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Disrespect and abuse of women during childbirth in selected health facilities in Sokoto metropolis, Nigeria

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Abstract

Background: The promotion of respectful care during delivery is of utmost importance if the goals of attainment of quality health care and utilization of skilled birth attendants in our health facilities are to be achieved. This study sought to assess the prevalence, forms, and factors associated with Disrespect and Abuse (D&A) of women during childbirth in Sokoto metropolis of Sokoto state.
Method: A descriptive cross-sectional design was used to study 290 women who had facility-based delivery within the past eight weeks in Sokoto metropolis and were attending childhood immunization or family planning clinics. Data was collected using a set of structured questionnaire and was analyzed using IBM SPSS version 23 computer software. Level of statistical significance was set at $p<0.05$ and approval for the study was obtained from the Research Ethics Committee of Usmanu Danfodiyo University Teaching Hospital, Sokoto while written informed consent was obtained from respondents after explaining the objectives of the study to them.
Results: A total of 57 (19.7%) of the respondents had experienced at least one form of D &A with bad attitude accounting for 75.4%, followed by Physical abuse (50.9%). Nurses and Midwives ranked highest (78.9%) among the perpetrators of D&A. Emotional distress, injury and death of baby were some of the negative effects of D&A.
Conclusion: The incidents of D&A have wider implications for the utilization of maternity services and maternal mortality. There is an urgent need for the training and re-training of health workers about respectful maternity care in Nigeria.

Keywords: Disrespect, abuse, delivery, maternity, Nigeria

Introduction

Every country and community worldwide sees pregnancy and childbirth as momentous events in the lives of women and families and represent a time of intense vulnerability, therefore, the relationship of the woman with maternity care providers and the system during pregnancy and childbirth is of great importance. These encounters no doubt serve as the vehicle for essential and potentially lifesaving health services and thus women's experiences with caregivers at this time have the potential to empower, comfort or inflict longer lasting damage and emotional trauma.[1]

Access to secure and high-quality sexual and reproductive health services is an essential right for women as these services make important contributions towards the reduction of maternal morbidity and mortality rates.[2] In Sokoto State, Nigeria, data from the 2018 NDHS showed that 24.3% of women who gave birth in the 5 years

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preceding the survey received antenatal care from a skilled provider at least once for their last birth, 30.7% of women had four or more ANC visits, 7.8% were delivered in a health facility, while only 12.9% of births were assisted by skilled providers.[3] The non-utilization of maternal health services has severally been attributable to several factors including long travel time and distance to health facilities, high cost of health services, negative attitude of health workers, long patient waiting time, and widely held traditions and customs that are at variance with modern health care delivery system.[4-7]

In Nigeria, access to routine maternity care is yet to be guaranteed for the vast majority of women during childbirth, however, findings from recent studies indicate that women using skilled birth attendants during childbirth are more often than not subjected to poor quality of care in form of abusive and disrespectful care.[8,9] Disrespect and abuse during childbirth are defined as "interactions and facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified"[10], including any form of inhumane treatment or uncaring behavior towards a woman during labor and delivery.[11]

Most of the time, in low-income countries, women do not get their expected quality of care and level of respect from the healthcare providers at healthcare facilities.[12,13] When the women are treated disrespectfully, their negative encounter with health workers during delivery leaves long-lasting damage and emotional trauma. These concurrences adversely affect skilled birth attendance during their subsequent deliveries.[14-16]

Disrespectful treatment may be due to absent or inadequate national human rights policies and their enforcement, lack of leadership in the health system, poor standards of care in facilities, provider demoralization, and shortages.[17] Recent studies have demonstrated that women across the world have experienced mistreatment during childbirth at facilities.[18-23]

Disrespect and abuse during childbirth can occur in various forms such as being shouted at, ignored, slapped by healthcare providers, and abandoned to deliver a child alone in health facilities.[24-26] However, D&A has broadly been categorized into seven domains as physical abuse, discrimination, non-consented care, non-dignified care, abandonment or neglect, non-confidential care, and detention in health facilities.[27]

Globally, many women experience D&A during childbirth, and this mistreatment cuts across all income levels and at all locations. Previous studies conducted in various countries have shown that 27.2 to 98% of women experienced at least one type of disrespectful and abusive behavior from care providers during facility-based childbirth.[19,28-32]

Studies have shown that some groups such as adolescents, unmarried women, women with Human Immuno-deficiency Virus/Acquired Immuno-deficiency Syndrome and those from low socio-economic status are, however, more vulnerable to experiencing D&A compared with their counterparts.[27] Several factors including poor communication between women and healthcare providers; inadequate healthcare policies; prejudices from healthcare providers; and low morale of healthcare providers in poorly performing health facilities have been identified to contribute to D&A in health facilities.[10,16,24]

Several adverse consequences of D&A on women's health and well-being have been reported including increased morbidity, mortality and risk of birth complications;[33] poor self-rated health, sleeping problems, and signs of post-traumatic stress disorder;[34] and subsequently the reluctance to use services provided by health facilities.[27]

Globally, there is a high prevalence of D&A in healthcare facilities, ranging from 15 to 99%;[10] the prevalence of D&A in one tertiary teaching hospital in Ethiopia was 91.7%,[32] 33.3% in Mexico,[35] and 71.0% in India.[36] Considerably higher prevalence rates have been recorded in some African countries,[37-39] including Nigeria, with the prevalence rates among women during childbirth in health facilities ranging between 23.7–98%.[6,8,40]

The World Health Organization (WHO) has provided stronger guidance for the prevention and elimination of disrespect and abuse in childbirth,[41] issued new recommendations on intrapartum care for a positive birth experience,[42] and developed an agenda (along with UNAIDS) for zero discrimination in health care. This study was therefore aimed at determining the prevalence, pattern and factors associated with disrespect and abuse of women during childbirth in selected health

facilities in Sokoto State. It is hoped that policy briefs will be developed from the findings of this study that will help policymakers and program officers at various levels of governance to come up with suitable interventions that will nip in the bud the menace posed by D&A.

Methodology

Background to study area: This descriptive cross-sectional study was carried out in Sokoto metropolis, the capital city of Sokoto state, Nigeria. Sokoto state is made up of twenty-three 23 local government areas (LGAs) out of which four are metropolitan, these include Sokoto North, Sokoto South, Wammako, and Dange Shuni LGAs. The health facilities in the metropolis comprise Health Posts, Dispensaries, Basic Health Clinics and Primary Health Care Centers, General and specialist hospitals, private hospitals, as well as the State Specialist Hospital and the Usmanu Danfodiyo University Teaching Hospital (UDUTH). Maternal and immunization services are rendered by most primary health care centers, all secondary and tertiary health centers.

Study Subjects and sample size

The study respondents comprised of all women who had facility-based delivery within the past eight weeks in Sokoto metropolis and were attending childhood immunization or family planning clinics. Using the formula for a descriptive study in a population of less than 10,000 a sample size of 294 was obtained after correcting for non-response.

Sampling technique

A multistage sampling technique was used to select the eligible respondents for the study.

Stage 1: Using simple random sampling by balloting, two (2) LGAs, namely Sokoto South and Wamakko were selected out of the four metropolitan LGAs. The health facilities in each of the selected local governments were line listed and that constituted the sampling frame, and then categorized into primary, secondary and tertiary.

Stage 2: Using simple random sampling by balloting, two primary health care centers and one secondary and tertiary health facility were selected. The days each of the selected facility carried out postnatal care (PNC) and immunization clinics were noted and the average number of women that attended PNC/Immunization clinics per month was also obtained from the facilities. Proportionate allocation (PA) was done to get the number of participants to be enrolled in each of the facilities per LGA as follows:

PA (n) = Average no. of women that attend PNC/Immunization per month in one selected facility/Total number of pregnant women that attend ANC/month in all selected facilities X sample size

Stage 3: Systematic sampling technique was used to enroll participants into the study; to obtain the sampling interval, the average number of PNC/Immunization clinics attendees in a health facility (representing 'N' the population) was divided by the sample size proportionally allocated to that facility (representing 'n'). The Sampling interval, k= N/n; was calculated for all the selected health facilities to get their sampling interval respectively. Eligible participants were numbered according to their seats, and by balloting, the first study participant was selected then subsequent participants were enrolled by adding the value of the sample interval to the serial number of the previously enrolled participant.

Data collection instrument

The data was collected using a semi-structured interviewer-administered questionnaire comprising of the following sections:

Section A: socio-demographic characteristics of respondents

Section B: Prevalence and pattern of Disrespect and Abuse

Section C: Perpetrators of Disrespect and Abuse

Section D: Consequences of disrespect and abuse

Data collection method

Six research assistants (RAs) comprising Resident Doctors and final year Medical students from the Department of Community Medicine, Usmanu Danfodiyo University Teaching Hospital Sokoto were recruited and trained on the objectives of the study and the general administration of the study instruments. The questionnaire was pre-tested in a facility outside the study area among women who met the inclusion criteria and the data from the pre-test was used to validate the questionnaire

Data was collected using Open Data Kit (ODK) Collect App, the questionnaire was built in Excel

(xlsx format) and loaded into the ODK (xml format), and later downloaded via a server on all the RAs smartphones or tablets via Google play store. Data collection was carried out in the various PNC and immunization clinics of the selected health facilities. Completed forms were extracted from ODK in Excel format, followed by data export to IBM® SPSS version 25.

Data Analysis

Exploratory data analysis was done to identify errors and determine the distribution of the data, this involved running descriptive statistics of all variables and the use of graphs like histograms and box plots (for continuous variables) to identify odd values, missing values, outliers and skewness of the data.

Quantitative variables were summarized using mean and standard deviation while categorical variables were summarized using frequencies and percentages.

Oyedeji's scoring method was used to classify respondents into different socio-economic classes (class I-V) using socio-economic index scores based on their occupation and educational attainment.[43] The mean of four scores (two for the husband and two for the wife) to the nearest whole number was the social class assigned to the respondent. For example, a husband who was a university lecturer scored 1 for his occupation and 1 for his education as a graduate, if the wife was business woman with the school certificate level of education, she scored 1 for her occupation and 3 for her education. The total of these four scores for the husband and wife was six (i.e., 2 for the husband and 4 for the wife) with an average of 1.5; when taken to the nearest whole number was 2. Thus, the social class assigned to the respondent was II. These social classes I to V were later categorized as:

Upper class (class I and II combined), Middle class (class III) and Lower class (class IV and V combined).

Dependent variables were the prevalence of disrespect and abuse, the pattern of disrespect and abuse while Independent variables were sociodemographic characteristics of the respondents, socioeconomic class, and place of delivery.

Frequency of socio-demographics, mean age of respondents, as well as prevalence and pattern of disrespect and abuse, were computed while the Chi-square and Fisher's exact tests were performed to assess the association between respondents' socio-demographic characteristics and the prevalence of disrespect and abuse among the respondents. Statistically significant associations were subjected to multivariate analysis. The level of statistical significance (α) for the analysis was set at $P < 0.05$ (i.e., 95% confidence interval).

Ethical consideration

Approval for the study was obtained from the Health Research Ethics Committee of Usmanu Danfodiyo University Teaching Hospital Sokoto. Permission to conduct the study was sought from the Sokoto state Ministry of Health, various heads of the departments and units of the respective health facilities. Written informed consent was also obtained from the respondents after explaining the purpose of the study to them.

Table 1: Sociodemographic characteristics of the respondents

Variable	Frequency n = 290	Percentage (%)
Age		
<20	6	2.1
20-29	205	70.7
30-39	71	24.5
≥40	8	2.8
Religion		
Islam	267	92.1
Christianity	23	7.9
Tribe		
Hausa	219	75.5
Fulani	40	13.8
Yoruba	16	5.5
Igbo	11	3.8
*Others	4	1.4
Marital status		
Single	2	0.7
Married	286	98.6
Widowed	1	0.3
Separated	1	0.3
Parity		
1	52	17.9
2 – 4	192	66.2
≥5	46	15.9
Place of last delivery		
Private hospital	13	4.5
PHC	56	19.3
Sec health facility	133	45.9
Tertiary	88	30.3

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Results

Of the 294 questionnaires administered, 290 were fully completed and used for analysis giving a response rate of 98.6%.

The ages of the respondents ranged from 18 to 45 years with a mean of 27.0 ± 4.7. Most, 205 (70.7%) were within 20 – 29 years of age, 267 (92.1%) were Muslims, and 219 (75.5%) were Hausa by tribe. The majority 286 (98.6%) of them were married, more than half 192 (66.2%) had 2 – 4 children. Most, 133 (45.9%) of the deliveries were in a secondary health facility (Table 1).

Table 2: Socio-economic class of respondents

Variables	Frequency n = 290	Percentage (%)
Educational level (Husband)		
University graduate or equivalent	122	42.1
School certificate, (Ordinary level GCE) who also had teaching or other professional training	124	42.8
School certificate or grade 2 teachers certificate holders or equivalents	39	13.4
Modern three and primary six certificate	4	1.4
Either just read and write or illiterate	1	0.3
Educational level (Wife)		
University graduate or equivalent	27	9.3
School certificate who also had teaching or other professional training	78	26.9
School certificate or grade 2 teachers certificate holders or equivalents	108	37.2
Modern three and primary six certificate	58	20.0
Either just read and write or illiterate	19	6.6
Occupation (Husband)		
Senior public servant, manager, professional, large-scale trader, businessman, contractor	79	27.2
Intermediate grade public servant, senior school teacher	161	55.5
Junior school teacher, artisan, driver	42	14.5
Petty trader, laborer, messenger	5	1.7
unemployed, full-term house wife, student, subsistence farmer	3	1.0
Occupation (Wife)		
Senior public servant, manager, professional, large-scale trader, businessman, contractor	5	1.7
Intermediate grade public servant, senior school teacher	49	16.9
Junior school teacher, artisan, driver	40	13.8
Petty trader, laborer, messenger	118	40.7
Socio-economic class		
Upper	109	37.6
Middle	146	50.3
Lower	35	12.1

Table 3: Pattern of Disrespect and Abuse among respondents

Variables	Frequency n = 57	Percentage (%)
Physical		
Use of harsh words at you	29	50.9
Shouted at	16	28.1
Scolded	15	26.3
Delivered in overcrowded labour room	12	21.1
Threatened to withdraw service	8	14.0
Given episiotomy or sutured without anaesthesia	5	8.8
Slapped	3	5.3
Laughed at	3	5.3
Non-consented care		
Episiotomy	6	10.5
Abdominal palpation	1	1.8
Attitude		
Treated unfriendly	43	75.4
Treated rudely	20	35.1
Treated arrogantly	15	26.3
Felt insulted	15	26.3
The personnel report late at work	7	12.3
Privacy		
Too many medical students or other Health workers around	15	26.3
Left uncovered during physical examination	4	7.0
There was no screen during delivery	4	7.0
Abandonment/neglect of care		
Left untreated	6	10.5
Denied necessary care	6	10.5
No encouragement during delivery	5	8.8
Support person or relative not allowed	5	8.8
Detention		
Kept in the hospital against her will	3	5.3
Detained for lack of payment	1	1.8
Discrimination		
Due to young Age	6	10.5
Due to race, ethnicity and economic status.	4	7.0
Due to religion	4	7.0

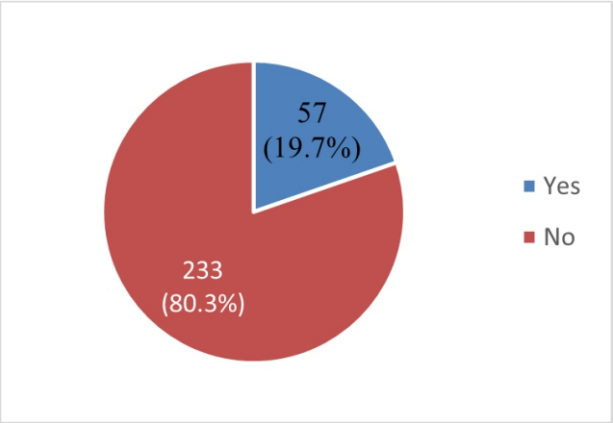

Figure 1: Prevalence of disrespect and abuse

Table 4: Perpetrators of Disrespect and Abuse

Variable	Yes Frequency(%)	No Frequency(%)
Perpetrators of the disrespect or abuse		
Nurse/midwife	45 (78.9)	12 (21.1)
Community health extension workers	13 (22.8)	44 (77.2)
Doctor	10 (17.5)	47 (82.5)
Record officer	5 (8.8)	52 (91.2)
Medical laboratory personnel	4 (7.0)	53 (93.0)
Pharmacist	3 (5.4)	53 (94.6)
Ward attendant	3 (5.3)	54 (94.7)
Potter	1 (1.8)	56 (98.2)

More than a quarter, 124 (42.8%) of the respondents' husbands had attained senior school certificate/ordinary level GCE and professional training; most 161 (55.5%) were intermediate grade civil servants while half, 146 (50.3%) of the respondents were in the middle socio-economic class (Table 2).

About 57 (19.7%) of the respondents had experienced at least one form of disrespect and abuse, while most, 233 (80.3%) did not experience any form of abuse during the last childbirth (Figure 1).

The commonest category of disrespect and abuse experienced by the respondents was bad attitude where 43 (75.4%) of the respondents were treated unfriendly, followed by physical abuse where about half 29 (50.9%) were abused using hash words.

Table 5: Relationship between respondents' socio-demographic characteristics and experience of disrespect and abuse during child birth

	Experience with disrespect and abuse			
Variable	Yes n(%)	No n(%)	Test statistic p value	OR (95% CI)
Age group (years)				
18 – 29	34 (16.1)	117 (83.9)	$\chi^2 = 6.151$	0.468 (0.254 – 0.859)
>29	23 (29.1)	56 (70.9)	p = 0.013	
Social class				
Upper	24 (22.0)	85 (78.0)	$\chi^2 = 0.618$	1.266 (0.702 – 2.283)
Lower	33 (18.2)	148 (81.8)	P = 0.432	
Marital status				
Married	57 (19.9)	229 (80.1)	Fisher's exact = Not available	0.801 (0.756 – 0.848)
Unmarried	0 (0)	4 (100)	p = 1.001	
Tribe				
Hausa/Fulani	50 (19.3)	209 (80.7)	$\chi^2 = 0.188$	0.820 (0.335 – 2.011)
Others	7 (22.6)	24 (77.4)	P = 0.664	
Religion				
Islam	49 (18.4)	218 (81.6)	Fisher's exact = Not available	0.421 (0.169 – 1.049)
Christianity	8 (34.8)	15 (65.2)	P = 0.095	
Parity				
1– 4	48 (19.7)	196 (80.3)	$\chi^2 = 0.000$	1.007 (0.455– 2.227)
5 and above	9 (19.6)	37 (80.4)	p = 0.987	
Place of last delivery				
Private	1 (7.7)	12 (92.3)	$\chi^2 = 4.572$	-
PHC	15 (26.8)	41 (73.2)	p = 0.334	
Secondary	15 (20.5)	58 (79.5)		
Tertiary	57 (19.7)	233 (80.3)		

χ^2 = Pearson's chi square, OR = unadjusted odds ratio, p = 0.005

Table 6: Consequences of Disrespect and Abuse

Variable	Yes n (%)	No n (%)
Any negative effect on health or pregnancy following the experience of disrespect or abuse?	11(19.3)	46(80.7)
If yes, what was the effect *		
Emotional distress	10 (90.9)	1 (9.1)
Made me cry	10 (90.9)	1(9.1)
So much pains	9 (81.8)	2 (18.2)
Injury to me	6 (54.6)	5 (44.4)
Vaginal bleeding	4 (36.4)	7 (63.6)
Injury to the baby	2 (18.2)	9 (81.8)
Death of the child	1 (9.1)	10 (90.9)
Others	1(9.1)	10 (90.9)

*Multiple responses allowed

Only 7 (12.3%) experienced non-consented care (Table 3)

Most, 45 (78.9%) of the respondents admitted that nurses/midwives were responsible for the disrespect and abuse they experienced during childbirth, followed by community health extension workers, while ten doctors were reported as perpetrators of disrespect and abuse (Table 4.)

The proportion of respondents who were >29 years of age that experienced disrespect and abuse was higher 23 (29.1%) than those within 18 – 29 years 34 (16.1%), and the association was statistically significant (p = 0.013). Respondents in the upper social class 24 (22.0%) experienced more disrespect and abuse compared to those in the lower class 33 (18.2%), but the association was not statistically significant (Table 5).

Only 11 (19.3%) of the respondents admitted having negative effects of D&A with most,10 (90.9%) showing signs of emotional distress; one of the respondents believed that D&A caused the death of her newborn child (Table 5).

Discussion

The promotion of respectful maternity care during childbirth is a sine quo non for the effective utilization of maternal health care and prevention of maternal and child deaths in every community. Disrespect and abuse during childbirth and maternity care have been documented throughout the world, thus attracting global attention to this menace.

In this study, the prevalence of D&A observed was found to be 19.7%, which is in agreement with findings from previous researches carried out in Kenya (20.1%),[12] Ethiopia (21.1%),[44] Tanzania (20%)[45] and Ile-Ife, Osun state south-western Nigeria (19%).[46] In contrast to the low prevalence rates in these studies, other studies conducted in Pakistan and elsewhere in Nigeria also found that almost all women (99.7 and 98%, respectively) experienced at least one type of D&A during childbirth.[8,28] In the same vein, the overall disrespect and abuse reported during facility-based childbirth was 70.1% in a study conducted in Pokhara, Nepal.[47] The disparity between the findings from this study and others could be due to the socio-cultural milieu of our study area.

The commonest pattern of D&A reported by respondents who experienced such acts in our study were unfriendly treatment and the use of harsh words by service providers. In a study from South East Nigeria, a gloomy picture of the attitude of health care providers was painted when one of the respondents reported thus, "I think the attitudes of our nurses are bad because they have no respect or mercy for a patient and they insult patients without any provocation";[48] similar findings were reported in previous studies across the globe.[12,27,49] However, in contrast to these findings, Nnebue and colleagues in their study reported a good attitude of the health workers.[50]

About half, (50.9%) of our respondents agreed to the experience of physical abuse in the forms of scolding, slaps, and given an episiotomy without anaesthesia and this conforms with the findings from similar studies in Southeast Nigeria[8] and Kenya[51] where the respondents experienced physical abuse in the hands of the health workers. In most developing nations, physical abuse has been grossly under-reported as it is often perceived by the women and the health workers as a subtle way of assisting the women push the baby out in order to have a safe delivery. Infact, the study by Bohren and his colleagues observed that "this kind of abuse is perceived as an effective way of saving the lives of mother and baby".[16] Anecdotal evidence in some parts of Nigeria has shown women who were disrespected and abused during childbirth engaging

the birth attendants in physical confrontations after recovering from the pains of delivery. This is seen as necessary reaction of a victim who ordinarily should have been pampered by the health worker while going through the agony of labour.

Findings from our study showed that non-consented care was reported by some of the respondents and these were in the form of episiotomy and abdominal palpation without their consent. In the study by Okafor and colleagues from Southeast Nigeria, 54.5% of their respondents reported non-consented care procedures such as augmentation of labor, shaving of pubic hair, sterilization and blood transfusion.[8] Non-consented care and lack of privacy were the most reported abuses during childbirth observed by Banks and colleagues in Ethiopia.[44] Abandonment and neglect of care in the form of a support person or relative not allowed around, no encouragement during delivery or left untreated were reported by some of our respondents. In the study from Kano state, Nigeria it was observed that the commonest types of D&A were abandonment/neglect of care.[52] In another study from Nigeria, Sule and his colleagues noted that 12% of the women were denied companionship during labour.[53] The need for a companion during delivery cannot be overstressed as such companions are better placed to give reassurance and guidance against mistreatment by the attending skilled health worker. This underscores the need for proper education of health workers on the need to allow for the presence of a companion during child birth regardless of socio-cultural restrictions. Similarly, lack of promptness of care and time wasting were reported by a range of 10-24% of women in other studies.[54-56] A global systematic review,[10] and other studies conducted in Nigeria[17] and Kenya[11] also reported the commonest form as abandonment/neglect of care. The healthcare environment in Nigeria is often degrading occasioned by the lack or inadequate facilities, poor remunerations and demotivating, thus breeding workers who invariably become disrespectful and abusive to patients, especially in maternity settings. Moreover, the lack of deterrence for unacceptable health worker behavior can fuel a sense of entitlement.[57] This underscores the need for collaborative efforts to stem this ugly menace if the goals of reducing maternal and child mortalities are to be achieved. According to WHO, "To achieve respectful and non-abusive care during childbirth, health systems must be responsive to specific needs of women at childbirth in a manner that ensures respect for their sexual and reproductive health and human rights".[2]

The need to encourage, support and pamper pregnant women by healthcare workers during the process of labour to achieve good outcome for both mother and the new-born is most desired now than ever before if the goals of SDG 3 to reduce maternal mortality are to be realised. Most times, healthcare workers have exhibited negative attitudes towards women seeking maternity care most especially during the process of childbirth. In this study, nurses/midwives (78.9%) were mostly implicated as perpetrators of D&A against women during child birth, and this may not be unconnected to the fact that they are the gatekeepers and foremost skilled attendants at most deliveries compared to other health professionals. This is consistent with findings from Nigeria.[8,52,58] Kenya[59] and Ghana.[60] In contrast to these findings, Terán and co-workers in Venezuela, found out that doctors were among the principal marked perpetrators of disrespect and abuse during childbirth.[61] In most developing nations, the few doctors available are often overwhelmed by a large number of patients waiting to be attended to and sometimes work in very unfriendly environments with little or no motivation and this most often than not, results in misplaced aggression towards their patients.

Several studies have observed different findings regarding the experience of D&A and socio-demographic characteristics. In our study, only age amongst all the socio-demographic characteristics was found to be significantly associated with D&A, with respondents who were >29 years of age more likely to experience disrespectful and abusive treatment during childbirth. Similar to this was the finding by Terán and colleagues in Venezuela who identified a positive association between dehumanizing treatment and extreme age groups (adolescents and older women).[61] In contrast to these, a similar study observed that respondents aged 20–25 years were 2.3 times more likely to experience disrespect and abuse as compared to respondents >31 years.[49] Okafor and colleagues observed no association between disrespectful or

abusive care during childbirth and any other factor analyzed (maternal age, tribe, marital status, educational status and parity).[8] Similarly, Abuya et al found no association of any type between disrespect/abuse and maternal age, educational level, marital status and the presence of family/friends.[38] In Kenya, women with higher parities were more likely to be detained for lack of payment and to experience non-consensual care compared to those without prior children.[12] In Kano northwestern Nigeria, researchers observed that respondents who were of the Christian faith, of non-Hausa/Fulani ethnicity, and better educated were more likely to report being abused.[52]

Findings from studies carried out 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 opportunities to report abuse.[18] This finding may not be related to the fact that such women are often seen as enlightened and therefore asks too many questions about the actions and inactions of the attending health worker which is seen as an affront to their authority.

The experience of D&A during child birth may have direct adverse consequences for both the mother and infant.[4] In this study, most of the women that experienced disrespect and abuse admitted having signs of emotional distress. This conforms to the findings of Silvera and colleagues who observed increased odds of having postpartum depression amongst women who experienced physical abuse during childbirth.[62] Similarly, it has been observed that verbal abuse in the forms of scolding and harsh words can potentially cause postpartum depression among women during childbirth.[62,63]

Conclusion

Although D&A in maternity care had been with us for long, few researches were carried out in Nigeria to determine its magnitude and associated factors. In the present study, the prevalence of D&A was low with unfriendly treatment by healthcare workers being the commonest pattern and nurses/midwives being the highest perpetrators.

Respectful maternity care provided to a woman during child birth is of utmost importance to her, the unborn child, the entire family and the nation at large so as to encourage facility delivery and skilled attendant thus reducing maternal mortality from the current 1,047 to <200 per 100,000 live births. Health care providers also require training, re-training and support to enable them practice respectful and responsible maternity care in the most effective ways.

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Conflict of Interest

The authors declared no conflict of interest

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