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Mistreatment of Women Throughout Birthing Process in Tertiary Healthcare Institutions in Rivers State: Implication For Quality Maternity Care

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ABSTRACT
This study examined mistreatment of women throughout birthing process in tertiary healthcare institutions in Rivers State: Implication for quality maternity care. A descriptive survey research design was adopted with a population which comprised of 520 women attending antenatal and post-natal clinics of University of Port Harcourt Teaching Hospital and Rivers State University Teaching Hospital out of which 249 were selected using the convenience sampling technique. The instrument for data collection was a self-structured questionnaire with a reliability index of 0.83. Data collection was done using the direct delivery and retrieval method to ensure high return rate. Data analysis was done using descriptive statistics of frequencies, percentages, mean and inferential statistics of chi-square. Results revealed that majority of pregnant women experience non-consented care, non confidential and non dignified care during birthing process to a significant extent. This study concluded that majority of pregnant women experience disrespectful care during childbirth. Based on the study findings, the following are hereby recommended; active participation of women in all aspects of their care including decision making, women should be provided with dignified care during childbirth and afterward and full informed consent should be sought for and obtained from women during childbirth and the principle of confidentiality should be respected at all times when caring for women during childbirth.
Keywords: childbirth, women, childbirth, non-confidential care

INTRODUCTION

Women worldwide face diverse forms of mistreatment during childbirth by health-care providers (World Health Organization, 2017). Mistreatment of women is defined by Meghan, et al., (2015) as a full range of unacceptable experiences of women of child bearing age in home, hospital and related settings which includes abuse, violations of privacy, stigma and discrimination, neglect as well as abandonment. These experiences can be active (such as intentional or deliberate physical abuse), passive (such as unintentional neglect due to staffing constraints or overcrowding), related to the behavior of individuals (verbal abuse by health care providers against women), or related to health system conditions (such as a lack of beds compromising basic privacy and confidentiality). However, they can all impact on a woman's health, her childbirth experiences, and her rights to respectful, dignified, and humane care during childbirth (Jenevic, Sripad, Bradley & Dimitrievska, 2011).

Every woman has the right to dignified, respectful sexual and reproductive health care, including during childbirth as highlighted by the Universal Rights of Childbearing Women Charter. Therefore, mistreatment during childbirth can represent a violation of women's fundamental human rights and can serve as a powerful disincentive for women to seek care in facilities for their subsequent deliveries. In line with this, the World Health Organization has called for greater research, action, advocacy and dialogue on this important public health issue of women mistreatment during childbirth in order to ensure safe, timely, respectful care during childbirth for all women. Likewise, respectful care is a key component of both the mother-baby friendly birthing facilities initiative and the WHO vision for quality of care for childbearing women and newborns.

Disrespectful care of women constitutes a violation of the right to the highest attainable standard of health, which includes the right to dignified, respectful healthcare throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination (Gulmezoglu et al., 2015). It is expected that health-care providers ensure high quality, evidence-based and respectful care to women and their infants during childbirth and labour, but evidence shows that some providers have misconceptions about what constitutes acceptable behaviour and thus display unacceptable behaviours reflecting abuse and overall mistreatment of patients. Balde et al. (2017) in a study conducted in Guinea reported that women experience different forms of mistreatment during childbirth which includes physical abuse, verbal abuse, abandonment and neglect. According to Balde et al., women described being slapped by providers, yelled at for noncompliance with provider requests, giving birth on the floor and without skilled attendance in the health facility. Furthermore, Maya et al., (2018) reported that, mistreatment was commonly experienced during the second stage of labour. Inability to push well during the second stage, disobedience to instructions from birth attendants, and not bringing prescribed items for childbirth (mama kit) often preceded mistreatment. Similarly, Diorgu and Steen (2017) in a Nigerian study submitted that many women receive disrespectful care and are often a passive participant in their own birth and not listened to.

Health systems are expected to be accountable for the treatment of women during childbirth, ensuring clear policies on rights and ethical standards are developed and implemented. However, reports reveal that mistreatment of women during childbirth occurs in countries across the world and puts the lives and well-being of women at risk (Tuncalp et al., 2015). While there are global efforts to increase facility-based childbirth, mistreatment of women with associated perceived poor quality of care pose a significant barrier in some settings, preventing women from attending facilities (Spangler, 2012). More recently, improving quality of care, including women's experiences of care, has been highlighted as a key component of strategies to further reduce preventable maternal mortality and morbidity (Magoma et al., 2010). Though, mistreatment of women by healthcare providers may not always be intentional, and may coexist with other compassionate and more respectful care practices, the experience of disrespectful care must be considered regardless of intent as such negative experiences could negatively influence the use of maternity services. This study therefore is on measuring mistreatment of women throughout birthing process in tertiary institution in Rivers State: Implication for quality maternity care.

Research Questions

The study provided answers to the following research questions:

1. To what extent do women experience non-confidential care during delivery in Tertiary Healthcare Institutions in Rivers State?
2. To what extent do women experience non-consented clinical care during delivery in Tertiary Healthcare Institutions in Rivers State?
3. To what extent do women experience denial of autonomy during delivery in Tertiary Healthcare Institutions in Rivers State?

Hypotheses

The following hypotheses were postulated to guide the study and were tested at 0.05 alpha level:

1. Women do not significantly experience non-confidential care during delivery in Tertiary Healthcare Institutions in Rivers State.
2. Women do not significantly experience non-consented clinical care during delivery in Tertiary Healthcare Institutions in Rivers State.
3. Women do not significantly experience denial of autonomy during delivery in Tertiary Healthcare Institutions in Rivers State.

METHODOLOGY

The study adopted a descriptive cross-sectional research design. The study population included women attending antenatal and post-natal clinics of the tertiary healthcare institutions in Rivers State at the time of conducting the study which was estimated at 520 based on the clinics register over the last three (3) months. The inclusion criterion was all women attending antenatal clinics of the tertiary healthcare institutions that have been pregnant before or have at least a child. A sample size of two hundred and forty-nine (249) was determined using the Taro Yamane's formula: $n = N/1 + N (e)^2$. Convenience sampling technique was used to select the study participants. Data was collected using a

researcher structured questionnaire titled "Mistreatment of Women throughout Birthing Process in Tertiary Healthcare Institutions Questionnaire (MWBPTHIQ)". The questionnaire was validated by two experts in midwifery. To ascertain the reliability of the instrument, the questionnaire was pre-tested it in a small survey of 30 respondents outside the study setting. A reliability coefficient of 0.83 was obtained indicating that the instrument was reliable for use. Data collection was done over a period of four (4) alternate antenatal and postnatal clinic days during the morning hours. Data collected from the field were coded and entered into the Statistical Package for Social Sciences (SPSS) software version 22.0 and analyzed using statistical tools such as percentage, mean, standard deviation and Chi-square statistics at 0.05 alpha level.

RESULTS

The results of this study are presented below in Table 1-5:

Table 1: The Extent to which Women Experience Non-Consented Clinical Care during Birthing Process (n=249)

S/N	Items	Yes	No	$\overline{X}$	Std Dev	Decision
1	Episiotomy	136	113	1.45	0.49	Moderate Extent
2	Augmentation of labour	199	50	1.20	0.40	Low Extent
3	Shaving of pubic hair	78	171	1.69	0.46	High Extent
4	Sterilization/family planning	-	249	1.00	0.00	Low Extent
5	Caesarean delivery	10	239	1.96	0.19	High Extent
6	Blood transfusion	54	195	1.78	0.41	High Extent
7	Vaginal examination	198	51	1.20	0.40	Low Extent
8	Suturing episiotomy	208	41	1.16	0.37	Low Extent
	Grand mean	110	139	1.43	0.34	Moderate Extent

1-1.29 (Low extent), 1.29-1.49 (Moderate extent), 1.50-2.00 (High extent)

Table 1 shows the extent to which women experience non-consented care during birthing process. The grand mean score of 1.43 which is lesser than the criterion mean of 1.5 indicates that women experience non-consented care during birthing process to a Moderate extent.

Table 2: The Extent to which Women Experience Non-Confidential Care during Birthing Process (n=249)

S/N	Items	Yes	No	$\overline{X}$	Std Dev	Decision
1	Age disclosure without consent	196	53	1.21	0.41	Low Extent
2	Provision of care without privacy	182	67	1.27	0.44	Low Extent
3	Medical history disclosure without consent	194	55	1.22	0.41	Low Extent
4	Disclosure of HIV status without consent	169	80	1.32	0.47	Moderate Extent
	Grand mean	185	64	1.25	0.43	Low extent

1-1.29 (Low extent), 1.29-1.49 (Moderate extent), 1.50-2.00 (High extent)

Table 2 shows the extent to which women experience non-confidential care during birthing process. The grand mean score of 1.25 which is lesser than the criterion mean of 1.5 and based on the categorization indicates that the extent to which women experience non-confidential care during birthing process was low.

Table 3: The Extent to which Women Experience Denial of Autonomy during Birthing Process (Criterion mean=1.50)

S/N	Items	Yes	No	$\overline{X}$	Std Dev	Decision
1	Non-involvement in healthcare decision making	175	74	1.30	0.46	Moderate Extent
2	Full control of healthcare planning and implementation by midwives and obstetricians	206	43	1.17	0.38	Low Extent
3	Disrespect of patients' right to self determination	194	55	1.22	0.42	Low Extent
4	Healthcare providers' disregard of the perceptions and views of patients about their care	210	39	1.16	0.36	Low Extent
5	Disrespect of patients' right to refuse or accept care	188	61	1.25	0.43	Low Extent
	Grand mean	**195**	**54**	**1.22**	**0.41**	**Low Extent**

1-1.29 (Low extent), 1.29-1.49 (Moderate extent), 1.50-2.00 (High extent)

Table 3 shows the extent to which women experience denial of autonomy during birthing process. The grand mean score of 1.22 which is lesser than the criterion mean of 1.5 and based on the categorization indicates that women experience denial of autonomy during birthing process to a low extent.

Table 4: Chi-Square Analysis on the Experience of Non-Consented Care amongst Women during Birthing Process (n=249)

S/N	Items	Yes	No	Df	$\chi 2$	P-value	Decision
1	Episiotomy	136	113	1	12.355	0.001	Significant
2	Augmentation of labour	199	50				
3	Shaving of pubic hair	78	171				
4	Sterilization/family planning	-	249				
5	Caesarean delivery	10	239				
6	Blood transfusion	54	195				
7	Vaginal examination	198	51				
8	Suturing episiotomy	208	41				

Table 4 shows the chi-square analysis on the experience of non consented care amongst women during birthing process. The P-value of 0.001 at df=1 and $\chi 2$=12.355 indicates that women significantly experience non-consented care during birthing process, thus, the null hypothesis which stated that women do not significantly experience non-consented clinical care during birthing process was rejected.

Table 5: Chi-Square Analysis on the Experience of Non-Confidential Clinical Care amongst Women during Birthing Process (n=249)

S/N	Items	Yes	No	Df	$\chi 2$	P-value	Decision
1	Age disclosure without consent	196	53	1	6.993	0.000	Significant
2	Provision of care without privacy	182	67				
3	Medical history disclosure without consent	194	55				
4	Disclosure of HIV status without consent	169	80				

Table 5 shows the chi-square analysis on the experience of non confidential care amongst women during birthing process. The P-value of 0.000 at df=1 and $\chi 2$=6.993 indicates that women significantly experience non-confidential care during birthing process. Thus, the null hypothesis which states that women do not significantly experience non-confidential care during birthing process was rejected.

Table 6: Chi-Square Analysis on the Experience of Denial of Autonomy amongst Women during Birthing Process (n=249)

S/N	Items	Yes	No	Df	$\chi 2$	P-value	Decision
1	Non-involvement in healthcare decision making	175	74	1	7.1182	0.010	Significant
2	Full control of healthcare planning and implementation by midwives and obstetricians	206	43				
3	Disrespect of patients' right to self determination	194	55				
4	Healthcare providers' disregard of the perceptions and view of patients about their care	210	39				
5	Disrespect of patients' right to refuse or accept care	188	61				

Table 6 shows the chi-square analysis on the experience of denial of autonomy amongst women during birthing process. The P-value of 0.010 at df=1 and $\chi 2$=7.1182 indicates that women significantly experience denial of autonomy during birthing process. Thus, the null hypothesis which states that women do not significantly experience denial of autonomy during birthing process was rejected.

DISCUSSION OF FINDINGS

Results from the study showed that women experience non-consented care during birthing process to a moderate extent. Chi-square analysis revealed that the experience of non-consented clinical care by women is significant during birthing process. This implies that a good number of women during childbirth experience non consented care in the areas of episiotomy, augmentation of labour, shaving of the pubic hair, caesarean section, blood transfusion, vaginal examination and suturing episiotomy amongst other procedures. These results are in line with the submission of Moyer et al. (2013) that majority of pregnant women experience non consented care. The result also agrees with the submission of Hassan et al. (2012) that majority of women reported feeling distressed as a result of the lack of information available to them before vaginal examinations, episiotomies and related procedures. The result also agrees with the findings of a study conducted by Duong et al. (2014) that a significant proportion of women remarked on the lack of information shared with them regarding the

progress of labour and the need for multiple tests and medications. The result also agrees with the submission of Oxnevad (2014) that most reported that routine episiotomies and repeated forceful vaginal examinations were indiscriminately done without any indication.

Findings from the study showed that women experience non-confidential care during birthing process to a low extent. Chi square analysis revealed that the experience of non-confidential care by women is significant during birthing process. This implies that most women during childbirth experience age disclosure without consent, provision of care without privacy, medical history disclosure without consent and disclosure of HIV status without due consent. The result is consistent with the findings of a study conducted by Mrisho et al. (2007) which revealed that women described humiliating experiences of lack of privacy when they were on the labour table without clothes in front of everybody, including people other than health providers. The result also agree with the submission of Lai and Levy (2012) that a significant proportion of pregnant women reported breach of confidentiality as sensitive patient information like HIV status, age, marital status and medical history were disclosed without any necessary medical or legal reasons. The result also agrees with the submission of Iyaniwura and Yusu (2019) that women reported non-confidential care in four studies including lack of privacy, and disclosure of sensitive patient information without consent.

The study findings showed that women experience denial of autonomy during birthing process to a low extent. Chi-square analysis revealed that the experience of denial of autonomy by women is significant during birthing process. This implies that majority of women are faced with situation where they are not involved in healthcare decision making, with full control of healthcare planning and implementation in the hands of midwives and obstetricians. The results also showed that the rights of women to self-determination during childbirth are disrespected by healthcare providers; healthcare providers' disregard of the perceptions and views of patients about their care and the right of patient to refuse or accept care is disrespected most times. This result agrees with the findings of a study conducted by Makumi (2015) that majority of pregnant women experience denial of autonomy and companionship during labor. The submission of Krampah (2018) that a good number of pregnant women experience denial of their right to self-determination during childbirth also supports the results of this study.

CONCLUSION

This study concludes that a large proportion of women experience non consented care, non confidential and non dignified care during birthing process to a significant extent.

RECOMMENDATIONS

Based on the study findings, the following are hereby recommended:

1. Active participation of women in all aspects of their care including decision making.
2. Women's right to self disclosure during childbirth should be respected,
3. Full informed consent should be sought for and obtained from women during childbirth,
4. The principle of confidentiality should be respected at all times when caring for women during childbirth.

REFERENCES

Balde, M. D., Diallo, B. A., Bangoura, A., Sall, O., Soumah, A. M., Vogel, J. P., & Bohren, M. A. (2017). Perceptions and experiences of the mistreatment of women during childbirth in health facilities in Guinea: A qualitative study with women and service providers. *Reproductive Health, 14(1),* 1–13.

Diorgu, C.F., & Steen, M.P. (2017). Nigerian mothers' perceived disrespectful care during labour and birth arising from lack of choices for birthing position and episiotomy. *Journal of Gynecology & Obstetrics, 1(3),* 105

Duong, D.V., Binns, C.W. & Lee, A.H. (2014). Utilization of delivery services at the primary health care level in rural Vietman. *Socio Science Medicine*, 59(12), 2585-2595Farah, D. (2016). Invisible wounds: obstetric violence in the United States. *Reproductive Health Matters, 24(47),* 56-64.

Gulmezoglu, A.M., Bahl, R., et al. (2015). Quality of care for pregnant women and newborns - The WHO vision. *BJOG,* 122*(8),*1045–9

Hassan, B., Popoola, A., Olokoba, A. & Salawu, F.K. (2011). A survey of neonatal tetanus at a district general hospital in north-east Nigeria. *Trop Doctor,* 41, 18–20.

Iyaniwura, C.A., & Yussuf, Q. (2019). Utilization of antenatal care and delivery services in Sagamu, South western Nigeria. *African Journal of Reproductive Health, 13(3),* 111–22.

Jenevic, T., Sripad, P., Bradley, E., & Dimitrievska, V. (2011). There's no kind of respect here: A qualitative study of racism and access to maternal health care among Romani women in the Balkans. *Int J Equity Health, 10,* 53.

Krampah, E. (2018). Factors associated with maltreatment of women during pregnancy and childbirth at the Tema general hospital. Retrieved from http://ugspace.ug.edu.gh/bitstream/handle/123456789/26302/Factors%20Associated%20with%20Maltreatment%20of%20Women%20During%20Pregnancy%20and

Lai, C.Y. & Levy, V. (2002). Hong Kong Chinese women;s experiences of vaginal examination in Labour. *Midwifery, 18(4),* 296-303.

Magoma, M., Requejo, J., Campbell, O.M., Cousens, S., & Filippi, V. (2010). High ANC coverage and low skilled attendance in a rural Tanzanian district: A case for implementing a birth plan intervention. *BMC Pregnancy Childbirth,* 10,13.

Makumi, I.W. (2015). Disrespect and Abuse of Women during Facility based Deliveries and its Effects on Intent to Use Maternity Services in Uringu Division Meru County. Retrieved from http://erepository.uonbi.ac.ke/bitstream/handle/11295/93224/Makumi,%20Ishmael%20W_abuse%20of%20women%20during%20facility%20based%20deliveries.pdf?s

Maya, E.T., Adu-Bonsaffoh, K., Dako-Gyeke, P., Badzi, C., Vogel, J.P., Bohren, M.A., & Adanu, R. (2018). Women's perspectives of mistreatment during childbirth at health facilities in Ghana: Findings from a qualitative study. *Reprod Health Matters, 26(53),* 70-87.

Meghan, A.B., Vogel, J.P., Hunter, E.C., Lutsiv, O., Makh, S.K., Souza, J.P. et al. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLoS Med,12(6),* e1001847.

Moyer, C. A., Dako-Gyeke, P., & Adanu, R. M. (2013). Facility-based delivery and maternal and early neonatal mortality in sub-Saharan Africa: A regional review of the literature. *African Journal of Reproductive Health, 17(3),* 30–43.

Mrisho, M., Schellenberg, JA, Mushi, AK, (2007). Factors affecting home delivery in rural Tanzania. *Tropical Medicine and International Health, 12(7),* 862-872.

Oxnevad, M. (2014). Perceptions and Practices Related to Home based and facility based birth. Retrieved from *reproductive-health-journal.biomedcentral.com*

Spangler, S.A. (2012). Assessing skilled birth attendants and emergency obstetric care in rural Tanzania: The inadequacy of using global standards and indicators to measure local realities. *Reprod Health Matters,* 20(39), 133–41.

Tuncalp, O., Were, W.M., Maclennan, C., Oladapo, O.T., Gulmezoglu, A.M., Bahl, R., et al. (2015). Quality of care for pregnant women and newborns - The WHO vision. *BJOG,* 122(8),1045–9.

World Health Organization (2017). *Mistreatment of women during childbirth a sad reality worldwide*. Geneva: WHO.