HHS Public Access

Author manuscript

SSM Qual Res Health. Author manuscript; available in PMC 2022 December 21.

Published in final edited form as:

SSM Qual Res Health. 2022 December ; 2: . doi:10.1016/j.ssmqr.2022.100178.

Provider verbal disrespect in the provision of family planning in public-sector facilities in Western Kenya

Katherine Tumlinson[a,b,*], **Laura E. Britton**[c], **Caitlin R. Williams**[a,d], **Debborah Muthoki Wambua**[e], **Dickens Otieno Onyango**[f,g], **Leigh Senderowicz**[h]

[a]Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, USA

[b]Carolina Population Center, University of North Carolina at Chapel Hill, USA

[c]Columbia University School of Nursing, New York City, USA

[d]Department of Mother and Child Health, Institute for Clinical Effectiveness and Health Policy (IECS-Argentina), Buenos Aires, Argentina

[e]Innovations for Poverty Action-Kenya (IPA-K), Nairobi, Kenya

[f]Kisumu County Department of Health, Kisumu, Kenya

[g]Julius Global Health, Julius Centre for Health Sciences and Primary Care, University Medical Centre, Utrecht, Netherlands

[h]Department of Obstetrics and Gynecology, School of Medicine and Public Health, University of Wisconsin, Madison, WI, USA

Abstract

Public-sector healthcare providers in low- and middle-income countries are a primary source of family planning but their disrespectful (i.e., demeaning or insulting) treatment of family planning clients may impede free contraceptive choice. The construct of disrespect and abuse has been widely applied to similar phenomena in maternity care and could help to better understand provider mistreatment of family planning clients. With a focus on public-sector family planning provision in western Kenya, we aim to estimate the prevalence and impact of disrespect and

*Corresponding author. Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, 135 Dauer Drive, 405a Rosenau Hall, CB #7445, Chapel Hill, NC, 27599-7445, USA. ktumlin@email.unc.edu (K. Tumlinson).

Author statement

Katherine Tumlinson: Conceptualization, Methodology, Formal analysis, Investigation, Writing – Original Draft and Review & Editing, Project administration, Funding acquisition **Laura Britton**: Formal analysis, Writing – Original Draft and Review & Editing **Caitlin Williams**: Writing – Original Draft and Review & Editing **Debborah Wambua**: Investigation, Writing – Original Draft and Review & Editing, Project administration **Dickens Onyango**: Writing – Original Draft and Review & Editing **Leigh Senderowicz**: Writing – Original Draft and Review & Editing.

Ethical approval and informed consent

Ethical approval for the study protocol was provided by the University of North Carolina at Chapel Hill and the Kenya Medical Research Institute (KEMRI).

Declaration of competing interest

None.

abuse from a variety of perspectives and advance methodological approaches to measuring this construct in the context of family planning provision. We combine and triangulate data from a variety of sources across five counties in western Kenya, including 180 mystery clients, 253 third-party observations, eight focus group discussions, 19 key informant interviews, and two journey mapping workshops. Across both mystery client and third-party observations conducted in public-sector facilities in western Kenya, approximately one out of every ten family planning seekers was treated with disrespect by their provider. Family planning clients were frequently scolded for seeking family planning while unmarried or low parity, but mistreatment was not limited to women with these specific characteristics. Women were also insulted for such characteristics as body size or perceived sexual promiscuity. Qualitative data confirmed both that client disrespect is widespread and leads women to avoid family planning services even when they desire to use a contraceptive method, sometimes leading to unintended pregnancies. Key informants attribute disrespectful provider practices to both low technical skill as well as poor motivation stemming from both intrinsic values as well as extrinsic factors such as low wages and high caseloads. Possible solutions suggested by key informants included changes to recruitment and admission for Kenyan medical/nursing schools, as well as values clarification to shift provider motivations. Interventions to reduce mistreatment must be multi-layered and well-evidenced to ensure that family planning clients receive the person-centered care that enables them to achieve their contraceptive desires and reproductive freedom.

Keywords

Disrespect; Abuse; Family planning; Reproductive justice; Patient-centered care; Quality of care; Kenya

1. Introduction

In recent years, there has been growing attention to the way women and people with capacity for pregnancy[1] are treated when seeking sexual and reproductive health services. Despite reports of instances of disrespect, abuse, and violence directed towards people seeking care within healthcare institutions, the topic was largely overlooked by the global health community until the 2010 publication of a landmark USAID landscape analysis on disrespect and abuse during facility-based childbirth (Bowser & Hill, 2010). This report galvanized the global maternal health community, leading to the rapid development of an extensive research literature and aligned advocacy efforts. In 2015, the World Health Organization (WHO) issued a statement disavowing mistreatment during childbirth (World Health Organization, 2015, pp. 1–4), clearly defined respectful treatment as part of quality care (Tunçalp et al., 2015), and opened a line of investigation of the topic (Bohren et al., 2015). Policymakers, too, have begun to take action, with multiple Latin American countries explicitly prohibiting “obstetric violence” (Williams et al., 2018) and the UN Special Rapporteur on Violence Against Women taking up disrespect and abuse in maternity care in her 2019 report to the UN General Assembly (Šimonović, 2019).

[1]We use the phrase “people with the capacity for pregnancy” to be inclusive of cisgender women as well as transgender men and non-binary individuals.

Decades before international attention turned to disrespect and abuse in maternity care, the global family planning community had begun to emphasize the importance of quality of care in reproductive health service provision. Throughout the 1980s–90s – and with the notable publication in 1990 of Judith Bruce's well-known framework on the quality of family planning service delivery – scholars elaborated the construct of quality of care in family planning to include both technical and interpersonal components (Bertrand et al., 1995; Bruce, 1990). In the years since, family planning scholars have further affirmed the importance of rights-based and person-centered approaches to contraceptive service provision (Dehlendorf et al., 2013; Newman, 2015). Most recently, some scholars have begun to reckon with both the long history of sterilization abuse and contemporary manifestations of contraceptive coercion in the family planning field (Harris & Wolfe, 2014; Roberts, 2015; Senderowicz, 2019).

In spite of this attention to reproductive rights, the global family planning community has not yet adequately conceptualized or addressed the threats to reproductive freedom and quality of care posed by provider disrespect and abuse of family planning clients. As a result, scholars not only have an incomplete understanding of these threats, but contraceptive seekers also continue to face provider judgements, insults, neglect, and other forms of ill-treatment (Comitéde América Latina y El Caribe para la Defensa de los Derechos de la Mujer (CLADEM) (1999); Hazel et al., 2021; Mané et al., n.d.; Siyoum et al., 2020). Despite the clear links between family planning and maternity care on the continuum of reproductive healthcare, the framework of disrespect and abuse that has been so transformative to maternal health has seldom been applied to family planning. Researchers have documented disrespectful, abusive, and violent interactions between family planning clients and healthcare providers in a range of settings, but the research literature on disrespect and abuse in family planning remains fairly thin and lacks a unifying theoretical framework. Extending the framework or construct of disrespect and abuse to family planning can be a helpful step toward understanding and addressing the ill-treatment contraceptive seekers often face as they attempt to access care.

Respectful family planning care has largely been ignored on the policy stage, too, though some policymakers have developed legislation that encompasses family planning. Some policy efforts to extend protections from violence and other mistreatment to family planning are underway around the world, with notable examples including Bolivia's Law 348 Guaranteeing Women a Life Free from Violence (Estado Plurinacional de Bolivia, 2013) and the Parliamentary Assembly of the Council on Europe's Resolution 2306 on "Obstetrical and Gynaecological Violence" (Parliamentary Assembly, 2019). Further, contraceptive coercion and reproductive justice have recently garnered more thoughtful attention among scholars in high-income countries, particularly in the wake of vastly increased promotion of long-acting reversible contraception over the last decade (American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women, and the Contraceptive Equity Expert Work Group, 2021; Gomez et al., 2014; Gutiérrez, 2008; Higgins, 2014; Kathawa & Arora, 2020; Roberts, 1997; Roberts and Kaplan, 2016; Schoen, 2005; Silliman et al., 2004). Additionally, there has been some recent effort by researchers to develop and test measures of disrespect and abuse in family planning service delivery, as part of contraceptive counseling scales (Diamond Smith et al.,

2020a, 2020b; Holt et al., 2019; Sudhinaraset et al., 2018, 2017). Yet, there is currently no consensus on how best to measure disrespectful and rights-violating treatment in family planning (Harris et al., 2016), particularly in the context of low- and middle-income countries, and very limited evidence on how to prevent and address mistreatment in family planning service delivery (Diamond Smith et al., 2018).

Within Kenya, respectful treatment in sexual and reproductive health services is a key priority of the government (Kenya Ministry of Health Division of Family Health, Oct 2018; Kenya Ministry of Health, 2022). Several of the landmark studies on mistreatment during childbirth have come from Kenya, including some of the first estimating prevalence, documenting drivers of mistreatment, and assessing potential interventions (Abuya et al., 2015; Warren et al., 2017). There has also been significant policy attention to mistreatment and violence in healthcare services, with Kenya's High Court finding as unconstitutional the detention of women in health facilities following childbirth due to inability to pay (Odallo et al., 2018). Disrespectful treatment has also been documented in family planning services in Kenya (Tumlinson et al., 2013), and some family planning users have reported seeking care in the private sector to avoid disrespectful treatment by public sector employees (Keesara et al., 2015). However, to the best of our knowledge, there has been no systematic accounting of the prevalence of disrespect and abuse in public-sector family planning provision in Kenya.

In the present study, we seek to address this gap, as well as advance methodological approaches to measuring disrespect and abuse in family planning services. Drawing from the gold standard instruments developed by WHO for measuring mistreatment during labor and delivery (Bohren et al., 2019), we propose multiple quantitative approaches for estimating and triangulating measures of prevalence. We also document the impact of disrespect and abuse in family planning – and possible causes - from a variety of perspectives using qualitative inquiry. Together, these concurrent mixed-methods approaches provide a holistic and rich description of disrespect and abuse in family planning service delivery in Western Kenya (Creswell & Plano Clark, 2006).

2. Materials and methods

Data for this analysis are from a mixed-methods parent study aimed at identifying barriers to high-quality, patient-centered contraceptive care in Western Kenya. Data for this assessment of disrespect and abuse in family planning service delivery are drawn from a variety of data collection methods, including mystery clients, third-party observations, focus group discussions, key informant interviews, and journey mapping workshops. The variety of different data collection techniques employed in this study allow us to use triangulation and expansion from multiple perspectives (Creswell & Plano Clark, 2006). As disrespectful treatment of family planning clients is rarely practiced in the presence of known observers, we sought to elicit information about this phenomenon in different ways. For example, the mystery client approach enables observations of covert provider behavior while client-provider observations allow observation of provider interactions with actual clients; both methods provided quantitative measure of disrespect and abuse. Focus group discussions with Kenyan women provided critical context for our quantitative findings while interviews

with healthcare sector key informants allowed us to solicit locally grounded solutions. Additionally, our mixed-methods study design enabled us to document the complex lived experiences of Kenyan women treated with disrespect in government facilities.

2.1. Mystery client methodology

In the mystery client approach, a data collector visits a facility while concealing the fact that they are not a real client. The mystery client observes the healthcare provider during service provision and the provider is unaware that the patient is collecting data on services received. Mystery clients typically report/record their observations shortly after their visit. Mystery clients are well-suited for measuring hidden provider behaviors and are also trained to assess aspects of service delivery not easily measured with client self-reports (Fitzpatrick & Tumlinson, 2017).

In this study, 15 female mystery clients visited 60 facilities randomly selected from all public-sector facilities located in Western and Nyanza Kenya. Mystery clients were trained over the course of seven days and their training included several days conducting extensive role play exercises as well as two days piloting in real facilities (outside the study area) to ensure objective measures and comfort conducting deceptive research. Each facility was visited once by each of three different mystery clients, for a total of 180 mystery client visits. Mystery clients presented as new family planning clients and maintained their actual profiles with respect to marital status, age, and parity; mystery clients ranged in age from 21 to 37, parity of zero to two children, and seven were married. Mystery clients recorded their provider observations on a short electronic questionnaire within 30 minutes of their visit. The electronic questionnaire asked mystery clients whether the provider did any of the following: shouted at them, scolded them, threatened to withhold services, called them by an insulting name, laughed at them, or treated them with scorn. Mystery clients were also provided with an open text box to describe instances of disrespect in greater detail.

2.2. Third-party observations

Mystery client observations in this study were supplemented with third-party observations of client-provider interactions conducted in a sub-sample of 10 public-sector facilities in Kisumu, Kenya. A trained female enumerator was present in each facility for 10 consecutive week-days, during which time she invited all family planning clients to participate to be observed during their interaction with their family planning provider. All women seeking family planning were eligible for participation in the study, and 98.8% of those invited chose to participate. All providers offering family planning on the day of observation were eligible for participation and were invited to participate to be observed while offering family planning services. Of the 20 eligible and invited providers, 100% chose to participate. All participants, both provider and client, were enrolled via an informed consent process. Observations of 253 family planning clients, seen by 20 public-sector providers, were conducted during the 10 days.

2.3. Focus group discussions

We led eight focus group discussions (FGDs) of 6–8 women ages 18–49 who were current or former contraceptive users (n = 55). We stratified by current versus prior use of family

planning and urban versus rural residence in Western Kenya. Recruitment began with initial contact by community health volunteers (CHVs), who identified 240 women, of whom 88 gave permission for contact by study personnel and then 55 participated. Participants were 18–46 years old. The percentage of participants who were married in each FGD ranged from 43 to 100%. Six experienced Kenyan field staff—three pairs of moderators-note-takers—used an 18-question guide to lead a discussion about utilization of contraceptive services. FGDs averaged 103 minutes. One FGD was conducted primarily in Ekegusii, two in Luo, and five in Kiswahili.

2.4. Key informant interviews

We conducted key informant interviews to solicit health system solutions from highly experienced and knowledgeable public health and health system experts in Kenya. Two experienced Kenyan field staff conducted key informant interviews (KII) with eight private sector/NGO high-level staff, one private sector facility director, three senior health providers, and seven senior government officials. Using a 19-question guide, a female Kenyan interviewer conducted the KIIs in English (mean length of 55 minutes).

2.5. Journey mapping

We used journey mapping to create a visualization of client and provider experiences, respectively, receiving and delivering contraceptive services. Journey mapping is a technique for identifying the important interactions with the healthcare system (Marquez et al., 2015). Synthesizing our findings from the other data collection methods, we identified what might impede a patient or provider in their ‘journeys’ towards a woman accessing her desired method. We used the same eligibility criteria and recruitment procedures as FGDs to recruit new women for the Kiswahili-language client journey map workshop (CJMW) (n = 9). Women in the client journey map workshop were 27–41 years old, all married, currently using family planning, and had two to four children. We used snowball sampling to recruit new public-sector providers for the English-language provider journey map workshops (PJMW) (n = 12). The moderator led a discussion evaluating the frequency, impact, and importance of the barriers to contraceptive services on the journey map. Providers were 27–45 years old and had provided family planning services for 2–12 years; nine were female and three were male.

2.6. Qualitative analysis

We audio recorded the FGDs, KIIs, CJMW, and PJMW, and recordings were subsequently professionally transcribed and translated. We performed content analysis to generate qualitative description (Sandelowski, 2010). Two analysts, one Kenyan and one from the U.S., read transcripts from FGDs and KIIs to get a sense of the whole, wrote memos, collaborated to generate a provisional codebook (with definitions, exclusions, and examples), and then applied codes to all transcripts using NVivo 11.0 (QRS International). Next, they identified primary themes and assessed data saturation. To produce the journey maps, the analysts integrated data from the qualitative analysis with findings from the quantitative analyses.

Additional details on sampling, mystery client selection, and the methodology for each of the study components can be found in (Tumlinson, 2021). All qualitative participants, as well as providers and clients observed by a third-party, provided written consent to participate; written consent was provided by all facility managers for facilities included in the mystery client component. Ethical approval for the study protocol was provided by the lead author's institution and the Kenya Medical Research Institute (KEMRI).

2.7. Quantitative analysis

We calculated instances of disrespect and abuse as the percent of all visits or observations during which such behavior occurred. For example, when estimating the prevalence of disrespect and abuse documented by mystery clients, the number of times a mystery client was treated with disrespect or abuse informed the numerator while the total number of mystery client visits (n = 180) was our denominator. Additionally, we measured facility type (clinic, dispensary, hospital), provider characteristics (gender, cadre), and mystery client characteristics (age, parity, marital status) and we used bivariate statistics and Pearson's chi-square tests to explore whether the distribution of these characteristics differed by whether disrespect or abuse occurred.

3. Results

3.1. The nature of disrespect and abuse in family planning provision

3.1.1. Mystery client and third-party observations—In eight percent of mystery client observations (15 out of 180) and 11 percent of third-party observations (29 out of 253), providers addressed their clients using disrespectful language (Table 1). In both methods of observing providers, the most common type of verbal disrespect observed was clients being laughed at or treated with scorn. This behavior on the part of providers sometimes appeared to be a response to certain patient characteristics deemed inappropriate or stigmatized by the provider in the context of seeking family planning, such as low or high parity, desiring a method not favored by the provider, young age, being unmarried, (presumably) seeking multiple and/or concurrent sexual partnerships, and large body size. For example, third-party observers recorded the following interactions between family planning clients and their providers (Table 1):

> "The provider told the client that, even though she is 19 years old, she should wait to get married first is when she should start using family planning, especially her current method that is injectable. The provider again asked the client with a lot of pettiness if she is jumpy jumpy lady who moves from one man to the other."

> "She said the client have added weight like a pig."

Both mystery clients and third-party observers also described providers shouting or scolding patients seeking family planning. This type of client disrespect similarly appears motivated by presumptions and negative judgments surrounding client motivations for pursuing family planning, for example one mystery client reported, "*The nurse said she didn't see the essence of a young lady who is single taking pills instead of abstaining*." However, providers also shouted or scolded clients for slow response, method choice (i.e., scolding unmarried and nulliparous women for using the injectable and admonishing a woman with five children

for not selecting a permanent method) raising concerns about side effects, or general impatience on the part of the provider.

In three third-party observations, providers threatened to withhold family planning services from the client in the future. Providers indicated they would withhold services if the client was unable to pay or if they came late for services. For example, one direct observer reported that, "*The client did not have money to pay for the implant, the provider sternly told her that next time she should come with the cash or risk not being given her method of choice."* Of note, public-sector family planning services in Kenya are free of charge; asking a client for payment is an indication the provider is requesting an informal fee rather than an official facility fee. Additional verbatim examples of scornful treatment, scolding or shouting, and withholding family planning are shown in Table 2.

Although some mystery clients appear to have been targeted by providers for seeking family planning while unmarried or low parity, within our sample size of 180 observations we did not detect statistically significant correlations between provider disrespect and mystery client age, parity, or marital status. There was also no discernible pattern of disrespect when stratifying by facility type (clinic, dispensary, or hospital), or provider gender or cadre (data not shown).

3.1.2. FGDs, KIIs, CJMW, and PJMW perceptions—Mystery client and third-party observations of disrespect and abuse were congruent with descriptions of provider behavior given by women in FGDs: general rudeness, failure to greet them, being chased away, refusal to provide or remove methods, shouting, being pushed, asking for informal payments, showing favoritism instead of seeing women in the queue in the order that they arrived, and saying disparaging things or divulging private information in earshot of other patients.

> We should have people who listen. You know it can be that you went for the three months one [the injectable] and it's not compatible and you want to change. But before you change this method, you must explain so that he can advise the one you can change. But when he shouts at you, you will not be willing to talk that you want to change, and it will force you continue with that one for three months. Because he hasn't given you time to tell him your problem and so it will force you to use that."
>
> (Rural former user).

Most but not all participants believed disrespect and abuse occurred. A single participant in each of two rural focus groups denied that it occurred, as did one key informant. A second key informant believed that such treatment occurred, but only in maternity and not contraceptive care. A third key informant reported that they had heard of disrespectful treatment in family planning but had not seen it personally. Some key informants were not sure where to draw the line between low technical quality of care and disrespectful treatment:

> "I have never seen a case in my practice of a provider mistreating a patient. Maybe just what I mentioned earlier, the lack of adequate knowledge, maybe not offering

> balanced counseling, maybe that can be termed as mistreating then yes, I have seen that."
>
> (Private sector/NGO high-level staff)

Disrespect included refusing to give women their desired method and coercing them to use methods they did not want:

> "Sometimes you go with your mind made up to get that medicine but when you get there you are told that medicine is not available or we cannot give you that medicine, this is what we can give you. You are also not told the reason why you won't be given the one you want. So, it forces you to take the one the doctor tells you."
>
> (Urban current user)

After women were coerced into using a method they did not want, they found providers could be hostile when they subsequently ascribe their unacceptable side effects to that method or sought to change their method:

> When you go to raise the complaint there, they don't listen to your complaint. They chase you away …. you will be talked to well but what you want you will not be given. But when you go back to tell them the problems caused by this thing, they will not listen.
>
> (Urban current user)

We observed a variety of framings of disrespect and abuse. Many women felt inconvenienced and obstructed. Some women felt harmed and dehumanized. One woman exhorted providers to "*talk to us as human beings. We are not animals*" (Urban current user). They observed that disrespect occurred in a power dynamic, and they had to tolerate such treatment to obtain services, saying "*you will just have to get used to it because you are the one with the problem*." (Urban current user). Another example was a woman describing "harsh" treatment when they did not seek care at the date on their card for getting their next contraceptive injection. Women were frustrated when they were chastised for lateness when they returned as instructed after being turned away previously when they sought care at the date on their card:

> When you go for the family planning services, maybe you did not go back the exact day you were to go to the hospital and he will be so harsh while asking why you did not go on that very same day and even if you explain to him he does not get it and so you have to be patient because he is the one whose there to attend to you."
>
> (Urban discontinued user)

With key informants, most of the discourse around disrespect and abuse was framed as a negative provider attitude or a customer service problem. One key informant described their efforts to address such behavior: "*I keep on telling them that you know it is just like you have gone to a supermarket to buy something, that is the way our customers should be treated with dignity and some of them even shout at clients*" (Private sector/NGO high-level staff). While most key informants did not characterize disrespect and abuse as a major barrier to contraceptive care, one key informant said "*this issue of disrespecting clients I*

think is the major contributor to our failure" to deliver comprehensive family planning to women in Kenya (Private sector/NGO high-level staff).

Women believed disrespect and abuse arose from disdain for family planning services, with one woman telling us "*they don't consider women who have gone for family planning services like someone important who has come for help*" (Rural current user). Some felt providers disdained patrons of the public healthcare sector generally, saying, "*You are answered rudely because you are getting the service for free*" (Urban current user). Women also identified disparate treatment by wealth, literacy, and familiarity:

> "There are those who are poor …. When they come to the queue and see a woman in the queue with a certain posture, you won't stand in the queue. She will be taken direct into the room. When she looks at the one in rubbers [canvas shoes that are considered to indicate low-income status], you will stay there until two in the afternoon."
>
> (Urban current user)

3.2. The impact of disrespect and abuse

Respondents in qualitative data components reported how disrespect and abuse can affect their contraceptive autonomy, obstructing desired contraception initiation, method continuation, or method change. Two FGD participants agreed that the consequences could be significant:

> Participant 1: I would like them to talk to us politely because if they talk harshly, I will walk away and go home. I did that once and became pregnant.
>
> Participant 2: They have made unwanted pregnancies to be many.
>
> (Rural former users)

A key informant echoed that disrespect could manifest into a failure to establish a productive patient-provider relationship in which women are effectively counseled to choose a method: "*I would say maybe poor interpersonal relationship with the patient. They don't you know, listen to the patient. So, there is a bit of poor counseling. Yeah, so people make wrong choices because of poor counseling and then there is the method discontinuation in a short while"* (Private sector/NGO high-levels staff).

Disrespect can reduce quality of care by inhibiting disclosure of clinical concerns; in contrast, with cordial treatment, "*You will feel free and tell her what's going on in your body*" (Rural former user). Multiple participants developed mistrust of their providers after experiencing disrespect, suspecting that disrespectful providers inserted expired devices, *"the wrong method"* (Rural current user), or failed to mix contraceptive injections properly. Women developed coping strategies, such as *"humbling myself"* (Rural current user) to try to prevent provoking providers. Disrespect and abuse could reduce women's willingness to interface with the public healthcare system in the future. One FGD participant described a friend whose method choice was disparaged who said: "*'Why can't they give me what I want instead of talking so negatively?' Until now she's scared and said she won't go back to*

that hospital. That at least she goes to a chemist than that hospital." Women in four FGDs said they switched from the public to private sector because of disrespectful treatment.

3.3. Workforce and health systems solutions to disrespect and abuse

Disrespectful treatment was a phenomenon situated in the healthcare systems and workforce. Participants in the qualitative study components suggested possible causes of mistreatment and commensurate interventions at the health systems and workforce levels that would improve provider behavior and ultimately improve client experiences and increase contraceptive autonomy.

Key informants had a different perspective on the cause of disrespect and abuse than women who patronized healthcare facilities for family planning. Some key informants saw disrespect as *"old school"* (Private Sector/NGO High-level Staff) and less normative among the younger generation of providers. They reported that disrespect could arise from multiple sources: first, low motivation, from pursuit of a medical career despite no passion for the work; second, high frustration because they viewed women's requests for method change or discontinuation as a failure or illegitimate; third, burnout (related to being understaffed and overworked, with stagnation in wages and promotions; frustration with the healthcare system; and challenges managing personal history of abuse or trouble in their personal lives); and fourth feeling insufficiently trained to offer contraceptive counseling or method insertion.

> "Disrespect, abuse of clients … one I find this is a demotivated service provider probably because of the low pay or the terms of employment. Two this is just somebody who also has inadequate knowledge, you know there is this disease when people are ignorant its [short pause] I don't know how to state it … but ignorant also brings some form of … some level of disrespect, this person maybe has not had adequate skills, adequate knowledge, adequate information in matters relating to family planning. Because maybe this guy has just come from school and had never gone for an intensive … something intensive training on FP to understand how to handle a client with FP, so that could be one of the reason."
>
> (Private Sector/NGO High-level Staff)

Regarding low motivation, women and key informants suspected that providers without a passion for family planning were prone to engaging in disrespectful care. Key informants affirmed this sentiment: "*If you don't have the passion that is where we have people abusing clients*" (Senior government official). The commensurate intervention would be to change recruitment strategies and incentive structures to limit medical education to individuals with a passion for the work: "*They should select the good doctors, those ones who have passion to work so that they can be placed in that section for family planning. They should not just pick any doctor. They are those who are harassers*" (Urban former user).

Regarding frustration with requests to change methods, key informants noted that providers could be disrespectful towards women seeking to change their method, especially if they ascribed side effects to the method that the providers viewed as unfounded (such as *"IUCD has caused malaria"*). Participants saw providers as lacking respect for women's method

dissatisfaction, not seeing the value in switching to a method they preferred. Key informants suggested that low quality of care could cascade into disrespect and abuse as frustrations mount. For example, a woman might receive insufficient counseling that did not properly educate her or support her to identify an optimal method; in a subsequent visit with a different provider, she may experience disrespectful or abusive treatment in response to her desire to change or discontinue her method. One key informant felt that providers did not appreciate that women lack information because a colleague failed to provide sufficient counseling: "*now you are not even siting down to counsel this client, "you are telling her she is stupid." You see this client will not come next time, even it were me I won't come*" (Private sector/NGO high-level staff). Participants suggested training providers to view requests for method change or discontinuation more positively, as a positive step towards achieving method satisfaction and reproductive self-determination, as well as supporting interventions to promote high-quality counseling would lead to greater patient satisfaction with the methods and reducing requests for stopping or changing methods.

Regarding burnout, participants thought provider burnout led to disrespect and abuse*: "with burnout you find this staff may not behave in a manner that it is professional to the people he or she is serving, so again that discourages the community"* (Senior government official). Disrespect and abuse could alienate patients, and difficult interactions with patients exacerbated burnout. Participants viewed burned out providers as prone to absenteeism, in the form of staff tardiness or not seeing patients during posted work hours. Providers thought unhappy patients disparaged the facility to their peers, so more patients came in with negative attitudes. Women felt they were treated poorly when they were told to wait but they could see providers not attending to patients or not working efficiently: "*They should not find you complaining because if they do, they will just be so harsh to you until you even wonder that you came to be attended to but now they are harsh. That really made me angry*" (Urban former user). A frustrated and harangued provider was seen as more likely to mistreat patients:

> "Negative attitude comes because me I have come on duty as a service provider then you get that line of around sixty clients who needs to be serviced and you are alone, and you need to serve those clients, so you get that attitude will develop the negative ones because of the workload, because there is no motivation."
>
> (Public Facility Senior Healthcare Provider).

Key informants suggested several interventions to reduce burnout, which could possibly reduce disrespect and abuse. These included increasing wages and promotions:

> "to increase the wages is one way of motivation. If they are motivated, I think they can be able to give quality care and even that attitude, negative attitude can be done away with so, yeah, yeah. Because when you overwork so much and looking at the wages obviously your attitude will change, it will be negative, whether you like it or not."
>
> (Senior government official)

Another participant demurred that finances were not the basis of a motivated provider who had positive interactions with clients: "*I personally I don't agree hundred percent that an*

increase in my salary will increase my outputs, I also need to have my personal, some personal discipline, some personal internal motivation that also motivates me to give the right care" (Private sector/NGO high-level staff). Others emphasized that burnout would be prevented by improving working conditions, especially by improving staffing, reducing the workload, shortening the queues, and assuring that all commodities were in stock.

Finally, women and key informants further specified that they believed insufficient training produced disrespectful care. Two types of training needs were viewed as interventions to reduce mistreatment. First, technical training in family planning would reduce mistreatment that arose when the provider could not provide the care requested:

> "This comes when a client who is informed about long term and reversible methods insists on a method, on that long-term and this provider who is not either competent or does not want to take a long time to serve this client now becomes very harsh with this client."
>
> (Private sector/NGO high-level staff)

Key informants and FGD participants were optimistic that providers who could confidently counsel and insert long-acting methods would not engage in negative behavior to deflect patients from requesting methods they could not provide. Key informants thought well of on-the-job trainings and mentorships, viewing these as more effective and convenient than workshops.

Additionally, women and key informants believed providers should be trained to have better "*soft skills of medicine … I have heard personally that they invest a lot in the western countries or that bit of the soft skills of medicine. And maybe that is the reason you get doctors from there are really committed and they love what they do*" (Private sector/NGO high-level staff). Women in the focus group expressed congruent sentiments: "*I was asking whether there is a family planning training centers for doctors. In case there is one, then those doctors should be trained on how to communicate with women. If they know how to talk to us nicely, then there is no problem there*" (Rural current user). Key informants largely endorsed training, noting the progress in respectful maternity care was a model of how "*to solve the issue of negative attitude of healthcare providers to the client, is to teach them about respectful care of the client and that is the way we're going*" (Senior government official). A key informant expressed how an absence of training in soft skills may lead to poor behavior among some providers:

> "… sometimes our training curriculum do not address how you will behave with, with clients. So, they may teach us the content, but they don't teach us how to behave when handling clients. So, some, a few individuals or providers may still shout at patients unknowingly or knowingly. But I believe it starts with our, the way we are trained."
>
> (Private sector/NGO high-level staff)

4. Discussion

Across both mystery client and third-party observations, approximately one out of every ten women seeking family planning was treated with disrespect by their provider. Family planning clients were frequently scolded or scorned for seeking family planning while unmarried or of low parity, but disrespectful and abusive language was not limited to women with these specific client characteristics. Providers made disrespectful comments based on presumptions of concurrent sexual partnerships among married and unmarried clients alike and engaged in disrespectful treatment if they deemed a client too large, too small, or just too slow in responding to their questions. These results are in sharp contrast to results of many large-scale facility-based surveys with exiting clients, for which the large majority of exiting clients indicate they are treated well or very well by their provider. For example, client exit interviews conducted in Kenya in 2014 found less than two percent of family planning clients reported they were treated poorly by their provider (Tumlinson et al., 2015). Prior research from sub-Saharan Africa demonstrates a similar difference between standard client self-reports and other measures and suggest differences are a result of courtesy bias, resulting in inflated estimates of service quality (Glick, 2009; Kruk et al., 2018). Our results support the courtesy bias interpretation of favorable clients' perceptions of family planning service delivery in LMICs and agree with a 2019 study in Nigeria in which mystery clients reported lower quality contraceptive care compared to actual clients seen by the same providers (Diamond-Smith et al., 2019). Furthermore, in addition to measurement error in self-reported indicators of client treatment, most large-scale surveys fail to directly probe for negative experiences and, as a result, many of the negative provider behaviors described in this analysis go largely undetected in traditional demographic surveys.

It is notable that our estimates of the frequency of disrespect did not vary by type of data collection. We hypothesized estimates based on mystery client data collection would be substantially larger than by third-party observation because providers are likely to hide any negative behaviors while knowingly under observation. The similarity in the estimates across both data collection techniques suggests that mystery clients – while very similar to actual clients – may possess a slightly greater degree of self-efficacy which may have been protective. As such, our estimates of the frequency of disrespectful and abusive treatment of family planning clients in Western Kenya may be biased downward, with the possibility that even greater proportions of women seeking family planning encounter this sizable facility-level barrier when not under observation by a third party.

Our qualitative data suggested that women, providers, and policymakers in the health sector are aware of a range of disrespectful and abusive treatment in family planning service delivery. Consequentially, such treatment can have an impact on family planning uptake, continuation, and future patronage of the public healthcare system. Disrespect was viewed as a multifaceted problem. Some women felt that a lack of respect for family planning manifested as a lack of respect for family planning clients. Others, including both women and key informants, thought disrespect emerged from a lack of provider motivation. Provider motivation could dwindle because of the heavy workload, or due to stagnant raises and promotions. While some expressed concern that the field lacked mechanisms for recruiting individuals with a passion and commitment to healthcare, others suggested that

low technical capacity could lower provider motivation when the provider is uncomfortable as a result of not knowing how to do their job well. A provider who lacks technical ability to insert an implant may deny the method to a client in a hostile manner because they feel frustrated or shameful about their low skill level.

We surfaced suggestions for improving how providers treat family planning clients. First, a desire for healthcare workers with strong intrinsic motivation and a passion for family planning triangulated across FGDs and KIIs. An upstream approach would mean changing recruitment for medical and nursing education to emphasize a personal commitment to healthcare and service; a downstream approach would mean finding ways to increase the intrinsic motivation of those providers in the field. One example comes from the Ipas organization's values clarification and attitude transformation approach (VCAT). VCAT is an approach used by safe abortion advocates (Turner & Chapman Page, 2008) (34) in which providers participate in workshops designed to help them closely examine personal beliefs related to abortion provision. The VCAT approach recognizes that values affecting provider attitudes towards reproductive health issues may change as providers gain a deeper understanding of the life-saving benefits of such services. Some participants felt that such efforts to increase empathy for clients should be rigorously evaluated prior to wide-spread adoption as provider attitudes were often viewed as somewhat intractable.

An important threat to provider motivation is the burnout that results from a demanding work environment, stagnant pay and promotions, and unhappy clientele. Key informants emphasized that technical skills alone are not sufficient to upskill the public-sector workforce to deliver family planning; trainings and interventions must also build resilience by addressing low provider motivation, effort, and empathy. Our finding that provider *effort* is equally as important as provider *skill* is widely confirmed in prior studies conducted by health economics in LMICs. These prior studies highlight the critical gap between provider knowledge and action and demonstrate that low provider competence is often "compounded" by low provider effort (Das et al., 2008). To enhance both technical skills and soft skills, key informants preferred on-the-job training, because taking providers out of the facilities for workshops can result in insufficient staffing to see clients, resulting in long queues and discontented patients – fueling further burnout. Prior work by Afulani and colleagues confirms moderate to high burnout and stress among Kenyan providers, identifies burnout as a factor contributing to biased or differential care, and indicates addressing structural and environmental causes of provider burnout as key for improving service quality (Afulani, Ogolla, et al., 2021; 2021b).

A growing body of recent scholarship demonstrates the potential harm of system-level incentives that may drive healthcare providers to coerce women into using or continuing provider-controlled methods (Holt et al., 2017, 2019; Senderowicz, 2019, 2020; Senderowicz et al., 2021). Traditional population-based measures of contraceptive prevalence are widely-used as a benchmark of programmatic success yet may minimize tenants of reproductive justice and fail to deliver on important aspects of person-centered care. Shifting towards quality of care measures that define quality based on the patient experience rather than contraceptive prevalence could provide much needed leverage to

motivate changes in negative provider behavior and ultimately reduce instances of disrespect and abuse in the provision of family planning in LMICs.

We acknowledge several limitations. First, third party observations are subject to the Hawthorne effect; providers may temper or hide negative treatment when under observation. If present in this study, this would bias the prevalence and severity of disrespect and abuse in a downward direction. Secondly, our focus group and journey mapping participants were skewed upward with respect to age and therefore we may not have adequately captured the experiences of adolescent women. Additionally, we did not stratify focus groups by marital status which may have discouraged transparent participation from unmarried women.

5. Conclusion

Around one in ten women seeking family planning from public facilities in Western Kenya faced disrespectful and abusive treatment from their healthcare provider. Disrespectful care was not limited to young and unmarried women and qualitative findings revealed such treatment reduces care-seeking behavior, with some women attributing unintended pregnancy to disrespectful or abusive care. Key informants emphasized that ensuring strong technical skills is a necessary but insufficient solution to poor quality of care. Addressing disrespectful and abusive client treatment will require a layered approach that addresses both technical skills and provider motivation and effort.

Acknowledgements

Support for this research was provided in part by a career development grant (R00 HD086270) to K. Tumlinson and an infrastructure grant for population research (P2C HD050924) to the Carolina Population Center at the University of North Carolina at Chapel Hill. LS's contribution was supported by a Ruth L Kirschstein National Research Service Award (T32 HD049302) and Population Research Infrastructure grant (P2C HD047873). The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health (NIH) awarded these grants. While writing this manuscript, LB was supported by NIH/NINR 32 NR007969 (PI: Bakken). The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the NIH/NICHD.

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Table 1

Frequency with which providers engage in disrespect and abuse during 180 mystery client visits and 253 client-provider observations in select public sector facilities in Western Kenya, 2018

	Total mystery client observations	Percentage	Total client-provider third party observations	Percentage
Provider engaged in disrespectful or verbally abusive behavior	N = 180		N = 253	
Yes	15	8%	29	11%
No	162	90%	224	89%
Missing	3	2%	0	0%
Provider did any of the following (multiple responses allowed)	N = 15		N = 29	
Shouted at me	1	7%	8	28%
Scolded me	3	20%	9	31%
Threatened to withhold services	0	0%	3	10%
Laughed at me or treated me with scorn	7	47%	11	38%
Other type of disrespect	5	33%	5	33%

Table 2

Quotes illustrating disrespectful care in family planning service provision; data collected via family planning mystery client and third-party observations, Western Kenya, 2019

Theme	Data Source	Illustrative quote
SCORNFUL TREATMENT	Mystery client reports	*"The provider laughed at me when she asked me if I have children and I said I don't have children, then she laughed at me saying that she wonders what is wrong with people who don't have children, but they need family planning."* *"The provider wanted me to prove that am not pregnant by going for a lab test and when I assured her that I am not pregnant she sneered at me and looked at me badly."*
	Third-party observations	*"The provider told the client that she was too young to have a co-wife. She went ahead to ask what the client did that made the husband to marry a second wife."* *"She said the client have added weight like a pig."* *"The provider scorned the client by telling her she had 5 kids and she was still considering injectable instead of Tubal ligation."* *"The provider told the client that, even though she is 19 years old, she should wait to get married first is when she should start using family planning especially her current method that is injectable. The provider again asked the client with a lot of pettiness if she is jumpy jumpy lady who moves from one man to the other."*
SCOLDING OR SHOUTING	Mystery client reports	*"I told the provider that I was visiting my sister within that village after which he made a comment that I came to look for men that's why I wanted family planning so that I don't get pregnant."* *"The nurse said she didn't see the essence of a young lady who is single taking pills instead of abstaining."* *"I went to ask about registration procedure, but she was harsh and told me that they don't talk to people through the window and commanded me to go sit down."*
	Third-party observations	*"When the provider asked for the clients phone number for their own records, the client told her to give her time to check the number from her phone then the provider shouted at her that she should know her number offhand or perhaps the number she is looking for from her phone is not hers."* *"The provider was seemingly annoyed at something during this session, and he had so little patience for this client. At one point he asked her age, and she didn't hear him well, he went ahead and angrily raised his voice at her saying that she needed to answer fast as there were other clients waiting."* *"The provider told the client in a high tone that she should not complain about the injectable because she was told to come back when the side effects she has been complaining about persisted and she never came back."* *"When the client told the provider that she was denied injectable in one of the facilities in Kisumu town because they don't encourage it, the provider scolded her by telling her that maybe she never followed the instructions in that facility and even them they can deny her injectable especially when the right choice is made by the provider and the client insist on her choice."* *"The provider told the client that small, small women are not straightforward especially someone like the client who gave birth 10 months ago and did not think of coming for family planning after six weeks."*
WITHHOLDING FAMILY PLANNING	Third-party observations	*"The client did not have money to pay for the implant, the provider sternly told her that next time she should come with the cash or risk not being given her method of choice."* *"The provider threatened to withdraw the service because the client come late for the service."*