Original Article

Disrespectful Maternity Care and Abuse During Childbirth: Exploring Perceptions and Experiences of Women Delivered at a Tertiary Hospital in Abakaliki, Nigeria

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Abstract

Background: An important but little understood component of poor care that women receive during antenatal care and childbirth is disrespect and abuse perpetuated by health workers. Fear of experiencing disrespect and abuse has negative influence on women's decision to seek care at health facility during pregnancy, labour and delivery. The objective of this study is to determine the prevalence, pattern and predictors of disrespect and abuse during labour and delivery.

Methodology: This is a questionnaire-based cross-sectional study conducted from February 1, 2019 to July 31, 2019 among postnatal women delivered at Alex Ekwueme Federal University Teaching Hospital, Abakaliki. Data were analyzed using SPSS version 22.

Results: The prevalence of disrespectful maternity care and abuse was 47.6%. The forms of disrespect and abuse experienced by the participants were detention in the health facility (40.2%), physical abuse (34.1%), non-dignified care (37.2%), non-consented care (20.1%), abandonment of care (18.9%), non-confidential care (25%) and discriminatory care (15.2%). Lack of companionship during delivery (AOR: 7.01, 95%CI: 1.27-4.49; $p = 0.007$), unbooked status (AOR: 2.37, 95%Cl: 0.31 - 0.92; $p = 0.01$) and rural residence (AOR = 4.52 95% CI: 2.33-8.75, $P<0.0001$) were factors associated with disrespect and abuse during childbirth.

Conclusion: Disrespectful maternity care and abuse during childbirth among women seeking maternity care is still prevalent (47.6%) in our hospital. Educating health workers on the importance of respectful maternity care would ensure acceptable, quality and dignified care for all women seeking maternity care in our facility.

Keywords: Disrespectful Maternity Care; Abuse During Childbirth; Abakaliki.

Introduction

About 295, 000 women died during and following pregnancy and childbirth in 2017 and 94% of these deaths occurred in low-resource settings.[1] Nigeria contributes nearly 20% of global maternal deaths with maternal mortality ratio (MMR) of over 800 maternal deaths per 100, 000 live births.[2]

A factor contributing to this high MMR is the low rate of skilled birth attendance with 43% of births in Nigeria attended by skilled health personnel.[3] Ensuring skilled birth attendance for all deliveries is a key strategy to reducing maternal mortality

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ratio, and achieving target 3.1 of the Sustainable Development Goal 3.[4] While access to routine maternity care is not yet guaranteed for many women during childbirth in Nigeria, recent studies indicate that women using skilled birth attendants at delivery are subjected to poor quality of care in form of abusive and disrespectful care.[4] In Nigeria, the frequency of disrespect and abuse during childbirth was high, ranging from 11% to 71%, in studies that reported on prevalence.[4]

Respectful care during childbirth has been described as a universal human right that encompasses the principles of ethics and respect for women's feelings, dignity, choices and preferences.[5] Disrespect and abuse (D&A) during childbirth infringes on these basic principles of human rights and violates the fundamental obligation to provide support and healing.[4-6] The problem of disrespect and abuse for women seeking maternity services is not a case of a few individuals but rather a problem that runs deep within maternity systems worldwide.[7,8] These acts include humiliation of women, discrimination based on specific attributes such as economic status, non-consented care, non-dignified care, non-confidential care, abandonment of care, detention in health facilities and physical and verbal abuse during childbirth.[9-12]

Increasing the population of women delivering in a health facility is challenging, as it requires comprehensive efforts to overcome multifaceted obstacles to accessing facility-based care as well as reforming poor quality of care at facilities.[13] Disrespect and abuse during childbirth represent important barriers to utilization of skilled birth care during subsequent deliveries and constitute a common cause of suffering and human rights violations for women in many countries.[14] Fear of experiencing disrespect and abuse has negative influence on women's decision to seek care at health facility during pregnancy, labour and delivery in developing countries, which often contribute to maternal morbidity and mortality.[15,16] Despite the widespread prevalence of disrespect and abuse in the maternity units worldwide, the experiences of women delivered in our facility are yet to be explored. It is crucial to know what forms of disrespect and abuse exist and to design interventions to prevent them so as to meet emotional, physical, socio-cultural and psychological needs as part of broader efforts to provide better quality care for women seeking maternity care services in the facility.

Therefore, the aim of this study is to determine the prevalence, pattern and factors associated with disrespect and abuse during antenatal care and childbirth among women delivered at Alex Ekwueme Federal University Teaching Hospital, Abakaliki.

Materials and methods

Study Area

This study was conducted at the postnatal ward of the Alex Ekwueme Federal University Teaching Hospital (formerly known as Federal Teaching Hospital) Abakaliki, Ebonyi state, Nigeria. The hospital manages about 4500 deliveries annually[16] and receives referral from all parts of the state and neighboring states of Benue, Enugu, Cross River and Abia as well as any part of the country. Department of Obstetrics and Gynaecology is 1 of the 10 clinical departments in the hospital, it has 10 teams with each comprising consultants, senior registrars, registrars, senior house officers and house officers. The department runs gynaecological clinics, preconception, antenatal, intrapartum and postnatal services.

Study design

This a hospital-based cross-sectional study conducted from February 1, 2019 to July 31, 2019.

Study participants

Consecutive postnatal women who delivered at the health facility during the study period were interviewed upon hospital discharge.

Sample size determination

Sample size was calculated using the formula for cross-sectional study.

$n = Z^2P(1-P)/d^2$,

Where n is the minimum sample size, Z is the standard normal deviate at 95% confidence interval (1.96), P is the proportion of postnatal women who suffered abuse and disrespect in previous study (0.2)[17] and d is the level of precision required, set at 0.05. The calculated sample size was 126. Considering a potential non-response rate of 10%, the minimum sample size required for this study was 139, however, 180 participants were enrolled in this study with 164 giving their consent to participate.

Data collection procedures

Researchers or the research assistants approached postnatal women upon discharge from the maternity ward after delivery to conducted the interviews using a semi-structured questionnaire after obtaining informed consent.

A two-day training session was provided for research assistants, who were House officers, before commencing data collection to ensure full understanding of the study objectives, data collection instruments, and informed consent procedures. The data collectors described the nature and objectives of the study, and obtained the consent of the women for participation in the study. All interviews were conducted in a private room at the health facility to ensure confidentiality and privacy.

Sampling technique

A total sampling method was used in the study and consecutive postnatal women who were discharge from the facility after delivery were approached to participate in the study.

Data collection instrument

The data was collected using pretested and validated interviewer-administered structured questionnaire. The questionnaire had three components that included socio-demographic characteristics, obstetric and maternal healthcare experiences and experiences of disrespectful and abusive maternity care during childbirth. The survey questionnaire and the consent form were first developed in English, translated into Igbo, and then back-translated to check for semantic equivalence. The reliability of the questionnaire was checked by conducting a pretest among pregnant women in the antenatal clinic, by taking 5% of the sample size. From the pretest, understandability, clarity, and organization of the questionnaire were checked. From the reliability test of knowledge and practice questions, 0.869 Cronbach's alpha value was found.

The outcome variable of the study was the subjective experience of disrespect and abuse among women who had given birth at the health facility. Disrespect and Abuse were measured using a framework developed by Bowser and Hill.[11] The types of D&A were then categorized as physical abuse, non-dignified care, abandonment, non-consented care, non-confidential care, detention and discrimination. These categories were then further extended to capture the particular events and specific forms of D&A as shown in Table 1. Questions addressing each of the different forms of D&A were posed to the respondents during the exit interview. If the women have experienced any type of D&A, then they were asked to describe the nature and extent of D&A.

Table 1: Categories and sub-components of disrespect and abuse

Categories of D&A	Forms of D&A
Physical abuse	Hitting (slapped, beaten or pinched), harshly forcing legs apart, tied down during labor
Non-dignified care	Shouted at, threat of withholding treatment, blamed or intimidated
Non-consented care	Non-consented episiotomy, C-section, tubal ligation
Non-confidential care	Provision of care without privacy, medical history disclosed without consent
Neglect/ abandonment	Gave birth outside delivery room (corridor, waiting room or floor), ignored when needed help, delivered without skilled attendant
Detention	Detention in health facility for failure to pay, request for bribe
Discrimination	Denial of need ed attention on the basis on areas of residence (urban/rural), denial of needed attention on the basis of age (old/young), denial of needed attention on the basis of occupation/education

Data analysis

Data was analyzed using SPSS version 22 (IBM Corp, Armonk, New York, USA). Descriptive statistics were presented using frequencies and proportions for categorical variables whereas continuous variables were presented as mean and standard deviation. The key outcome of the study was any form of D&A experienced by delivering women. The specific categories of D&A (physical abuse, non-dignified care, non-consented care, non-confidential care, abandonment, and discrimination) were also considered as outcomes of this study. Multivariable logistic regression analysis was used to show association between maternal socio-demographic and obstetric characteristics and disrespect and abuse during delivery. Results were then presented as adjusted odds ratios (AOR) with 95% confidence interval. A $P < 0.05$ was considered statistically significant.

Ethical consideration

Ethical approval was obtained from the Research and Ethics Committee of Alex Ekwueme Federal University Teaching Hospital, Abakaliki. The purpose and process of the study were explained to all participants. They were informed that their participation was voluntary and that they could withdraw at any time for any reason without any penalty either personal or affecting their future medical care. The verbal consent was obtained by asking the women if she would like to participate in the study after explaining the purpose and reassuring her of the confidentiality of the survey. No identifiers were used in the analysis to ensure confidentiality.

Results

Among 180 women who delivered in the facility that were enrolled in this study, 164 women participated in the study (91% response rate).

Table 2 shows the sociodemographic characteristics of the respondents. The mean age of the participants was 26 ± 2.2 years, ranged from 15 to 42 years and the modal age group was 21 - 26 years. Majority (72.6%) of the respondents were married while 12.2% were single. Of the 164 study participants, 93.9 were christian and 53% were residing in rural areas. Less than half (40.9%) of the participants had secondary education and 20.7% had no formal education. Fourty-five percent of the participants were farmers whereas traders and civil servants accounted for 20.7% and 34.2% of the cohorts respectively. The modal parity was para 3 (25.6%).

The obstetric and maternal healthcare experiences of the participants are shown in table 3. Among the 164 interviewed women, the majority (53.7%) had between 2 to 4 living children, 53.1% did not receive antenatal care in the study facility, 63.5% had four or more antenatal visits, 68.9% had history of previous delivery in a health facility and 59.1% had delivered in the study facility in the previous delivery. Of the 164 study cohorts, 54.3% were delivered during day time, 65.2% were attended to by between 4 to 6 healthcare providers during delivery, 76.8% had a companion with them during labour and delivery, and 43.3% would prefer to have future delivery in the study facility.

Table 4 shows the categories and forms of disrespect and abuse experienced by the participants. Less than half of the respondents (47.6%) reported facing at least one form of D&A during their delivery care (Figure 1). Detention in the health facility after delivery was found to be the most prevalent category of D&A (40.2%). Among subcomponents of detention after delivery, detention in health facility for failure to pay hospital bill was found to be the most common form of detention (36.6%). Non-dignified care was the other most common type of D&A (37.2%). About one-third of all women (34.1%) said that health care professionals shouted at them during labor and delivery, whereas threat of withholding treatment and being blamed or intimidated during delivery were reported in 14% and 20.7% of the respondents respectively. Physical abuse was the third most common form of D&A, with 34.1% of women reporting physical abuse. Hitting, harshly forcing the legs apart and being tied down during delivery were the forms of physical abuse reported by 31.7%, 22% and 29.3% of the participants respectively. Fourty-one (25%) women reported that the confidentiality of care was breached, and of these 24.4% experienced lack of privacy during labor and delivery, while 9.1% of women reported that their medical history was disclosed by the healthcare professionals without their consent. Non-consented care was reported by 20.1% of women. Among subcomponents of non-consented care, unconsented episiotomy was performed in 17.1% of the participants. Thirty-one participants (18.9%) reported that they felt neglected and abandoned during labour and delivery. The most commonly encountered form of neglect/abandonment reported was being ignored when needing help, (15.9%) followed by giving birth outside of the delivery room (4.9%). Discrimination during labour and delivery was another form D&A reported by 15.2% of women. Denial of attention during delivery care on the basis of rural residence (15.2%) and lack of formal education (14.6%) were the most common forms of discrimination reported by the study cohorts.

Logistic regression analysis showing predictors of D&A during labour and delivery is shown in table 5. Area of residence is a significant predictor of D&A during childbirth, with those residing in rural areas almost 5 times more likely to experience D&A when compared with those residing in urban areas (AOR = 4.52 95% CI: 2.33-8.75, P<0.0001). Women who did not book for antenatal care at the hospital were also more likely to experience D&A than women who booked for antenatal care, with unbooked women 2 times more likely to experience D&A than booked women (AOR = 2.37, 95% CI: 1.27-4.49, P=0.007). Lack of a companion during labor and delivery was found to be a statistically significant predictor of D&A, with those without a companion almost 7 times more likely to experience disrespect or abuse (AOR = 7.01, 95% CI: 3.39-14.5, P<0.0001).

Table 2: Socio-demographic characteristics of the respondents (N=164)

Characteristics	Frequency (%)
Age (years)	
15 - 20	12 (7.3)
21 - 26	56 (34.1)
27 - 32	38 (23.2)
33 - 38	35 (21.3)
≥ 39	23 (14.2)
Marital status	
Single	20 (12.2)
Married	119 (72.6)
Separated	16 (9.8)
Divorced	9 (5.4)
Religion	
Christian	154 (93.9)
Muslim	10 (6.1)
Place of residence	
Rural	87 (53.0)
Urban	77 (47.0)
Highest level of education	
No formal education	34 (20.7)
Primary	20 (12.2)
Secondary	67 (40.9)
Tertiary	43 (26.2)
Occupation	
Farmer	74 (45.1)
Trader	34 (20.7)
Civil servant	56 (34.2)
Parity	
1	34 (20.7)
2	21 (12.8)
3	42 (25.6)
4	29 (17.7)
≥ 5	38 (23.2)

Table 3: Obstetric and maternal healthcare experiences of the respondents (N=164)

Variables	Frequency (%)
Number of living children	
1	26 (15.9)
2-4	88 (53.7)
≥ 5	50 (30.4)
History of ANC use for current pregnancy	
Yes	77 (46.9)
No	87 (53.1)
Number of antenatal visit	
1	10 (6.1)
2	15 (9.1)
3	35 (21.3)
≥ 4	104 (63.5)
History of previous delivery in a health facility	
Yes	113 (68.9)
No	51 (31.1)
Previous delivery in the current facility	
Yes	97 (59.1)
No	67 (40.9)
Time of delivery	
Day	89 (54.3)
Night	75 (45.7)
Number of care providers during delivery	
1 - 3	12 (7.3)
4 - 6	107 (65.2)
> 6	45 (27.5)
Birth complication	
Yes	32 (19.5)
No	132 (80.5)
Support of family/friends	
Yes	126 (76.8)
No	38 (23.2)
Delivery place preference in the future	
Traditional birth attendant (TBA)	37 (22.6)
Health centre	56 (34.1)
Current facility	74 (43.3)

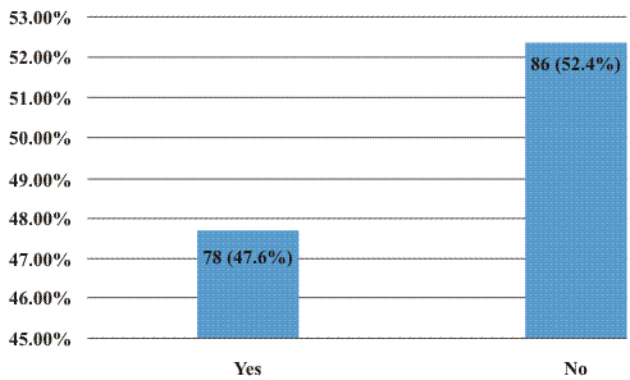

Figure 1: Number of participants that experienced disrespect and abuse

Table 4: Categories and forms of disrespect and abuse experienced during childbirth (N=164)

Types of disrespect and abuse	Frequency	Percent
Physical abuse	**56**	**34.1**
Hitting (slapped, beaten or pinched)	52	31.7
Harshly forcing leg apart	36	22.0
Tied down during labour	48	29.3
Non-dignified care	**61**	**37.2**
Shouted at	56	34.1
Threat of withholding treatment	23	14.0
Blamed or intimidated	34	20.7
Non-consented care	**33**	**20.1**
Non-consented episiotomy	28	17.1
Non-consented Caesarean section	12	7.3
Non-consented tubal ligation	8	4.9
Non-confidential care	**41**	**25.0**
Provision of care without privacy	40	24.4
Medical history disclosed without consent	15	9.1
Neglect/abandonment	**31**	**18.9**
Gave birth outside delivery room (corridor, waiting room or floor)	8	4.9
Ignored when needed help	26	15.9
Delivered without skilled attendant	3	1.8
Detention	**66**	**40.2**
Detention in health facility for failure to pay	60	36.6
Inappropriate demands for payment	15	9.1
Discrimination	**25**	**15.2**
Denial of needed attention on the basis of low social class	13	7.9
Denial of needed attention on the basis of age young (< 19 years)	8	4.9
Denial of needed attention on the basis of residence area (rural)	25	15.2
Denial of needed attention on the basis of education (no formal education)	24	14.6

Table 5: Multivariable logistic regression analysis of factors associated with disrespect and abuse during childbirth

Variables	Disrespected and abused		AOR (95%CI)	*P* value
	Yes	No		
Age (years)				
< 18	6	4	1.65(0.45-6.07)	0.45
19 - 35	64	24	1.00	
> 35	8	58	0.15(0.56-4.33)	0.51
Marital status				
Single	15	5	2.35(0.81-6.80)	0.12
Married	64	55	1.00	
Divorced	4	5	0.63(0.16-2.43)	0.49
Area of residence				
Rural	56	31	4.52(2.33-8.75)	<0.0001
Urban	22	55	1.00	
Booking status				
unbooked	51	38	2.37(1.27-4.49)	0.007
Booked	27	48	1.00	
Parity				
1-4	50	76	0.24(0.11-2.53)	0.46
≥ 5	28	10	1.00	
Presence of a companion during birth				
No	45	14	7.01(3.39-14.5)	<0.0001
Yes	33	72	1.00	
Complication during birth				
No	66	66	0.6(0.27-1.33)	0.21
Yes	12	20	1.00	
Detained for failure to pay hospital bill				
Yes	13	8	1.95(0.76-4.99)	0.16
No	65	78	1.00	

Note: 1.00 = Reference for category

Discussion

The findings of this study showed that D&A during labour and delivery is a common experience among mothers in our facility. Nearly half (47.6%) of the participants in this study reported experiences of D&A during childbirth. This similar to the findings of studies done in Kano (55.9%),[6] but lower than 64.3% reported in Kogi[4] and 70.8% in Rivers State[10]. The high prevalence of disrespectful and abusive behaviour found in this study may accounts for the low utilization of delivery care at health facilities in the study area and other similar settings as it creates psychological distance between women and healthcare providers. A woman's perception that she will receive respectful and friendly care will promote use of services when pregnant next time, and can also influence the perceptions of her social network.

Detention in the health facility after delivery was found to be the most prevalent category of D&A (40.2%). Detention was mostly due to failure to pay hospital bill after delivery. In Abakaliki, like other settings in sub-Saharan African countries, most women are of low socioeconomic status and out-of-pocket payment for healthcare is the norm.[15] In this setting, poverty is one of the factors limiting access to healthcare during pregnancy and delivery, which often leads to high maternal morbidity and mortality. Therefore, detaining women who delivered in health facilities would further undermine access to maternal services and drive these women to unorthodox practitioners during labour and delivery with its devastating consequences on maternal mortality profile.

In this study, 34.1% of the participants reported experiences of physical abuse during delivery. This finding is similar to findings of studies done in Kano,[6] but lower than finding of a study conducted in Ogbomoso. Studies done in Osun, Nairobi, Tanzania and Ghana reported lower incidence of physical abuse when compared with this study.[7,12,18,19] Physical abuse, such as hitting and slapping, has been justified by healthcare providers as a way of making 'uncooperative and misbehaving' women in labour to become cooperative in order to ensure safe delivery of the baby. Rather than being supported, women in labour who are suffering the pain of childbirth are being abused by healthcare providers. Participants' experience with the health facility setting also matters in shaping perceptions of women who gave birth in the health facility. In this study, participants who booked for antenatal care were less likely to report D&A during childbirth when compared to unbooked women. This is probably because unbooked women were unfamiliar with the way services are commonly provided at the health facility which made more likely to experience D&A at the health facility.

Area of residence is a significant predictor of D&A during childbirth, with those residing in rural areas almost 5 times more likely to experience D&A when compared with those residing in urban areas. The reason for this difference may be because women in urban areas more likely to be booked, more educated, more aware of their rights, more sensitive to mistreatment, and very likely to report any form of D&A they faced. This implies that initiatives to empower women and help them understand their rights when visiting health facilities to seek care should target women who are less educated and residing in rural areas.

Another predictor of D&A during labour and childbirth was lack of a companion during labor and delivery. Participants without a companion were almost 7 times more likely to experience disrespect or abuse when compared with those with companion. This finding was similar to the findings of studies conducted in Ethiopia, Kenya, Ghana and Ogbomoso.[9,12,19,20] This shows that healthcare providers are more likely to exercise caution on how to act and speak to pregnant women when a companion a woman is present, which suggests that the healthcare providers know that the way they behave in the absence of a companion is inappropriate. The protective effect of having a companion with the mother during labor could also indicate that companions serve an important role as advocates for the laboring mother.[21,22] Allowing a family member or a relative to accompany a laboring woman not only minimizes the possibility of D&A by health professionals but will make mothers more comfortable while delivering in a health facility setting. Furthermore, presence of a companion has already been suggested for inclusion in the list of process indicators to monitor quality of childbirth care in the health facility.

The study participants reported different forms of disrespectful and abusive experiences which calls for serious attention. To combat disrespectful and abusive treatment at health facilities, health managers and policymakers should prioritize enabling companions during labor and delivery, engage community members in health facility management boards, strengthen accountability through legal frameworks to appropriately address D&A, and improve the work environment for providers, coupled with training and introduction of care standards to professionals.[20]

Adopting a patient-centered approach and strengthening health system resources directed towards maternity care could significantly improve the quality of care provided to delivering women.[21] It is recommended that endeavors to promote birth at health facilities must address the issue of D&A to ensure higher utilization by women and to protect women's fundamental rights during facility delivery.[22] Possible interventions that could be designed and implemented at the health facility level include quality improvement interventions that focus on improving cultural responsiveness to mother's preferences (e.g. birth companion and choice of birthing position).[16,22] Addressing the unequal relationship between the women giving birth and skilled care providers is also a key area to addressing disrespectful care. Health facilities can also fight D&A by ensuring accountability (e.g. instruct and enforce desired standards of care, describing the nature of care that skilled providers and health facilities should offer to patients).[21] Performance-based contracts and systems for providers and other health facility staff to report observed D&A by their peer providers represent another approach to promoting accountability.[20] Furthermore, the compassionate, respectful, caring workforce initiative of the government should address the critical role of resource availability at point of care, in addition to training of health professionals on ethical conduct and good practice.[22] The use of reliable and validated questionnaire to assess the prevalence and forms of disrespect and abuse experienced by the participants is one of the strengths of this study. Another strength of the study was that the clients were assessed at hospital discharge (exit interview) and this assisted to minimize or eliminated client-associated bias. Besides these strengths, the present study had a limitation. It is single-centered study and therefore our findings cannot be generalized to other health facilities in other parts of Nigeria.

Conclusion

In conclusion, disrespect and abuse during childbirth among women seeking maternity care is still common (47.6%) in our hospital. Rural residence, unbooked status and lack of companionship during childbirth were factors associated with disrespect and abuse during childbirth. There is an urgent need to educate health workers on respectful maternity care so as to ensure acceptable, quality and dignified care for all women seeking maternity care in our facility.

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Conflict of interest

The authors declare no conflict of interest.

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