Master of Science in Public Health

Disrespect and abuse faced by women during facility based childbirth in District Chakwal

By

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Declaration

In submitting this dissertation, I certify that I have read and understood the rules and regulations of DPH and QAU regarding assessment procedures and offences and formally declare that all work contained within this document is my own apart from properly referenced quotations.

I understand that plagiarism is the use or presentation of any work by others, whether published or not, and can include the work of other candidates. I also understand that any quotation from the published or unpublished works of other persons, including other candidates, must be clearly identified as such by being placed inside quotation marks and a full reference to their source must be provided in proper form.

This dissertation is the result of an independent investigation. Where my work is indebted to others, I have made acknowledgments.

I declare that this work has not been accepted in substance for any other degree, nor is it currently being submitted in candidature for any other degree.

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(Dr.Ume Sughra)

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ABSTRACT

BACKGROUND: Disrespectful and abusive practices by the providers during childbirth discourage many women to seek care at health facilities. This results in huge burden of maternal morbidities and mortalities. Despite severe impacts, such practices remain under the cover and are rarely reported in developing countries.

OBJECTIVE: The study was carried out to estimate the prevalence and determinants of the disrespect and abuse (D & A) during child birth.

METHODS: A cross sectional study was conducted in the tehsil Chakwal of District Chakwal. Data was collected using an interview based questionnaire from the women who had a live birth within last 24 hours (n=310). The Disrespect and Abuse scale was based on BOWSER AND HILL tool. Multiple logistic regression was used to assess the determinants of reported Disrespect and abuse. Chi-square was used to assess the determinants of Experienced Disrespect and abuse.

RESULTS: Almost all the women experienced Disrespect and abuse (99.4%) during childbirth.

However, only 26.2% reported it. Disrespect and abuse was more commonly reported for non-consented care. Disrespect and Abuse was reported by women living in Neutral household type (CI=1.256 – 4.529, OR = 2.385), further women living in any other household type reported Disrespect and Abuse (CI=0.104 – 34.118, OR = 1.886). Further, women attended by non-skilled birth attendants reported disrespect and abuse (CI= 1.716 – 34.137, OR= 7.653) and women attended by skilled birth attendants reported disrespect

and abuse (CI= 1.776 – 7.298, OR= 3.600) , these are the main predictors of Reported Disrespect and Abuse.

CONCLUSION: Disrespect and abuse during childbirth is highly prevalent in Pakistan. High Prevalence at facilities is may be a reason for underutilization of this sector for childbirth. To ensure respectful maternity Disrespect and abuse during Childbirth need to be eliminated.

KEY WORDS: Maternal health, Disrespect and Abuse, Childbirth, Pakistan, Respectful Maternity Care.

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In the name of Allah, the most Merciful and Beneficent

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LIST OF ABBREVIATIONS

D & A	Disrespect and abuse
IRB	Institutional review board
AOR	Adjusted odds ratio
SBA	Skilled birth attendant
Non SBA	Non-skilled birth attendant
BHU	Basic health unit
RHC	Rural health Centre
TBA	Traditional birth attendant
CI	Confidence Interval
df	degree of freedom

CHAPTER I: Introduction

Childbirth is a normal physiological process yet it brings a great loss in the form of morbidity and mortality to mothers every year. Despite all the efforts and advancements in the medical field still, a considerable number of women die every day during childbirth due to multiple reasons. The maternal mortality of Pakistan is 140 deaths per 100,000 live births which is quite high and the government wants to reduce it to 70 deaths per 100,000 births (Omer et al., 2021). Pakistan is one of the six countries which contribute to 50% of maternal deaths (Rashid & Makhdoom, 2019) with the MMR of 177 per 100,000 births (Aziz et al., 2020). The rate is high as compared to other neighbor developing countries like Sri Lanka with MMR of 36 deaths per 100,000 births (*Maternal Mortality Ratio (Modeled Estimate, per 100,000 Live Births) - Sri Lanka | Data*, n.d.) and Iran with an MMR of 16 deaths per 100,000 births. The majority of maternal deaths are preventable by providing appropriate solutions like the availability of trained birth attendants in public and private sectors, antenatal services, and quality care during and after childbirth. National maternal mortality figure has been reduced by increasing skilled birth attendance from 39-52 % and institutional deliveries from 34-48% (Noor et al., n.d.). 52% women give birth at home assisted by skilled birth attendants (Hameed & Avan, 2018).

Certain conventional factors prevent women from seeking specialized healthcare services during and after childbirth which includes poverty, educational status, lack of awareness, lack of information, lack of will, lack of decision making power, distant health facilities, broken roads, lack of transport, inadequate and inappropriate services (Omer et al., 2021).

Inappropriate and inadequate services are major barriers to achieving targets regarding maternal mortality. These manifest as unavailability of staff and equipment on health facilities, delayed care, malpractice, and disrespectful behavior, abusive and rude attitudes of health providers. Bowser and Hill reported disrespectful practices as one of the major reasons which decrease access to SBA (Bowser & Hill, n.d.). Evidence shows that Disrespect and Abuse(D & A) by providers turn out to be ma major inhibitors in access to skilled care at birth than financial, geographical, and cultural factors (Bowser & Hill, n.d.). The three delay model has a major contribution towards maternal mortality. Out of three delays first delay is very common and important that is a delay in decision making by husband and other family members, almost 70% women face the first delay. Because in our society women is dependent on their husband and mothers-in-law for decision-making. (Mattoo et al., 2019) Similarly, inappropriate behavior of provider is the main reason that women do not access health services in Kenya (Abuya et al., 2015).

The health sector of Pakistan has made huge progress in recent years. Improvement in number of hospitals 1282 hospitals, 5472 BHUs, 670 RHCs, 5743 Dispensaries, 752 maternal and child health centers and increase in the number of registered doctors 245,987. The health budget also increases from 1.1 percent of GDP to 1.2 percent of GDP. All these improvements reflect the development. This progress is also evident from the decline in Infant Mortality Rate(IMR) from 62.1 deaths per 1000 live births to 55.7deaths per 1000 live births, neonatal mortality rates also the decline from 45.2 deaths per 1000 live births to 41.2 deaths per 1000 live births, percentage of births attended by skilled health providers increased from 58% to 68% and Maternal mortality decreases from 256 deaths per 100,000

live births to 189 deaths per 100,000 live births (*11-Health.Pdf*, n.d.). at the community level different programs are carried out by the government with help of lady health workers, which include family planning, TB control program, polio campaigns etc. each LHW covers 1000 people in the community and extends her services in the catchment area with monthly home visits. Almost 90,000 LHWs are working all over the country and health indicators are significantly better in the past (Hafeez et al., 2011).

The Health System of Pakistan is comprised of the public and private sector. Two-thirds of births are delivered in a health facility, primarily in private sector facilities. One in three births still occurs at home (*SR257.Pdf*, n.d.). 66% of the total births are delivered in the facility of which 69% are assisted by skilled birth attendants(SBAs) (*SR257.Pdf*, n.d.). It is estimated that almost 303,000 women still die due to preventable causes during pregnancy and childbirth (You et al., 2015). Despite providing all essential medicines in all health facilities and an increasing number of skilled, attendants the maternal mortality is still not decreasing. Problems related to provider behavior and attitude are more important deterring factors in utilizing skilled birth attendants as compared to financial and geographical issues (Hameed & Avan, 2018). Low utilization of institutions and skilled birth attendants can be somewhere ascribed to personal past experiences at health facilities. Women tend to come to health facilities for first delivery as it is considered more complicated and important. Women's preference for home deliveries is mainly because of their past experiences of poor health services which include poor availability of medicines and instruments, incompetent staff, rude and disrespectful behavior of health providers, and lack of privacy (*JPMA - Journal Of Pakistan Medical Association*, n.d.). These bad experiences when shared

in peer and close groups have an impact on them as well. It is reported the that public sector remains underutilized because of hurdles caused by the employees (Javed & Ilyas, 2018). Maltreatment faced by women during facility-based childbirth makes women hesitant towards services (Anastasi et al., 2015). This is the strong factor that holds women from utilizing available services. To control this we need to adopt women rights protection approach like WHO elaborated "Every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth" (*WHO | Prevention and Elimination of Disrespect and Abuse during Childbirth*, n.d.). This WHO statement highlights the commitment to promote women's rights and promote access to safe and respectful care during childbirth. There is growing evidence of disrespectful and abusive practices by the provider and their negative impact on developing countries (Bowser & Hill, n.d.).

Incidences of malpractices and unethical issues are areas to scrutinize if we want to get a deeper understanding of poor maternal health and low utilization of services for childbirth in

Pakistan.

1.1. RATIONALE

Maternal indicators are poor in Pakistan with low levels of ANCs, SBA, and utilization of public health services. Pakistan lags in all of the MDGs related to maternal health. A possible cause behind this is the prevalence of disrespect and abuse during childbirth. There is less research done on disrespect and abuse which women face during childbirth. However, multiple clues support Disrespect and abuse existence. Women's rights should

be considered for women's welfare and protection during childbirth (Khosla et al., 2016). The safe motherhood program has been critically evaluated at the facility level (*JPMA - Journal Of Pakistan Medical Association*, n.d.). Provision of a dignified environment during childbirth has been emphasized.

Disrespect and abuse during childbirth has to be recognized at individual, community and Policy level to design valid and reliable policies and protocols to reduce disrespect and abuse. This study will highlight this issue in Pakistan by quantifying the prevalence of Disrespect and Abuse during childbirth. The study would further help to address RMC at the international level. Findings could help to improve the utilization of health facilities for maternal care. To identify the factors associated with Disrespect and Abuse, estimation of the proportion of all the manifestations for all deliveries occurring in a health facility.

1.2. OBJECTIVES

The objectives of the study were:

1. To estimate the level of Disrespect and Abuse and its manifestations during childbirth in District Chakwal.
2. To estimate the level of reported and experienced Disrespect and Abuse during childbirth in District Chakwal.
3. To determine the determinants of Disrespect and Abuse during childbirth in District Chakwal.

CHAPTER II: LITERATURE REVIEW

The research and discussion on maternal health have been evolving over the years. In early times (1985) first maternal mortality statistics by WHO were published. It emphasizes the safe motherhood initiative to reduce maternal mortality focusing on three main pillars, having optimum and proper care during prenatal, childbirth, and postnatal period. In 1997, university of Columbia presented guidelines of EmOC services in collaboration with UNICEF, WHO and UNIFPA focuses on providing a sufficient number of health facilities, all essential services and quality of care. Afterward, indicators of EmOC services became the indicators for the assessment of maternal mortality of any country.

After the efforts of many years, the conventional concept of services assurance diverted towards "client-centered care" suggesting health system responsiveness (*Patient-centered Care and Adherence: Definitions and Applications to Improve Outcomes - Robinson - 2008 - Journal of the American Academy of Nurse Practitioners - Wiley Online Library*, n.d.). The main focus was protecting the dignity of patients and providing respectful care (Vogel et al., 2016). Responsiveness is an also important indicator to assess the patient's satisfaction which is important to retain the patients (Naseer et al., 2012). Thus, the feeling of safety, patient friendliness, politeness and being informed about everything became the ultimate indicators of being treated respectfully (Moridi et al., 2020).

Slow progress towards MDG 5 adopted the concept of respectful maternity along with other interventions. In past, almost all interventions regarding maternal health were focused on quality improvement of clinical equipment, medicines, services, staff knowledge, and skills. Emphasis on the prevention of maternal mortality and morbidity is not enough. Care

during pregnancy need to include basic human rights along with rights to respect, dignity, confidentiality, informed consent, right the to achieve the highest level of health, elimination discrimination, and all other forms of ill-treatment.

Respectful maternity journey started in 1940 with universal declaration of human rights. Disrespect and Abuse have never been given as much importance as now even on international platforms. It is considered a violation of human rights which was never practiced before. There is a need to understand the role of socio-cultural and gender-based discriminations on health outcomes. Unaddressed issues of emotional, physical and psychological damages to women during facility-based childbirth required to be addressed ("Respectful Maternity Care Charter," n.d.). An important but little previously known aspect of respectful maternity care emerged as elimination of D&A during childbirth which is much highlighted by WHO as well (*WHO | Prevention and Elimination of Disrespect and Abuse during Childbirth*, n.d.). The concept was highlighted by USAID's, TRAction project 2010. Shreds of evidence of D&A has been found in different countries like Ethiopia, Kenya, Ghana, and Tanzania.

2.1. DISRESPECT AND ABUSE DURING CHILDBIRTH:

Disrespect and Abuse during childbirth are fundamental to women's health rights. Provision of adequate, accessible, acceptable, and quality care by adequate staff, equipment, and infrastructure is the utmost priority. It consists of seven categories physical abuse, discriminatory care, detention in a facility, abandonment of care, non-consented, non-dignified, non-confidential care (Bowser & Hill, n.d.). These categories are

overlapping. Women have been disrespected in one or more than one way (Asefa & Bekele, 2015).

Table 1: Categories of disrespect in abuse (Bowser and Hill)

CATEGORIES	LEGAL DEFINITIONS
Physical abuse	The right not to be subjected to cruel, inhuman, or degrading treatment
Non-consented care	Medical procedures that are performed without patients consent may constitute an actionable tort of 'trespass' to the patient's body
Non-dignified care	The right to dignity: 'every individual has the right to the respect of the dignity inherent in a human being'
Discrimination	The right to be free from discrimination The rights to equality and non-discrimination
Abandonment/neglect	offense
Detention	The right to liberty and security of person. The right not to be detained for non-payment of debt
Non-confidential	The right to privacy

Disrespect and Abuse is one of the major restraints to the utilization of skilled birth attendants for childbirth (Bowser & Hill, n.d.). Evidence of disrespect and abuse has been identified in many developing countries like Nigeria, Kenya, Ghana, and Tanzania. Practices of disrespect and abuse vary from unattended women during labor, discriminatory treatment, and verbal abuse to even harassment and physical abuse (Abuya et al., 2015). Disrespect and abusive behaviors are very common but they remain hidden under the cover of normalization and unawareness which ultimately results in unethical practices.

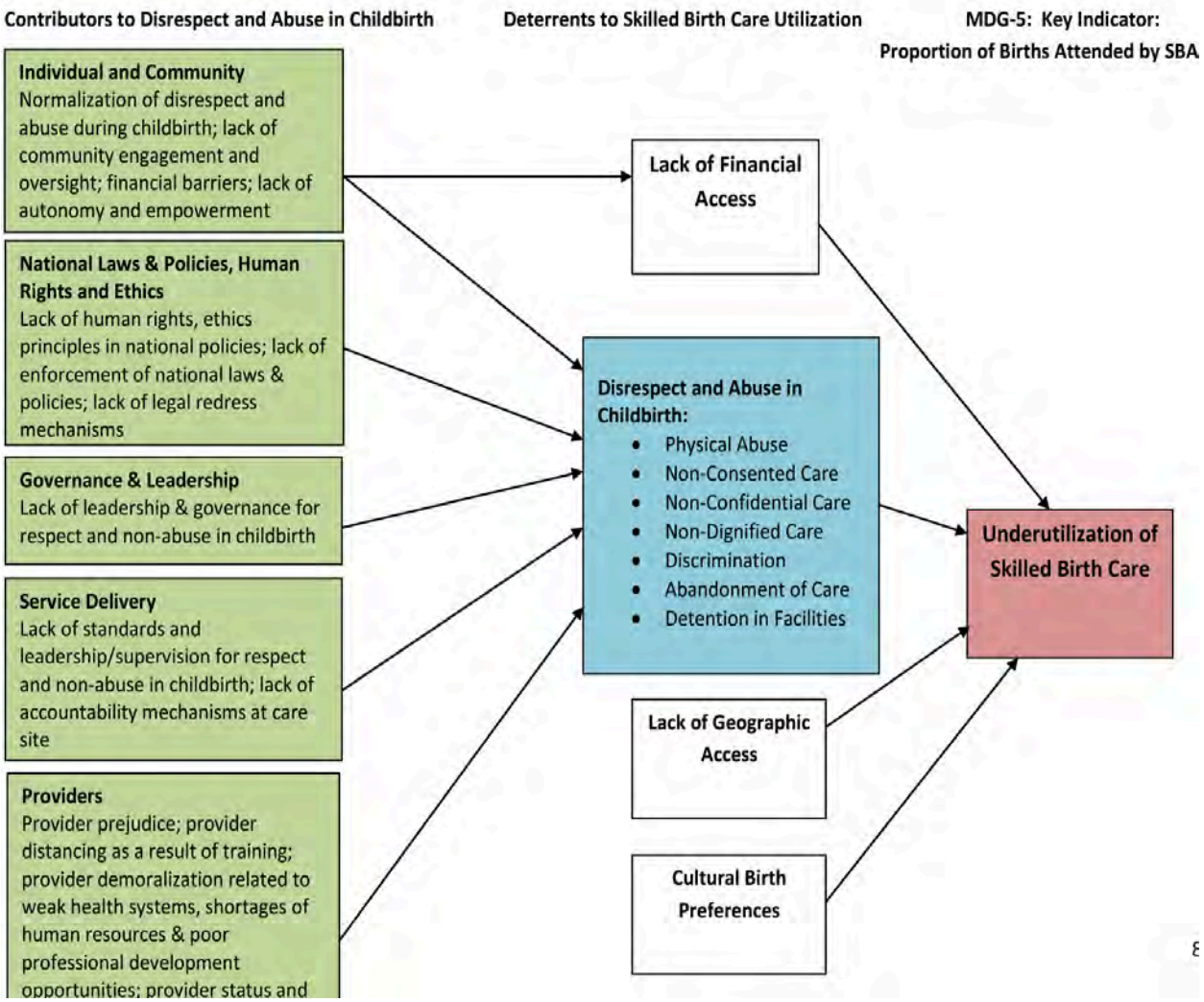


Figure 1: Contributor to disrespectful and abusive practices and impact on skilled care utilization for childbirth (Bowser and Hill 2010)

2.2. GLOBAL BURDEN OF Disrespect & Abuse

The prevalence of Disrespect and Abuse is related to specific cultural and geographical aspects. There is limited work done regarding D&A that's why there is limited evidence to

estimate the prevalence of D&A. In Nigeria, almost 98% of respondents experienced Disrespect and abuse during childbirth and the most common type of abuse reported was non-consented care that was around 54.5% (Okafor et al., 2015). In Ethiopia, Asefa and Bekele (Asefa & Bekele, 2015) estimated almost 16% of Disrespect and Abuse reported by the women when almost 78% experienced Disrespect and Abuse and the dominant component was lack of right informed consent 94.8%. The manifestation of Disrespect and Abuse varied in its seven categories varied from 4.18% to the total prevalence of 20% in Kenya (Warren et al., 2013). The most commonly reported negative experience is feeling ignored and neglected (McMahon et al., 2014).

2.3. IMPACT OF DISRESPECT AND ABUSE:

Disrespect and Abuse during facility-based childbirth harms women, it makes them reluctant to utilize facility services in the future and they feel comfortable and respected towards traditional birth attendents(TBAs). These women also negatively impact other women and they also avoid facilities (Warren et al., 2013). The one factor which has been highlighted by 60% of women is the change of attitudes of provider from disrespectful to respectful and kind, it can improve the utilization of facilities (Sando et al., 2016). Around 25% of women didn't access the health facility because of inappropriate behaviors (Warren et al., 2013). Poor interpersonal relation leads to delivery at home.

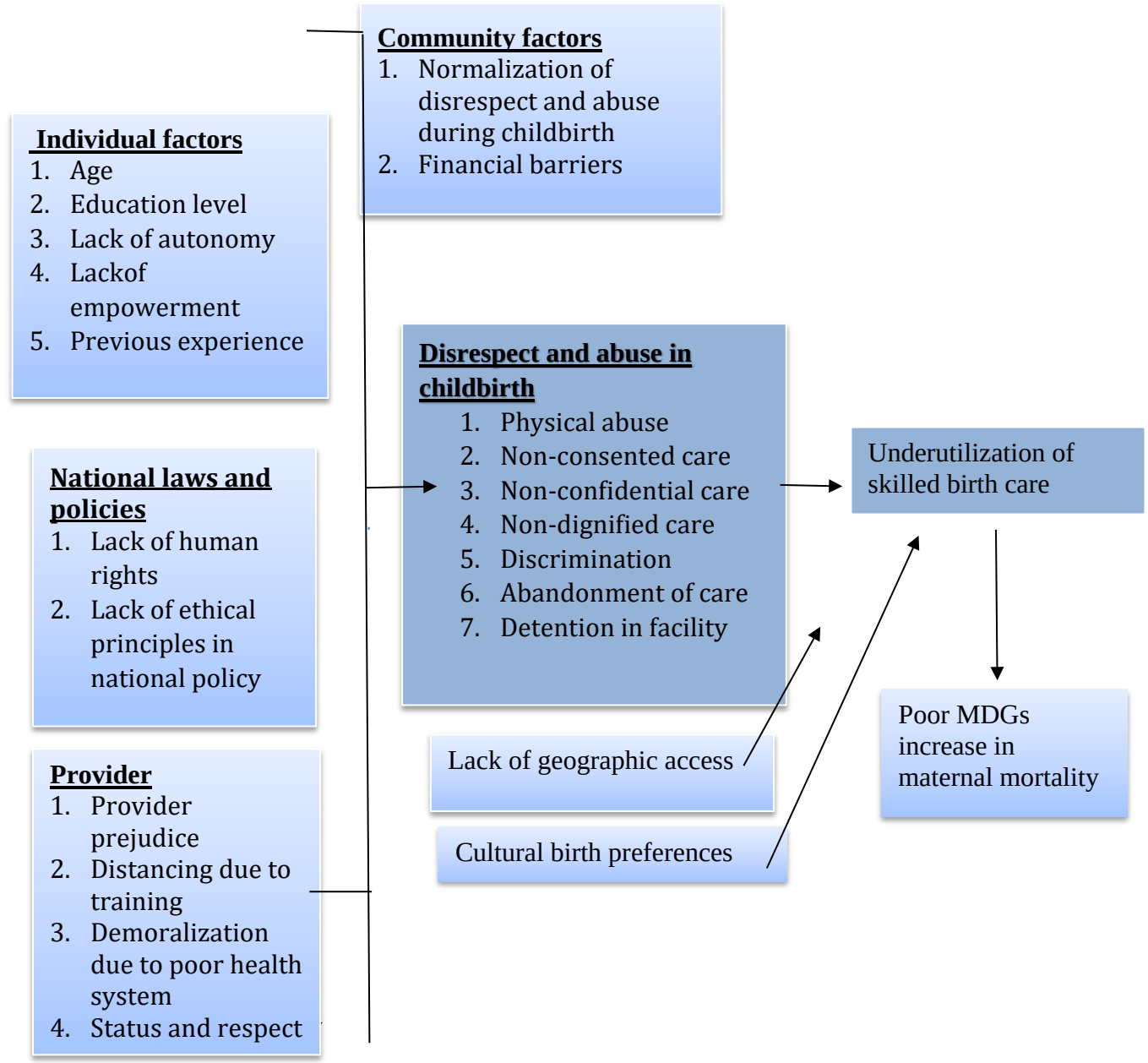
Awareness among providers can reduce this problem. A study was conducted in Tanzania, women were aware of HIV positive patients that's why providers showed less disrespect and abusive towards them as compared to HIV-negative patients (Sando et al., 2014)

2.4. RESPECTFUL MATERNITY CARE:

Recent advancement in women's rights is respectful maternity care (RMC). White ribbon alliance developed the RMC charter which is based on the framework of human rights and evidence of Disrespect and Abuse. It supports the idea to add RMC to maternal health projects to increase the effectivity ("Respectful Maternity Care Charter," n.d.). The charter encloses the universal declaration of Human rights, social and cultural rights, civil and political rights, elimination of violence against Women, elimination of discrimination against women and right to prevent morbidity and mortality. Practicing this charter can improve care, respect, trust, empathy, support and empowerment for the women ("Respectful Maternity Care Charter," n.d.).

2.5. CONCEPTUAL FRAMEWORK:

Conceptual Framework:



2.6. OPERATIONAL DEFINITIONS

2.6.1. DISRESPECT AND ABUSE

Disrespect and abuse during facility based childbirth is described as interactions or facility conditions that local consensus seems to be humiliating and undignified, and those interactions or conditions that are experienced as or intended to be humiliating and undignified (Freedman et al., 2014). Disrespect and Abuse has many manifestations. It has seven categories (Bowser & Hill, n.d.).

2.6.2. RESPECTFUL MATERNITY CARE

It is an approach based on principles of ethics and respect for human rights (Bulto et al., 2020).RMC is universal right of every childbearing women ("Respectful Maternity Care Charter," n.d.).

2.6.3. MATERNAL HEALTH

The health of women during pregnancy, childbirth and post-natal period (*Maternal Health*, n.d.).

CHAPTER III: METHODOLOGY

3.1. STUDY DESIGN

A quantitative research approach using cross-sectional study was carried out to assess disrespect and abuse during facility based childbirth in Tehsil and District Chakwal, Pakistan.

3.2. STUDY DURATION

Study period for the current research was 6 months from October 2021 to March 2022.

3.3. STUDY SETTING

This study was carried out in District Chakwal, located in northern Punjab. It is comprised of 5 Tehsils Chakwal, Kalar kahar, Choa saidan shah, Talagang and Lawa. The population of district Chakwal is estimated 1.495m (District Profile | Chakwal, n.d.). Mostly people of this district belongs to civil arm services, overseas and agriculture. The literacy rate of district is 90%. Health services are provided by public and private sector. Public sector comprised of one District headquarter hospital (DHQ), 3THQs (Tehsil headquarter), 10 RHCs (Rural health center), 64 BHUs (Basic health units), 36 rural dispensaries, 9 MCH centers and one city hospital Talagang. Lady health workers play major role in provision of health services. The private sector contains highly skilled and trained doctors working in private well equipped hospitals to clinics, to quacks and TBAs. Out of 5 tehsils, Chakwal was selected randomly. Tehsil Chakwal is home to diverse ethnic groups.

3.4. RESEARCH PARTICIPANTS

Data was collected from women who had experienced live childbirth during 24-48hours.

3.4.1. INCLUSION CRITERIA

1. Women who had delivered within 24-48hours.
2. Women who had live birth.

3.4.2. EXCLUSION CRITERIA

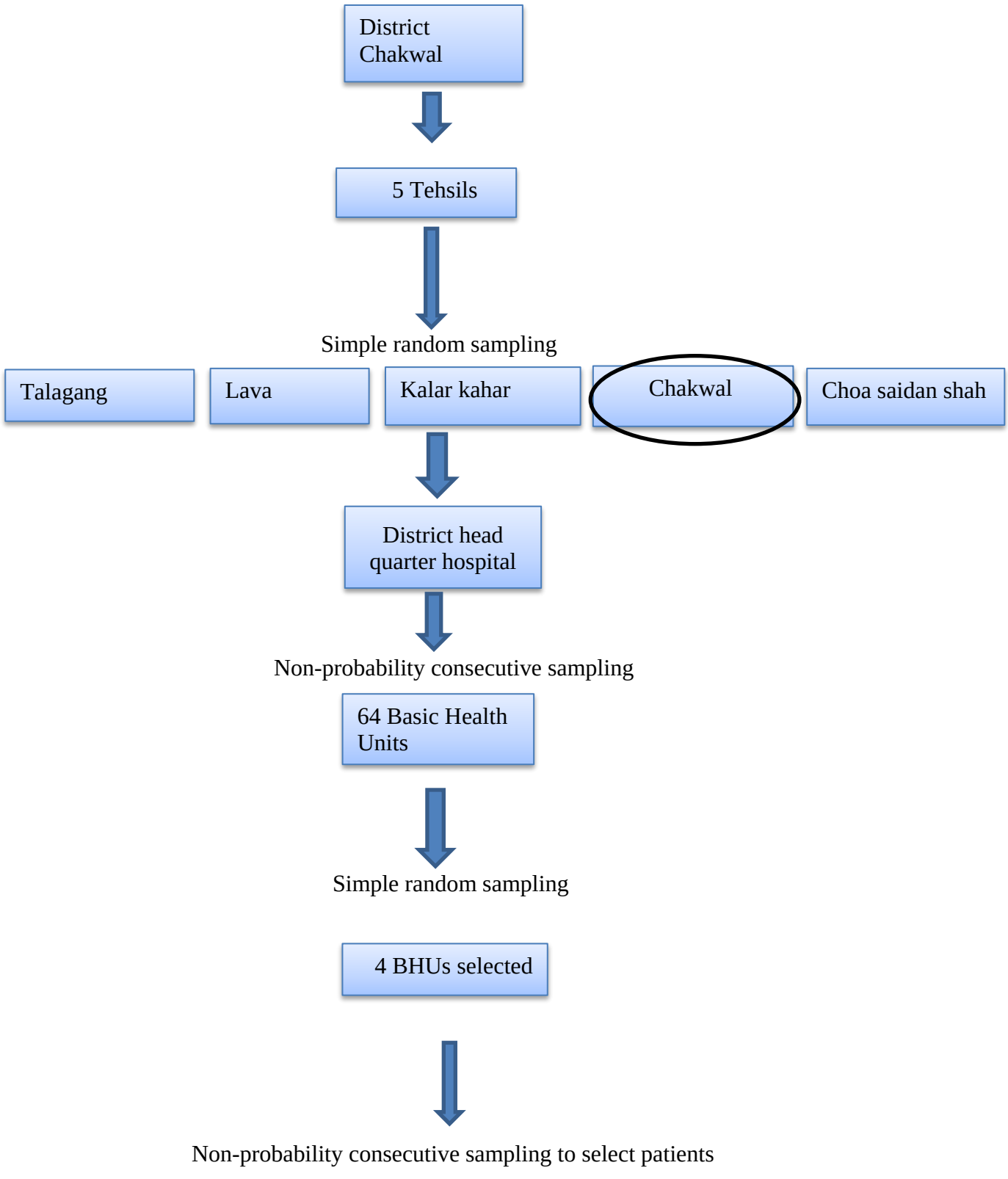
1. Women who delivered under general anesthesia.
2. Women who had cesarean section.
3. Women who had still birth.
4. Women whose child died in case of multiple pregnancies.

3.5. SAMPLE SIZE CALCULATION

A sample size of 305 was calculated by using proportion formula on Open Epi software version 3. Previous prevalence of disrespect and abuse during facility based childbirth was taken as 27.2 as reported by study conducted in Gujrat, Pakistan(Azhar et al., 2018). Calculated sample was 305 with 95% confidence interval and 5% margin of error.

3.6. SAMPLING STRATEGY

District Chakwal has five tehsils from which Chakwal tehsil was selected through simple random sampling. Further, Non-probability consecutive sampling was used for selection of patients from biggest public hospital that is District head quarter Chakwal (DHQ). There are 64 BHUs in District Chakwal from which 4 BHUs were selected from simple random sampling. Further, non-probability consecutive sampling was used to select patients from basic health units.


District Chakwal
5 Tehsils
Simple random sampling
Talagang
Lava
Kalar kahar
Chakwal
Choa saidan shah
District head quarter hospital
Non-probability consecutive sampling
64 Basic Health Units
Simple random sampling
4 BHUs selected
Non-probability consecutive sampling to select patients

3.7. DATA COLLECTION INSTRUNMENT

3.7.1 QUESTIONNAIRE DESIGN

Data was collected through interview-based questionnaire in which researcher asked the questions from respondents and recorded their responses accordingly. A Performa was developed to collect data regarding sociodemographic characters of respondents, history of utilization of facility, history of antenatal visits and Disrespect and Abuse experiences during childbirth.

3.7.2 CONTENT OF QUESTIONNAIRE

The questionnaire contained 3 major sections.

1. First part contained questions regarding sociodemographic characters of respondents.
2. Section part contained questions about utilization of antenatal services and history of previous deliveries.
3. Third part include the validated tool of 25 itemed scale for the assessment of disrespect and abuse during childbirth (Bowser & Hill, n.d.). It consist of seven categories physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care and detention in facility.

3.7.3. STUDY VARIABLES

3.7.3.1 OUT COME VARIABLES

Women was considered to have **Experienced Disrespect and Abuse** if she reported yes to any one of the questions of 25 item scale. The other outcome variable is *felt Disrespect and Abuse* which is known as **Reported Disrespect and Abuse**. This variable was based on questions asked at the end of seven categories which asked women if they had felt being disrespected and abuse during particular category. If a women responded *yes* to any of the category is considered as **Reported Disrespect and Abuse.**

S.No.	Categories and items of D & A scale
1	**Non-consented care**
1.1	Provider did not introduce herself
1.2	Provider did not encourage to ask questions
1.3	Provider didn't responded politely, truthfully and promptly
1.4	Provider didn't explained procedure and explained expectations
1.5	Provider didn't give the periodic updates on status and progress
1.6	Provider didn't allow to move during delivery
1.7	Provider didn't allow to assume position of choice
1.8	Provider didn't obtain consent prior to procedure
2	**Non confidential care**
2.1	Curtains and physical barriers were not used
2.2	Drape or body covering was not used
2.3	The number of staff members around were not logical
3	**Non-dignified care**
3.1	Provider didn't speak politely
3.2	Provider made insults, threats etc.
3.3	Provider used abusive language
4	**Discriminatory care**
4.1.	Provider used language difficult to understand
4.2	Provider showed disrespect based on specific attribute
5	**Abandonment in facility**
5.1	Provider didn't encouraged to call if needed
5.2	Provider made patient feel alone or unattended
5.3	Provider didn't come quickly when needed
6	**Physical abuse**
6.1	Provider used physical force, slapped or hit the woman
6.2	Woman was physically restrained
6.3	Baby was separated without medical indication
6.4	Didn't receive comfort, pain relief as necessary
6.5	Provider didn't demonstrated in culturally appropriate way
7	**Detention in facility**

https://doi.org/10.1371/journal.pone.0200318.t001

3.7.3.2 INDEPENDENT VARIABLES

Data on independent variables was collected through structured Performa that is constructed after national and international literature review. The Performa included

sociodemographic variables which includes age, gender, educational level, income, marital status, place of residence etc. In addition it also included some questions related to antenatal visits, place of previous deliveries and provider. It also included questions about disrespect and abuse during facility based childbirth.

3.8. DATA COLLECTION PROCESS

3.8.1. PILOT TESTING

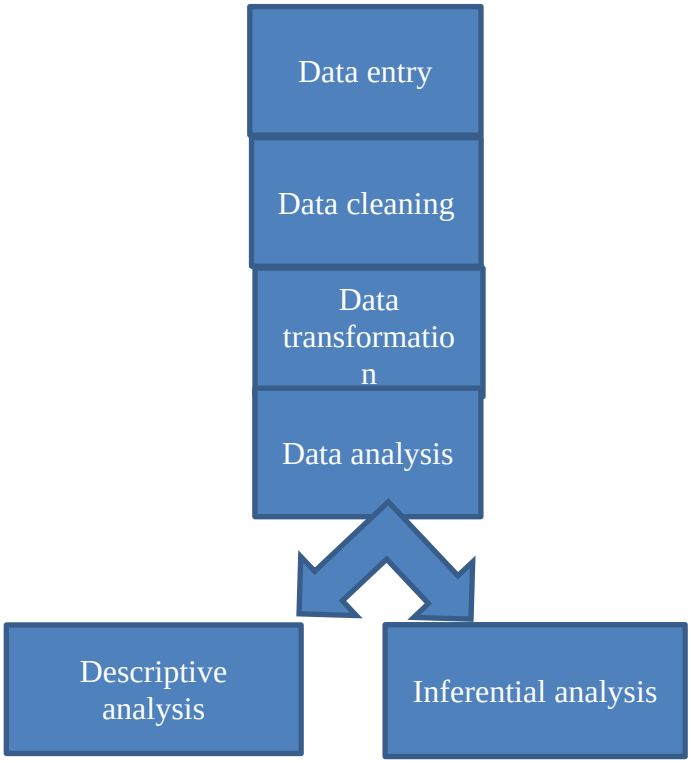
Pilot testing was performed before starting the formal data collection procedure by including 10% of the actual sample size. Performa was tested for any future changes, no major changes was done after pilot testing. Data from pilot testing was not included in final analysis.

3.8.2. FORMAL DATA COLLECTION

Data was collected by the researcher herself and no data collectors were hired. All the patients admitted in hospital, who met the inclusion criteria were approached. Consent was taken from all patients and only those patients were selected who agreed to take part in research process. After taking consent, respondents were interviewed and their responses were recorded by the researcher. Data collection was completed in almost two months. All questionnaires were kept in plastic bag and no one had access to them other than researcher.

3.8.3. DATA ANALYSIS PROCEDURE

Code book was developed and data was entered in Statistical Package for Social Sciences (SPSS) version 26. After careful data entry data was checked for any mistakes before proceeding to further analysis. After data cleaning, data transformation was done for some variables. Data analysis was done in two phases that are descriptive analysis and inferential analysis.



3.9. DATA TRANSFORMATION

All the determinants of Disrespect and Abuse during childbirth are transformed into categorical variables upon entry into SPSS. Disrespect and abuse has seven categories; non-consented care, non-dignified care, non-confidential care, abandonment in facility, physical abuse, discriminator care, detention in facility.

3.9.1 DESCRIPTIVE ANALYSIS

Descriptive statistics were generated for socio-demographic characteristics and categories of disrespect and abuse. For categorical variables data was summarized in the form of frequencies and percentages and presented in table form, bar chart and pie chart. Frequencies and percentages were also reported for various categories of disrespect and abuse. Continuous variables were summarized by mean and standard deviation as the data was normally distributed.

3.9.2 INFERENTIAL ANAYSIS

Second phase of the analyses was on inferential statistics. Association of reported Disrespect and Abuse and Experienced Disrespect and Abuse was determined with socio-demographic variables using Pearson Chi Square test of Independence. Furthermore, multivariate binary logistic regression was used to identify main predictors of each type of

Disrespect and Abuse. ENTER method was used for regression. First category of each categorical variable was selected as reference category. Coding was done as 0 and 1 for binary variables. Results of Omnibus test were used to check if the model was significant or not while for checking the overall effect of independent variables on dependent variable, Negelkerke R square and Cox & Snell R square test were used.

3.10. ETHICAL CONSIDERATION

Before starting formal data collection, approval from Institutional Review Board (IRB) of Al-Shifa School Of Public Health Rawalpindi, Pakistan has been taken. Permission letter from the head of department of Al-Shifa School Of Public Health was obtained regarding access to study facility. Permission was taken from facility for conducting research. Patients were explained purpose of research and oral consent was taken from each participant. Participants were assured for confidentiality of their data. Data collected from the respondents was remained anonymous and was not shared with anyone. Data was entered in SPSS anonymously. After data entry, hard copies were collected and kept in safe place.

CHAPTER IV: RESULTS

4.1. SOCIODEMOGRAPHIC PROFILE

Total 310 women who had birth to a live child in the past 24hours participated in study. Their mean age was 26.39(S.D=4.789) ranged from 17-38years. Majority of the respondents were married 98.4% followed by 1.0% widowed and 0.6% separated. Women who lived in combined household were 77.7% and 21.6% live in separate houses. Most of the women had only matric level education which was around 48.7%, women who had intermediate education were 37.4% and 9.0% were illiterate and only 4.8% women were above intermediate level. The median household expenditure was 15000 ranging from 5000 to 50000. 62.9% households had income ranged from 15000-30000, 30.0% were below 15000 and only 7.1% had income above 30000. Most of the women participating were not working them were 91.6% of total women and only 8.4% were working. The occupation of husband showed that 31.0% had some kind of employment, 26.1% had business, 19.4% do agriculture work, 8% are labor and work abroad respectively and 6.8% are jobless.

Table 2: Descriptive statistics of social demographics variables

Sr.No	VARIABLE	FREQUENCY	PERCENTAGE
1	**MARITAL STATUS**		
	Married	305	98.4%
	Widowed	3	1.0%
	Separated	2	0.6%
3	**EDUCATION of women**		
	Illiterate	28	9.0%
	Matric	151	48.7%
	Intermediate	116	37.4%
	Above	15	4.8%
4	**TYPE OF HOUSEHOLD**		
	Combine	241	77.7%
	Neutral	67	21.6%
5	**MONTHLY EXPENDITURE**		
	Below 15000	93	30.0%
	15000-30000	195	62.9%
	More than 30000	22	7.1%

6	**WHETHER WOMEN WORKS OR NOT**		
	Yes	26	8.4%
	no	284	91.6%
7	**HUSBAND OCCUPATION**		
	Labor	27	8.7%
	Business	81	26.1%
	Abroad	25	8.1%
	Agriculture	60	19.4%
	Employ	96	31.0%
	Jobless	21	6.8%

4.2. HISTORY OF PREGNANCY AND CHILDBIRTH

Mean number of children per women were 2.44 (SD= 1.30) ranging from 1 to 6 children. Total of 57.2% respondents had children less than two. Less number of couples have increase number of children. Women who had delivered their younger child at home were 9.0% while 91.0% delivered at health facility. The main care provider was medical doctor followed by other SBAs (skilled birth attendants) and TBAs (traditional birth attendants). 46.8% of nurses attended patient first after reaching hospital followed by 38.1% doctors. In 11.9% cases respondents had not visited facility for Antenatal checkups while 88.1% had antenatal checkups. The main reason behind choose of facility for delivery is family prioritization 36.8%, followed by economical 22.9% and referred due to complications.

14.5% Cases in which any attendant of the women accompanied her inside the labor room were 32.3% and 67.7% of women believed that there should not be any attendant inside during delivery.

Table 3: Descriptive Statistics of Childbirth Variables

Sr.No	VARIABLE	FREQUENCY(N)	PERCENTAGE (%)
1.	**Total no of children born in hospital**		
	1-2 children	231	74.5%
	3-5 children	74	23.9%
	6 or more	5	1.6%
2.	**Delivery place of youngest child**		
	Home	28	9.0%
	Any facility	282	91%
3.	**Women visited facility for ANC**		
	Yes	273	88.1%
	no	37	11.9%
4.	**Reason to choose facility**		

	Trust developed	19	6.1%
	Economical	71	22.9%
	Complications	45	14.5%
	Family prioritization	114	36.8%
	(Nearer availability,	34	11.0%
	Delivery started)		
	Insufficient facilities	27	8.7%
5.	**who among the staff first attended patient**		
	doctor	118	38.1%
	Skilled birth attendent	179	57.7%
	Non Skilled birth attendent	13	4.2%
6.	**Main care provider during delivery**		
	Doctor	161	51.9%
	Skilled birth attendants(SBA)	108	34.8%
	Non-skilled birth attendants	41	13.2%

7.	**Attendants along with women inside labor room**		
	Yes	100	32.3%
	no	210	67.7%

4.3 DISRESPECT AND ABUSE

Almost 99.4 % women experienced at least one type of Disrespect and Abuse during childbirth. However, only 26.8% women reported D & A during childbirth. The most experienced and reported categories of Disrespect and Abuse were non consented care, non-dignified and abandonment of care (Table 4). The mean scores of experienced Disrespect and Abuse was 17.02 (S.D. 3.402) ranging from 0 –23. Within sub-categories of experienced Disrespect and Abuse, most dominant type was that provider didn't introduce herself followed by lack of periodic updates and lack of encouragement to call by the providers in case of any need (table 5).

Table 4: Categories of disrespect and abuse

CATEGORY	EXPERIENCED D&A	REPORTED D&A
Non consented care	(97.7%) 303	(11.0 %)34
Non confidential care	(57.1%)179	(4.2%) 13
Non dignified care	(62.3%)193	(9.0%) 28
Discriminatory care	(7.7%) 24	(6.1%) 19
Abandonment of care	(60.3%) 187	(11.0%) 34
Physical abuse	(9.7%) 30	(0.6%) 2
Detention in facility	0	0
TOTAL	(99.4%)308	(26.8%) 83

4.3.1. DETERMINANTS OF DISRESPECT AND ABUSE

Table 5: Experienced disrespect and abuse in different categories of disrespect and abuse

CRITERIA	FREQUENCY	PERCENTAGE
NON CONSENTED CARE		
Provider didn't introduced herself	299	96.5%
Provider didn't encourage to ask questions	174	43.9%
Provider didn't respond politely, truthfully and promptly	121	39.0%
Provider didn't explain procedure and expectations	101	32.6%
Provider didn't give periodic updates on status and progress	227	73.2%
Provider didn't allow to move during delivery	19	6.1%
Provider didn't allow to assume position of choice	25	8.1%
Provider didn't obtain consent prior to procedure	152	49.0%

NON CONFEDENTIAL CARE		
Curtains and physical barriers were not used	36	11.6%
Drape or body covering was not used	179	57.7%
The number pf staff members were not logical	33	10.6%
NON DIGNIFIED CARE		
Provider didn’t speak politely	120	38.7%
Provider made insults and threats	41	13.2%
Provider used abusive language	34	11.0%
DISCRIMINATORY CARE		
Provider used language difficult to understand	50	16.1%
Provider showed disrespect based on specific attribute	26	8.4%
ABANDONMENT OF CARE		
Provider didn’t encourage to call if needed	189	61.0%
Provider made patient feel alone or unattended	152	49.0%
Provider didn’t come quickly when needed	115	37.1%

PHYSICAL ABUSE		
Provider used physical force, slapped or hit the women	18	5.8%
Women was physically restrained	1	0.3%
Baby was separated without medical indication	25	8.1%
Didn't receive comfort, pain relief as necessary	0	0
Provider didn't demonstrated in culturally appropriate way	26	8.4%
DETENTION IN HOSPITAL		
Detention in facility	0	0

4.4. Reported Disrespect and Abuse

Reported Disrespect and Abuse was maximum in non-consented care and abandonment of care.

Table 6: **Determinants of Reported Disrespect and Abuse**

VARIABLES	CATEGORIES	REPORTED Disrespect and Abuse	TEST STATISTICS X2 (DF)	P-VALUE
MARITAL STATUS	Married	81 (26.1%)	0.556 (2)	0.757
	Widowed	1 (0.3%)		
	separated	1 (0.3%)		
EDUCATION LEVEL OF WOMEN	Illiterate	8 (2.6%)	1.701(3)	0.637
	Matric	43 (13.9%)		
	Intermediate	30(9.7%)		
	Above	2 (0.6%)		
HOUSEHOLD TYPE	Combine	58 (18.8%)	3.708(1)	0.054
	neutral	24 (7.8%)		
MONTHLY EXPENDITURE	Below 15000	33 (10.6%)	9.412(2)	0.009
	15000-30000	49 (15.8%)		
	More than 30000	1 (0.3%)		
WOMEN EMPLOYMENT	Yes	5 (1.6%)	.824 (1)	0.364
	no	78 (25.2%)		
HUSBAND OCCUPATION	Labor	8 (2.6%)	5.142(5)	0.399
	Business	26 (8.4%)		
	Abroad	6 (1.9%)		

	Agriculture	16 (5.2%)		
	Employ	19 (6.1%)		
	Jobless	8 (2.6%)		
TOTAL NO OF CHILDREN	1	22 (7.1%)	8.457(5)	0.133
	2	18 (5.8 %)		
	3	24 (7.7%)		
	4	16 (5.2%)		
	5	1(0.3%)		
	more	2 (0.6%)		
CHILDREN BORN AT HOSPITAL	1-2 children	57 (18.4%)	2.419(2)	0.298
	3-5 children	25 (8.1%)		
	6	1 (0.3%)		
DELIVERY PLACE OF YOUNGER CHILD	Home	1(0.3%)	8.452 (1)	**0.004**
	Facility	82 (26.5%)		
ANC VISIT	Yes	73 (23.5%)	.001(1)	0.970
	No	10(3.2%)		
REASON TO ADOPT FACILITY	Trust develop	3 (1.0%)	3.021(5)	0.697
	Economical	21 (6.8%)		
	Complications	15 (4.8%)		
	reffered			

	Family prioritization	28(9.0%)		
	Near, availability	8 (2.6%)		
	Insufficient facilities	8 (2.6%)		
WHO ATTENDED FIRST AT FACILITY	Doctor	15 (4.8%)	24.070(2)	**0.000**
	SBA	60 (19.4%)		
	TBA	8 (2.6%)		
TOTAL NO OF PROVIDERS ATTENDED	1	24 (7.7%)	17.196 (4)	**0.002**
	2	21 (6.8%)		
	3	29 (9.4%)		
	4	7 (2.3%)		
	5 or more	2 (0.6%)		
MAIN CARE PROVIDER	Doctor	34 (11.0%)	10.690	**0.005**
	SBA	30 (9.7%)		
	Non SBA	19 (6.1%)		
ATTENDED ALONG WITH WOMEN	Yes	36 (11.6%)	6.409(1)	**0.011**
	no	47 (15.2%)		

Association of reported disrespect and abuse with demographic variables was determined using Chi Square Test of Independence after confirming the assumptions of the test. All p-values below 0.05 were considered statistically significant. A summary of association of sociodemographic characters and reported disrespect and abuse is given in table above. Results of the Chi square analysis show that reported disrespect and abuse is significantly associated with household type (p value=0.054), delivery place of younger child (p value=0.004), who attended first at facility (p value=0.000), total number of providers attended (p value=0.002), main care provider (p value=0.005), attended along with women inside labor room (p value=0.01).

4.5. Experienced Disrespect and Abuse

Table 7: Determinants of Experienced Disrespect and Abuse

VARIABLES	CATEGORIES	TEST STATISTICS X2 (DF)	P-VALUE
MARITAL STATUS	Married 303 (97.7%) Widowed 3 (1.0%) Separated 2 (0.6%)	0.065 (2)	0.968
EDUCATION LEVEL OF WOMEN	Illiterate 28 (9.0%) Matric 150 (48.4%) Intermediate 115 (37.1%) Above 15 (4.8%)	0.634 (3)	0.947
TYPE OF HOUSEHOLD	Combine 239 (77.6%) Neutral 67 (21.8%)	0.985 (1)	0.321
MONTHLY EXPENDITURE	Below 15000 93 (30%) 15000-30000 193 (62.3%) More than 30000 22 (7.1%)	1.862 (2)	0.394
WOMEN WORK OR NOT	Yes 26 (8.4%) No 282 (91.0%)	0.352 (1)	0.553
HUSBAND OCCUPATION	Labor 27 (8.7%) Business 81 (26.1%)	2.871 (5)	0.720

	Abroad 25 (8.1%) Agriculture 59 (19.0%) Employ 95 (30.6%) Jobless 21 (6.8%)		
TOTAL NUMBER OF CHILDREN WOMEN HAVE	1 85 (27.4%) 2 88 (28.4%) 3 75 (24.2%) 4 40 (12.9%) 5 10 (3.25%) More 10 (3.2 %)	6.562 (5)	0.255
CHILDREN BORN IN HOSPITAL	1-2 child 230 (74.2%) 3-5 child 74 (23.9%) 6 child 4 (1.3%)	6.276 (2)	**0.043**
DELIVERY PLACE OF YOUNGER CHILD	Home 28 (9.0%) Any facility 280 (90.3%)	0.380(1)	0.538
ANC VISIT	Yes 271 (87.4%) No 37 (11.9%)	0.510 (1)	0.475
REASON TO CHOOSE FACILITY	Trust developed 19 (6.1%) Economical 70 (22.6%) Complication reffered 45 (14.5%) Family prioritization 114 (36.8%)	4.627 (5)	0.463

	Nearer availability and or delivery started 33 (10.6%) Insufficient facilities 27 (8.7%)		
WHO FIRST ATTEND AT HOSPITAL	Doctor 118 (38.1%) SBA 177 (57.1%) NON SBA 13 (4.2%)	2.202 (2)	0.332
TOTAL NO OF PROVIDERS ATTENDED	1 48 (15.5%) 2 95 (30.6%) 3 130 (41.9%) 4 31 (10.0%) 5 4 (1.3%)	3.433 (4)	0.488
MAIN CARE PROVIDER	Doctor 159 (51.3%) SBA 108 (34.8%) Non- SBA 41 (13.2%)	2.633 (2)	0.268
ATTENDED WITH WOMEN INSIDE LABOR ROOM	Yes 100 (32.3%) No 208 (67.1%)	1.564 (1)	0.211

Association of experienced disrespect and abuse with demographic variables was determined using Chi Square Test of Independence after confirming the assumptions of the test. All p-values below 0.05 were considered statistically significant. A summary of association of sociodemographic characters and experienced disrespect and abuse is given

in table above. Results of the Chi square analysis show that experienced disrespect and abuse is significantly associated with only one variable that is children born in hospital (p-value: 0.043).

Table 8: Determinants of Reported Disrespect and Abuse using Multivariate Binary Logistic Regression

VARIABLES	AOR	P-VAUE	95% CI	
			Lower	Upper
TYPE OF HOUSHOLD				
Combine	1			
Neutral	2.385	**0.008**	1.256	4.529
Any other	1.886			
WHO FIRST ATTENDED WOMEN AT FACILITY				
Doctor	1			
SBA	3.600	**0.000**	1.776	7.298
NON SBA	7.653	**0.008**	1.716	34.137

TOTAL NO OF PROVIDERS DURING CHIDBIRTH				
1	1			
2	0.212		0.019	2.312
3	0.125	0.066	0.014	1.152
4	0.161		0.019	1.363
5 or more	0.252		0.026	2.424
MAIN CARE PROVIDER				
Doctor	1			
SBA	0.774	0.627	0.276	2.172
NON SBA	0.839		0.318	2.212
ATTENDED INSIDE LABOR ROOM WITH WOMEN				
Yes	1			
No	1.768	0.230	0.697	4.483

Results showed that full model containing all predictors was statistically significant (p = 0.0001) indicating that the model was able to distinguish between respondents who

reported high and low levels of disrespect and abuse. Model summary showed that it can cause a deviation in the levels of Disrespect and Abuse in the range of 12.3%-17.8%. It was observed that odds of patients living in Neutral household type had 2.385 more likely to report Disrespect and Abuse as compared to odds of women living in combined household type (CI= 1.256 – 4.529, P-value < 0.05, OR= 2.385), while odds of women living in any other type of household had 1.886 times more likely to report disrespect and abuse as compared to the odds of living in combined household (CI=0.104 – 34.118, p value < 0.05, OR = 1.886). Similarly, odds of women attended by NON SBA (non-skilled birth attended) had 7.653 times more likely to report disrespect and abuse as compared to women attended by doctor (CI= 1.716 – 34.137, P-value< 0.05, OR= 7.653) while odds of women attended by SBA (skilled birth attended) were 3.600 times more likely to report disrespect and abuse as compared to women attended by doctors (CI= 1.776 – 7.298, P-value<0.05, OR= 3.600).

CHAPTER V: DISCUSSION

The study aimed to investigate the prevalence of disrespectful and abusive practices during childbirth. It was intended to obtain both the Reported and Experienced Disrespect and abuse during childbirth. The overall prevalence of reported Disrespect and Abuse during childbirth in the study population of 310 women was 26.8%, where actually almost all the women (99.4%) experienced at least one of its categories. The findings are coherent with study of Ethiopia where 78% of women experienced Disrespect and Abuse in one or more categories but only 16.2% subjectively experienced it (Asefa & Bekele, 2015). And in Kenya 20% women have reported any form of Disrespect and Abuse (Abuya et al., 2015). The Theory of Freud Defense Mechanism and Empirical Findings in social sciences explains this disparity by saying that the normal population protects their self-esteem unconsciously by denial mechanism. Women may experience anxiety from misbehavior of providers but they just refuses to report it.

Pakistan has reported the highest level of Disrespect and Abuse as compared to other countries. This is an alarming finding and can be an important reason for poor utilization of public health facilities for childbirth as well as for post-natal care. Studies are needed to investigate the impact of Disrespect and Abuse on health seeking behavior later. The most prevalent Experienced form of Disrespect and Abuse was the Non consented care (303, 97.7%) followed by Non dignified care (193, 62.3%) and Abandonment of care (187, 60.3%). These three categories were also the most reported forms with prevalence of (34, 11.0%) in Non-consented care and Abandonment of care respectively and (28, 9.0%) prevalence in Non-dignified care. The evidence clearly follows the study (Asefa & Bekele,

2015) where lack of information and informed choices (Non-consented care) was 94.8% and Abandonment of care with 39.3% dominated the other categories. The evidence also clearly follows the study done in District Gujrat, PAKISTAN (Azhar et al., 2018) in which all women experienced disrespect and abuse (objective disrespect) 99.7% during childbirth and 27.2% reported subjective experience of Disrespect and Abuse (Reported Disrespect and Abuse) .

Kurk (2009) described that the women rate quality of services based on how well informed and explained they were. This extreme prevalence can be allied to the fact that the most physicians in our society believe that patients are uneducated, they couldn't decide for themselves and they wanted the doctors to decide for themselves (Humayun et al.2008).

The second most prevalent Experienced Disrespect and Abuse was Non-dignified care and Reported category of Disrespect and Abuse was the Abandonment of care with 62.4% and 11.0% respectively. This is clearly against the guidelines to the Respectful maternity care that states that any woman who is in labor or just delivered a baby should never be left alone or without care at all (Vogel et al., 2016). Negligence and carelessness on the part of the providers may not just have the negative maternal outcomes but also the long lasting psychological impacts. Women remember the process of childbirth and the events of the surroundings for many years (*Simkin - 1992 - Birth - Wiley Online Library*, n.d.) means that lack of care can build an everlasting hesitation and reluctance for future utilization. This concludes that this non responsive attitude of the providers ultimately results in a resorted situation where health care facilities are only utilized for complications (Mselle et al., 2013)

Another huge violation of respectful maternity care was observed as non-confidential care 57.1% of women experienced this, which was higher than the studies on Disrespect and Abuse conducted in other countries like 21.4% in Ethopia (Asefa & Bekele, 2015) and 8.5% in Kenya (Abuya et al., 2015) . There should be every effort to ensure a private and respected environment during childbirth (Hodnett et al., 2013). However in our research half of them didn't had any covering (57.7%) and 11.6% were not protected by physical barrier or curtains. Women wellbeing certainly requires attention to her privacy in the birth place, but unfortunately in developing countries the hospitals are overcrowded and privacy and personal support is difficult (Technical Working Group, 1997). Interestingly none of the women experienced detention or reported any concerns about that in Pakistan unlike recent studies conducted by (Okafor et al., 2015) which resulted in 22% of detention and (Abuya et al., 2015) with 8.1% of detention because of inability to pay. In the other six categories reported D & A varied from 0.6%-11.0 % and actual experienced Disrespect and Abuse ranged from 9.7%- 97.7%.

The mean score of Disrespect and abuse was comparatively low for the respondents of young age, having less time since marriage, in case of their first child or women residing in combine household type. Young women in our societal setup are especially susceptible to subordination (Mumtaz& Sulvay 2007).

Our study contradicts the finding that women want constant family support inside labor room (Abuya et al 2015) as more than 60% of women were not comfortable to have any family member inside labor room with them, secondly only less than 5% women wanted to have their partner inside. The reason lies in the cultural practices, women's perception

can also be attributed to the fact this is not our common cultural practice and women have not actually ever considered it, Although husband can have an important role in ensuring better pregnancy outcomes and maternal survival because they are the decision makers in the society like Pakistan and maternal outcome turned out to be better when there is support from the husband (Impact of CommunityBased Interventions on Maternal and Neonatal Health Indicators: Results from a Community Randomized Trial in Rural Balochistan, Pakistan | Reproductive Health | Full Text, n.d.).

Women were when asked to give response that how they can possibly protect them from the disrespect and abuse than most of them had a response of not taking any kind of action and there were only 12.2% of population who had an opinion to take some action or report the providers and don't let them do it to women. This kind of response can make Disrespect and Abuse a lasting practice in future as public weak feedback have an ultimately weak prediction of bringing change in future.

Women who tried in past to report the behaviors and attitude of providers were disappointed with the system and gave a response as "kuch nahi ho sakta" or nothing is possible to avoid the Disrespect and Abuse. They further justified act of disrespect and abuse by the providers by explaining it as either strict routine of the providers burden or because the patients make them furious, The stance of empathy was also the expression of normalize behavior where women were not thinking as this action as an abnormal, unlawful or ethically wrong (Abuya, 2015) or women become empathized to over worked facilitators (McMahon et al., 2014).

There were few limitations of study as many women may have underreported the Disrespect and Abuse as women who belonged to combine household type were 76.7%

.The quantitative analysis and close ended questions might have missed some of the aspect which should be analyzed in more depth by qualitative studies. Our study settings varied from rural, peri-urban to urban areas, which couldn't be differentiated, so there should be further studies separately in all setups. We conducted our study at hospital level so women can share their experience completely before they forget all incidence once they get discharged. Secondly quantitative assessment helped to highlight frequencies in all the seven categories showing which one is more prevalent in Pakistan. The union councils selected randomly gave diversity in geographical selection and all the areas in it had vast variations.

Under reporting because women have perceived few practices as "normalized" is tackled by asking questions on both experienced and satisfaction about the practices. It is highly recommended to conduct studies at mass levels and by using mixed method approach to deliver more information on the exact extent of disrespect and abuse during childbirth, It should be made applicable to deliver the findings to health care workers to promote the respectful care. In community, awareness should have made in such a way that the veil of silence may break and women can express and ask for her rights openly and confidently. There is also need to conduct separate studies at all the levels of health care centers and with every provider separately.

We can suggest by these results that interventions should be developed to reduce the Disrespect and Abuse during childbirth as it is neither normal nor acceptable. Articulation of theories of change, implementation strategies and movement of respectful maternity at all the levels i.e., local and national combine can contribute towards likelihood to improve maternal outcome and respectful maternity.

5.1. STRENGTHS

The current study has used validated and internationally accepted tools for assessment of Disrespect and Abuse among study population (Bowser And Hill). This tool was widely used for Disrespect and Abuse assessment in various previous studies. This tool helped in assessment of different forms of Disrespect and Abuse. Moreover, the current study is somehow successful in assessing the Disrespect and Abuse among women during childbirth as a representative sample was calculated for this study. Furthermore, present study has also identified the major risk groups for facing disrespect and abuse. In addition, current study is unique in aspect as it included the patients' point of view which is a major strength of this study as little literature is available in Pakistan regarding patients' suggestions for experienced and reported disrespect and abuse. Moreover, the current study included a diverse sample comprising women from different socioeconomic groups, educational background and ethnic groups. The findings of the current study can be generalized to the similar patient population from other parts of Pakistan due to similar contextual factors.

5.2. LIMITATIONS

Despite the sincere efforts of the researcher, few limitations were still present in the current study. Firstly, it was a cross-sectional study and hence no causal relationship can be

established in this study. Secondly, the patients who did not understand Urdu or Punjabi were excluded from the current study which can be a source of selection bias in current study. Third, in the present study disrespect and abuse was measured at a single instance, but during the course of study it was noted that if researcher had measured disrespect and abuse at multiple instances before childbirth and also extended the measurement to after the delivery of child in post-partum period and in both private and public settings, it would have increased the credibility of the present study. It is important to note that for current study, patients who were undergoing cesarean section were excluded, so it would be inappropriate to extrapolate these results to higher risk pregnant women without further investigation.

CONCLUSIONS AND WAY FORWARD

Disrespect and Abuse during childbirth is highly prevalent in Pakistan, although remains underreported. Determinants of experienced Disrespect and Abuse were married women 97.7% ,women who had delivered younger child at any facility 90.3% and women who had Antenatal visits 87.4%. While Reported Disrespect and Abuse is more prevalent among married women 26.1&, women who were unemployed (non-working) 25.2% and women who had younger child delivered at facility 23.5%. These findings not only provide an insight but also specify the low utilization of public sector in Pakistan. Almost half of the women opted to go to other health facility next time if they reported being disrespect and abused during childbirth.

To increase the skilled birth attendants (SBAs), efforts should not be only focused on service delivery but also to eliminate the Disrespect and Abuse during childbirth. Exploratory studies with in-depth assessments and the similar comparative studies with different study settings can further help to comprehend the issue. Effective Interventions should be designed and implemented to reduce the Disrespect and Abuse during childbirth in facilities and also at community level. Providers should be addressed and directed towards standardized and respectful maternity care. There must be a national system of counseling and accountability for providers to eliminate the mistreatment. There is also need to articulate the policy makers, community members and women to bring effective programs and advocacy to ensure dignity of women during childbirth.

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Appendix A
DATA COLLECTION TOOL

SECTION-A

1. Respondent ID number?
2. What is your age? (in years) ----------
3. What is your current marital status?
    1) Single
    2) Married
    3) Widow
    4) Divorced
    5) Separated
4. What is education level of women?
    a) Illiterate
    b) primary
    c) Middle
    d) Matric
    e) Intermediate
    f) Graduation
    g) more
5. Are you working women?
    a) Yes
    b) No
6. What's your husband occupation? ----------
7. What is total earning of your family?
    a) below 15000
    b) 15000- 30000
    c) Above 30000
8. What is the type of household women lives in?
    a) Combine
    b) Neutral
    c) Any other
9. How many children do you have? _____

SECTION - B

1. How many children delivered at hospital?
   a) 0
   b) 1
   c) 2
   d) 3
   e) 4
   f) 5
   g) 6 or more
2. What was the place of delivery of younger child?
   a) Home
   b) At any facility
3. History of Antenatal visit?
   a) Yes
   b) No
4. What was the reason to choose current facility
   a) Have trust on facility
   b) Economical
   c) Referred due to complications
   d) Family prioritization
   e) Near to home or delivery started
   f) Insufficient facilities
5. Who among the staff first attended women after reaching facility?
   a) Doctor
   b) nurse
   c) LHV
   d) Midwife
   e) Ayaa
   f) Any other
6. How many healthcare providers present during birth?
   a) 1
   b) 2
   c) 3
   d) 4
   e) 5 or more
7. Who was main care provider during delivery?

   a) Doctor
   b) Nurse
   c) LHV
   d) Midwife
   e) Any other

8. Any family member was present at the time of delivery?
   a) yes
   b) no

SECTION - C
Categories of disrespect and abuse

1. Non-consented care
   i. Did provider introduce herself?
      a) yes b) no
   ii. Did provider encourage to ask questions?
      a) yes b) no
   iii. Did provider responded politely, truthfully and promptly?
      a) yes b) no
   iv. Did provider explained procedure and explained expectations?
      a) yes b) no
   v. Did provider give periodic updates on status and progress?
      a) yes b) no
   vi. Did provider allow to move during delivery?
      a) yes b) no
   vii. Did provider allow to assume position of choice?
      a) yes b) no
   viii. Did provider obtain consent prior to procedure?
      a) yes b) no
2. Non-confidential care
   i. Did curtains and physical barriers were used?
      a) yes b) no
   ii. Did drape or body covering was used?
      a) yes b) no
   iii. The number of staff members around were logical?
      a) yes b) no
3. Non-dignified care
   i. Did provider speak politely?
      a) yes b) no
   ii. Did provider made insults, threats etc ?
      a) yes b) no
   iii. Did provider used abusive language?
      a) yes b) no
4. Discriminator care

i. Did provider used language difficult to understand?
   a) yes b) no
ii. Did provider showed disrespect based on specific attribute?
   a) yes b) no

5. Abandonment in facility
   i. Did provider encourage to call if needed?
      a) yes b) no
   ii. Did provider made you feel alone or unattended?
      a) yes b) no
   iii. Did provider come quickly when needed?
      a) yes) b) no
6. Physical abuse
   i. Did provider used physical force, slapped or hit the women?
      a) yes b) no
   ii. Did women was physically restrained?
      a) yes b) no
   iii. Did baby was separated without medical indication?
      a) yes b) no
   iv. Did you receive comfort, pain relief as necessary?
      a) yes b) no
   v. Did provider demonstrated in culturally appropriate way?
      a) yes b) no
7. Detention in facility
   i. Was there detention in facility due to failure of pay?
      a) yes b) no

Appendix B – Consent Form

.

I am Dr. .Maryam Munawar, student of MSPH- Final Semester, Alshifa School of Public Health, Alshifa Eye Hospital, Rawalpindi. I am doing research on Disrespect and Abuse faced by women during facility based childbirth in district Chakwal.

PURPOSE OF THE RESEARCH

The purpose of this study is to assess Disrespect and Abuse faced by women during facility based childbirth in District Chakwal.

PARTICIPATION

I do not anticipate that taking this study will contain any risk or inconvenience to you. Your participation is strictly voluntary and you may withdraw your participation at any time without penalty. I request you to answer the questions as honestly as possible. It will take no longer than 20 minutes to complete a questionnaire. All information collected will be used only for research purpose and will be kept highly confidential. Your identity and your responses will not be identifiable; all data will be stored anonymously. As this is solely a student project no incentive will be provided. Once study is completed, I would be happy to share the results with you if you desire.

Thank you for agreeing to participate in this study. Your feedback is important.

Consent

I have read and understand the information sheet and agree to take part in the study.

Signature_____ Date_____

APPENDIX C – IRB LETTER

AL-SHIFA SCHOOL OF PUBLIC HEALTH
PAKISTAN INSTITUTE OF OPHTHALMOLOGY
AL-SHIFA TRUST, RAWALPINDI

No. MSPH-IRB/12-09
Date: 01st Oct, 2021

TO WHOM IT MAY CONCERN

This is to certify that **Maryam Munawar** D/O **Munawar Hussain** is a student of Master of Science in Public Health (MSPH) final semester at Al-Shifa School of Public Health, PIO, Al-Shifa Trust Rawalpindi. She has to conduct a research project as part of curriculum & compulsory requirement for the award of degree by the Quaid-I-Azam University, Islamabad. Her research topic which has already been approved by the Institutional Review Board (IRB) is **"Disrespect and abuse faced by women during facility based childbirth in district Chakwal".**

Please provide her necessary help and support in completion of the research project. Thank you.

Sincerely,

Dr. Ayesha Babar Kawish
Head of Department, MSPH
School of Public Health, PIO
Al-Shifa Trust, Rawalpindi

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