

Factors affecting Disrespect and Abuse during facility-based care in rural and urban setting in Kano, northwest Nigeria; A mixed-method study

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Abstract

Objectives: This study was undertaken to explore various factors affecting disrespect and abuse (D&A) of women during childbirths in health facilities in selected locations in Kano, a north-west Nigerian State.

Method: Ethical approval and informed consent were obtained. The study adopted quantitative and qualitative data collection methods. A sample size of 292 women who delivered in the past 1 year preceding the study. Quantitative data was analyzed using descriptive statistics (frequencies, percentages, means and standard deviation) and inferential statistics (chi-square). Qualitative data was analyzed along themes using Atlas. ti. *P* value is ≤ 0.05 was considered statistically significant.

Results: The age group 25-29 years had the highest proportion of D&A (61.84%). Those who were single had more proportion of D&A (55.6%) compared to those who were married (45.7%). The women that leaved in urban setting (75.3%) had more proportion of D&A compared to those who lived in a rural setting (18.3%). The proportion of D&A was highest among parity group 7-8 (100%). D&A greater if the respondent spends 2 days (95.7%) and above in the hospital compared to when they spent < 2 (45.8%). 94.2% of those who will not recommend the facility for delivery had D&A compared to 22.4% of those who will recommend the facility. Health system inadequacies including lack of supervision, poor remuneration, inadequate staffing and supplies were common barriers mentioned.

Conclusion: Socio-demographic, obstetrics, level of health facility, health system inadequacy and social class affect occurrence of D&A. improved socio-demographic status and health systems can reduce the occurrence of D&A.

Keywords: Factors; Disrespect; Abuse; Health Facility; Nigeria

Introduction

DA reported by women did not differ significantly by age group, religion, education, and parity in some studies [Diamond-Smith et al, 2017; Nawab T, 2015]. Okafor *et al.* have also reported that maternal characteristics such as age, parity, and educational status did not affect prevalence of DA significantly [Okafor, Ugwu, Obi; 2015]. Among the various sociodemographic determinants of DA, SES was found to be a significant one, with odds 3.6 times more among females with low SES [Nawab T, 2015; Azhar, Oyeboode, Masud, 2017]. Health providers may treat lower SES females poorly as they are less likely to report it or reply back. On the other hand, some authors have found that females belonging to higher wealth quintiles reported more mistreatment [Diamond-Smith et al, 2017]. Females of higher SES may have more expectations from facility and are more likely to be sensitive to their needs and behavior meted out to them. No significant association was found between the time of delivery (daytime or night) and DA in this study [Nawab T, 2015].

Moronkola et al speculated that women who are not aware of their rights and have never been exposed to any other system of care are not sensitive to the disrespect and abuse of health care workers and see such behavior and attitude as normal [Moronkola et al; 2007]. It has also been observed that an important barrier to respectful care at childbirth as well as skilled delivery service is

the financial status of the woman [Moronkola et al,2007; Iyaniwura and Yussuf, 2009; Lamina, Sule-Odu, Jagun, 2004]. Some women indicated that they report to hospitals late or not at all because of the costs involved. Studies showed that majority of women reporting disrespect and abuse were uneducated and of low socioeconomic status [Moronkola et al,2007; Iyaniwura and Yussuf, 2009]. The authors of these studies concluded that educated women are better aware of their rights thereby reducing the likelihood of being subjected to disrespectful and abusive behavior. Lamina et al also commented on the higher rate of hospital deliveries in educated women postulating they were less likely to be disrespected thereby increasing their level of utilization [Lamina, Sule-Odu, Jagun, 2004]. Moore et al reported that as policies that protect the rights of women are hardly enforced and providers are rarely held accountable for their actions these result in cases of disrespect and abusive [Moore et al;2002]. According to Igboanugo et al, women feel that health workers are disrespectful and abusive because sometimes, there is weak leadership and no supervision [Igboanugo and Martin;2011]. The negative effects of under-resourced and strained health systems on provider motivation were described as contributors to disrespect and abuse in three studies⁹. Bad attitude of health workers was attributed to health facilities being understaffed leading to them becoming overworked, tired and easily irritable [Igboanugo and Martin;2011]. Lack of training of staff to improve quality of care [Igboanugo and Martin;2011]., poor remuneration and lack of motivation [Moore, Alex-Hart, George;2011] could contribute to negative attitude. Poorly designed hospital environment with minimal privacy and lacking equipment and infrastructure was also reported with as contributing factors to disrespect and abuse of women [Igboanugo and Martin;2011].

Disrespect and abuse in facility-based childbirth often acts as a barrier to current and/or future utilization of facility-based childbirth services. Several studies highlight the connection between disrespectful facility-based childbirth care as described by women users and a decision by women users not to use facility-based childbirth services. The bad attitude of health workers was cited as one major reasons for women avoiding skilled delivery services [Moronkola et al, 2007; Onah, Ikeako, Iloabachie, 2006], and choosing to deliver at home or in spiritual church based centers¹². Some women reported presenting to the hospital was a last resort because the health staff were usually very rude and abusive [Moronkola et al, 2007].

This study was undertaken to explore various factors affecting D&A of women during childbirths in health facilities in selected locations in Kano, a north-west Nigerian State.

Method

Ethical approval and informed consent were obtained. The study adopted a quantitative data collection utilizing questionnaire and qualitative data collection by utilizing in-depth interviews (IDIs) for health workers and focus group discussions (FGDs) for recently delivered women. It was a hospital-based survey which took place in the postnatal and immunization clinic and involved women of reproductive age (15-49years) in the selected communities who delivered their babies in the health facility within the past 1year.

Simple random sampling was used to select women who delivered in the facility in the last one year preceding the study. A sample size of 292 was used to include respondents selected from facilities in the urban and rural setting. Using a prevalence of disrespect and abuse of 55.9% reported in Kano recently, North-west Nigeria [Amole et al;2019], a sample size for the women's survey was calculated with the formula as $n = z^2 P q / d^2$ (where n = Sample size, z = Standard normal deviation = 1.96 at 95% Confidence limit, P = Prevalence rate of disrespect and abuse = 55.9%, $q = 1 - P = 1 - 0.559 = 0.441$, d = Error margin = 5%). This gave a sample size of 292 after adding 20% to account for attrition. An IDI and FGD guides were used to collect information from health workers and recently delivered women respectively.

We collected socio-demographic and obstetrics variable. The tools were administered in English and Hausa languages to clients depending on preference. The potential risks related to recruitment in the study were minimal. The researchers were trained on privacy and confidentiality. During the recruitment process, personal identifiers of potential (eligible) interviewee such as names, addresses and phone numbers were kept confidential. Qualitative data notes were transcribed and analyzed along themes. Quantitative data was analyzed using descriptive statistics (frequencies, percentages,

means and standard deviation) and inferential statistics (chi-square). Statistical The dependent variable was D&A at hospital with a “yes” or “no” and in some cases a “choose not to answer” option. significance was achieved when P value is ≤ 0.05 .

At the end of data collection, the data collection tools were checked for completeness and coded. Data entry was done into Microsoft excel, cleaned and exported to statistical package for social sciences (SPSS) version 20.0 software (Chicago IL USA) for analysis. Qualitative data notes was transcribed and analyzed along themes using Atlas.ti. Quantitative data was analyzed using descriptive statistics (frequencies, percentages, means and standard deviation) and inferential statistics (chi-square and logistic regression). The statistical test was used for evaluating association between dependent and independent variables. Statistical significance was said to be achieved when P value is ≤ 0.05 . The dependent variable was D&A at hospital with a “yes” or “no”.

Results

Table 1. Socio-demographic Determinants of D & A

Variable		Yes D&A (%)	No D & A (%)	Na D&A (%)	Fisher's Exact Test	p-value
Age					36.362	0.004*
15-19	28	15(53.57)	13(46.43)	0		
20-24	63	32((50.79)	31(49.21)	0		
25-29	76	47(61.84)	29(38.16)	0		
30-34	67	31(46.27)	33(49.25)	3(4.48)		
35-39	27	9(33.33)	18(66.67)	0		
40-44	23	2(8.70)	20(86.95)	1(4.35)		
45-49	4	1(2.5)	3(97.5)	0		
Marital Status					38.772	0.004*
Single	9	5(55.6)	4(44.4)	0		
Married	276	129(45.7)	147(54.3)	0		
Divorces	3	0 (0)	3(100)	0		
Occupation					64.314	0.000*
House wife Farming	198	109(55.1)	88(44.4))	1(0.5)		
Teaching	15	4(26.7)	10(66.6)	1(6.7)		
Trading	20	4(20)	16(80)	0(0)		
Hand work Health work	24	9(37.5)	15(62.5)	0(0)		
Student	12	6(50)	6(50)	0(0)		
Not employed	9	0(0)	9(100)	0(0)		
Other	5	2(40)	3(60)	0(0)		
	4	0(0)	4(100)	0(0)		
	1	0(0)	1(0)	0(0)		
Language					19.229	0.539
English	7	1(14.3)	5(71.4)	1(14.3)		
Fulani	3	1(33.3)	2(66.7)	0(0)		
Hausa	245	123(50.2)	122(49.8)	0(0)		
Igbo	7	3(42.86)	4(57.14)	0(0)		
Others	10	3(30)	7(70)	0(0)		
Yoruba	16	1(6.25)	15(93.75)	0(0)		
Education					23.348	0.018*
None	11	6(54.5)	5(45.5)	0(0)		
Quaranic	39	14(35.9)	25(64.1)	0(0)		
Primary	150	82(54.7)	68(45.3)	0(0)		

Secondary	59	20(33.9)	34(57.6)	5(8.5)		
Tertiary	29	6(20.7)	23(79.3)	0(0)		
Location					21.699	0.000*
Urban	146	110 (75.3)	35(24)	1(0.7)		
Rural	142	26(18.30)	104(73.2)	12(8.5)		

Table 1 showed that the respondents in the age group 25-29years had the highest proportion of disrespect and abuse (61.84%) and was followed by 15-19 years (53.57%), 20-24years (50.79%), 30-34years (46.27), 35-39 years (33.33%), etc. Those who were single had more proportion of D&A (55.6%) compared to those who were married (45.7%). The housewives had more proportion of D&A compared to other occupation groups such as traders, farmers, teachers or students. Hausa women had higher proportions of D&A (50.2%), compared to the other ethnic groups, followed by the Igbos (42.9%) and the Yoruba ethnic group had the lowest (6.3%). Those who had no education or had a primary education had more proportions of D&A (54.5 and 54.7% respectively) compared to those who had quaranic (35.9%), secondary (33.9%) or tertiary education (20.7%). The women that leaved in urban setting (75.3%) had more proportion of D&A compared to those who lived in a rural setting (18.3%). Age is a predictor of D & A and younger women and adolescents have more proportion of D&A. House wives and unemployed have more proportion of D&A compared to other occupation group; there is no statistically significant difference in D&A with ethnic groups ($p>0.05$); those who had no education or primary education have more proportions of D&A; those who leave in urban setting (75.3%) have more proportion of D&A compared to those leaving in rural setting (18.30%) and this is statistically significant.

Table 2. Social class Determinants of D & A

Variable	Frequency	Yes D&A (%)	No D&A (%)	NA D&A (%)	Chi square test	p-value
Husband's highest education					19.935	0.107
None	2	0(0)	2(100)	0(0)		
Quaranic	14	5(35.7)	9(64.3)	0(0)		
Primary	35	21(60)	14(40)	0(0)		
Secondary	179	88(49.2)	63(35.2)	28(15.6)		
Tertiary	67	17(25.4)	47(70.2)	3(4.4)		
Husbands occupation					53.971	0.007*
Farming	24	5(20.8)	18(75)	1(4.2)		
Teaching	25	6(24)	19(76)	0(0)		
Trading	180	109(60.6)	69(37.2)	2(2.2)		
Hand work	26	10(38.5)	16(61.5)	0(0)		
Health work	7	1(14.3)	6(85.7)	0(0)		
Student	2	1(50)	1(50)	0(0)		
Not employed	3	0(0)	3(100)	0(0)		
Others ^a	8	1(12.5)	6(75)	1(12.5)		
NA	13	2(15.4)	11(84.6)	0(0)		
Average family income monthly in naira					237.058	0.529
1000-9999	17	4(23.5)	13(76.5)	0(0)		
10,000-19,999	29	11(38)	18(62)	0(0)		
20,000-29,999	32	15(47)	17(53)	0(0)		
30,000-39,999	36	20(55.6)	14(38.9)	2(5.5)		
40,000-49,999	58	41(70.7)	17(29.3)	0(0)		
50,000-59,999	35	23(65.7)	12(34.3)	0(0)		
60,000-69,999	11	7(63.6)	4(36.4)	0(0)		
≥70,000	36	11(30.6)	25(69.4)	0(0)		
	32	4(12.5)	28(87.5)	0(0)		

Chooosed not to answer						
Amount paid for delivery	108	23(22.3)	82(75.9)	3(1.8)	29.231	0.000*
0 ^b	31	7(22.9)	23(74.2)	1(3)		
1-2,499	1	0(0)	1(100)	0(0)		
2500-4,999	69	49(71)	19(27.5)	1(1.5)		
5,000-7,499	72	52(72.2)	20(27.8)	0(0)		
7,500-9,999	5	5(100)	0(0)	0(0)		
10,000-12,499						

^a= include 2 bankers, 1 lawyer and 2 unspecified; ^b= 5 women who paid nothing gave HWs foodstuff and wrapper as gifts.

Table 2 shows that traders have higher proportion of D&A (p=0.0038); D&A was higher among those who paid N10,000-12,499 and lowest among those who paid nothing for delivery. Education of husbands and family monthly incomes did not affect the proportions of D&A.

Table 3. Obstetrics Determinants of D & A

Variable		Yes D&A (%)	No D&A (%)	na D&A (%)	Statistical test	P-value
Facility type at delivery					17.967	0.71
Hospital	274	127(46.4)	0(0)	28(53.6)		
Health Centre	8	2(25)	6(75)	0(0)		
Other	6	2(33.3)	4(66.7)	0(0)		
Parity					72.912	0.000*
1-2	61	33(54)	27(44.3)	1(1.7)		
3-4	84	41(48.8)	42(50)	1(1.2)		
5-6	83	46(55.4)	35(42.2)	2(2.4)		
7-8	33	10(100)	0(0)	0(0)		
≥9	27	5(18.5)	22(81.5)	0(0)		
Companion in labour					10.716	0.061
Yes	198	90(45.5)	105(53.0)	3(1.5)		
No	90	46(51.1)	42(46.7)	2(2.2)		
ID of Companion in labour (n=198)					34.460	0.400
Mother-in-law	16	7(43.8)	8(50)	1(6.2)		
Mother	102	58(56.9)	43(42.2)	1(0.9)		
Husband	40	18(45)	22(55)	0(0)		
Health workers	8	2(25)	6(75)	0(0)		
friend	32	14(43.8)	17(53.1)	1(3.1)		
age of LCB					130.805	0.000*
0-11	7	1(14.3)	6(85.7)	0(0)		
12-23	137	84(61.3)	52(38.0)	1(0.7)		
24-35	56	19(33.9)	37(66.1)	0(0)		
36-47	32	6(18.8)	25(78.1)	1(3.1)		
≥48	22	4(18.2)	17(77.3)	1(4.5)		
NA	36	19(52.8)	16(44.4)	1(2.8)		
How many of your previous baby did you deliver outside the health facility					69.975	0.000*
0-1	236	122(51.7)	101(42.8)	3(5.5)		
2-3	25	6(24)	19(76)	0(0)		
	13	6(46.2)	7(53.8)	0(0)		
	10	2(20)	8(80)	0(0)		
	3	0(0)	2(66.7)	1(33.3)		

4-5 6-7 8-9						
Have you had another delivery in this facility before? Yes No	231 57	111(48.1) 25(100)	116(50.2) 0(0)	4(1.7) 0(0)	33.433	0.000*
Will you have another delivery in this facility? Yes No	145 143	65(44.8) 72(50.4)	76(52.4) 70(49)	4(2.8) 1(0.6)		
Will your recommendation Yes No	149 138	22(14.8) 114(100)	124(83.2) 0(0)	3(2) 0(0)	38.133	0.000*
Time of the day delivery happened Day Afternoon Night NA	111 83 83 10	58(52.3) 46(55.4) 30(36.1) 2	53(47.7) 37(44.6) 53(63.9) 8	0(0) 0(0) 0(0) 0	19.239	0.007*
Cadre of HCW who assisted in last delivery CHEW Doctor Nurse-midwife	22 28 238	9(40.9) 15(53.6) 102(42.9)	13(59.1) 13(46.4) 136(57.1)	0(0) 0(0) 0(0)	79.532	0.004*

Table 3 showed that D&A was highest when delivery was at hospital (46.4%) and lowest when it was at a health centre (25%) but level of facility did not significantly affect the occurrence of D & A. The proportion of D&A was highest among parity group 7-8 (100%), compared to ≥ 9 (18.5%), 3-4 (48.8%), 1-2 (54%), 5-6 (55.4%). D&A was higher when there was no companion in labour (51.1%) compared to when there was a companion (45.5%). D&A was highest if the companion was the mother (56.9%) and lowest if it was a health worker (25%) but these differences are not statistically significant. D&A was highest if LCB was 12-23months and lowest if it was ≥ 48 . D&A was more if the client had previously delivered 0-1 babies outside the facility (51.7%) compared to 6-7 (20%). D&A was more if the respondent has not had a previous delivery at the facility (100%), compared to when she had (48.1%). D&A was highest among clients who had their delivery in the afternoon (55.4%) and morning (52.3%) compare to those who delivered at night (36.1%). D&A was highest when a doctor assisted the delivery (53.6%) than when a nurse-midwife (42.9%) or CHEW (40.9%).

Table 4. Outcomes of labour as a factor for D & A

Variable	Frequency (%)	Yes D&A (%)	No D&A (%)	Na D&A (%)	Fisher's Exact Test	P-value
How many days or hours did you spend in the hospital during labour?					90.100	0.004*
NA	16	6(37.5)	10(62.5)	0(0)		
0-3	79	45(57)	34(43)	0(0)		
4-7	149	56(37.6)	93(62.4)	0(0)		
8-11	8	7(87.5)	1(12.5)	0(0)		
12-15	10	4(40)	6(60)	0(0)		
16-19	1	1(100)	0(0)	0(0)		
20-23	1	1(100)	0(0)	0(0)		
24-27	20	14(70)	5(25)	1(5)		
≥28	4	3(75)	1(25)	0(0)		
How many days or hours did you spend in the hospital after labour?					107.112	0.000*
NA	19	7(36.8)	12(63.2)	0(0)		
0-3	65	38(58.5)	27(41.5)	0(0)		
4-7	124	47(37.9)	74(59.7)	3(2.4)		
8-11	57	31(54.4)	25(43.9)	1(1.7)		
12-15	5	3(60)	2(40)	0(0)		
16-19	0	0	0	0		
20-23	0	0	0	0		
24-27	13	6(46.2)	6(46.2)	1(7.6)		
≥28	5	4(80)	1(20)	0(0)		
What is the outcome of your labour?					49.686	0.004*
live baby healthy	248	125(50.4)	122(49.2)	1(0.4)		
live baby sick	3	2(66.7)	1(33.3)	0(0)		
excess bleeding	1	1(100)	0(0)	0(0)		
convulsion	2	0(0)	2(100)	0(0)		
caesarean section	3	2(66.7)	1(33.3)	0(0)		
vaginal delivery	7	0(0)	7(100)	0(0)		
delivered dead baby	10	3(30)	7(70)	0(0)		
I had fever	14	4(28.6)	0(71.4)	0(0)		
Number of days women was in the hospital after delivery					14.518	0.046*
NA	24	11(45.8)	13(54.2)	0(0)		
<2	101	32(31.7)	69(68.3)	0(0)		
2	23	22(95.7)	1(4.3)	0(0)		
>2	139	92(66.2)	46(33.1)	1(0.7)		
Maternal complications reported					142.673	0.000*
Too much bleeding	15	4(26.7)	11(73.3)	0(0)		
Infection or fever	7	2(28.6)	5(71.4)	0(0)		
Caesarean section	3	0(0)	3(100)	0(0)		
High blood pressure or seizure	7	2(28.6)	5(71.4)	0(0)		
Labor lasting	10	1(10)	8(80)	1(0)		
	233	124(53.2)	106(45.5)	3(1.3)		

more than 1 day No complications others	5	1(20)	4(80)	0(0)		
Newborn complications reported	240	130(54.2)	110(45.8)	0(0)	75.047	0.000*
No complications	13	1(7.7)	12(92.3)	0(0)		
Trouble breathing after delivery	11	2(18.2)	9(81.8)	0(0)		
Infection or fever	4	1(25)	3(75)	0(0)		
Born too early or very small	16	2(12.5)	14(87.5)	0(0)		
born after the expected date, too late or too big	1	0(0)	1(100)	0(0)		
others						
Baby outcome immediately at birth	279	135(48.4)	120(43)	3(8.6)	23.673	0.004*
alive	9	1(11.1)	8(88.9)	0(0)		
dead						

Table 4 showed that D&A was present at various proportions if respondents spent 16-19hours (100%), 20-23hours (100%), 8-11(87.5%), ≥ 28 (75%), 24-27hours (70%), 0-3hours (57%) and 4-7hours (37.6%). D&A greater if the respondent spends 2days (95.7%) and >2 (66.2%) compared to when they spent <2 (45.8%). Among respondents that had maternal complications, D&A occurred at various proportions including infection/fever (28.6%), high blood pressure or seizures (28.6%), too much bleeding (26.7%) and labour lasting more than 1day. Among respondents that had newborn complications, D&A occurred in 25% for those with babies born too early or very small, infection/fever (18.2%) and born after EDD, too late or too big (12.5%).

Table 5. Other factors affecting D & A

Variable	Frequency (%)	Yes D&A (%)	No D & A(%)	Na D &A (%)	Chi square test	p-value
Point of disrespectful treatment:	13	6(46.2)	7(53.8)	0(0)	81.052	0.100
ANC	7	2(28.6)	5(71.4)	0(0)		
During labour	6	4(66.7)	2(33.3)	0(0)		
At delivery	6	2(33.3)	4(66.7)	0(0)		
After delivery	4	1(25)	3(75)	0(0)		
During postnatal visit	14	12(85.7)	2(14.3)	0(0)		
ANC & labour	30	30(100)	0(0)	0(0)		
ANC, labour & delivery	14	13(92.9)	1(7.1)	0(0)		
ANC, delivery	4	2(50)	2(50)	0(0)		
ANC&PNC	7	7(100)	0(0)	0(0)		
Labour/delivery	14	13(92.9)	1(7.1)	0(0)		
Anc and at delivery	4	2(50)	2(50)	0(0)		
ANC and after delivery	7	7(100)	0(0)	0(0)		
During labour & delivery	4	2(50)	1(25)	1(25)		
Labour & after delivery						
Ever disrespected and abused a HCW?	11	1(9.1)	9(81.8)	1(9.1)	57.854	0.000*
Yes	243	123(50.6)	117(48.1)	3(1.3)		

No Choose not to answer	33	12(36.7)	18(54.5)	3(8.8)		
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Table 5, D&A occurred during Anc, labour& delivery (100%), Labour and delivery (100%), ANC and delivery (92.9%), ANC and labour (85.7%) and was least during postnatal visit (25%). The table however showed that there is a statistically significant association between being disrespectful and abusive to a health worker with experience of D&A.

Table 6. D & A as factor affecting utilization of facility birth

Variable	Frequency (%)	Yes D&A (%)	No D&A (%)	Na D&A (%)	Chi square test	p-value
I will use this facility for future delivery	143	32(22.4)	111(77.6)	0(0)	18.739	0.243
Yes	128	100(78.1)	28(21.9)	0(0)		
No	17	2(11.8)	15(88.2)	0(0)		
NA						
I will recommend this facility to a friend or relation in their delivery	174	39(22.4)	135(77.6)	0(0)	15.675	0.121
Yes	104	98(94.2)	6(5.8)	0(0)		
No	10	2(20)	8(80)	0(0)		
NA						

Table 6 showed that about half of the respondents said that they will not have another delivery in the facility and 78.1% had D&A compared to 22.4% who said that they will have another delivery in the hospital. 94.2% of those who will not recommend the facility for delivery had D&A compared to 22.4% of those who will recommend the facility. These differences were however not statistically significant.

Findings from the qualitative study also shed more light as shown in the sections that follow.

D&A can occur when clients or their relatives' disrespect and abuse healthcare workers

A respondent said,

'Some women have no patience; they quarrel the health personnel and show them that they know the health work better than the health personnel and this can cause them more problems in the hospital'

One respondent said that,

'One day one woman was in the labor room and when her relatives came, they said that they must see her and that was not the right time. So, when the doctors refused them seeing her, they started fighting the doctors'.

When women experience D&A their relatives may retaliate

A respondent said,

'When my sister came here for delivery the nurse beat her on her lap when the baby was coming out, so after the delivery my sister said that she must revenge the beating and that lead to fight'

D&A are commoner in hospitals than other cadre of health facilities.

During an FGD in the urban setting, a respondent said concerning the type of health facility a woman would like to deliver he baby, that,

'The women like to deliver in the hospital but the private ones because they are the one that can give the adequate care'

Another said,

'No, these cares are not found in all the hospitals we have, though it maybe because of lack of sufficient health personnel in the hospital. We can only get these cares in private hospitals but not in government hospital because weather they work or they did not work the government will pay them'

Socioeconomic and obstetrics characteristics determine D&A

Respondents said,

'Woman with the first issue receive more attention and care in the hospital than the one that had experience'

Also,

'The married women are given more respect and care than the single ladies because the society knows that their own condition illegal'

It is also opined that,

'The illiterate ones use to face more problems'

Respondents believe a weak health system and ineffective clinical governance structure is responsible for D&A

'Honestly it is the fault of the general management the health sector they don't carry out they duty. There is no regular hospital checkup that is why every worker did the way they like'

'What my sisters said is true it is the fault of the leaders because whenever they know there will be visitor from the above you would find out that they tidy everywhere in the hospital'

'Sometimes the nature of their salaries can make them to behave one kind most especially when they compare it with the bulky work they do'

Women choose to deliver at home or elsewhere because of D&A

Respondents noted that,

'Some people choose to deliver at home because they are not pet in the hospital'

Another said that,

'I was not neglected but I saw when they neglected one woman that I came to the hospital together with, she was bleeding but they refused to accept her and that make her to went back I don't know where she went'

'My neighbor told me that her dignity is more protected; because she will not be asking to lay upside people will be seeing her nakedness. That is why she likes to deliver at home'

'At home your people will show you love and they will give you whatever you like to eat which if it is in the hospital, they will not give you what like to eat they will be said you can shit for them'

Discussion

D&A reported by women differed significantly by age group, education, and parity in this study. Younger women and adolescents, women who had no education or primary education and those of high parity suffer more D&A. A previous study reported higher D&A among women older than 19years [Kruk et al; 2018]. This is contrary to Nawab et al and Okafor et al. who reported that maternal characteristics such as age, parity, and educational status did not affect prevalence of DA significantly [Nawab et al, 2019; Okafor, 2015 et al.].

There was significant association found between D&A and the time of delivery (daytime or night) in this study as women who delivered at night reported less D&A than those who delivered in the day time. This is similar to the findings of Banks et al. [Banks et al, 2018] that women who delivered at night were less likely to report D&A than those who delivered during day, but the difference was not significant and Nawab et al report no variation with time of delivery [Nawab et al, 2019]. D&A was highest when delivery was at hospital (46.4%) and lowest when it was at a health center (25%). Similar findings have been reported by Hameed et al. [Hameed and Avan, 2018]. This may be because of higher patient load and unfavorable patient-provider ratio in public hospitals. The present study noted that D&A is associated with the cadre of health worker, but a previous study reported that the cadre of health worker was not significantly associated with reporting of D&A [Banks et al, 2018]

As reported in a previous study, the present study showed that D & A were reported more by women who experienced longer labour duration, and also by women who did not have support

persons present during labour and delivery [Mengistu et al, 2018]. As in previous study, the present study also showed that mothers who stayed in a health facility longer than 2 days after delivery were likely to experience D&A [17, 18]. The present study findings also corroborate with previous studies that childbirth complications were associated with reporting D&A [Banks et al, 2018; Abuya, 2015].

The present study has shown that D&A was commoner among women with high monthly family income. Similarly, some authors have found that females belonging to higher wealth quintiles reported more mistreatment [Kruk et al, 2018, Mengistu et al, 2018]. Females of higher incomes may have more expectations from facility and are more likely to be sensitive to any D&A. The same applies for women who had paid significantly for the delivery services compared with those paying nothing. A recent study in the contrary reported higher proportion of D&A among women of low socioeconomic status by some authors [Ishola, Owolabi, Filippi; 2017].

Various studies agree with the result of the study that D&A determine where woman chooses to deliver her baby or recommend to others [Ishola, Owolabi, Filippi; 2017; Orpin, 2018]. Women who experienced D&A were unlikely to use the facility or recommend it to others.

Socio-demographic, obstetrics, level of health facility, cadre of health worker and social class characteristics affect occurrence of D&A. Health system inadequacies such as lack of supervision, poor remuneration, inadequate staffing, supplies and equipment were the most common barrier mentioned.

Overall, there are areas in which successful interventions can interrupt the trend of D&A in our health facilities. For example, health system inadequacies can be corrected through adequate staffing, supply of needed hospital equipment, training and retraining of health care providers. Health care providers' capacity should be built through training/retraining in order to comply with new concepts of respectful maternity care (RMC) and human right. It is also important to consider allowing support persons to accompany women during facility care as this may reduce D&A.

The study limitation was that this study assessed opinion which is generally subjective. An observational study would be more objective.

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