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Original Research

Prevalence and perception of disrespect and abuse during childbirth in public healthcare facilities in Lagos, Nigeria

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Abstract

Background: There is increasing awareness of disrespect and abuse (DAA) during childbirth. Globally, DAA during delivery is a common cause of suffering and violation of the human rights of birthing mothers. Respectful maternal care is necessary to improve the quality of care and uptake of institutional delivery services to reduce maternal and perinatal morbidity and mortality. The study aims to determine the prevalence, common forms, and perception of maternal DAA among mothers who just gave birth and are still in the hospital.

Methodology: A cross-sectional study on 261 consenting postnatal women at four public healthcare facilities in Lagos, Nigeria. An interviewer-administered pretested questionnaire was used to obtain data on sociodemographic characteristics and experiences of DAA. We analysed the data using Statistical Package for Social Sciences (SPSS) version 25. Logistic regression analysis was used to assess significant risk factors for DAA during delivery and early puerperium.

Results: The prevalence of DAA during childbirth was 82%. Perceptions of non-consented care and abandonment/neglect were the most reported forms of DAA reported by 86.8% and 45.6% of respondents, respectively. The odds for DAA were four times greater in women who had pregnancy complications compared to those who did not (aOR: 4.50, 95%CI: 1.50-13.46) and doubled in women who had vaginal delivery compared to Caesarean section (aOR: 2.10, 95%CI: 1.07-4.12).

Conclusion: DAA is prevalent during childbirth in our public healthcare facilities. This goes against the proposed standard of care where respectful maternal care is every womans right, posing a risk for reduced use of institutional delivery services.

Keywords: *Disrespect; Abuse; Prevalence; Perception; Maternal Care; Childbirth; Lagos; Nigeria.*

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Introduction:

All women deserve respect and dignity during childbirth. In 2014, the World Health Organization (WHO)[1] called for the prevention and elimination of disrespect and abuse of all women during childbirth. Every woman aspires to enjoy the highest attainable standard of healthcare including the right to dignified and respectful care during pregnancy and childbirth.[1]

It is hoped that access to good quality healthcare during pregnancy and delivery will reduce the risk and burden of maternal and perinatal morbidity and mortality.

However, there have been reports of disrespect and abuse during labour and delivery from around the world, including in developing countries. Disrespect and abuse (DAA) refer to humiliating or undignified interactions women experience during childbirth. There are seven categories of disrespectful maternity care according to the landmark paper written by Bowser and Hill on the analysis of disrespect and abuse: physical and verbal abuse, non-consented clinical care, non-dignified care, discrimination, non-confidential care, abandonment, and detainment in a health facility.[2]

There is growing evidence that perceptions of DAA by women during labour and delivery may influence their choice of where to deliver, a probable reason why many women choose to deliver at home.[3]

Respectful maternity care is a fundamental woman's right according to the World Health Organization and an essential component of positive childbirth experience.[4] The focus on the prevalence and perception of disrespect and abuse among women in Nigeria is essential to address the issue of women right's and increase the utilization of facility-based childbirth services to facilitate a reduction in the incidence of maternal and perinatal morbidity and mortality,

The "Mother-Baby Friendly Birthing Facilities Initiative" contains criteria for the provision of dignified care for both mothers and babies, and this includes privacy in labour rooms, birth companions, immediate skin-to-skin contact, and exclusive breastfeeding support.[5]

Much emphasis has been placed on improving clinical care but very little is said about how women perceive the care they receive. Disrespect and abuse are increasingly recognized in low- and middle-income countries as a barrier to the utilization of institutional childbirth services.[6] Therefore, there is a need to understand the perception and prevalence of disrespect and abuse in our local settings to aid in planning policies to improve the positive childbirth experience.

Very few studies in Nigeria and Africa at large described the prevalence of disrespect and abuse during institutional childbirth. Hopefully, this study will add to the body of knowledge on the subject matter and provide a basis for further studies and policy changes to enhance positive childbirth experience. The objectives of this study were to determine the prevalence, identify the common forms, and mothers' perception of DAA among parturient women in public healthcare facilities in Lagos, Nigeria.

Methodology

Study design: A multicentre cross-sectional study.

Study location: The study was conducted at the Lagos University Teaching Hospital (LUTH), Idi-araba, Lagos; Randle General Hospital, Surulere, Lagos; Mushin General Hospital, Mushin, Lagos, and Lagos Island Maternity Hospital (LIMH), Lagos Island from 1st of March 2021 to 30th of June 2021. LIMH is located on Lagos Island while the other health facilities are located on Lagos Mainland. They all offer antenatal care and delivery services to pregnant women. The delivery rate at LUTH which operates at the tertiary level of healthcare is an average of 100 deliveries per month. All the other three health facilities

provide care at the secondary level of healthcare. The average monthly delivery rate at these facilities is300 deliveries per month at LIMH, 120 at Randle General Hospital, and 80 at Mushin General Hospital, Lagos. They all have obstetric teams comprising doctors of various cadres, nurses, and midwives.

Study population: The participants interviewed were women who gave birth and were within 48 hours post-partum and who gave informed written consent. Women who had a stillbirth or a baby with congenital anomalies were excluded from the study**.**

Sample size calculation: Using Cochrane's formula,[7] a sample size of 261 women was estimated to be adequate for this study at a significance level of 0.05 and an error margin of 5% based on a prevalence of 19% for DAA among parturient in a previous study conducted in South-West, Nigeria[6]and considering 10% attrition.

Sampling method: Consecutive sampling method was adopted across all sites and the participants were enrolled simultaneously at the sites until the desired sample size was attained.

Data collection: A pretested semi-structured interviewer-administered questionnaire was used to obtain information on socio-demographic characteristics which included age, marital status, parity, level of education, religion, and tribe. The income level of the respondents was defined using an Africa Development Bank report (2010) which put low income as less than $2 a day, middle income between $2-$20 range and high income above $20 a day.[8]The questionnaires were administered by authors OJN, TTS and COM who are doctors assisted by two research assistants with first degree who were specifically employed for this project. All the research team members were trained by OJN and OAB before the commencement of the research.

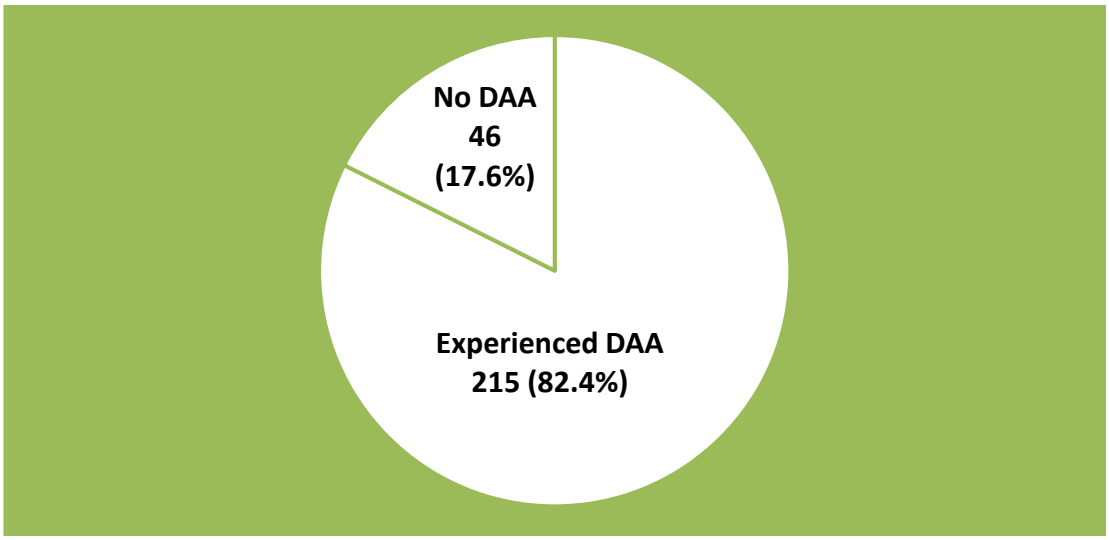
Pretesting: The questionnaire was pretested on 30 consecutively selected women within 48 hours post-delivery at General Hospital, Somolu to determine the women's comprehension of the questions, how well the questions were linked, and the ease of administering the questionnaire. We identified the need to rephrase a question to enhance clarity, and this was done. The final version of the questionnaire was used for this study. The pretest data collected was not included in the data analysed for this study.

Statistical analysis: We analysed the data using Statistical Package for Social Sciences (SPSS) version 25(IBM Corp. Released 2017. IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp). Descriptive statistics were performed. Categorical variables were presented as frequency and percentages. Prevalence was presented as a percentage with 95% confidence intervals. Binary logistic regression analysis was used to identify risk factors for DAA during delivery and early puerperium. Logistic regression analysis was conducted using the backward stepwise elimination method. A p-value of less than 0.05 was considered statistically significant.

Ethical considerations: The study was conducted per the World Medical Association principles of the Declaration of Helsinki. Ethical clearance was obtained from the Health Research and Ethics Committee (HREC) of the Lagos University Teaching Hospital, Idi-Araba (ADM/DSCT/HREC/APP/4371) and the Lagos State Health Service Commission (LSHSC/2222/VOLIV/9). All participants were granted full autonomy to decide whether to partake in the study. Each participant signed a written informed consent before being allowed to participate in the study. The data collected was de-identified and saved in a passworded laptop to ensure confidentiality.

Results

A total of 261 newly delivered mothers were surveyed and all participants were included in the analysis. The mean age of the women was 31±2yrs. They were predominantly married women (92.3%), and most had at least a secondary level of education (92.4%), *Table 1*. About 215 (82.4%) participants reported experiencing DAA during delivery, *Figure 1*. About half of the women had term delivery, with 53.6% of all the participants delivering vaginally



DAA – Disrespect and Abuse during childbirth.

Fig 1: Overall occurrence of disrespect and abuse among study participants

Table 1: Socio-demographic characteristics and birth history of study participants

Socio-demographic characteristics (n = 261)	Frequency (%)
Age (years)	
≤20	6 (2.3)
21 – 30	101 (38.7)
31 – 40	137 (52.5)
>40	17 (6.5)
Marital status	
Married	241 (92.3)
Not married (single, widow)	20 (7.7)
Education	
None	3 (1.1)
Primary	17 (6.5)
Secondary	100 (38.3)
Tertiary	141 (54.1)
Income	

Low	129 (49.4)
Middle	116 (44.4)
High	16 (6.2)
Parity	
1 – 4	246 (94.3)
>4	15 (5.7)
Mode of delivery	
Caesarean section	121 (46.4)
Assisted vaginal delivery	37 (14.2)
Spontaneous vaginal delivery	103 (39.4)
Gestational age at birth (weeks)	
<34	7 (2.7)
34 – 37	117 (44.8)
>37	137 (52.5)

The most common forms of disrespect and abuse suffered by mothers during delivery included non-consented care (86.6%), abandonment (45.6%), and non-dignified care including verbal insults (25.7%).

Table 2: Forms of disrespect and abuse among study participants (multiple responses allowed)

Category of disrespect and abuse (n = 261)	Forms of disrespect and abuse	Frequency (%)	Total (%)
Non-consented care	Episiotomy	54 (20.7)	86.6
	Augmentation of labour	49 (18.8)	
	Shaving of pubic hair	35 (13.4)	
	Sterilization (bilateral tubal ligation)	43 (16.5)	
	Caesarean delivery	36 (13.8)	
	Blood transfusion	9 (3.4)	
	Blood transfusion	9 (3.4)	
Physical abuse	Restrained or tied down during labour	8 (3.1)	11.4
	Episiotomy given or sutured without anaesthesia	9 (3.4)	
	Beaten, slapped, or punched	10 (3.8)	
	Sexually harassment by a healthcare worker	3 (1.1)	
Non-dignified care	Blamed or intimidated during childbirth	20 (7.7)	25.7
	Threatened with caesarean delivery to discourage the patient from shouting	15 (5.7)	
	Scolded, shouted at, or called stupid	32 (12.3)	

Abandonment/neglect of care	Denied companionship	84 (32.2)	45.6
	Left unattended in the second stage of labour	17 (6.5)	
	Birth attendant failed to intervene in a life-threatening situation	6 (2.3)	
	Not granted requested attention because the staff was exhausted	12 (4.6)	
Non-confidential care	Age disclosed without consent	2 (0.8)	9.3
	Provision of care without privacy	20 (7.7)	
	Medical history disclosure without consent	2 (0.8)	
	Disclosure of HIV status without consent	0 (0.0)	
Detention in the health facility	Discharge postponed until her hospital bills are paid	37 (14.2)	14.2
Non-confidential care	Denial of needed attention because of low social class	1 (0.4)	0.8
	Denial of attention because of age	1 (0.4)	

Some participants experienced more than one form of disrespect and abuse.

Pregnant women undergoing vaginal delivery had twice greater odds of suffering from disrespect and abuse than those scheduled for caesarean section, aOR: 2.10 (95%CI: 1.07 - 4.12). Women with pregnancy complications had 4.5 times higher odds of suffering disrespect and abuse than women without pregnancy complications, aOR: 4.50 (95%CI: 1.50 - 13.46).

Table 3: Risk factors for disrespect and abuse during delivery and early puerperium

PREDICTORS	**Crude odds ratio (OR)**			**Adjusted OR (aOR)**	
	OR (95%CI)	**p-value**	**LR p-value**	**aOR (95%CI)**	**p-value**
Age (years)					
Less than 20	1.00			-	-
21 – 30	0.31 (0.04 - 2.49)	0.270		-	-
31 – 40	0.23 (0.03 - 1.83)	0.166	0.209	-	-
41 – 50	1.00			-	-
Parity					
1 and below	1.00			1.00	
2 – 4	1.24 (0.64 - 2.37)	0.525	0.721	1.15 (0.59 - 2.24)	0.685
5 and above	1.65 (0.34 - 7.89)	0.533		1.31 (0.26 - 6.45)	0.743
Marital status					
Single	1.00	-	-	-	-
Married	1.00	-		-	-
Highest level of education					
None	1.00	-		-	-
Primary	0.85 (0.65 – 1.12)	0.254		-	-
Secondary	1.06 (0.55 - 2.02)	0.868	0.868	-	-

Tertiary	1.00			-	-
Religion					
Christianity	1.00	-		1.00	-
Islam	0.90 (0.48 - 1.70)	0.742	0.742	0.70 (0.36 - 1.37)	0.304
Tribe					
Hausa	1.00			-	-
Igbo	0.65 (0.13 - 3.29)	0.606		-	-
Yoruba	0.67 (.143 - 3.10)	0.605	0.857	-	-
Other	1.00			-	-
Earnings per year					
Low income	1.00			-	-
Middle income	1.03 (0.54 - 1.98)	0.919	0.822	-	-
High income	1.60 (0.54 - 1.98)	0.551		-	-
Mode of delivery					
Caesarean section	1.00	-		1.00	-
Vaginal delivery	1.72 (0.91 - 3.26)	0.095	0.093	2.10 (1.07 - 4.12)	**0.031**
Gestational age at delivery (weeks)					
Less than 34	1.00	-		-	-
34 – 37	0.86 (0.10 - 7.55)	0.892	0.746	-	-
Greater than 37	0.68 (0.08 - 5.88)	0.725		-	-
Pregnancy complications					
No	1.00	-		1.00	-
Yes	3.72 (0.08 - 5.88)	**0.016**	0.006	4.50 (1.50 - 13.46)	**0.007**

Total number of participants = 261. For the multivariable model, likelihood ratio (LR) p-value <0.020, and Hosmer and Lemeshow goodness of fit p-value = 0.293.
OR – crude odds ratio, aOR – adjusted odds ratio, 95%CI – 95% confidence interval, LR – likelihood ratio.

Discussion

This study showed that disrespect and abuse during childbirth are still issues of concern in public healthcare facilities. From the study, 82.4% of respondents experienced some form of disrespect and abuse during facility-based delivery. This is similar to findings in a study by Okafor et al. (2015) which reported that 98% of their respondents had experienced one form of disrespect and/or abuse during their last delivery.[9]

Non-consented care was the most reported form of disrespect and abuse in the study with a prevalence of 86.6%. This may have been due to the women not being carried along properly during decision-making due to perceived ignorance.[9] This misconception deprives the affected women of total control concerning the care they receive during childbirth. Providing adequate counselling and obtaining informed consent for any intervention during childbirth will help avoid possible ethical or medico-legal problems.

About 32.2% of women in the study reported being denied companionship during labour. The recommendation by the World Health Organisation on intrapartum care encourages companionship during childbirth as one of the strategies to ensure women have a positive childbirth experience.[1] LUTH allows companionship in the labour ward unit because the delivery suites are designed such that each woman is managed in an ensuite room. Unfortunately, many labour ward units in our environment like the other study sites are built as open wards with facilities to screen patients during procedures; this does not assure privacy. In addition, it may not allow for continuous companionship. Modelling and

remodelling of labour wards in our environment with an emphasis on privacy for all women may help resolve the problem.

Non-confidential care is a breach of the code of ethics in healthcare. It was reported by 9.3% of women in this study. The open floor nature of many labour wards in our environment may have partly contributed. It is generally believed that physicians will protect information shared in confidence. Women should feel at ease in disclosing sensitive personal information to enable their healthcare providers to provide needed services effectively. In the current study, a few women reported undue disclosure of personal information like age, HIV status and medical history without their consent; while a sizeable proportion considered being attended to by the healthcare workers without due consideration for their privacy, to be disrespectful and abusive. These are obviously issues that breach a woman's confidentiality. These findings were similar to the findings in a qualitative study done in Tunisia.[10] The Tunisian study further identified the impact of these factors which may worsen already existing social stigmatization within the society.[10] This underscores the need for training and retraining of healthcare workers on medical ethics and the provision of respectful care to patients.

About 25% of women reported some form of non-dignified care during childbirth ranging from receiving slanderous remarks to being threatened with Caesarean delivery. Unfortunately, there are instances where health providers may be left frustrated by difficult or uncooperative patients with the well-being of the foetus at the forefront of the provider's mind.[9] Such instances may result in an overreaction by the provider, who goes ahead to make slanderous remarks or threaten the parturient with the risk of a Caesarean delivery if she fails to cooperate. This may be misconstrued by the patient, and she might get discouraged from facility-based delivery subsequently. The negative experience may endear patients towards other options such as traditional birth attendants who may treat them with more dignity and respect.[9] Provider's attitude towards patients may also be a factor where some providers do not properly communicate decisions or intended actions to be undertaken to patients. Other factors may include inadequate personnel, physician burnout and poorly motivated staff.[11]

Another 3.4% of respondents reported some form of physical abuse during childbirth. These findings are comparable to findings in a similar study done in Gombe by Umar et al.[12]

This may be seen in some cases with uncooperative patients, especially during the second stage of delivery which requires patient cooperation to deliver the baby. However, some occurrences may also be due to the wrong provider's attitude. The findings substantiate the notion that some women have erroneously accepted physical abuse, particularly during the second stage of labour as part of the birthing process and do not complain thereafter. This practice seems to be more prevalent in low-resource countries like Nigeria and should be discouraged.[12]

Detention in the health facility was experienced by some women in the study as they could not afford the bills for healthcare. Most women in our environment pay out of pocket for healthcare as only a minority of people are covered by health insurance.[9] This makes basic healthcare delivery unaffordable for many families in Nigeria. This problem can be ameliorated with health insurance made available to the general populace.

This study showed the odds of DAA were twice higher for women that had vaginal delivery compared to those that had Caesarean delivery. The result is similar to findings in a study by Mesenburg et al which showed greater violence was experienced by women who went into labour and had vaginal delivery compared to those who did not undergo labour before Caesarean delivery.[13] It was also noted that the odds of DAA were 4.5 times higher for women who suffered complications compared to those who did

not. The result is similar to findings in a meta-analysis on DAA in Eastern Africa.[14]A higher risk of complication may increase susceptibility to DAA as health providers may be on edge in such cases. DAA may also arise when the health care provider attempts to shift the burden for the complication to the woman.

Further qualitative studies may be needed that will involve the views of all stakeholders (patients, health providers and policymakers) with the aim of seeking holistic measures and policies that will stem the problem of DAA in facility-based delivery.

Conclusion

DAA are still issues of concern among women who have facility-based delivery. These findings provide an insight into the extent of the problem as it affects our public healthcare facilities. To address this problem, immediate and sustained attention to the quality of care offered to women during delivery is needed to ensure an overall positive experience for women.

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