Respectful Maternity Care: Women's Experiences of Disrespect and Abuse During Childbirth in Ilorin, North Central Nigeria.

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Abstract

Disrespect and abuse during childbirth can be described as a violation of the human rights of concerned parturients. The occurrence of these events may negatively impact upon uptake of antenatal and delivery services by pregnant women and this in turn may contribute to an increased maternal and perinatal mortality and morbidity. Disrespect and abuse during childbirth is a relatively common occurrence and little research has been done on this issue that could negatively affect our health care indices.

This study was carried out among recently delivered women (women who had delivered not more than 6 weeks previously), attending pre-identified child immunization clinics in Ilorin. Women who had Caesarean delivery, preterm delivery, instrumental vaginal delivery and women with multiple delivery in which one of the babies suffered a mortality were excluded.

Two hundred and seventy-one recently delivered women were recruited. The mean age was **27.67 ± 3.85.** Majority of respondents were Muslim (68.3%), married (98.9%) and had at least a secondary school education (76.4%). The commonest place of delivery was a secondary health care facility (40.6%) and the most frequent attendant at delivery was a doctor (39.9%). Forms of disrespect and abuse experienced by respondents included non-consented care, being left alone for prolonged periods, (88.6%), being ignored when they called for help (10.7%) and undue detention at facility due to non-payment of bills (6.3%). Despite the foregoing however, 8.1% believed they received disrespectful and abusive care.

There is a disconnect between women's actual child-birth experiences and report of disrespect and abuse during childbirth. There is a need to improve education of women and providers about what constitutes disrespect and abuse during childbirth as this will translate into increased confidence uptake of facility births and a reduction in maternal and perinatal morbidity and mortality.

Keywords: Disrespect and abuse, facility childbirth, Ilorin

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Introduction

Nigeria with an estimated population of close to 200 million people[1] is the most populous nation in Africa and the 7th most populous country in the World.[2] Unfortunately, Nigeria is plagued with one of the worst health care indices in the world, accounting for close to 20% of all global maternal deaths, with women in Nigeria having an astounding 1 in 22 lifetime risk of dying during pregnancy, childbirth or postpartum/post-abortion compared to a risk of 1 in 4,900 in developed countries.[3]Nigeria and India had the highest estimated numbers of maternal deaths, accounting for approximately one third (35%) of estimated global maternal deaths in 2017, with approximately 67,000 and 35,000 maternal deaths (23% and 12% of global maternal deaths), respectively.[4]

Absence of skilled attendants at birth has been identified as one of the factors contributing to the unacceptably high rate of maternal mortality in low and middle income countries[5]and evidence has revealed that skilled care before, during and after childbirth can save the lives of women and children.[6]

The 2018 national demographic health survey found that even though 67% of women in Nigeria receive antenatal care from a skilled health provider, only 39% deliver at a health facility and 43% of births were assisted by a skilled provider.[2]This low percentage of skilled birth attendants at birth negatively contributed to the attainment of the 5th Millennium development goal by Nigeria and will have a negative impact on the sustainable development goals as well.

Several studies have shown that disrespect and abuse (D & A) during facility-based childbirth is a common occurrence worldwide (in both low- and high-income countries [7-12]and may negatively impact on women's decisions to access maternal health services or their decision to deliver at a particular health care facility, as choice of place of delivery is largely influenced by their perception of how they will be

treated at these facilities.[11-13]

The WHO states that "Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care".[10]At present, despite the widespread occurrence of disrespect and abuse during childbirth, there is no consensus definition, or scientific way of measuring disrespect and abuse.[10]

To underscore the importance of addressing issues of disrespect and abuse during childbirth, the USAID, through the Heshima project partnered with some professional groups in Kenya to tackle the problem of D & A during childbirth in Kenya. The Heshima project defines D & A as "any form of inhumane treatment or uncaring behavior towards a woman during labor and delivery".[10]

The exact magnitude of the problem (including prevalence and impact on women's health) is difficult to determine because of lack of a consensus definition, underreporting and lack of identification of the problem (what appears to be a disrespectful or abusive practice by an outside advocate or trained observer may appear normal to patients or health care providers).[11]

In a study performed in Kenya, 20% of women reported feeling humiliated at some point during their most recent delivery and 90% of health care providers had either heard of or witnessed inhumane treatment of child-bearing women by their colleagues.[10]

Identified contributory factors to D & Ainclude complacency of law makers, lack of understanding of client's rights, staff shortages resulting in higher stress, and complex mechanisms for seeking of redress.[10] In a Lancet publication byd" Oliviera and colleagues, human rights violations occurring in health institutions was related to poor quality and ineffective health services.[5] These acts of violence were perpetuated by doctors and nurses and ranged from neglect to verbal, physical and sexual abuse.[5]

In 2010, Bowser and Hill[12]categorized disrespect and abuse during childbirth into 7 groups which form a continuum from subtle disrespect to various acts of violence viz: Physical abuse (slapping; pinching; poking; pushing; beating); Non-consented clinical care (treatment given without permission or knowledge); Non-confidential care (lack of privacy, no curtains or private information shared); Non-dignified care (including verbal abuse, harsh tone or language, unkind expression, dirty bedding); Discrimination based on specific patient attributes (prejudice based on ethnicity, poverty, or HIV status); Abandonment or denial of care (ignored when birth is imminent or pain relief is needed); Detention in facilities (detained for failure to pay for services or bribes requested)

In 2011, The respectful maternity care (RMC) charter[13]was developed by the White Ribbon Alliance in conjunction with the Bill and Melinda Gates foundation and with the support of the USAID Health Policy project. This charter established the rights of all women to timely, high-quality and respectful care during pregnancy, delivery and afterward by enumerating the 7 rights of all childbearing women to include the following: Right to be free from harm and ill treatment; Right to information, informed consent &refusal and respect for choices and preferences including companionship during maternity care; Right to privacy and confidentiality; Right to be treated with dignity and respect; Right to equality, freedom from discrimination, and equitable care; Right to health care and highest attainable level of health and Right to liberty, autonomy, self-autonomy and freedom from coercion. It also reiterated that "disrespect and abuse during maternity care are a violation of women's basic human rights".[13]

Despite the worldwide occurrence of D & A during facility-based childbirth, there is a paucity of local data relating to women's experiences of these during childbirth. Studies have revealed that women's previous experiences at health care facilities influence future decisions regarding place of delivery. This study aimed to determine women's experiences of disrespect and abuse in different delivery settings thus providing data on the prevalence of D & A which will be utilized to ensure that respectful maternity care is provided to all women at delivery, thereby increasing the percentage of women delivering at health facilities. In the long-term, this will help to reduce maternal and perinatal morbidity and mortality.

This study determined women's subjective views on their experience of disrespect and abuse during childbirth, identified factors associated with its occurrence and determined the relationship between place of birth and occurrence of disrespect and abuse. It also compared various forms of D & A that occurred across various delivery settings in ilorin. This will aid in improving awareness of the problem and in generating local prevalence data that will serve as a baseline for further studies in order to minimize the occurrence of D & A thereby improving women's experiences at delivery, improving facility births and ultimately reducing maternal and perinatal morbidity and mortality.

Methodology

Setting / Background of The Study Site

This study was carried out in child immunization clinics in Ilorin, Kwara State Nigeria. The state has 16 local government areas with a diverse population consisting of the 3 major ethnic groups of Yoruba's, Hausas, Ibos, as well as several other minority ethnic groups. The State serves as a gateway city between the Northern and Southwestern parts of Nigeria.

Study Population

The study population were women who had a vaginal delivery in the 6 weeks preceding the study, irrespective of place of delivery and attended any of the pre-identified immunization clinics to receive immunization for their newborn. Women who had Caesarean, preterm or instrumental vaginal delivery and women with multiple delivery in which one of the babies suffered a mortality were excluded from the study in order to maintain similarity between mode of delivery and rule out the possible effect of adverse perinatal outcome, and post-operative complications on the outcome of the study.

Study Design

It was a quantitative cross-sectional study using an interviewer-administered questionnaire to 271 women who presented within 6 weeks of birth, for childhood immunization at any of three pre-selected child immunization clinics in Ilorin. Convenience sampling was performed to identify 3 immunization centers within Ilorin metropolis viz: UITH maternity hospital, civil service clinic and SOBI specialist hospital.

Adequate information about the study was provided to the respondents, consent obtained, and reassurance provided about confidentiality. Due interpretation in the local language was performed when necessary. All consecutive and consenting mothers who met the inclusion criteria were recruited by trained research assistants until the desired sample size was attained. Reported disrespect and abuse during childbirth was determined under various categories. Administered questionnaires contained sections on socio-demographic characteristics, obstetric history, and questions regarding experiences of disrespect and abuse during their most recent childbirth. All information obtained was entered into the questionnaire and confidentiality was ensured.

Data Analysis

The data obtained was analyzed using the Statistical Package for the Social Sciences (SPSS) software package, version 21.0; Chicago, Illinois, USA).Statistical significance was elicited using the chi-square test and student's *t*-test. A p-value of < 0.05 was taken as statistically significant. Linear regression analysis was used to estimate the independent association of factors associated with disrespect and abuse during childbirth.

Results

Sociodemographic and obstetric characteristics of respondents

More than half of respondents' (58.3%) belonged to the 25-29 year age group while only one (0.4%) respondent was above 40 years old. The mean age was 27.67 ± 3.85. Majority of re-spondents were

Table 1: Socio-demographicvariables N=271

Variables	Frequency	Percentage
Age Groups		
≤24	41	15.1
25 – 29	158	58.3
30 – 34	56	20.7
35 – 39	15	5.5
≥40	1	0.4
Mean ± SD	**27.67 ± 3.85**	
Religion		
Islam	185	68.3
Christianity	86	31.7
Occupation		
House wife	38	14.0
Trader	107	39.5
Artisan	81	29.9
Civil Servant	28	10.3
Students	17	6.3
MaritalStatus		
Single	3	1.1
Married	268	98.9
EducationalLevel		
No formal education	27	10.0
Primary	35	12.9
Secondary	135	49.8
Tertiary	72	26.6
Islamic	2	0.7

Table 2: Birth attendantpresent at delivery

Variables	Frequency	Percentage
Doctor	108	39.9
Nurse midwife	140	51.7
Student nurse/midwives	2	0.7
Traditionalbirth attendant	17	6.3
Relatives	4	1.5

Table 3: Treated poorly during delivery as a result of:

Variables	Yes (%)	No (%)
Age	14 (5.2)	257 (94.8)
Parity	16 (5.9)	255 (94.1)
Educationalstatus	12 (4.4)	259 (95.6)
Religion	11 (4.1)	260 (95.9)
Ethnicity	11 (4.1)	260 (95.9)
Social class	11 (4.1)	260 (95.9)

Table 4: Disrespect by health care worker

Variables	Frequency	Percentage
Health personnelshow disrespect		
Yes	22	8.1
No	249	91.9
Details of disrespect	n=22	
Abuse by nurse	13	61.9
Angry at patient because of referral	5	23.8
Others	3	14.3

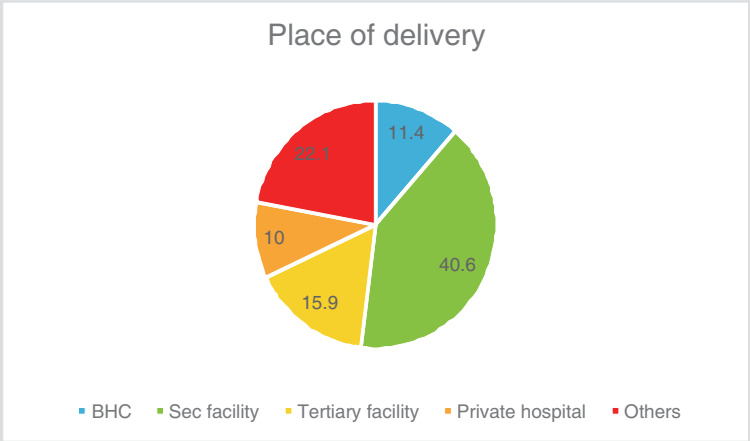

Figure 1 : Place of Delivery

Table 5: Experiences during last delivery

Variables	Yes (%)	No (%)
Pain relief was provided	60 (22.1)	211 (77.9)
Informed before episiotomy	25 (9.2)	246 (91.8)
Anaesthesia before episiotomy	86 (31.7)	185 (68.3)
Anaesthesia before episiotomy or perineal laceration was sutured	103 (38.0)	168 (62.0)
Health care worker respond quickly	173 (63.8)	98 (36.2)
Left alone by health workers when in need of support	31 (11.4)	240 (88.6)
Abandon for a long time during last delivery	39 (14.4)	232 (85.6)
Encouraged to call for assistance if needed	167 (61.6)	104 (38.4)
Ignored when calling for help	29 (10.7)	242 (89.3)
Left to deliver without assistance	18 (6.6)	253 (93.4)
Neglected after delivery	17 (6.3)	254 (93.7)
Unnecessarily separated from baby	5 (1.8)	266 (98.2)
Unduly detained due to lack of payment of medical bill	17 (6.3)	254 (93.7)
Feel unsafe during labour	65 (24.0)	206 (76.0)
Respectful and non judgmental care received	167 (61.6)	104 (38.4)

Muslim (68.3%), married (98.9%) and had at least a secondary school education (76.4%). (Table 1).

The commonest occupation among the study respondents was trading (39.5%) while 29.9% were artisans. The commonest place of delivery of study respondents were secondary health care centres (40.6%). Less frequent places of delivery were tertiary centers (15.9%), basic health centers (BHC) (11.4%) and private hospitals (10%). Other respondents either delivered at home, at a spiritual home or with a traditional birth attendant (Figure 1). The commonest birth attendant were mid- wives in 51.7% (140) of deliveries, while delivery was attended by a doctor in 39.9% (108), TBA in 6.3% (17) and relatives in 1.5% (4). (Table 2).

Types of disrespect and abuse during childbirth experienced by respondents

Regarding physical or verbal abuse during childbirth, 18 (6.6%) respondents reported that they experienced some form of abuse during their last delivery with 17 (17/18; 94.4%) of them reporting verbal abuse while 1 respondent was actually hit during delivery.

When asked about their experiences in their immediate past delivery, a majority of respondents (over 94%) did not believe they were treated poorly as a result of their age, parity, religion, social class or level of education; however, 5.9% were of the view that they were treated poorly as a result of their parity, and 5.2% as a result of their age (Table 4). Only 22 respondents felt they were treated with disrespect by the care giver (8.1%); examples of disrespect reported included abuse by a nurse in 13 women; while 5 women observed that the health worker was angry that they were referred to that health care facility.

Regarding non-consented care, 91.8% of respondents, received episiotomy without being told beforehand, and only about one-third(31.7%)received local anesthesia prior to episiotomy,

Two hundred and forty women (88.6%) reported being left alone for prolonged periods without

any support, 29 (10.7%) reported being ignored when they called for help, 18 (6.6%) said they were left to deliver alone without assistance, 17 (6.3%) were neglected after delivery, 6.3% were unduly detained at the facility due to lack of payment of bills, and about a quarter of respondents(65/271, 24%) felt unsafe during labour. Despite the foregoing however, more than half of respondents (167, 61.6%) still believed they received respectful and non-judgemental care and majority of respondents (259, 95.6%) were satisfied with overall care received. Most respondents (238, 87.8%) would recommend the health care facility where they had their last delivery to other women.

When asked to suggest areas of improvement at the facility at which they had their last child birth, over half of respondents (147; 54.2%) opined that it was imperative to ensure respectful manner among the health care practitioners; 36.5% (99) women believed there should be improved monitoring of women during labour; 66 (24.3%) were of the opinion that there was a need to improve staff strength; and 59 (21.8%) believed there was need to improve privacy at the health facilities; other recommended areas for improvement were to be allowed any birth position and to be allowed a companion of choice in labour.

Discussion

In 2017, Nigeria was one of the two countries with the highest estimated numbers of maternal deaths, contributing 23% to global maternal deaths.[4]There is evidence to support the fact that skilled care during and after childbirth can help to reduce these unacceptably high numbers.[5,6]Although the 2018 national demographic health survey found that about two-thirds of women in Nigeria receive antenatal care from a skilled health provider, a little over one third deliver at a health facility and a skilled provider was present in less than half of births.[2]

This study investigated women's experiences of disrespect and abuse during childbirth in Ilorin, North central Nigeria. Over three-quarters of respondents had their last delivery conducted at a health facility, with over one-thirds delivering at a secondary health care facility, and less than 20% having a home delivery. This differs from the findings of the 2018 NDHS which observed that only 39% of women surveyed had their last delivery at a health facility.[2]This difference may be due to the difference in the population of women studied. This study was carried out in an urban center and in a majorly educated population unlike the NDHS which surveyed both urban and rural women who may likely have different educational background and health-seeking behaviour. To further support this, when comparing urban to rural births, the NDHS found that 61% were delivered in a health facility while only 26% of rural births occurred in a health facility.[2]

Presence of a skilled birth attendant has been found to have a major impact on reducing maternal and perinatal mortality. This study found that a majority of respondents (91.6%) had their last delivery supervised by a skilled birth attendant. This differs from findings from the 2018 NDHS in which less than half of deliveries were attended by a skilled birth attendant.[2]Similarly, to the findings of the NDHS however, midwives were found to be the most frequent birth attendant at deliveries in this study although this study also observed a disproportionately higher number of deliveries attended by medical doctors when compared to findings from the NDHS (39.9% versus 9%). This is probably due to the finding of two-thirds of deliveries occurring in either a secondary, tertiary or private hospital among this study respondents. Respondents may also have been unable to distinguish between the various cadres of health workers present at delivery particularly if the staff at these places wear scrubs without any name tags or identification.

Despite respondent's experiences of various forms of disrespect and abuse during facility child-birth however, majority (91.9%) of respondents denied experiencing disrespectful maternity care. Examples of disrespectful behaviour however reported to have been experienced by respondents included verbal abuse, being abandoned for a long time, being ignored after calling for help, receiving disrespectful and judgmental care, use of unfriendly language, receiving episiotomy without being told before-hand,healthcare practitioner being angry that patient was referred to that facility, among others. Despite experiencing the foregoing however, most respondents denied having experienced disrespect and abuse during childbirth. This finding is similar to findings by Asefa et al in Ethiopia who observed that despite identifying occurrences of disrespect and abuse in over three-quarters of women, only 16.2% reported that they had experienced disrespect and abuse. [5] This may be as a result of the patriarchal nature of healthcare where it is believed that the health-care provider can 'do no harm', or the respondents did not perceive these actions as being disrespectful. It is interesting to note however that over half of respondents when asked about what they would like to be changed at the facility where they had their last delivery, stated that they would like to see healthcare workers treat women with more respect during childbirth. This study was carried out among recently delivered women at child immunization clinics in order to remove possible fear of reprisals from the study respondents. However, it appears that despite these measures taken by the researchers, the respondents still experienced some reluctance in categorically stating that they experienced disrespect and abuse during facility delivery.

Conclusion

There is a high occurrence of disrespect and abuse during facility childbirth in Ilorin metropolis. Disrespect and abuse were also seen to occur at different scales during facility childbirth in Ilorin. There is a reluctance among women to label the care they received during their most recent childbirth as being disrespectful or abusive. This may be because they do not want to appear as being critical of the health care providers at these facilities even though this study was carried out outside these facilities. There appears to be a disconnect between women's actual child-birth experiences and their perception of whether these experiences were disrespectful or abusive. It is important to find out providers attitudes to occurrences of disrespect and abuse during facility childbirth in order to proffer solutions to ending this menace. When women are assured of being respected during childbirth, it is likely to translate to an increased confidence in the formal health sector resulting in improved utilization of antenatal and delivery services and a resultant decrease in maternal and perinatal morbidity and mortality. There is also a need to improve education of women and providers about what constitutes disrespect and abuse during childbirth.

References

1. National Bureau of Statistics. 2017 Demographic statistics bulletin.
2. Nigeria Demographic and Health Survey 2018. National Population Commission (NPC) [Nigeria] and ICF. 2019. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF. Available at https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf. Accessed 21/02/21
3. WHO. Maternal health in Nigeria: generating information for action. Available at https://www.who.int/reproductivehealth/maternal-health-nigeria/en/. Accessed 2/01/2021.
4. Trends in maternal mortality 2000-2017. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the UN Population Division.Available at https://data.unicef.org/resources/trends-maternal-mortality-2000-2017/. Accessed 30/03/21
5. AntenehAsefa, DelayehuBekele. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reproductive Health 2015, 12:33.available at http://www.reproductive-health-journal.com/content/12/1/33#B9. Accessed 30/01/21
6. WHO. Maternal mortality key facts. https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality. Accessed 30/01/21
7. Kruk ME, Paczkowski M, Mbaruku G, de Pinho H, Galea S. Women's preferences for place of delivery in rural Tanzania: a population-based discrete choice experiment. Am J Public Health 2009; 99: 1666–72.
8. Leonard K. "Active patients" in rural African health care: implications for research and policy. Health Policy Plan 2014; 29: 85–95.
9. Bohren M, Hunter EC, Munther-Kaas HM, Souza JP, Vogel JP, Gulmezoglu AM. Facilitators and barriers to facility-based delivery in low- and middle-income countries: A systematic review of qualitative evidence. Submitted to Reprod Health. 2014.
10. Heshima project. Available at:http://www.health.go.ke/websitedocs/HRH%20REPORTS/Heshima%20Project%20Brief%202014.pdf. Accessed 6/02/2021
11. Lynn P Freedman, Margaret E Kruk. Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. www.thelancet.com Vol 384 September 20, 2014. pages e42-e44. available at http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)60859-X.pdf.
12. Bowser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth. Report of a Landscape Analysis. USAID-TRAction Project. Harvard School of Public Health University Research Co., LLC. September 20, 2010
13. RMC Charter. available at http://impatientoptimists.org/Posts/2012/01/Take-Action-Respectful-Maternity-Care-is-a-Universal-Right#.VUo-qYs-C9a