DISRESPECT AND ABUSIVE MATERNITY CARE AND ASSOCIATED FACTORS IN THE LABOR AND DELIVERY WARDS OF PUBLIC HEALTH FACILITIES IN ASSOSA ZONE, ETHIOPIA

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ABSTRACT

BACKGROUND: Disrespect & abuse (D&A) during maternity care significantly affects a woman's decision to look for services and the quality of care she receives. Yet, its burden is not well identified in the developing regions of Ethiopia, specifically in the study area.

METHODS: Facility-based cross-sectional study design was employed. A total of 437 sampled mothers who attended labor and delivery wards of public health facilities of the Assosa zone were recruited using a systematic random sampling method. Data were collected using a semi-structured interviewer-administered questionnaire which consisted of 25 verification criteria. A binary logistic regression model was fitted to determine the presence of a statistically significant association between predictors and outcome variable at p-value <0.05 and AOR with 95% CI using SPSS version 23.0.

RESULTS: The overall prevalence of D&A was 82.4%, (95% CI: 79.4, 86.4). The most reported types of D&A were non-consented care (68.0%), non-confidentiality (35.5%), physical harm (33.6%), and abandonment or denial of care (20.7%) followed by discrimination, detention in health facilities, and non-dignified care, respectively.

CONCLUSIONS: The overall prevalence of disrespect and abusive maternity care in the study area was high. Thus, healthcare facilities especially, hospitals should be given special attention in terms of staffing, training, and motivating care providers to advance the quality of care they provide.

KEYWORDS: Disrespect; Abusive care; Mistreatment; Childbirth; Maternity care.

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INTRODUCTION

Disrespect and abuse during childbirth are common causes of suffering and violation of human rights in low-income countries and significantly affect the overall utilization of maternal healthcare services [1]. Different scholars defined and classified D&A into distinct manifestations. The predominantly used classification is by Bowser and Hill with seven different manifestations; physical harm, non-confidential care, non-consented care, non-dignified care, discrimination, abandonment or denial of care, and detention in facilities. [2-4].

There is still a high number of women dying daily from pregnancy and childbirth complications worldwide. D&A is one of the multiple factors that hinder the effort of reducing the maternal mortality ratio [4-6].

The status of D&A varies across countries worldwide. It ranges from 17.6% in Ethiopia to 98% in Nigeria [7-10]. Similarly, studies from different parts of Ethiopia show the same pattern [11-15]. The common manifestations of D&A also vary from non-consented, non-dignified care, physical abuse to detention in healthcare facilities [10, 16].

D&A during childbirth is recognized as a major cause of suffering for women and puts significant barriers to women in choosing maternal healthcare services like skilled delivery by many maternal health experts. It significantly affects the mother's intention of delivering in the same facility in the future [4, 11, 17]. As a result, it is becoming a significant community concern in terms of research, service quality, education, human rights, and civil rights activism to improve the utilization and quality of maternity care [18-20].

Although there are different strategies and interventions like Health Sector Transformation Plan [21] and Compassionate and Respectful care [22] available in Ethiopia to provide respectful and compassionate health services, little is known about their effectiveness. Thus, the results of this study will be an input to policy designers, program managers, and service providers, in measuring the prevalence of D&A and identifying contributing factors to develop mitigation strategies in the study area and other regions of Ethiopia with low infrastructure access like roads, power supply, and well-built and equipped buildings.

METHOD AND MATERIALS

Study design, area, and period

The study was conducted in the labor wards of public health facilities in the Assosa zone, Benishangul-Gumuz (BG) region, Ethiopia. A facility-based cross-sectional study design was employed from October 12 – to November 13, 2020.

Study population

The source population was all mothers who have attended labor and delivery wards and gave birth in the public health facilities of the Assosa zone. The study population was sampled mothers from the source population during the study period. Women who used private wings for delivery services and mothers who were immediately referred to another facility due to obstetrics emergencies were excluded from the study.

Sample size determination and sampling technique

A single population proportion formula was used to estimate the sample size required for this study, with a margin of error (d=0.05), and a 95% confidence level ($Z\alpha/2=1.96$) using a proportion of D&A in a study done in 2020 [15]. By taking a 1.5 design effect, and considering a 10% potential non-response rate, the final sample size for this study was 437 mothers. One general hospital, one primary hospital, and 12 health centers in half of the districts in the zone were selected based on the World Health Organization's facility sampling technique recommendation [23]. Proportional allocation to sample size technique was used based on each facility's previous year data [24]. A systematic random sampling method was used to identify the number of study participants from each facility.

Data collection procedures and Analysis

A face-to-face semi-structured interviewer-administered questionnaire was adapted based on the items developed by the Maternal and Child

Health Integrated Program to assess D&A [4]. The questionnaire was developed in English and was translated into the region's working language, Amharic then back to English for clarity and consistency. A pre-test was conducted on 5% [22] of the sample size at a health center out of selected health facilities for the study, and necessary amendments were made before the actual data collection. A two-day training was given for seven bachelor degree holder female data collectors and four supervisors before data collection. Data were collected right after the mother was discharged (exit interview) with regular supervision by the supervisors. Collected data were entered to Epidata version 3.1 and transported to SPSS version 23.0 for analysis. Bivariate logistic regression was carried out to identify candidate variables at a p-value less than 0.25 for final analysis. Multivariate analysis using the backward method was performed to determine the presence of a statistically significant association between independent variables and the outcome variable at a p-value less than or equal to 0.05 and AOR with 95% CI.

Ethical consideration

Ethical clearance was obtained from the Institution Review Broad of the Institute of Health, Jimma University with a reference number of IHRPGY/953/20. An official letter was written by the zonal health department to the respective district health offices, and facility heads approved the request, accordingly. Verbal consent was obtained from each participant before data collection. Confidentiality and privacy were assured by using a coding system, removing any personal identifiers, and conducting all interviews in separate rooms.

RESULTS

Socio-demographic characteristics of study participants

Out of the 437 sampled mothers, 425 of them participated in the study yielding a response rate of 97.25%. The mean age of respondents was 24.4 years (±SD 6.48 years) with the age range of 16-46 years. The majority of respondents (398, 93.9%) were married and 218 (51.3%) of them have not attended formal education. Three hundred forty-three (80.7%) of study subjects resided in rural areas, 167(39.3%) of them were farmers by occupation, and 188 (44.3%) of them were Muslims by religion. The mean monthly income of the respondents was 1607.2 ETB (±SD 1109.3) with a range of 500 ETB-5,000 ETB.

Obstetric history of respondents

Of the total respondents, 197 (46.4%) and 193 (45.4%) had visited health centers and a general hospital, respectively, and 374 (88.0%) had at least one Antenatal Care (ANC) visit at a healthcare facility during the current pregnancy while only 47 (12.5%) of them had four ANCs and above. Also, 167 (39.3%) of them had given birth at home previously and 133 (31.3%) mothers have encountered birth complications like obstructed labor, hypertensive disorders, and the like. Nearly four out of five deliveries (339, 79.8%) were attended by only one healthcare professional.

Prevalence of D&A during labor and delivery

Out of the 425 mothers, 350 (82.4%) reported that they had faced at least one type of D&A during the current delivery. The most reported types of D&A were non-consented care (68.0%), non-confidentiality and privacy (35.5%), physical harm (33.6%), and abandonment or denial of care (20.7%). The study has also found that 14.8%, 8.9%, and 3.8% of mothers reported discrimination, detention in health facilities, and non-dignified care, respectively. (Table 1).

Table 1. Prevalence of D&A, Assosa Zone, BG region, Ethiopia, October 2020.

Variables (n=425)	Frequency	Percent
Experienced at least one form of D&A during labor and delivery	350	82.4%
Physical Harm	143	33.6%
Physically abused during labor/delivery (force/slapped /hit/beat)	33	7.8%
Verbally (insult) abuse during labor or delivery	11	2.6%
A separate mother from the baby without medical indication	0	0%
Denied from food or fluid in labor unless medically necessitated	13	3.1%
Receiving unnecessary uncomfortable/pain-relief treatment	80	18.8%
Support staffs insult me and my companion	13	3.1%
Demonstrating caring in a culturally inappropriate way	5	1.2%
Non-consented care:	289	68.0%
Providers did not introduce themselves	236	55.5%
Providers do not encourage the mother to ask questions	31	7.3%
Providers do not respond to the mother's question with promptness, politeness, and truthfulness	10	2.4%
The provider didn't explain what is being done and what to expect throughout labor and birth	35	8.2%
Providers didn't give updates on the status and progress of your labor	43	10.1%
Providers deny the mother freedom of movement during labor	38	8.9%
Providers deny the mother the choice of position for birth	22	5.2%
Mother lack consent or permission before any procedure	26	6.1%
Non Confidentiality and privacy	151	35.5%
Providers didn't use drapes or covering to protect the mother's privacy	36	8.5%
Delivery couches/beds not separated by a screen	127	29.9%
Non-dignified care	16	3.8%
The provider didn't speak politely	16	3.8%
Discrimination	63	14.8%
Providers discriminate by race, ethnicity, and economic status	3	0.7%
Providers speak in a language and at a language-level, that mother can't understand	62	14.6%
Abandonment or denial of care	88	20.7%
Mother left alone or unattended during labor and delivery	69	16.2%
Mother lack encouragement of call if needed	21	4.9%
The provider didn't come quickly when the mother called him/her	11	2.6%
Detention in facilities	38	8.9%
The mother was detained in a health facility against her will	37	8.7%
The mother was detained at the facility because of a lack of payment of fees	1	0.2%

Independent predictors of D&A during labor and delivery

After controlling for the effects of potentially confounding variables using backward multivariate logistic regression, the study found out that, the risk of being disrespected and abused increases by 1.92 times as labor duration increases by one hour (AOR=1.92, 95% CI [1.58– 2.33]). Mothers who gave birth in the general hospital were 3.52 times more likely to face D&A than clients who deliver at health centers (AOR=3.52, 95% CI [1.34–9.25]). Clients with no formal education

were 3.97 times more likely to be disrespected and abused as compared with mothers with above secondary education (AOR =3.97, 95% CI [1.66–9.51]). Mothers who were using only two ANC visits during the current pregnancy were 2.65 times more likely to face D&A than clients who had four times and more ANC visits (AOR =2.65, 95% CI [1.065 – 6.62]). Mothers who had a previous history of home delivery were 3.22 times more likely to be disrespected and abused when compared to their counterparts (AOR =3.22, 95% CI [1.36–7.64]). Deliveries assisted by only one healthcare professional were 4.41 times more likely to face D&A as compared with deliveries attended by three to four professionals (AOR= 4.41, 95% CI [1.677–11.589]). Similarly, laboring and delivering mothers with no birth companion during labor and delivery were 3.39 times more likely to be disrespected and abused as compared with mothers who had a birth companion in the delivery room (AOR [95% CI] 3.39 [1.245– 9.238]) (Table 2).

Table 2. Independent predictors of D&A, Assosa Zone, BG region, Ethiopia, October 2020.

Variable (n=425)		D&A status		COR 95% CI	AOR 95% CI	P-value
		No D&A (%)	D&A (%)			
Type of Health Facility	Health center	60 (30.5%)	137 (69.5%)	1	1	
	Primary hospital	5 (14.3%)	30 (85.7%)	1.312 [0.492 – 3.502]	1.312 [0.492– 3.502]	0.587
	General hospital	10 (5.2%)	183 (94.8%)	7.123 [3.544 – 14.315]*	3.517 [1.338– 9.245]*	0.011**
Educational Level	No formal education	15 (6.9%)	203 (93.1%)	5.524 [3.019 – 10.108]*	3.968 [1.655– 9.513]*	0.002**
	Only read and write	13 (11.3%)	102 (88.7%)	1.962 [1.033 – 3.723]*	0.102	
	Primary education	4 (10%)	36 (90%)	2.035 [0.702 – 5.901]	2.035 [0.702 – 5.901]	0.191
	Secondary education	12 (80%)	3 (20%)	0.045 [0.012 – 0.165]*	0.045 [0.012 – 0.165]*	0.000**
	Above secondary education	31 (83.8%)	6 (16.2%)	1	1	
Longer labor duration				1.764 [1.551 – 2.006] *	1.916 [1.577– 2.328] *	0.000**
Number of ANC	Once	7 (9.9%)	64 (90.1%)	2.174 [0.954 – 4.955]	2.174 [0.954 – 4.955]	0.065
	Twice	15 (7.7%)	179 (92.3%)	4.187 [2.290 – 7.655] *	2.655 [1.065 – 6.620] *	0.036**
	Three times	7 (11.3%)	55 (88.7%)	1.811 [0.790 – 4.152]	1.811 [0.790 – 4.152]	0.161
	Four times and above	33 (70.2%)	14 (29.8%)	1	1	
History of home delivery	Yes	16 (9.6%)	151 (90.4%)	2.798 [1.549 – 5.056] *	3.222 [1.358– 7.643] *	0.008**
	No	41 (25.2%)	122 (74.8%)	1	1	
Number of Professionals Attending the delivery	One professional	31 (9.1%)	308 (90.9%)	10.409 [5.937 – 18.247] *	4.409 [1.677–11.589] *	0.003**
	Two professionals	37 (50%)	37 (50%)	0.121 [0.069 – 0.214] *	0.121 [0.069 – 0.214] *	0.000**
	Three to four professionals	7 (63.6%)	4 (36.4%)	1	1	
Birth companion	Yes	33 (40.7%)	48 (59.3%)	1	1	
	No	42 (12.2%)	302 (87.8%)	4.943 [2.857 – 8.554] *	3.391 [1.245– 9.238] *	0.017**

*show strength of association

**significant at p-value <0.05

DISCUSSION

The study showed that more than one in five mothers who attended labor and delivery in the study area experienced at least one type of D&A. This finding is higher than previous studies [7, 8, 12, 25]. However, it is lower than other studies done in Ethiopia [11, 13, 14, 15]. The difference might be due to measurement tool differences, programmatic factors like providing training for health professionals, and the availability of guidelines and ethical standards in some of the facilities.

We found out that clients with no formal education were 3.97 times more likely to be disrespected and abused as compared with mothers with above secondary education. This finding is consistent with other studies [7, 11, & 13]. This might be because clients with no formal education are less likely to be aware of their rights and demand respectful care as compared with formally educated ones.

This study also found out that mothers who gave birth in a general hospital setting were 3.52 times more likely to be disrespected and abused than clients who deliver at health centers. This finding is in line with other studies in Ethiopia [14, 15]. This might be due to hospitals compromising the quality of service they provide due to client/patient overload, unlike health centers. This illustrates the necessity of providing sufficient and targeted support to hospitals to decrease service provider burnouts and raise motivation and a sense of accountability to provide quality and client-centered maternity care services.

We have also found out that longer labor duration was attributed to a high level of D&A. The risk of being disrespected and abused increases by 1.92 times as labor duration rises by an hour. This finding is consistent with the finding of a study done in the northern part of Ethiopia [12]. The possible explanation could be that the quality of care decreases due to providers' fatigue as the time of care gets prolonged.

The study also revealed that mothers who deliver having only two ANC visits were 2.65 times more likely to face D&A than clients who had four times and more ANC visits. This finding is in line with a study done in Ethiopia [15]. This might be due to the result of an acquaintance of the mother with the facility and the care providers, which is the result of previous ANC visits. Therefore, early initiation of ANC services should be encouraged.

Moreover, mothers with a history of home delivery were 3.22 times more likely to face D&A when compared with their counterparts. This might be due to the reason mothers compare the service they get at the health facility to the traditional care they receive during home delivery, which is more client-friendly and culturally sound. This is in line with a study done in Kenyan [26] that revealed women reported that they received more respect from traditional birth attendants and were treated better. So, it is vital to align services healthcare facilities provide to be attuned to the community's preferences and be culturally sound.

The study has also found out that, mothers with no birth companion were 3.39 times more likely to face D&A as compared with mothers who had a birth companion in the delivery room. This finding is consistent with multiple studies [8, 12, 14, 25, 27, & 28]. The reason behind this might be the presence of a close relative might bridge the communication gap between the care provider and the client and also, the presence of a third party might be seen as a "watchdog" by the caregiver to alert them to be more caring. Hence, facilities should encourage the presence of a family member in labor and delivery rooms to enhance the quality of service the client receives.

The study also found out that, the majority of respondents (61.4%) still think it is for the benefit of the mother that the care provider does "not-good" things. This implies, most of them have accepted and normalized the act of D&A and don't even know that their rights have been violated. This finding is consistent with other studies [16, 29, & 30]. This shows the strong need for working on enabling clients, especially mothers to their knowledge of sexual and reproductive health rights in healthcare facilities.

CONCLUSION

The overall prevalence of disrespect and abusive maternity care in the study area was high. Thus, healthcare facilities especially, hospitals should be given special attention in terms of staffing, training, and motivating care providers to advance the quality of care they provide.

Educating women on their sexual and reproductive rights and the importance of utilization of the recommended minimum of four ANC visits is vital. The presence of a birth companion in the delivery rooms should be encouraged by health facilities for better communication and smoother service provision. Moreover, health facility managers, health professionals, professional associations, and other development partners in the region should aim to make healthcare facilities more client-centered and provide the best service the community deserves for delivery and other maternal healthcare services.

LIMITATION OF THE STUDY

Interpretation of this study should be taken into consideration of the following limitations. There might be a potential of social desirability bias from the study participants since the study relied on self-report and interviews of the mothers were held at the same health facility where they gave birth.

DECLARATIONS:

Competing interests: The authors declare that they have no competing interests.

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