewed, and being guided by the seven categories of disrespect and abuse and the corresponding rights of women during childbirth to assess the drivers of D&A, types of abuse being experienced by the women and the health care service factors associated with RMC.

3.6.1 Validity and Reliability

The researcher assessed validity by checking how well the results of the study correspond to established theories and other measures of respectful maternity care. The researcher was assessing reliability by checking the consistency of results across time, across different observers, and across parts of the test itself. The researcher

ensured that the instrument used was structured in simple and understandable ways to avoid ambiguity.

3.7 Pretesting of instruments

This involved testing the research instrument in conditions as similar as possible to the research, but not in order to report results but rather to check for glitches in wording of questions, lack of clarity of instructions and, anything that could have impeded the instrument's ability to collect data in an economical and systematic fashion. The data collection tools were pretested at Mabvuku Poly Clinic after which necessary adjustments were done before commencement of the actual study. This was done to check acceptability and understandable of the questions as well as the ability of the questionnaire to collect the intended data. The researcher also checked on the time needed to complete the questionnaire.

3.8 Data Collection Procedure

Interviewer administered questionnaires were used to collect data from the women who had given birth in 2020 and had given consent to participate. The study participants who were recruited into the study comprised of women coming for their postnatal care visit which is at six weeks post-delivery, women who were coming to immunize their babies and the women who would have just delivered who were admitted in the post natal ward. They were required to give their written informed consent to participate in the study. The researcher conducted 10 interviews per day.

The researcher would first liaise with the nurse on duty. The nurses at Ruwa Poly Clinic would refer the eligible study participants to see the researcher only after they had received all the services they required. The researcher then asked participants to

choose the language they were most comfortable with either English or Shona to use for the study.

A written informed consent from the study participants was obtained first before collecting data after the researcher have explained in detail what the study is all about as indicated in the information given in the consent form The researcher allowed the participants to ask questions where they needed clarity and they were told to freely decide on whether or not to participate in the study as it was their right. Interviews were done in a separate individualised room to allow privacy.

Interviewer administered questionnaires were used to collect data from the nurses and midwives, working in maternity department. The researcher gave information about the study to midwives and nurse and a reassurance was given that the information they were giving will remain confidential and anonymous. They were requested to participate in the interviews when they were not busy so as not to interfere with their work. They were interviewed on their knowledge of RMC, women's rights during childbirth, working environment and healthcare factors associated with RMC or that could be contributory to D&A. The interview questions were formulated basing on the reviewed literature and the basic principles of women's rights.

The researcher used both open-ended and close-ended questions in the questionnaire for both the women participating and the nurses and midwives at Ruwa clinic maternity department. Open-ended questions gave participants more options for responding and it allowed them to freely explain themselves. Close ended questions were also used to help reduce respondent thinking time and thus making questionnaire completion easy and making the participants more willing to

participate. They also guaranteed consistency of the responses for easy data analysis and interpretation. Observation of COVID-19 safety precautions were being adhered to throughout data collection process. The researcher and participants wore face masks correctly, practiced physical distancing and the use of sanitizers.

3.9 Analysis and Organization of Data

Data was field edited then entered using Epi info version 7 and analyzed using Stata 13. Epi-Info 7 was also be used to generate frequencies. Stata has the advantage of that it automatically sets up and import designated variables, it is extremely a powerful tool for manipulating data and it avoids errors. Data cleaning was done by ensuring that data has been correctly and accurately entered in Epi infor 7 through questionnaire inspection and by running frequencies for all study variables and correcting data entry mistakes before analysis. Stata 13 was used to perform generated frequencies, and a p-value <0.05 and clinical importance of variables were used to select variables for multivariable logistic regression. Then a p-value <0.05 was used to declare statistical significance. Adjusted Odds Ratio and a 95% Confidence Interval were used to report the strength of association between D&A and independent variables.

3.10 Ethical Considerations

The researcher sought the permission to carry out the study from Africa University Research Ethics Committee (AUREC) before embarking on the study. The researcher through the University office sought permission from Administrator of Ruwa Local Board to be given permission to carry out the research at their Ruwa Poly Clinic.

Written informed consent was sought from the participants after explaining to them the purpose and benefits of the study. Participation in the study was voluntary and participants were free to withdraw from the study at any time they wished during the study without any prejudice or coercion. The participants were assured that their decision to participate, not participate, or withdraw from the study was not affect them in any way in getting their usual services. In this study, the subjects were assured of both confidentiality and anonymity. To ensure impartiality and confidentiality for respondents, the questionnaire were constructed and data analysed in such a way that information is not traceable to individuals. Participants were told that there was no monetary benefits for participating, but their participation will help in improving the quality of maternity care provided by health care workers.

Researchers have an ethical responsibility to recognise and protect rights of human research subjects. During data collection observation of COVID-19 management protocols were observed, that is use of face masks during interviews, maintaining social distancing and hand sanitizing were being done throughout the data collection.

3.11 Summary

This chapter of the dissertation focused on the research methodology. It included the research design, the study setting, the targeted population, sampling procedure, data collection instrument and procedures for data collection. Data was analysed using known statistical packages. The chapter ended by describing ethical considerations

CHAPTER 4 DATA ANALYSIS AND PRESENTATION

4.0 Introduction

Disrespect and abuse can be a barrier to RMC. The aim of this research was to determine the factors associated with respectful maternity care during childbirth in Ruwa, Goromonzi District, Zimbabwe in the year 2020. A total of 60 postnatal mothers who delivered at Ruwa Poly Clinic, Goromonzi District in 2020 were recruited into the study in line with the required minimum sample size of 60, and a total number of 6 nurses working in the maternity department were recruited into the study. Data collection was done from the 14th of December 2020 to 25 March 2021. This chapter presents the results on socio-demographic characteristics, drivers of D&A, categories of D&A, rights for childbearing women and healthcare service factors associated with respectful maternity care.

4.1 The socio-demographic characteristics of pregnant women associated with disrespect and abuse of women during childbirth

A total of 60 women who had given birth at Ruwa Poly Clinic in Ruwa Goromonzi District were interviewed and response rate was 100%, except for the women who responded on the question of being in a polygamous marriage or not which was 86.67% response rate. The mean age of the study participants was 28.33 years. More than three quarters of the women (86.67%) were married/cohabiting, 61.67% of them attained secondary as the highest level of education, 46.67% were Pentecostal religion, and 45% of the women were unemployed. Of the participants, 52 were married or cohabiting, 5(8.33%) of the women were in a polygamous marriage. This is shown in table 4.1.

Table 4.1: Socio-demographic Characteristics of pregnant women associated with D&A in Ruwa Goromonzi District, 2020

Variable	Category	n=60	(%)
Marital Status			
	Divorced	4	6.67%
	Widowed	1	1.67%
	Married/Cohabiting	52	86.67%
	Single	3	5%
	Total	**60**	**100%**
Level of Education	Primary	4	6.67%
	Secondary	37	61.67%
	Tertiary	16	26.67%
	None	3	5%
	Grand Total	**60**	**100%**
Religion	Catholic	8	13.33%
	Apostolic	6	10%
	Pentecostal	28	46.67%
	Protestant	18	30%
	Total	**60**	**100%**
Employment Status	Formally Employed	11	18.33%
	Informally Employed	22	36.67%
	Unemployed	27	45%
	Total	**60**	**100%**
Polygamous Marriage (those who were married or cohabiting)	No	47	78.33%
	Yes	5	8.33%
	Total	**52**	**86.67%**
Mean age:28.3years			

4.1.1 Obstetrics History of women who delivered in 2020 at Ruwa Clinic, Goromonzi District

Of the women who participated in the study, 50% of the women had a parity of 1 to 3. 13-24 hours was noted to be the highest duration of labour of 46.67%, 95% of the women had no history of still births, 68,33% of the women managed to have at least 1-3 number of ANC Visits, only 20% had more than 4 ANC visits with 11.6% who did not attend to a single visit. This is shown in table 4.2.

Table 4.2. Obstetrics History of women who delivered in 2020 at Ruwa Clinic, Goromonzi District

Variable	Category	n = 60 (%)
Age	15 – 19 years	6 (10%)
	20 – 24 years	13 (21.7%)
	25 – 29 years	17 (28.3%)
	30 – 34 years	12 (20%)
	35 – 39 years	9 (15%)
	40 and above	3 (5%)
	Total	60(100%)
Mean age: 28.3years		
Mother's Parity	First baby	18 (30%)
	1to3	30 (50%)
	4 and above	12 (20%)
	Total	60(100%)
Duration of labour	≤12 hours	20 (33.3%)
	13-24 hours	28 (46.67%)
	≥25 hours	12 (20%)
	Total	60(100%)
History of still birth	Yes	3 (5%)
	No	57 (95%)
	Total	60(100)
Number of ANC Visits	Nil	7 (11.6%)
	1-3	41 (68.33%)
	4 and above	12 (20%)
	Total	60(100%)

4.2 Types of abuse women are facing during childbirth at Ruwa Clinic, Goromonzi District in the year 2020

Overally the seven women's rights, were not in the same way violated; ranging from 3.3% on non-confidential care to 65% on neglect/abandonment of care. Of the participants, all of them reported at least one of the violations of the seven women's rights, meaning they have received non-respectful and abusive care. Below is the table (table 4.3), showing the types of disrespect and abuse which were faced by women at Ruwa Poly Clinic which violated their rights.

Table 4.3 describes the status of respectful maternity care at Ruwa Poly clinic. Physical abuse, described as being pushed, beaten, poked, being slapped and pinched during labour and delivery was reported by 8(13.33) women. Non-confidential care was reported by 2(3.33%) women. Non-dignified care was also reported by women, which was seen as service providers not introducing themselves 14(23.3%); staff attitude not being polite 18(30%); insults or threats 17(28.33); and not getting enough explanation on what should be done 8 (13.33). Neglect or abandonment of care, was reported by 18(30%) women, and described the staff as not quickly responding to their needs. All of the participants 60(100%), reported that they were not given any pain relief during labour.

Among the participants, some reported non-consented care, being given by the health care workers, which included not having the right to choose 17(28.33%); not being requested to ask question 6(10%); labour process not being explained enough to the women 29(48.33%); 16 (26.67%) were not allowed to choose their desired status or position on bed or outside it; and 20(33.33%) of the women were not asked for a permission by the health care workers to do any action. Of the participants, 4(6.67%) reported they have been detained for failure to settle bills and being

requested to pay extra service charges by health care workers. A significant number 8(13.33%) of women, felt they were discriminated by nurses and midwives.

Table 4.3 Types of abuse women are facing during child birth

Category of D&A	**Yes n= 60(%)**	**No n = 60(%)**	**Total**
Physical Abuse			
pushed, beaten, poked	8 (13.33)	52 (86.67)	60(100%)
slapping pinched,			
Non-confidential care			
privacy maintained	58 (96.67)	2 (3.33)	60(100%)
Non-dignified care			
Service providers introducing themselves	46 (76.7)	14 (23.3)	60(100%)
Staff attitude being polite	42 (70)	18 (30)	60(100%)
Any insults or threats happened	17 (28.33)	43 (71.67)	60(100%)
Neglect / Abandonment of care - Highest attainable level of healthcare and continuous support			
Staff quickly responding to the needs in cases of any help or information needed	42 (70)	18 (30)	60(100%)
use of pain relief during labour	0	60 (100)	60(100%)
Information, informed consent, and respect for her choices and preferences			
The right to choose	43 (71.67)	17 (28.33)	60(100%)
The staff allowing to ask questions	54 (90)	6 (10)	60(100%)
The staff explaining the labour process	31 (51.67)	29 (48.33)	60(100%)
Allowed to choose a desired status or position on bed or outside it	44 (73.33)	16 (26.67)	60(100%)
The staff asking for a permission before any action			

Explanation on what to do	40 (66.67)	20 (33.33)	60(100%)
	52 (86.87)	8 (13.33)	60(100%)
Inappropriate demands for failure to pay Hospital detention for non-payment of related fees, or being requested to pay extra charges	4 (6.67)	56 (93.33)	60(100%)
Discrimination based on specific attributes			
Discrimination because of ethnicity, race, economic situation or any other form	8 (13.33)	52 (86.67)	60(100%)

4.2.1 Status of D&A at Ruwa Poly Clinic, Goromonzi District, 2020

Neglect / Abandonment of care (65%) was found to be the highest of the women's rights being violated, followed by non-consented care (29.33%), and non-confidential care (3.3%) being the least of them all. This is shown in Figure 4.1.

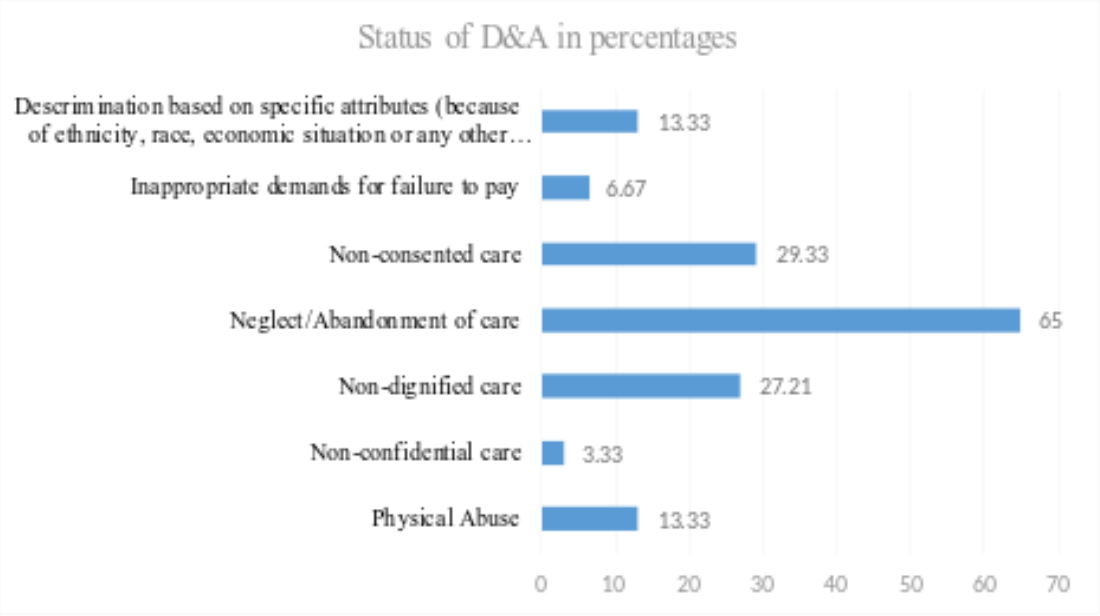


Figure 4.1 Status of D&A at Ruwa Poly Clinic, Goromonzi District, 2020

4.3 Multiple regression analysis of variables associated with RMC

The disrespectful maternity care variables that were reported by the participants are physical abuse, non-dignified care, non-confidential care, non-consented care, abandonment, and detention. Data from Microsoft Excel was then exported to STATA 13 software to compute multivariate regression exploring the relationship between RMC and demographic factors, as shown in table 4.4.

The independent variables of interest to this study were age, marital status, employment status, and education, and parity, number of children and history of antenatal care. The depended variables for RMC were physical abuse, non-dignified care, non-confidential care, non-consented care, abandonment, discrimination and detention or inappropriate demands for failure to pay.

Women with secondary and tertiary education increased their odds of being insulted by hospital staff by compared to those with primary education. An increase of one year in age of women decreased the odds of non-dignified care of staff being impolite by 14 % (statistically significant p = 0.031: 95% CI 0.7374, 0.98520) meaning that staff were likely to be impolite with older women and polite to younger women. An additional one more pregnancy and one more hour of the duration of labour increased the odds of women to be denied their right to choose by 7% (95% CI 0.4469, 2.559) and 26.3% (95% CI 0.4506, 3541) respectively.

An additional one more pregnancy and one more hour of the duration of labour increased the odds of women to be denied their right to ask questions by 66 % (95% CI 0.5926, 4.6592) and 86.7% (95% CI 0.6439, 5.4141) respectively. An additional one more pregnancy and one more hour of the duration of labour increased the odds of staff not explaining the labour process to the women by 502.6 (statistically

significant p = 0.019: 95% CI 1.337, 27.481). Being formally and informally employed increased the odds of not being allowed to choose desired status or position on bed by 6.9% (95% CI 0.4469, 2.5592) and 26.3% (95% CI 0.4506, 3.5411) respectively compared unemployed women.

Women who were informally employed had an 48,7% (CI 0.253,8.761) increase in odds of neglect/abandonment of care by having hospital care not quickly responding to their needs in case of need for help or information compared to those who were not employed. On the other hand, an additional single pregnancy increases the odds of neglect/abandonment of care by having health care workers not quickly responding to their needs in case of need for help or information by 36.5% (CI 0.553, 3.371).

Those women who did not attend any ANC visit decreased their odds of neglect/abandonment of care by having hospital care not quickly responding to their needs in case of need for help or information by 89 % (statistically significant, p =0.025; (95 % CI 0.0138, 07753) compared to those who attended an ANC visit. Those who attended ANC visits had the highest odds 2900% (95% CI 0.003, 26399) of being detained for failure to pay compared to those who did not. Being a protestant increased the odds of discrimination by 300 % (95% CI0.1900, 48,6355) compared to other religion.

Table 4.4 Multiple regression analysis of variables associated with RMC

Dependent variable	**Independent variable**	**OR[95%CI]**	**P-value**
Physical abuse	Level of education:		
	Secondary	9.65[0.9-103.12]	0.061
	Tertiary	2.58[0.201-33.154]	0.47

Non-dignified care:			
Polite attitude	Age	0.852[0.734-0.985]	0.031*
Non-consented care:			
The right to choose	Parity	1.069[0.447-2.559]	0.88
	Duration of labour	1.263[0.450-3.541]	0.657
Allowed to ask questions	Parity	1.66[0.59-4.65]	0.33
	Duration of labour	1.867[0.644-5.41]	0.25
Given information on labour process	Parity	6.062[1.337-27.481]	0.019*
	Duration of labour	1.052[0.38-2.91]	0.923
Allowed to choose desired status or position on bed	Formally employed	3.81[0.351-41.38]	0.271
	Informally employed	6.159[0.612-62.01]	0.123
Neglect or abandonment(quickly responding to the women's needs)	Formally employed	1.488[0.253-8.76]	0.661
	Informally employed	0.609[0.091-4.076]	0.609
Inappropriate demands for failure to pay	Attended ANC visits	29.56[0.03-263999.3]	0.466
Discrimination based on specific attributes	Religion: Protestant	3.04[0.190-48.63]	0.432

**Statistically significant*

4.4 Women's Knowledge on the rights of women during child birth

More than half of the participants 32 (53.33%) did not have the knowledge on the rights of women during childbirth, as shown in figure 4.2.

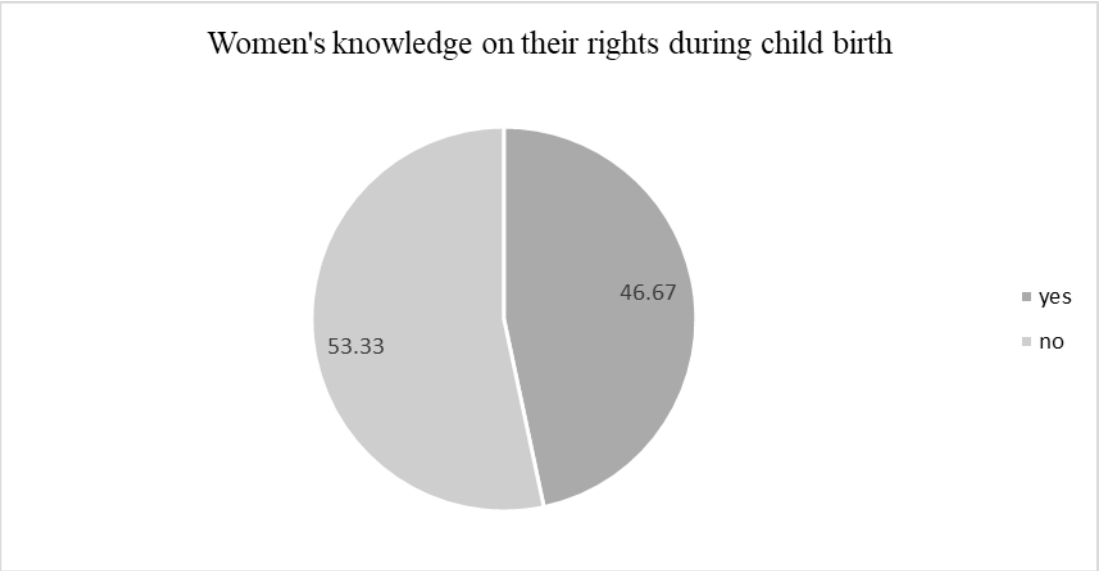


Figure 4.2 Women's Knowledge on the rights of women during childbirth

4.5 Drivers of disrespect and abuse of women during childbirth at Ruwa Clinic, Goromonzi District in the year 2020

Women's perspectives on the drivers of D&A

For many of the responders, they said they are drivers associated with disrespect and abuse of women by health care workers during childbirth, more than half 35(58.33%) of the participants mentioned that D&A, is the norm of the nurses and midwives as they shout a lot to the patients, not sympathetic and not supportive:

'*It is well known that nurses are rough, they just shout at you even if you have done nothing wrong'.*

Some participants eight (13.33%) said shortage of staff, is one of the causes why nurses and midwives are disrespectful. One of the participants said:

'When you are in need of help, you call for assistance the nurse will not come in time, as she will be attending to the other patients'.

Another woman reported that she experienced a lack of supportive care, and the midwives were so reluctant to help and they were not quickly responding to her needs when she was in labour.

'*I was bearing down whilst I was standing beside the bed, and I could feel my baby was coming, so I called for help, but they did not respond immediately, when they later came the baby's head was now visible almost coming out. They started shouting at me and threatening me that my baby was going to die. I then managed to get onto the bed and delivered my baby'*.

Another participant said:

'After I had delivered my baby I started bleeding whilst in the toilet, I called the sister and when she came, I had messed up the toilet, she just told me to get back to your bed and to take off my wet dress, and she was not even assisting me. At that moment I couldn't, I was feeling dizzy and weak, I could not do anything, she told me not to waste her time as she must go back to her labour ward bed'.

A significant number of the women 23(38.33%) said that poor remunerations might be the causes of disrespectful behaviour.

Of the participants, three (5%) said the health care workers lack customer care training.

A small number of the study participants four (6.67%), complained of the extra fees which are needed before admission which delays admission as it is a lot of money. One of the participants said:

'Ï came in advanced labour and I was denied access into the clinic as I was not holding $200 USD which they say is for the ambulance in case you need to be transferred to the hospital. So I waited for some time, and later they allowed me to enter into the labour ward as I was now bearing down'.

4.6 Nurses and Midwives Results

A total of six key informants were interviewed. These included five midwives and one primary care nurse. . The median years in service was 11 ($Q_1 = 8$, $Q_3 = 16$). In the maternity department, they are seven nurses and midwives who work there, the researcher managed to interview six of them. Could not interview the 7th nurse as she had less than six months working at Ruwa Clinic maternity department. Of these, five out of six (83.33%) said they have knowledge on RMC. The key informants revealed that staff is not adequate and all of them said they need at least 10 more trained midwives. Material on RMC and respectful maternity charter were not displayed in the maternity department. Awareness campaigns on RMC are being done in the District but not quite often.

4.6.1 Key informant perspectives on the drivers of disrespect and abuse

The nurses and midwives talked of staff burnout, individual stress, staff shortage, attitude of the nurses as well as of the clients as the major causes of disrespectful maternity care. A quote from one of the midwives:

'Patients not cooperating can lead to disrespectful maternity care. As midwives, we are forced to be firm and at one point shout at the patient, for us to have good outcomes. If we continue to listen to the women in labour we will end up having a still birth, so sometimes you can even push or clap the patient in so doing that she will cooperate'.

Another midwife pointed out patient's attitudes and expectations as being viewed as drivers of D&A. She said:

'When a patient comes, she will be having an impression that she will be shouted at, so merely talking to this woman might be seen as rough. Some women may come

with high expectations, that the nurses should do it all, and she will be expected to be lifted from the bed even if it is still early labour, so if you just explain to her to do some of the things on her on she will see it as abuse.

Attitude of the staff was seen as barrier to RMC. One of the midwives commented on the staff attitude as the biggest driver to D&A:

As midwives, we do not give enough support to women in labour, as we just say labour was meant to be so painful. We do not explain enough on the labour process, we do not give analgesia to minimise pain, and not giving them information on the non-pharmacological pain relief during labour.

A nurse who works in maternity department also commented that stress could also lead to D&A of women during labour. She gave an experience:

'One day I came on duty and was so stressed because of what had happened at home, so the whole day I was just shouting at everyone especially the clients. Also stress can be caused by staff burnout because of shortage of staff within the maternity department'.

Shortage of staff at the clinic and staff burnout was also seen as causes of D&A at the clinic, they are only seven (five midwives and two Nurses who work in Maternity Department. One nurse said:

'It is very difficult to please every patient, and we become so impatient to the clients as we are very few here. You will not have time to explain anything about labour and sometimes you end up shouting if the woman is taking so much time for her to be examined, as she will be in pain. Sometimes you will become so impatient at a point that you can leave the patient if she is uncooperative and taking too much of your time and will come back later when she is willing to be checked. This will be because there will be many women in labour needing assistance'.

4.6.2 Health care service factors in the maternity department associated with D&A

The midwives were asked to tell the conditions acting as health care service barriers to fully implementing RMC practices in their place of work. They said they are sometimes facing challenges in implementing RMC as their biggest challenge is shortage of staff, and shortage of supplies. This, limits the capacity of the clinic to give the quality RMC.

Poor remuneration was seen as a barrier to respectful maternity care, as trained midwives are leaving for greener pastures, leading to shortage of staff. Few trainings, being done on RMC were also seen as a hinder to best RMC.

4.6.3 Nurses and Midwives recommendations to promote RMC during child birth

The midwives emphasised on the continued health educational talks during antenatal care visits on labour preparedness and education to women on the difference between firmness and disrespectful care, so that they have a good outcome. The nurse and midwives commented that there is need for giving health workers incentives and good remuneration to retain staff. They also said there is shortage of staff at the clinic, so recruitment of more midwives and nurses in the maternity department, will improve quality of RMC. Frequent in-service training to existing healthcare workers as well as induction of new staff on RMC was also seen as a way of promoting RMC. Midwives also gave a recommendation on buying of enough sundries needed in maternity department so that women will not need to buy

CHAPTER 5 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study examined the factors associated with respectful maternity care during childbirth in Ruwa, Goromonzi District, Zimbabwe in the year 2021. The RMC Charter was used as a framework to explore disrespectful maternity care being experienced by women at Ruwa Poly Clinic. This chapter focuses on the discussion, conclusion and recommendations following the results got in this study on socio-demographic characteristics, drivers of D&A, categories of D&A, rights for childbearing women and healthcare service factors associated with respectful maternity care.

5.2 Discussion

5.2.1 Socio-demographic factors associated with RMC

In this study the researcher found out that the educational level of the mothers were associated with RMC. Women who had attained secondary and tertiary education were more likely to receive RMC as compared to those with primary education. Women with secondary and tertiary education increased their odds of being insulted by hospital staff compared to those with primary education. This can be because they know their rights, and have the knowledge on what is expected to be done by the midwives. This is in contrary with a study done by Abuya et al., (2015), which found out that there were no statistical associations between different categories of reported D&A with client age, education, and socio-economic status.

It was found that being formally and informally employed increased the odds of not being allowed to choose desired status or position on bed compared to those unemployed women. Women who were informally employed had an increase in odds of neglect/abandonment of care by having staff not quickly responding to their needs in case of need for help or information compared to those who were not employed. This could be because the working class might be having information on what is supposed to be done during childbirth, so if not done it will be seen as disrespectful maternity care.

5.2.2 Types of abuse women are facing during childbirth

Overally, the seven women's rights were not equally violate these were ranging from 3.3% on non-confidential care to 65% on neglect/abandonment of care. Of the participants, all of them reported at least one of the violations of the seven women's rights, meaning they have received non-respectful and abusive care. This was also similar in a study done by Orpin, Puthussery, Davidson, & Burden (2018) which revealed that all the participants in the study, described at least one episode of D&A during their last maternity care in health facilities.

The neglect and abandonment of women by midwives during childbirth was common. Women not receiving pain relief during labour, was a common form of disrespectful maternity care. Every woman has the right to receive the highest attainable standard of healthcare and dignified care (WHO, 2020). It was noted that several studies done recently have similar findings. A study by Malatji & Madiba (2020) showed that the denial of pain relief medication during childbirth was a common form of D&A.

Almost half 48.33% of the women who participated in the study reported that the staff was not explaining the labour process to them. They said sometimes they did not even know what to do and expected during labour. When a client is informed on what will be expected during labour will help the women to be cooperative and understanding. It was found that an additional one more pregnancy and one more hour of the duration of labour increased the odds of staff not explaining the labour process to the women. Failure to explain the labour process might be because the midwives might assume those with high parity and those who have been in labour for long will be experienced and understands better on the labour process.

In this study, it was found that the participants could see non-dignified care as a norm that they have accepted like being shouted at. More than half of the participants mentioned that D&A, it is the norm of the nurses and midwives and the nurses are not sympathetic and not supportive. This finding is consistent with a study done by Orpin et al. (2018) in Nigeria, which noted that the use of abusive language and shouting as 'normal' behaviours from healthcare providers in health facilities during maternity care; therefore, such practices were expected and not necessarily seen as a violation of human rights.

The views of the women about D&A, were seen as actions essentially well- intended from experts in order to have a good outcome that is to save both their lives and their unborn children.

A study done by Afulani et al. (2020) showed that the common reason healthcare workers gave for undignified and physical abuse (shouting at, threatening, pinching or slapping women) was that they do it to save the baby when the woman will be uncooperative or problematic.

Non-consented care was found to be the second highest form of D&A including the right to choose, and failure to get informed consent by midwives before carrying out procedures. An additional one more pregnancy and one more hour of the duration of labour increased the odds of women to be denied their right to choose. Non-consented care was another form of D&A that was ranked high in the participant's self-report by Shimoda, Leshabari, & Horiuchi (2020). This is in agreement with a study done by Sando et al., (2016), which revealed that by direct observation of client-provider interactions that midwives failed to get informed consent from about 80% of women before performing the procedures.

Those women who did not attend any ANC visit decreased their odds of neglect/abandonment of care by having hospital care not quickly responding to their needs in case of need for help or information compared to those who attended an ANC visit. Those who attended ANC visits had the highest odds of being detained for failure to pay compared to those who did not attend ANC.

Discrimination was also reported by few as a form of D&A. Being a protestant increased the odds of discrimination compared with other religion. Malatji & Madiba, (2020) did a study in South Africa, which also find out that women were discriminated, called names, they were labelled, and they were referred to in demeaning terms. Researchers in other settings reported similar forms of adverse discrimination during childbirth (Freedman et al., 2014 & Afulani et al., 2020). Therefore, the rights of women were violated. Women should be free from discrimination, as well as to have liberty, autonomy, self-determination, and freedom from coercion.

Physical abuse was not reported by many though 13.33% said they had been pushed, beaten, poked, slapped or pinched whilst giving birth. This is in consistent with a study done by Warren et al. (2017) which found that women reported physical abuse of slapping, pushing and beating during childbirth. The women were attaching different meanings to the actions and some of the women especially the younger ones felt that slapping was justifiable because it was to ensure their cooperation and attention to the process of childbirth (Warren et al., 2017).

5.2.3 Drivers of D&A of women during childbirth at Ruwa Clinic

It was pointed out by the midwives that patient's attitudes and expectations can be drivers of D&A. Some women in labour may be very uncooperative during labour, as a result the nurses and midwives might try to be firm with the patient so as to save the mother and baby. The firmness will be seen as undignified care or the nurses and midwives will lose out of control and become impolite. This study also found out that staff attitude is a driver to D&A, midwives and nurses do not give enough support to women in labour, and some are so arrogant.

More than half of the participants 32 (53.33) did not have the knowledge on the rights of women during child birth. There could be lack of information dissemination of the RMC charter. World Health Organisation, (2018) states that RMC is a universal human right that is due to every child-bearing woman in every health system in which the maternity care is expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights. There is a need to promote the rights of child-bearing women as outlined in the Respectful Maternity Care Charter at Ruwa Clinic.

The main reasons, which were seen by nurses and midwives as major drivers of D&A include staff burnout, and staff shortage at Ruwa Clinic. Findings of this study are similar to a study done by Webber et al., (2018). Shortage of staff ~~will~~ have a negative impact on the delivery of health services and deprive the rights of women during childbirth.

5.2.4 Health service factors associated with D&A

The nurse and midwives said that insufficient supplies and inadequate staffing common concerns, which likely contribute to negative staff attitudes, towards the women in labour. Poor remuneration was seen as a barrier to respectful maternity care, as trained midwives are leaving for greener pastures, leading to shortage of staff. This was in consistence with the results found in a study done by Webber et al., (2018). To retain staff there is need for rewarding and supporting health workers as this will boost morale, mitigate burnout, and improve job motivation and satisfaction. Difficult situations in the health care system can have an impact on the delivery of quality maternity care, bringing about disrespectful maternity care.

Few trainings on RMC being done at Ruwa Clinic were also seen by the midwives as a hinder to quality RMC, as the staff need to be kept updated and reminded on the RMC.

5.3 Limitations to the study

There are a few limitations to this study. The women, who were interviewed, may have under reported the factors associated with D&A as the interviews were done within the facility grounds, as they will be in fear of being intimidated and denied access to health care services in future. The healthcare workers and the postnatal

women might be afraid to say out the truth in fear of being victimised. In view of this the researcher gave assurance to the participants on anonymity and confidentiality and that the results were to be used for the purpose of the study and non-other than that.

There was a possibility of recall bias but this was minimized by recruiting women who gave birth in 2020. Defining if certain behaviour is “abuse”, will need to be subjective, and based on beliefs, and personal anticipation or experience, as some might see as abuse and some as not (Freedman and Kruk, 2014).

5.4 Study conclusion/summary

Based on the findings of this study ~~we~~ the researcher concluded that disrespect, non-consented care, discrimination, undignified care, neglect, abandonment, and abuse may be barriers to RMC in Ruwa, Goromonzi District and causing women not to access healthcare in time.

5.5 Implications to practice

These results have contributed to the improvement of the interventions in place at Ruwa Clinic at policy, health facility and community level to ensure that women and providers understand that mistreatment is neither normal nor acceptable, and to create a culture of support, understanding, accountability and professionalism among health care providers.

5.6 Recommendations

Based on the findings of this study, there is lack of information dissemination on RMC and the rights of women are being violated. It is therefore, important to promote the rights of childbearing women by conducting community

awareness campaigns on the rights of women during childbirth, printing and distributing IEC materials on RMC charter. To improve on the knowledge gap there is also need to train new health workers, and providing in-service training to existing health workers on RMC.

At Ruwa clinic, it was found that that shortage of midwives is a barrier to RMC. In this regard there is need to boost the staff morale, through positive work environment, compensation and incentives, housing benefits and free transportation. Recruiting more nurses and midwives to work in the maternity department, will improve the quality of maternity care.

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APPENDIX 1: Consent Form for Study Participants

Study Title: Barriers to Respectful Maternity Care in Ruwa, Goromonzi District Mashonaland East, Zimbabwe, 2020.

Principal Investigator: Rosemary Chiromba-Magonya

Contact number: 0772919886

What you should know about this research study:

- Your participation is voluntary
- The consent form will be given for you to sign so that you may read about the purpose, and benefits of this research study.
- The main goal of research studies is to gain knowledge that may help future patients and improve the quality of care.
- You have the right to refuse to take part or agree to take part now and change your mind.
- You are free to ask question before answering the questionnaire.

PURPOSE

You are being requested to participate in a research study of barriers to quality maternity care to women during childbirth. The main aim of the study is to determine factors associated with respectful maternity care in Ruwa Goromonzi District, 2020. This study is expected to come up with information that will guide in the promotion of respectful maternity care. The findings of this study are expected to come up with recommendations on respectful maternity care.

PROCEDURES AND DURATION

If you agree to participate, you will go through an interview using a questionnaire. We will ask you questions and write down the responses. The interview will take about fifteen to twenty minutes and will be done once.

RISKS AND DISCOMFORTS

The study is not expected to cause any physical harm. You are free to skip the questions that make you uncomfortable.

CONFIDENTIALITY

If you show your willingness to participate in this study by signing this paper, we will not include your name. Information that is got in connection with this study cannot be recognized with you. Information will remain confidential during and after the study.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your choice will not affect your future relations with the Ministry of Health and Child Care. If you decide to participate, you are free to withdraw your consent and to end participation at any time without penalty.

AUTHORIZATION

You are making a choice whether or not to participate in this study. Your signature shows that you have read and understood the information provided above, have had all your questions answered, and have decided to take part voluntarily.

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Name of Research Participant (please print) Date

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Signature of Participant or legally authorized representative Date

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

APPENDIX 2: Consent Form for Study Participants in Shona

Gwaro remvumo yekupinda mutsvakurudzo

Mudzidzi: Rosemary Chiromba-Magonya

Runhare: 0772919886

Zita rechikoro: Africa University

Zita reongororo: Zvinodzivisa kuti madzimai asabatwe zvakaknaka panguva yekusununguka muguta re Ruwa, mudunhu re Goromonzi Mashonaland East, Zimbabwe, 2020.

Zvamunofanirwa kuziva nezvetsvakurudzo iyi:

- Hamumanikidzwe kupinda mutsvakiridzo iyi.
- Gwaro remvumo yekupinda mutsvakiridzo munopiwa kuti muverenge moziva nezve chinangwa and uye nezvakanakira tsvakurudzo iyi.
- Chinangwa chikuru ndechekuwana ruzivo maererano nekubatwa zvakanaka kwemadzimai panguva yekusununguka zvingazobatsira kuti varambe vachibatwa zvakanaka nevehutano.
- Mune mvumo yekuramba kupinda mutsvakurudzo kana kubvuma kana kuzochinja kusapfuurira mberi ne tsvakurudzo.
- Munotenderwa kutanga mabvunza mibvunzo musati matanga kupindura mibvunzo yakabvunzwa.

Chinangwa

Munokumbirwa kuti muve munopinda mutsvakurudzo ye zvingava zvingakanganisa madzimai asabatwe zvakanaka panguva yekusununguka. Chinangwa chikuru ndechekuona zvakatenderedza kubatwa kwebadzimai zvakanaka nguva

yekusununguka pa Ruwa Clinic, Goromonzi District, 2020. Ongororo iyi inotarisirwa kuti ichabatsira kuwana kuwana zvingasimudzire kubatwa zvakanaka kwemadzimai munguva yekusununguka.

Maitirwe eongororo

Kana mabvuma kukupinda muonongororo, muchabvunzwa mibvunzo, yamunofanirwa kupindura ichinyorwa pasi munguva inogona kuita gumi neshanu, uye zvinongoitwa kamwe chete.

Zvingava zvingakukanganisai

Ongororo iyi haisi kutarisirwa kuti ichakanganisa hutano kana muviri wenyu. Munokwanisa kupfuura henyu pamubvunzo unenge usina kukuitirai zvakanaka.

Tsindidzo nekuchengetedzwa kwemashoko achabuda mutsvakurudzo

Kana mawirirana nekuisa runyoro rwenyu pabepa rino, zita renyu harinyorwe pabepa nemibvunzo. Zvamunenge mapindura pa bepa hapana anokwanisa kuona kuti ndiani aipindura mibvunzo. Zvabuda mutsvakurudzo zvicharamba zvakachengetedzeka munguva yetsavkurudzo uye kana yapera.

Kodzero yekuva muongororo

Mune kodzero yekuramba kupinda muongororo kana kubudira pamunoda. Hamuzombopiwa mhosva yekuramba kana kubuda muongororo uye hazvizokanganisa magariro enyu neramangwana renyu.

Kubvuma kupinda mutsvakurudzo

Muri kuisa runyoro rwenyu kuti mabvuma kupinda muongororo iyi uye maverenga mukanzwisisa mukatsanangurirwa nezveongororo iyi, pasina kumanikidzwa.

Runyoro rwenyu_____

Zuva_____

Zita renyu (Printed) _____

Runyoro rwemutsvakiridzi_____

Zuva_____

MUCHAPIWA BEPA IRI RAMAISA RUNYORO RWENYU

APPENDIX 3: Questionnaire for Study Participants

My name is Rosemary Chiromba-Magonya, a student at Africa University College of Health Sciences. I am currently studying for a Master's in Public Health Degree. I am carrying out an academic research on: **Barriers to Quality Maternity Care in Ruwa, Goromonzi District of Zimbabwe, 2020.** I kindly ask for your participation

in answering the following questions. Your responses will be treated as confidential and will not be used for any other purpose other than those intended.

Instructions for completion

1. Tick in the spaces provided

2. Write your responses in the spaces provided

.

Demographic questions

1. What is your age in years? _____

2. What is your marital status?

a. Married	[ ]	b. Cohabiting	[ ]	c. Single	[ ]
d. Divorced	[ ]	e. Widowed	[ ]	f. Separated	[ ]

3. If married, is your marriage polygamous?

a. Yes [ ]

b. No [ ]

4. What is your uppermost level of education?

a. None [ ]

b. Primary [ ]

c. Secondary [ ]

d. Tertiary [ ]

5. What is your religion?

a. Pentecostal [ ]

b. Protestant [ ]

c. Catholic [ ]

d. Apostolic [ ]

e. Muslim [ ]

f. Traditional [ ]

g. L8Any other (specify)----------

6. What do you do for a living?

a. Formally employed [ ]

b. Informal employment [ ]

c. Unemployed [ ]

Other *(specify)*.....

Pregnancy History

7. How many pregnancies have you ever had, including abortions/miscarriages?----------

8. How many alive children do you have?----------

9. What was the length of your labour?

a. ≤ 12 hours [ ]

b. 13-24hours [ ]

c. 25-48hours [ ]

d. 49-72hours [ ]

e. ≥72hours [ ]

10. Have you ever had a still birth?

a. Yes [ ]

b. No [ ]

11. Did you attend any ANC visit?

a. Yes [ ]

b. No [ ]

12. If yes, how many times did you receive the ANC service during your pregnancy?

a. 1-3 [ ]

b. 4 and above [ ]

Health Services Factors

13. Did the service providers beat you, pocked you, slapped you or pinched you during child birth?

a. Yes [ ]

b. No [ ]

14. Was the staff approach with you politely?

a. Yes [ ]

b. No [ ]

15. Did you have the right to choose?

a. Yes [ ]

b. No [ ]

16. Did the staff tolerable you to ask questions?

a. Yes [ ]

b. No [ ]

17. Any insults or threats occurred against you?

a. Yes [ ]

b. No [ ]

18. Did the care provider use pain reliever?

a. Yes [ ]

b. No [ ]

19. Did the care provider and staff consider your comfort?

a. Yes [ ]

b. No [ ]

20. Was your privacy maintained during the examinations that is closing doors and use of curtains?

a. Yes [ ]

b. No [ ]

21. Did the staff explain to you the labour process?

a. Yes [ ]

b. No [ ]

22. Were you allowed to choose your desired status or position on the bed or outside it?

a. Yes [ ]

b. No [ ]

23. Were you discriminated because of ethnicity, race, economic situation or any other from rest of admitted women?

a. Yes [ ]

b. No [ ]

24. Did the staff describe to you about what you need to do?

a. Yes [ ]

b. No [ ]

25. Did the staff ask for your permission before any action and practice?

a. Yes [ ]

b. No [ ]

26. Were the staff quickly responding to your needs in case of any help and information?

a. Yes [ ]

b. No [ ]

27. Have you been hospitalized too much due to the delay or non-payment of the related costs?

a. Yes [ ]

b. No [ ]

28. Do you have any knowledge of the rights of women during labour?

a. Yes [ ]

b. No [ ]

29. What do you thing are the drivers of disrespect and abuse of women during childbirth by health care providers?

---

30. What was the most dissatisfaction you encounter?

Thank you

APPENDIX 4: Shona Questionnaire for Study Participants

Mibvunzo muchishona

Zita rangu ndinonzi Rosemary Chiromba-Magonya, mudzidzi wepa Africa University College of Health Sciences ndichiita Masters muhutano hweruzhinji. Ndiri kuita tsvakurudzo yekuona kana pane zvino dzivisa madzimai kuti asawane rubatsiro rwakanaka panguva yekusununguka mu Ruwa, mudunhu reGoromonzi. Tsvakiridzo iyi inotarisirwa kuburitsa humbowo huchashandiswa kudzivirira dambudziko iri. Zita renyu haridiwi pabepa rine mibvunzo yamuchapindura. Tichachengetedza zvakanyanya humbowo hwenyu kuti pasawana umwe munhu anogona kuwona humbowo hwenyu. Isarudzo yenyu kupinda mutsvagurudzo iyi.

Kana muchibvumirana nazvo isai runyoro rwenyu sechiratidzo chekubvumira zviri pamusoro apa ----------

Pakupindura mibvunzo munotarisirwa kuisa umbowo hwenyu mune nzvimbo dzakapiwa.

1. Mune makore manganic? ----------

2. . Muri pachikamu chipi chewanano?

a. Handina kuwanikwa [ ]

b. Ndakaroorwa [ ]

c. Takarambana [ ]

d. Takaparadzana [ ]

e. Ndakafirwa [ ]

f. Tirikungogara hedu [ ]

3. Muri pabarika muwanano yenyu here?

a. Hongu [ ]

b. Kwete [ ]

4. Makadzidza kusvika papi?

a. None [ ]

b. Primary [ ]

c. Secondary [ ]

d. Tertiary [ ]

5. Muri wechitendero chipi?

a. Pendekositi [ ]

b. Vapositora [ ]

c. Vezvechinyakare [ ]

d. Moziremu [ ]

f. Zvimwe (*tsanangurai*)…….

6. Mune mubato wemaoko here?

a. Handishandi [ ]

b. Ndinozviitira mabasa emaoko [ ]

c. Ndine mubato wemaoko kwawo [ ]

d. Zvimwe (*tsanangurai*).....

7. Makaita mimba kangani kusanganisira nedzakambobva? ----------

8. Mune vana vangani vapenyu? ----------

9. Makatora kuva yakadii pakubatsirwa?

a. ≤ 12 hours [ ]

b. 13-24hours [ ]

c. 25-48hours [ ]

d. 49-72hours [ ]

e. ≥72hours [ ]

10. Makambobara mwana akafa here?

a. Hongu [ ]

b. Kwete [ ]

11. Makaenda ku ANC here?

a. Hongu [ ]

b. Kwete [ ]

12. Kana iri hongu, makaenda kangani?

a. 1-3 [ ]

b. 4 and above [ ]

13. Pamaibatsirwa makambo rohwa here kana kutswinya?

a. Hongu [ ]

b. Kwete [ ]

14. Vashandi vepa kiriniki vakarakidza kuita hunu hwakanaka here kwamuri?

a. Hongu [ ]

b. Kwete [ ]

15. Makava nemukana wekusarura zvamaida here?

a. Hongu [ ]

b. Kwete [ ]

16. Maitenderwa kubvunza mibvunzo here pamaibatsirwa?

a. Hongu [ ]

b. Kwete [ ]

17. Makavhunditsirwa here kana kutukwa?

a. Hongu [ ]

b. Kwete [ ]

18. Pamairwadziwa makapiwa zvekunyaradza marwadzo here?

a. Hongu [ ]

b. Kwete [ ]

19. Vashandi vepakiriniki vaikoshesa kufarikana kwenyu here?

a. Hongu [ ]

b. Kwete [ ]

20. Pamaivhenekwa maive muri pakavharirwa here?

a. Hongu [ ]

b. Kwete [ ]

21. Makatsanangurirwa here, zvanga zvichaitika kusvika pakuzvarwa kwemwana?

a. Hongu [ ]

b. Kwete [ ]

22. Makabvumidzwa kuita magariro amainzwa kuda here?

a. Hongu [ ]

b. Kwete [ ]

23. Makaona muchiitwa zvekusarurwa here?

a. Hongu [ ]

b. Kwete [ ]

24. Vashandi vepakiriniki vaikutsanangurirai here zvamaifanirwa kuita?

a. Hongu [ ]

b. Kwete [ ]

25. Vashandi vaikumbira mvumo kubva kwamuri here kana pane zvavanoda kuita pamuri?

a. Hongu [ ]

b. Kwete [ ]

26. Vashandi vaikurumidza kudaira kuzvikumbiro zvenyu here?

a. Hongu [ ]

b. Kwete [ ]

27. Makambodziviswa kubuda mukiriniki here kuenda kumba nekuda kwemari dzamunenge musati mabhadhara?

a. Hongu [ ]

b. Kwete [ ]

28. Mungava muine ruzivo nezvekodzero dzemadzimai panguva yekusununguka here?

a. Hongu [ ]

b. Kwete [ ]

29. Ndezvipi zvamungafunga kuti zvinokonzera kuti madzimai asabatwe zvakanaka navanaNyamukuta nguva yekusununguka?

---

30. Ndechipi chinhu chakanyanya kusakuitirai zvakanaka nguva yamakasununguka.

Tatenda

APPENDIX 5: Questionnaire for Nurses and Midwives

Designation _____

1. How many years do you have in your current position? _____

2. What could be the possible reasons or drivers for disrespect and abuse of women during labour by staff members?

_____

_____

_____

_____

_____

_____

_____

_____

_____

____

3. Do you have adequate staff in maternity at your health facilities? [ ]Yes [ ]No

4. If no, how many more do you need?_____

5. Does your clinic have material on respectful maternity care including the respectful maternity charter? [ ]Yes [ ]No

6. Do you have any knowledge on respectful maternity care? [ ] Yes [ ] No

7. Are there any awareness campaigns that are being done for Respectful Maternity Care in your district? [ ] Yes [ ]No

8. If yes, how often?_____

9. Do you sometimes have any challenges in implementing Respectful Maternity Care? [ ] Yes [ ] No

If yes in what way and your recommendations?

_____

_____

_____

_____

10. Which are the health care service factors at your in maternity department associated with RMC?

_____

_____

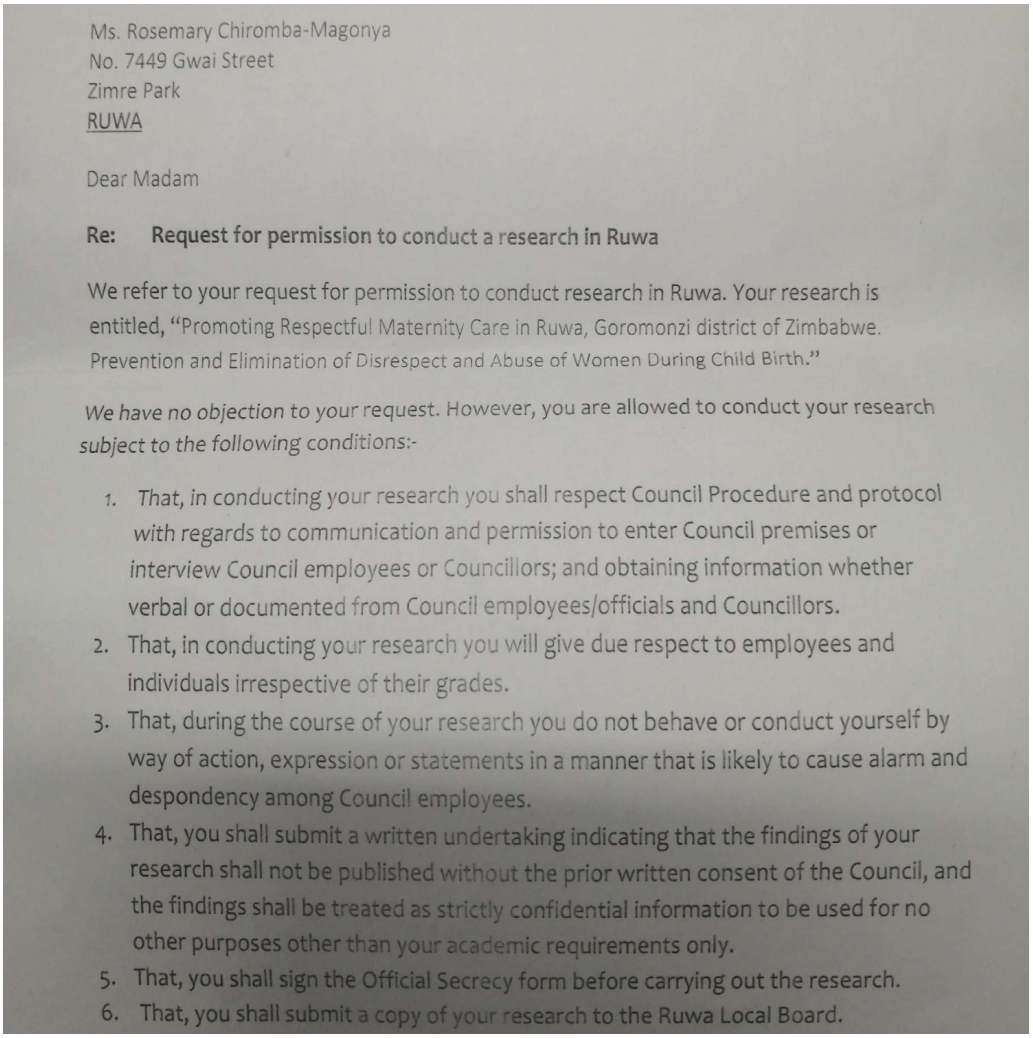
_____

_____

_____

Thank you

APPENDIX 6: Permission Letter to Carry out A Study at Ruwa Poly Clinic from Africa University Research Ethics Committee



Ms. Rosemary Chiromba-Magonya
No. 7449 Gwai Street
Zimre Park
RUWA

Dear Madam

Re: Request for permission to conduct a research in Ruwa

We refer to your request for permission to conduct research in Ruwa. Your research is entitled, "Promoting Respectful Maternity Care in Ruwa, Goromonzi district of Zimbabwe. Prevention and Elimination of Disrespect and Abuse of Women During Child Birth."

We have no objection to your request. However, you are allowed to conduct your research *subject to the following conditions:-*

1. *That, in conducting your research you shall respect Council Procedure and protocol with regards to communication and permission to enter Council premises or interview Council employees or Councillors; and obtaining information whether verbal or documented from Council employees/officials and Councillors.*
2. That, in conducting your research you will give due respect to employees and individuals irrespective of their grades.
3. That, during the course of your research you do not behave or conduct yourself by way of action, expression or statements in a manner that is likely to cause alarm and despondency among Council employees.
4. That, you shall submit a written undertaking indicating that the findings of your research shall not be published without the prior written consent of the Council, and the findings shall be treated as strictly confidential information to be used for no other purposes other than your academic requirements only.
5. That, you shall sign the Official Secrecy form before carrying out the research.
6. That, you shall submit a copy of your research to the Ruwa Local Board.

Appendix 7: Permission letter to carry out a study at Ruwa Poly Clinic.

Appendix 8: Confirmation Letter from the Academic Supervisor (Mrs Chituku)

Africa University

P O Box 1320

Mutare

09 October 2020

AUREC

Africa University

Mutare

Dear Madam

RE: CONFIRMATION OF SUPERVISION OF ROSEMARY CHIROMBA-MAGONYA - REG NUMBER: 170842

This letter serves to confirm that I supervised and worked with the above named student's proposal with the title below.

Barriers to Quality Maternity Care in Ruwa, Goromonzi District, Mashonaland East, Zimbabwe, 2020

With regards

Mrs Chituku S.

Signature: 

Appendix 9: Plagiarism report

Plagiarism report

Curiginal

Document Information

Analyzed document	ROSEMARY CHIROMBA MPH DISSERTATION.docx (D104368312)
Submitted	5/10/2021 12:23:00 PM
Submitted by	Dr Eltony Mugomeri
Submitter email	mugomerie@africau.edu
Similarity	23%
Analysis address	mugomerie.africa@analysis.urkund.com

Sources included in the report

The researcher acknowledges similarity of content that came out of the plagiarism report. Use of own words, paraphrasing, were necessary and use of synonyms for key words were used to address the plagiarism problem as noted in the report. Proper acknowledgement of sources was also used to address the problem. It should however be noted that, there are some sections that were left unchanged such as the format of the report, abstract, declaration, chapter headings and subheadings as these

were part of the research format. Some references were also not changed as similar sources could have been used in other research work by other scholars.