

# Disrespect and abuse during facility based childbirth: The experience of mothers in Kano, Northern Nigeria

AMOLE TG<sup>1,2</sup>, TUKUR MJ<sup>1</sup>, FAROUK SL<sup>1</sup>, ASHIMI AO<sup>3</sup>

<sup>1</sup>Department of Community Medicine, Bayero University Kano, <sup>2</sup>Aminu Kano Teaching Hospital, Kano, <sup>3</sup>Federal Medical Centre, Birnin Kudu, Jigawa State, Nigeria

## ABSTRACT

**Context:** An important but little understood concept that retards the goal to reduce maternal mortality and increase universal access to reproductive health is disrespect and abuse (D&A) during childbirth.

**Aim:** This study aims to determine the prevalence, pattern, perpetrators, and determinants of D&A during childbirth among recently parturient women in Kano, north western Nigeria.

**Settings and Design:** Using a cross-sectional design, 332 women accessing child immunization and postnatal services at Murtala Muhammad Specialist Hospital, Kano, were selected.

**Subjects and Methods:** Respondents were selected using systematic sampling technique and data collected using an adapted, interviewer administered tool.

**Statistical Analysis:** Data was analysed using IBM SPSS version 21.0 and level of significance set at 0.05.

**Results:** Respondents ( $n = 306$ ) had a mean age of  $27.7 \pm 6.3$  years and more than half (55.9%;  $n = 171$ ) had experienced at least one form of D&A during childbirth. Commonest forms of abuse were abandonment and nonconfidential care (84.5%,  $n = 142$ ; 67.9%,  $n = 114$ , respectively). Main perpetrators were nurses/midwives (83.0%,  $n = 142$ ). The experience during the last childbirth was significantly higher among respondents of non-Hausa/Fulani ethnic group ( $\chi^2 = 6.10$ ;  $P = 0.014$ ), of the Christian faith ( $\chi^2 = 8.62$ ;  $P = 0.003$ ), and with formal education ( $\chi^2 = 19.94$ ;  $P = 0.0001$ ). After controlling for confounders, formal education remained a predictor for experiencing abuse at childbirth (AOR = 2.43; 95% confidence interval = 1.11--5.32).

**Conclusions:** D&A during childbirth is prevalent in our setting. Educating healthcare providers and women about their responsibilities and rights will enhance provision and utilization of quality maternal health services.


**Key words:** Childbirth; disrespect and abuse; facility; mothers.

## Introduction

The death of a woman during pregnancy, childbirth, or within 42 days of terminating the pregnancy or delivery remains a source of agony to the immediate family and a socioeconomic loss to community. In 2010, an estimated 287,000 maternal deaths occurred worldwide, majority of which were from developing nations and Nigeria accounted for 14%.<sup>[1]</sup> At this estimate, Nigeria's maternal mortality ratio (MMR) was put at

630 with a range of 370--1,200/100,000 live births.<sup>[2]</sup> According to the Nigeria Demographic Health Survey (NDHS) of 2013, the MMR was estimated to be 576/100,000 live births,<sup>[3,4]</sup> with values notably higher in the northern region compared with the south and also in the rural areas. The reasons for

**Address for correspondence:** Dr. Amole TG, Department of Community Medicine, Bayero University Kano/Aminu Kano Teaching Hospital, Kano, Nigeria. E-mail: tayade10@yahoo.com

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this high MMR are multipronged and complex; access to, and utilization of emergency obstetric care services in various parts of the country regarded as main causes.<sup>[4]</sup> Reduction of maternal mortality has long been a global concern and priority as enunciated by the Millennium Development Goals (MDG) framework, the Global Strategy for Women's and Children's Health, and the Sustainable Development Goals.<sup>[5-7]</sup> To further advance the reduction of maternal mortality in Nigeria, factors influencing nonutilization of maternal health services need to be addressed, since it is the patient that presents to the facility that counts.

According to the NDHS 2013 and other reports,<sup>[3,8-10]</sup> cost of healthcare services, distance of health facility, services not conforming to tradition, waiting time, and negative attitude of providers, all play significant roles in nonutilization of maternal healthcare services in Nigeria. This may explain the high rates of home delivery among pregnant women irrespective of having received prenatal care or not, especially in northern Nigeria.<sup>[10]</sup>

What constitutes negative providers' attitude to clients varies, but certainly includes disrespect and abuse (D&A). These ultimately affect the quality of care, and may influence subsequent utilization of the services provided by the facility, consequently, negatively influencing other clients. D&A towards patients is subjective and challenging to define as it is often dependent and modified by the environment, time, birth outcomes, and personal expectations.<sup>[11]</sup> Researchers have defined D&A during childbirth as "interactions and facility conditions that local consensus deem to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified;"<sup>[12]</sup> and any form of inhumane treatment or uncaring behavior towards a woman during labor and delivery.<sup>[13]</sup> Although Bowser and Hill identified seven categories of D&A: physical abuse, nonconsented care, nonconfidential care, nondignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities,<sup>[14]</sup> d'Oliveira worked on four types of violence: neglect; verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation; physical violence, including denial of pain relief when technically indicated; and sexual violence.<sup>[15]</sup> Women in labor expect empathy, support, confidentiality, and respect from their birth attendants.<sup>[16]</sup>

D&A can constitute poor quality of care and become a powerful disincentive for women to use and seek maternal healthcare services.<sup>[17,18]</sup> The documented proportion of women across the globe experiencing disrespectful, abusive,

or neglectful treatment during childbirth varies: 13--28% of women attending gynecological clinics in northern Europe had experienced abuse within the healthcare system during pregnancy, delivery, or the postnatal period;<sup>[19]</sup> a comparable 20% in Kenya;<sup>[20]</sup> and an astronomically high 98% from a facility based study in Enugu, southeast Nigeria.<sup>[16]</sup>

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<sup>[12]</sup> as well as reforming poor quality of care at facilities.<sup>[20,21]</sup> D&A 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.<sup>[14]</sup> The fear of experiencing D&A negatively influences women's decisions to seek care at health facility during labor and delivery.

In Nigeria, the proportion of births supervised by skilled birth attendance (36%) has remained low despite high uptake of prenatal care (60%).<sup>[6]</sup> D&A is an important but poorly understood component of the quality of care that women receive during childbirth in our facilities. To improve quality of care given by healthcare providers as a way of driving uptake, this study sought to quantify D&A in our setting, describe the pattern, the perpetrators, as well as associated factors during childbirth in Kano, northwestern Nigeria.

## Subjects and Methods

### Study setting

The study was conducted at the Murtala Muhammad Specialist Hospital (MMSH) in Kano, Nigeria. The hospital is located in Kano city, a place often described as the core of Kano state. There are three state owned tertiary hospitals in the state and all are in Kano city. The MMSH is one of the state government owned tertiary hospitals and is the most patronized. It is the oldest hospital in northern Nigeria having been established in 1927. It was initially called City Hospital, was renamed after the assassination of the former Nigeria Head of State, General Murtala Ramat Muhammad in 1976 and became a specialist hospital in 1987. It is located along Kofar Mata road in Kano Municipal Local Government Area. It receives referrals from all the 44 local governments in the state, neighboring states of Jigawa, Katsina, Bauchi, and Zamfara. The hospital is a 250 bedded facility and it has four main clinical departments and other nonclinical departments. The hospital provides free maternal and child care facilities especially for children under 5 years, a programme initiated by the state government 17 years ago before this study.

The department of Obstetrics and Gynecology is run by three consultants, six medical officers, three senior medical officers, and 69 nurses and midwives who run shifts. The total number of deliveries in 2016 was 9,585 with an average of 799 deliveries/month.

### Study design

A cross-sectional descriptive study design was used.

### Selection and description of participants

Mothers accessing services at the postnatal and immunization clinics of MMSH, who delivered at MMSH within the last 6 weeks prior to the study were included. Women delivered at home were excluded from the study.

### Sample size

The sample size for this study (333) was calculated using the formula<sup>[22]</sup>:  $n = z^2 pq/d^2$ ; where  $z$  is the standard normal deviate at 95% confidence level, “ $p$ ” is prevalence of abandonment/neglect during childbirth in a previous study<sup>[16]</sup> = 0.291, degree of precision was set at 5% and calculated sample size adjusted by 5% to compensate for nonresponse.

### Sampling technique

The average number of women attending the immunization clinic for the first and second visit (0--6 weeks) and the postnatal clinic were estimated and the average monthly attendance estimated to form a sampling frame. Subsequently, the sampling fraction and the sampling interval were calculated. The first respondent each day was chosen using simple random sampling technique (using a random number table). This was repeated on subsequent clinic day until the sample size was achieved.

### Study instruments and data collection

A pretested, structured interviewer administered questionnaire was used to collect data. The questionnaire was adapted from tools used in previous studies on related topics.<sup>[16]</sup> The tool had four sections: section A obtained information on sociodemographic characteristics (age, gender, religion, marital status, occupation, and parity) of the respondent; section B determined prevalence and pattern of D&A (questions on forms of physical and verbal abuse, failure to meet professional standards of care and poor rapport between woman and provider); section C determined the perpetrators (cadre of skilled birth attendant) of D&A; and section D assessed factors (such as the experience of complication(s) during last delivery) that may be associated with D&A in childbirth. Specific questions used in the study were pilot tested with a small random sample of potential respondents (number = 40; not included in the study) to ascertain the appropriateness of the items included. In

general, there was good internal consistency among the items indicating that the instrument was reliable and valid. On each immunization and postnatal clinic day, selected participants were invited individually into a separate room and informed consent obtained using the consent form. They were assured of privacy, no revelation of identifying information, and no interference with the quality of care they will receive with nonparticipation. Only consenting participants were interviewed. The questionnaires were administered to the respondents by trained research assistants who were female medical students. Their training included obtaining informed consent and interviewing techniques.

### Pretest

The tool was pretested among 40 postnatal women accessing immunization services at Aminu Kano Teaching Hospital. This was to identify ambiguous questions, ensure appropriateness of questions, and skip patterns.

### Data analysis

Data was entered and analyzed using IBM SPSS version 21. Qualitative data was summarized using frequencies and percentages, whereas quantitative data was summarized using mean and standard deviation. Chi-square test was used to determine significant associations between respondents' sociodemographic characteristics and the experience of D&A at childbirth. Statistical significance was set at  $P \leq 5\%$ . Using a  $P$  value of 0.1 as cut-off, variables associated with D&A were put into the logistic regression model to determine the predictors for D&A.

### Ethical considerations

The study proposal was approved by the State Ministry of Health Research and Ethics Committee and informed consent was obtained from respondents. Provisions of the Helsinki declaration were respected during the study.

### Results

Of the 333 questionnaires distributed, 306 were retrieved giving a response rate of 91.9%. The age of the respondents ranged from 16 to 45 years with a mean of  $27.7 \pm 6.3$  years. Majority (91.2%) were married, of the Hausa/Fulani ethnic group (84.6%), Muslims (90.8), and (45.1%) were housewives. The sociodemographic characteristics of the respondents are shown in Table 1.

### Prevalence of disrespect and abuse during childbirth

More than half 55.9% ( $n = 171$ ) of the respondents had experienced at least one form of abuse, whereas 44.1% ( $n = 135$ ) did not experience any form of abuse during the last childbirth.

### Pattern of disrespect and abuse

The commonest types of D&A were abandonment/neglect of care ( $n = 142$ ; 84.5%), nonconfidential care ( $n = 114$ ; 67.9%), and nondignified care ( $n = 87$ ; 51.8%). [Table 2]. The least common was request for bribe ( $n = 12$ ; 7.1%). Some respondents reported experiencing multiple forms of D&A.

**Table 1: Socio-demographic Characteristics of Respondents**

Socio-demographic characteristics	Frequency (n)	Percentage
Age group (years)		
<20	21	6.9
20-29	175	57.2
30-39	91	29.7
40 and above	19	6.2
Tribe		
Hausa	187	61.1
Fulani	72	23.5
Yoruba	26	8.5
Igbo	10	3.3
Others	11	3.6
Religion		
Islam	278	90.8
Christianity	28	9.2
Educational Qualification		
None	6	2.0
Quranic	28	9.2
Primary	28	9.2
Secondary	142	46.4
Tertiary	102	33.3
Marital status		
Married	279	91.2
Divorced	20	6.5
Single	7	2.3
Occupation		
Housewife	138	45.1
Trading	89	29.1
Civil service	56	18.3
Students	18	5.9
Tailoring	5	1.6
Parity		
1	43	14.1
2-4 children	177	57.8
≥5 children	86	28.1

**Table 2: Pattern of disrespect and abuse during childbirth**

Pattern of abuse	Frequency (n=171)	Percentage
*Abandonment/neglect of care	142	84.5
*Non confidential care	114	67.9
*Non dignified care	87	51.8
*Non consented care	75	44.6
*Physical abuse	47	28.0
Detention in health facility	17	10.1
Request for bribe	12	7.1

\*Multiple options

### Perpetrators of D&A during childbirth

The nurses/midwives were responsible for majority ( $n = 142$ ; 83.0%) of the reported D & As during childbirth. Attending doctors ( $n = 20$ ; 11.7%) and hospital attendants ( $n = 14$ ; 8.2%) were responsible in some cases. A few reported experiencing D&A from multiple perpetrators.

### Factors associated with D&A during childbirth

At bivariate level, respondents who were of non-Hausa/Fulani ethnic group, of the Christian faith, and with formal education experienced D&A more than others [Table 3]. Factors that had  $P$  value of  $\leq 0.1$  were subjected to logistic regression analysis and formal education remained a predictor for experiencing D&A during childbirth.

### Discussion

Encouraging respectful care during childbirth is crucial to improve quality of care and utilization of skilled birth services<sup>[21]</sup> D&A adversely impacts the utilization of health services for skilled delivery, an intervention that has been noted globally to greatly reduce maternal mortality.<sup>[14,18,23]</sup> Although the introduction of free maternal health services in Kano State resulted in increased utilization of ANC and delivery services, major impacts in maternal health indices are yet to be observed and have been explained by the social factors peculiar to women in our environment.<sup>[21]</sup> In this study, D&A during the last childbirth was common as one in every two women (55.9%) experienced it.

In many African settings, parturients are often ignored in labor until they shout "head is coming down" or the birth attendant can sight the head of the baby. This may explain abandonment/neglect of care as the commonest form of D&A reported in this study. When this is done intentionally, it may be because of negligence, provider temperament, and superiority complex, or unintentional when the health worker is overworked, busy with other tasks, or attending to other patients. Inadequacy of health workers have also contributed to D&A during childbirth.<sup>[12,24]</sup> A global systematic review,<sup>[12]</sup> landscape analysis by Bowser and Hill,<sup>[14]</sup> and other studies conducted in Nigeria<sup>[14]</sup> and Kenya,<sup>[13]</sup> also reported the commonest form as abandonment/neglect of care. Analgesia is not commonly given to parturients in this environment,<sup>[23]</sup> as such many women mentioned that they were ignored when they sought pain relief and left unattended to. D&A may adversely impact the utilisation of health services for delivery, an intervention that has been noted globally to reduce maternal mortality.<sup>[25]</sup> Despite the fewer number of midwives in the labour ward compared with the number of parturients in labor at any point in time, there are few options to pain relief accessible to the midwives.

**Table 3: Respondents' characteristics associated with D&A in childbirth**

Socio-demographic characteristic	Had D&A in last childbirth		$\chi^2$	P
	Yes n (%)	No n (%)		
Age group (years)				
<20	10 (47.6)	11 (52.4)	0.62	0.43
≥20	161 (56.5)	124 (43.5)		
Tribe				
Hausa/Fulani	137 (52.9)	122 (47.1)	6.10	0.014*
Others	34 (72.3)	13 (27.7)		
Religion				
Islam	148 (53.2)	130 (46.8)	8.62	0.003*
Christianity	23 (82.1)	5 (17.9)		
Educational status				
Informal	14 (41.2)	20 (58.8)	19.94	0.0001*
Primary	13 (46.4)	15 (53.6)		
Secondary	69 (48.6)	73 (51.4)		
Tertiary	75 (73.5)	27 (26.5)		
*Statistically significant				
Marital				
Married	154 (52.2)	125 (44.8)	0.60	0.44
Unmarried	17 (63.0)	10 (37.0)		
Occupation				
Housewife/student	85 (54.5)	71 (45.5)	5.74	0.057
Trading/Tailoring	47 (50.0)	47 (50.0)		
Civil service	39 (69.6)	17 (30.4)		
Parity (Number of children)				
1	24 (55.8)	19 (44.2)	0.3	0.86
2-4	101 (57.1)	76 (42.6)		
≥5	46 (53.5)	40 (46.5)		
Had complication in last delivery				
Yes	37 (60.7)	24 (39.3)	0.70	0.40
No	134 (54.7)	111 (45.3)		

Other poor quality services such as being uncovered during delivery or examination and medical history disclosure without consent violates the privacy of women during childbirth and may discourage them from delivering in health facilities. Although this study did not ascertain the HIV status of the patients studied, a similar study in Kenya among HIV-positive women reiterated that issues related to trust in the treatment offered at health facilities could affect demand and utilization of services. The lack of trust in the confidentiality of treatment at health facilities was so great that the women chose to deliver at home, where their HIV status would not be disclosed to other community members or health workers.<sup>[12]</sup>

The perpetrators of D&A included doctors, nurses/midwives, and attendants. Although the provision of free maternal health services in the health facility led to increased utilization, the resultant increase in workload precipitated decreased staff morale and poor quality of services.<sup>[21,23]</sup> The midwives who are often the foremost skilled attendant

at most deliveries were reported by the majority as the perpetrators (83.0%), similar to what was found globally in a mixed systematic review,<sup>[12]</sup> and also in studies conducted in Ghana,<sup>[26]</sup> Kenya,<sup>[27]</sup> and Nigeria.<sup>[28,29]</sup> Healthcare providers may perpetrate disrespectful and abusive care as a result of their perception and beliefs. Also providers may want to “train and discipline” the women rather than treat them.<sup>[14]</sup> Healthcare providers may also feel that they are entitled to use a range of strategies, including physical violence to achieve control and punish perceived disobedience. Such negative behavior may stem from the social norms which influence both practice and expectations of power, often implying that care providers are in control of women. Moreover, lack of repercussions for unacceptable health worker behavior can fuel a sense of entitlement.<sup>[30]</sup>

Respondents who were of the Christian faith, of non-Hausa/Fulani ethnicity, and better educated were more likely to report being abused than those of Islamic faith, Hausa/Fulani ethnicity, and those with informal education. Women of minority tribes are more likely to report abusive care because they speak different languages, with different cultural norms and practices from those of the majority and the caregivers as well.<sup>[31]</sup> Also, in the Hausa/Fulani communities who constituted the majority in this setting, the culture and tradition discourages women from shouting, crying, or showing much distress during labor. Better educated women probably have higher expectations of quality of care. Findings in Tanzania and India noted that D&A was higher among women who were better educated, had higher expectations of quality of care, and with greater empowerment to report abuse.<sup>[32]</sup> Lack of awareness on respectful maternity care among respondents with lower level of education may contribute to their inability to differentiate between acceptable standard of care, and what is regarded as abnormal or unethical. Women may underreport abuse because of normalization of the poor quality care.<sup>[14,23]</sup> Other social factors such as marital status were noted to affect D&A as unmarried women were more likely to be abused than those married. This is probably because of lack of support from partner or family members and financial instability.

Education of service providers and women as regards their responsibilities and rights while providing or receiving care is of utmost importance in the prevention of D&A. Clear delineations of what a provider is expected to give while providing care, and what quality of health service a woman should expect would need to be displayed at all health facilities and in the most understood language. To understand and quantify D&A in Nigeria, the government

and health development partners would need to promote and support further research into defining D&A. With this, interventions that holistically address policy makers, healthcare workers' training, and service delivery as well as individuals and communities can be planned and implemented.

This study may be limited as it used only quantitative methods to assess women in a health facility immunization and postnatal clinics, whereas a significant proportion of women in this environment deliver at home and do not access postnatal care.<sup>[16]</sup> Subsequent research will need to employ qualitative research methods to explore the interplay between choice of place of delivery, the birth attendant, and D&A at childbirth. Although some of the responses may be due to social desirability bias, pertinent information was gathered from this study.

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### Conflicts of interest

There are no conflicts of interest.

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