Original article

"Respectful Maternity Care" or "Disrespect and Abuse during Maternity Care"; Experience of Pregnant Women in Ogbomoso, South West Nigeria

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ABSTRACT

Introduction: Globally, "Respectful maternity care" is gaining muchdeserved recognition and attention from experts working in the field of reproductive health. Disrespect and abuse have been common in maternal and child health care delivery, hence deterring women in seeking proper health services.

Objectives: This article places emphasis on the understanding of the experience of respectful maternity care or disrespect and abuse during maternity care in the past amongst women currently receiving antenatal care in Bowen University Teaching Hospital, Ogbomoso, Southwest Nigeria.

Methods: A cross-sectional study was carried out on 438 women receiving antenatal care in Bowen University Teaching Hospital to determine whether they had experienced disrespect and abuse during maternity care in the past or not.

Results: The study showed that 93.2% (408) of the respondents had experienced one form of disrespect and abuse. Sociodemographic variables were a significant contributor to the knowledge and experience of respectful maternity care.

Discussion: There is an important need to ensure a reorientation of healthcare workers and health education to the members of the community.

Keywords: Respectful maternity care; Disrespect and Abuse; Maltreatment Hospitals, Maternity; Nigeria; Africa

INTRODUCTION

Over the years, the focus on improving service delivery by government and non-governmental organizations has been based on quality of staff, their skills, treatment protocol, and availability of medical supplies in a satisfactory healthcare facility [1, 2]. However, for patients choices have to be made; these choices have potential consequences associated with them. These choices include the need to seek health care in a health facility or to even seek health care with traditional health care givers.

Bowser and Hill's landscape analysis on facility based childbirth in 2010 categorized the adverse behaviors of disrespect and abuse during maternity care into seven types: physical abuse, non-consented care, nonconfidential care, non-dignified care and verbally abused, discrimination, abandonment of care and detention in facilities [2]. Despite the acknowledgement of these problems as widespread, there is paucity of information on this subject. Research in Nigeria reveals that the practice of disrespect and abuse in maternity care is as high as 98% [3]. This indicates the burden posed by abuse to the quality health care delivery in Nigeria. A recent survey in Kenya, found that the poor practice of respectful maternity care discourages many women from facility based births due to traditional birthing attendants giving women more respect during childbirth than professional health care givers [4]. In a multi facility based survey conducted in Burkina Faso on Respectful Maternity Care, the Key issues included good reception, humanistic clinical examination, attentive listening and responsiveness to patient needs, privacy, discretion, and confidentiality, availability and comfort. It was observed that poor working conditions were found to negatively impact the quality of care. High staff turnover, frequent technical malfunctions, and inadequate infrastructure were identified as issues that require future focus to ensure improvements in quality of care are sustainable [5]. Surveys carried out in Ethiopia, Madagascar, Rwanda, and Tanzania also show the burden of disrespect and abuse as a deterrent to quality health care delivery [6]. It can be concluded that promoting respectful maternity care will be of an immense benefit in improving maternal health and child health care delivery, thus helping towards the achievement of the health related Sustainable Development Goals (SDGs) proposed in 2014 to the United Nations General Assembly targeted to be achieved by 2030. Hence, achieving this will go a long way towards ensuring an increased proportion of births attended by skilled birth health care givers [7].

Disrespect and abuse of women seeking maternity care is becoming an urgent problem and creating a growing concern that spans the domain of health care research, quality, human rights and civil rights advocacy [2, 6]. This study was embarked upon as an audit to ascertain the burden of disrespect and abuse during maternity care either in the past or present amongst pregnant women currently receiving antenatal care in Bowen University Teaching Hospital, Ogbomoso, South west Nigeria.

METHODS

A cross-sectional study was carried among 438 pregnant women currently attending antenatal clinic in Bowen University Teaching hospital, Ogbomoso, Southwest Nigeria. The duration of the study was greater than six (6) months. The pregnant women involved in the study were selected by balloting, the women were free to decline participation in the study. The criteria to be included was pregnancy in apparently healthy woman, while those that were ill were excluded from participation in the study.

Data was obtained using a structured questionnaire; the questionnaire was designed to contain the seven measures of disrespect and abuse as itemized by Bowser and Hills landscape study. Information obtained from the participants included socio-demographic characteristics, their experience of disrespect and abuse during maternity care in the past and present, especially as it concerns the pregnancy, delivery and postpartum experiences. The questionnaire was simple to read and understand.

A pretest was done prior to the commencement of the study. Women who do not understand English language had their questionnaires administered to them by trained interpreters. None of the women were interviewed more than once.

The minimum sample size was calculated using the Lesley Kish formula for estimating single proportion. The precision was set at 5% and correction for nonresponse made. Women who had serious co-morbid health conditions in pregnancy and those who failed to give their consent were excluded from the study.

Data was analyzed using SPSS (Version 17). Initial analyses were done by generating frequency tables and graphs. A Chi-square test was carried out to assess statistical association between relevant variables. The level of statistical significance was set at a p-value of less than 0.05.

Ethical approval for this study was obtained from Bowen University Teaching Hospital's Research and Ethics Committee. A written informed consent was obtained from all respondents. The participation of women attending the antenatal clinic was voluntary and their confidentiality was assured.

RESULTS

A total of 438pregnant women were interviewed. The mean age of these women was 31.29 ± 4.24years and their mean gestational age was 32.39±5.27 weeks. Three hundred and twelve (312; 71.2%) of these women had had one or more parous experience (Table 1).

Table 1: Socio demographic variables of respondents, awareness of respectful maternity care and experience of disrespect during maternity care.

Socio demographic variables	Frequency (N = 438)	Percent	Aware of respectful maternity care		Experience of disrespect during maternity care	
			Yes	p-value	Yes	p-value
Age group			N=354 (%)			
≤ 25	18	4.1	18 (5.0)	0.012*Y	18 (100.0)	0.692Y
26 – 30	192	43.8	144 (40.0)		180 (93.8)	
31 – 35	168	38.4	138 (40.0)		156 (92.9)	
36 – 40	48	11.0	42 (12.0)		42 (87.5)	
> 40	12	2.7	12 (3.0)		12 (100.0)	
Ethnicity						
Yoruba	378	86.3	318 (90.0)	<0.001*Y	348 (92.1)	0.438Y
Igbo	36	8.2	24 (7.0)		36 (100.0)	
Hausa	6	1.4	0 (0.0)		6 (100.0)	
Others	18	4.1	12 (3.0)		18 (100.0)	
Occupation						
Professional	300	68.5	264 (75.0)	0.002*	288 (96.0)	<0.001*
Skilled labor	114	26.0	72 (20.0)		96 (84.2)	
Unskilled labor	24	5.5	18 (5.0)		24 (100.0)	
Educational status						
Tertiary	372	84.9	324 (92.0)	< 0.001*Y	348 (93.5)	0.011Y*
Secondary	24	5.5	6 (2.0)		18 (75.0)	
Primary	30	6.8	12 (3.0)		30 (100.0)	
No formal education	12	2.7	12 (3.0)		12 (100.0)	
Educational status of partner						
Tertiary	354	80.8	Unknown		Unknown	0.027*
Secondary	54	12.3				
Primary	24	5.5				
No formal education	6	1.4				
Parity						
0	126	28.8	84 (24.0)	<0.001*Y	114 (90.5)	
1	198	45.2	180 (50.0)		180 (90.9)	
2	108	24.7	84 (24.0)		108 (100)	
≥ 3	6	1.4	6 (2.0)		6 (100.0)	

χ^2: Chi square; *: Statistically significant (i.e. *p* value < 0.05); Y: Yates corrected Chi square

Table 2 showed how the participants responded to the seven adverse behaviors of disrespect and abuse during maternity care, as proposed by Bowser and Hill.

Table 2: Participants response to the seven behaviors of disrespect and abuse proposed by Bowser and Hill

Disrespect in maternity care	Agree n (%)	Undecided n (%)	Disagree n (%)
Physical abuse	192 (43.8)	36 (8.2)	210 (47.9)
Non consented care	210 (47.9)	48 (11.0)	180 (41.1)
Non confidential care	210 (47.9)	48 (11.0)	180 (41.1)
Non dignified care and verbal abuse	168 (38.4)	54 (12.3)	216 (49.3)
Discrimination based on specific attributes	180 (41.1)	126 (28.8)	132 (30.1)
Abandonment or denial of care	154 (39.7)	96 (21.9)	168 (38.4)
Detention in facilities	150 (34.2)	102 (23.3)	186 (42.5)

Sociodemographic variables have been shown to have a statistically significant relationship with awareness of the various components of disrespect and abuse during maternity care (Table 1). However, there was no statistically significant relationship between sociodemographic variables such as age and ethnicity and experience of disrespect and abuse in maternity care, whereas there was a significant statistical relationship between occupation, educational status, parity and experience of disrespect and abuse in maternity care amongst the respondents

Four hundred and eight (93.2%) of the respondents had experienced one for of disrespect and abuse or the other (Table 1). The most common forms of disrespect and abuse experienced by these women were non-consented care and non-confidential care as shown in Figure 1.

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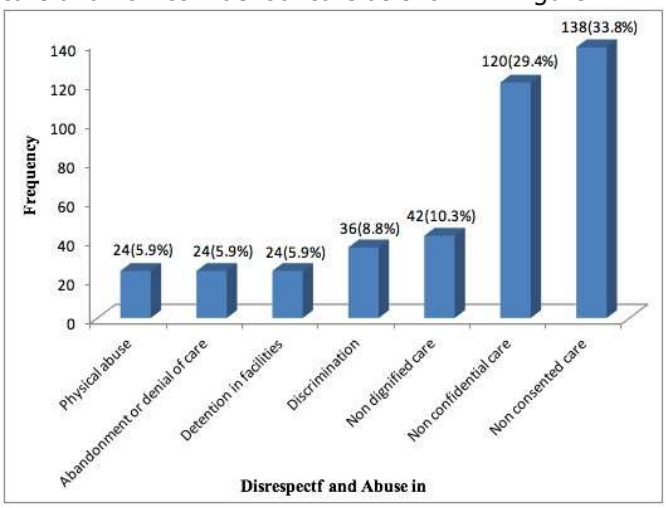

Figure 1: Patients who have experienced disrespect and abuse during maternity care (N = 408)

DISCUSSION

Pregnancy and childbirth are memorable events in the lives of women and their families. However, this period represents a time of intense vulnerability, especially in the hands of healthcare providers. Abuse and disrespect during pregnancy and childbirth is responsible for the low healthcare facility based births amongst the populace, hence resulting in slow progress in the attainment of improved health care delivery [1,5,6,7,8].

The ideal treatment expected from a maternity care provider to a woman during childbirth is of importance to the woman, her unborn offspring and the entire family [10]. Naturally, a relationship characterized by empathy, support, trust, confidence, and empowerment, as well as gentle, respectful and effective communication enabling informed decision making is expected. Unfortunately, many women experience care that does not match this image too often.

As a growing body of anecdotal and research evidence collected in maternity care systems worldwide paints a disturbing picture [10,11,12]. This is an urgent problem which creates a growing concern that spans the domains of health care research, quality, human rights and civil rights advocacy [8].

Research revealed that the burden of disrespectful maternity care is high, though grossly underreported by those who experience it. In fact, some women see it as normal to be ill-treated during maternity care [12]. Disrespect and abuse during maternity care had been experienced by 93.2% of our respondents. The majority (89.7%) of the women admitted experiencing disrespect and abuse from healthcare workers in the hospital setting. This was similar to the reports from other parts of the developing world [13]. Abuse and disrespect during pregnancy and childbirth is why most women only report to the hospital for care as a last resort [13].

Using the Bowser and Hills landscape analysis on facility based childbirth in 2010, non-consented care and nonconfidential care were the major forms of disrespect and abuse experienced, where as physical abuse, nondignified care including verbal abuse, discrimination based on specific attributes, abandonment or denial of care and detention in facilities were not considered as strong contributors of disrespect and abuse in maternity care by these women. This finding further emphasizes the need for enlightenment campaigns to women of reproductive age on their reproductive health rights, and also places emphasis on the training and retraining of healthcare givers to ensure that women are given quality maternity care.

Non-Governmental Organizations (NGOs) and Government Agencies need to ensure that the financial and geographical barriers and poor quality of healthcare services rendered in our hospitals improve to serve as a means of increasing the number of women who seek healthcare in health facilities in Sub-Saharan Africa [13]. Evidence in Rwanda has shown that healthcare behavior can change with investment in teaching and mentoring programmes [14].

CONCLUSION

Disrespect and abuse in maternity care has been with us for quite some time though not initially recognized as a deterrent to healthcare delivery; with the advent of the concept "respectful maternity care", disrespect and abuse are now being recognized as a masquerade limiting quality health care delivery. There is an urgent need for policy makers working in the field of reproductive health to embark on a behavioral change communication program for healthcare workers and the populace to enhance patronage of skilled birth attendants, thereby reducing the maternal and child morbidity and mortality figures in Nigeria. Hence, programs that aim to improve the maternity experience by linking good practice with humanistic care merit should be embarked upon in healthcare facilities in Nigeria and other Sub-Saharan African countries.

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