



ORIGINAL ARTICLE

A Facility-Based Assessment on Maternal Experiences of Disrespect and Abuse during Childbirth in Edo State, Nigeria

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ABSTRACT

Background: Disrespect and abuse during facility-based childbirth violate women's rights to dignified and non-violent healthcare. Despite global efforts to promote respectful maternity care, disrespect and abuse remain a significant barrier to optimal maternal health outcomes, particularly in low- and middle-income countries. This study assessed women's knowledge of and attitudes regarding disrespect and abuse during facility-based childbirth in Esan Central Local Government Area, Edo State, Nigeria.

Methods: A descriptive cross-sectional study utilizing a mixed-methods approach was conducted among 614 women who delivered in healthcare facilities in the preceding 18 months. Respondents were selected using multistage sampling. Data collection included semi-structured questionnaires and focus group discussions. Quantitative data were analysed using SPSS version 21.0, while thematic analysis was used for qualitative data. Logistic regression identified predictors of knowledge and attitudes, with statistical significance set at $p < 0.05$.

Results: Respondents' mean age was 30 ± 6 years, and 73.1% were married. Good knowledge of disrespect and abuse was observed in 57.8% of respondents, yet awareness of specific abusive practices, such as physical abuse (20.2%) and financial detention (26.9%), was low. While 71.8% strongly supported respectful care, 42.7% considered financial detention acceptable. Qualitative data highlighted the normalization of abusive behaviours, justified as necessary for safe delivery. Being married increased the likelihood of good knowledge, while formal education and good knowledge reduced the likelihood of accepting disrespect and abuse.

Conclusion: Significant gaps in knowledge and normalization of abusive practices underscore the need for targeted interventions, such as community education, healthcare provider training, and policy reforms, to eliminate disrespectful maternity care.

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INTRODUCTION

Maternal health remains a significant global health priority, especially in low- and middle-income countries (LMICs), where maternal mortality rates are disproportionately high.¹ Facility-based childbirth under the supervision of skilled birth attendants is a widely promoted strategy to reduce maternal and neonatal mortality.² However, achieving safe and dignified care during childbirth requires more than the presence of skilled attendants; it necessitates adherence to respectful maternity care (RMC). Disrespect and abuse (D&A) during facility-based childbirth undermine these efforts, representing a serious violation of women's fundamental rights to dignified and non-violent healthcare.^{3,4}

D&A during childbirth encompasses a range of harmful behaviours, including physical violence, verbal abuse, discrimination, neglect, non-consensual medical procedures, and detention for failure to pay medical bills.^{5,6} Such mistreatment often arises from systemic issues in healthcare settings, including inadequate staffing, training deficiencies, and entrenched cultural norms that devalue women's autonomy during childbirth.⁶⁻⁸ For instance, a systematic review reported global prevalence rates of D&A ranging from 15% in Tanzania to 98% in Nigeria, with physical and verbal abuse being the most frequently reported forms.^{6,9}

The consequences of D&A are far-reaching, affecting both immediate and long-term health outcomes. Women subjected to D&A are at

increased risk of postpartum depression, post-traumatic stress disorder, and avoidance of facility-based care in future pregnancies, undermining global efforts to reduce maternal mortality and morbidity.¹⁰⁻¹² Furthermore, systemic acceptance of D&A discourages community trust in healthcare systems, perpetuating cycles of poor health outcomes and inequities.^{13,14}

Although RMC is gaining recognition as a critical component of quality maternal care, evidence suggests significant gaps in knowledge and attitudes toward D&A among women. Many women, particularly in LMICs, lack awareness of their rights to respectful care, normalizing abusive behaviours and hindering efforts to address the issue.^{7,15} Understanding these knowledge and attitude gaps is essential for designing effective, context-specific interventions that promote RMC and safeguard maternal rights during childbirth.

This study seeks to assess knowledge of and attitudes toward D&A among women who experienced facility-based childbirth in Esan Central Local Government Area, Edo State, Nigeria. The findings will contribute to the growing body of evidence for implementing culturally sensitive and sustainable policies to eliminate D&A in maternal care settings.

METHODS

The study was conducted in Esan Central Local Government Area (LGA), Edo State, Nigeria. Edo State lies in the south-south region of

Nigeria, with a total land area of 19,281.93 square kilometres.¹⁶ Esan Central LGA is one of 18 LGAs in the state, with its administrative headquarters in Irrua, approximately 100 kilometres from Benin City, the state capital. The LGA is divided into 10 geopolitical wards and 58 villages.¹⁷ The predominant language is Esan, and the population mainly comprises farmers and traders. Healthcare services are provided through 13 public primary health centres, one tertiary hospital, two general hospitals, and 11 private hospitals, with primary health centres staffed by an average of three nurses/midwives, two community health extension workers (CHEWs), and one health attendant per facility.

This was a descriptive cross-sectional study utilizing a mixed-methods approach to assess the knowledge of and attitudes toward D&A during facility-based childbirth. Quantitative data were collected using interviewer-administered semi-structured questionnaires, while qualitative data were obtained through a focus group discussion (FGD). The integration of these methods enabled a comprehensive analysis, capturing both the prevalence and context of D&A.

The study population included women of reproductive age (15–49 years) residing in Esan Central LGA who had given birth in a health facility within 18 months preceding the study. Women who experienced stillbirths or whose infants died within one month of birth were excluded, as such experiences might affect their perceptions and attitudes toward D&A.

The minimum sample size for the quantitative component was calculated using Cochran's formula for cross-sectional studies:¹⁸

$$n = \frac{Z^2 p(1-p)D}{d^2}$$

where n = sample size required, Z = standard normal deviate for 95% confidence, p = prevalence of D&A from a previous study in Gombe State, Nigeria,¹⁹ and d = margin of error. Accounting for a design effect of 1.5 due to multistage sampling and a 10% non-response rate, the final sample size was increased to 614 participants.

A multistage sampling technique comprising three stages was employed to select participants:

1. **Selection of Wards:** Four wards (Opoji, Otoruwo II, Ugbegun, and Otoruwo I) were randomly selected from the 10 wards in Esan Central LGA using balloting.
2. **Selection of Communities:** Two communities were selected per ward through simple random sampling from a list provided by the local government secretariat, resulting in a total of eight communities (Okhore, Ujosalen, Idumebo, Usugbenu, Eguare Ugbegun, Idumogo, Akho, and Usenu).
3. **Selection of Respondents:** In each selected community, two clusters were identified. One cluster was chosen per community via balloting, and all eligible women within these clusters were invited to participate.

For the qualitative component, seven women aged 29–39 years with prior awareness of D&A

were purposively selected to ensure diverse perspectives during the FGD.

Quantitative data were collected using pre-tested, interviewer-administered, semi-structured questionnaires designed from existing literature.^{19,20} The questionnaire captured socio-demographic information, knowledge of and attitudes towards D&A. The qualitative component utilized an FGD guide adapted from existing literature.^{21,22} The FGD explored community perceptions of and attitudes toward D&A, including the acceptability of specific behaviours during facility-based childbirth. The FGD was audio-recorded with participants' consent, and verbatim transcription followed the session.

Measurement of Variables: Knowledge of D&A was assessed using 14 binary (yes/no) questions. Correct responses received a score of 1, while incorrect responses scored 0. Total knowledge scores were expressed as percentages. Scores above 50% indicated "good knowledge," while scores of 50% or below indicated "poor knowledge."

Attitude toward D&A was measured using nine Likert-scale statements. Responses ranged from "strongly agree" to "strongly disagree," with scores from 1 to 5 assigned accordingly. Total scores were categorised as "good attitude" (>60%), indicating an attitude that does not accept D&A, or "poor attitude" (≤60%), indicating an attitude that accepts D&A.

Data Analysis: Quantitative data were analysed using IBM SPSS version 21.0. Descriptive

statistics were used to summarise variables, including frequencies and percentages for categorical data and means with standard deviations for continuous variables. Chi-square and Fisher's exact tests assessed associations between socio-demographic factors and knowledge or attitudes toward D&A. Multivariable logistic regression identified significant predictors of knowledge and attitudes. Statistical significance was set at $P < 0.05$.

Qualitative data from the FGD were analysed thematically. The transcripts were reviewed and coded to identify patterns and emerging themes. Findings from the qualitative component complemented quantitative results, providing a richer understanding of the issues.

Ethical approval was obtained from the Health Research Ethics Committee of Irrua Specialist Teaching Hospital (ISTH/HREC/20211304/180). Written informed consent was secured from all participants, who were assured of confidentiality, anonymity, and the voluntary nature of their participation.

RESULTS

Sociodemographic Characteristics of Respondents

A total of 614 women participated in the study, with a mean age of 30.02 ± 6.10 years. The largest proportion (45.8%) was aged 20–29 years, followed closely by those aged 30–39 years (45.1%), while only 2.3% were under 20 years. The majority (73.1%) of respondents were married, with 15.5% cohabiting. Esan ethnicity predominated (47.4%), followed by Igbo (16.6%) and Yoruba (14.2%). Christianity was the predominant religion (84.2%), and nearly half of the respondents (48.9%) had attained secondary

education. Regarding occupation, 62.1% were engaged in skill-level 3 activities, 17.9% reported no income, and the median monthly income was

₦28,000 (interquartile range: ₦10,000–₦50,000). (Table 1).

Table 1: Sociodemographic Characteristics of Respondents

Variables	Frequency (n = 614)	Percent (100%)
Age (in years)		
≤19	14	2.3
20 – 29	281	45.8
30 – 39	277	45.1
40 – 49	42	6.8
Mean (±SD)	30.02 (±6.10)	
Marital status		
Single	38	6.2
Married	449	73.1
Widowed	8	1.3
Divorced	8	1.3
Separated	16	2.6
Cohabiting	95	15.5
Ethnicity		
Esan	291	47.4
Igbo	102	16.6
Yoruba	87	14.2
Bini	82	13.4
Hausa	37	6.0
Others*	15	2.4
Religion		
Christianity	517	84.2
Islam	79	12.9
African traditional religion	18	2.9
Completed level of education		
No formal education	49	8.0
Primary	128	20.8
Secondary	300	48.9
Tertiary	137	22.3
Occupation		
Skill level 0	129	21.0
Skill level 1	53	8.6
Skill level 2	29	4.7
Skill level 3	381	62.1
Skill level 4	22	3.6
Monthly income (₦)		
No income	108	17.9
< 30000	195	32.3
30000 – 90000	263	43.5
>90000	38	6.3
Median (IQR)	28000 (10000-50000)	

*Ibibio 0.32%, Ijaw 0.32%, Etsako 0.32%, Delta Ibo 0.32%, Ogoni 0.32%, Urhobo 0.16%, Owan 0.16%, Igede 0.16%, Plateau 0.16%, Ghanaian 0.16%

Knowledge of Disrespect and Abuse during Facility-Based Childbirth

Among the respondents, 37.5% had heard the term “disrespect and abuse during facility-based childbirth,” with family and friends cited as the most common source (46.3%). Despite the limited awareness of the term, 70.7% recognised that D&A violates women’s basic rights. While 86.2% identified neglect (e.g., leaving a woman

unattended during labour) as a form of D&A, only 20.2% recognised physical abuse, such as slapping to hasten delivery. Additionally, 26.9% were aware that detaining women due to inability to pay for childbirth services constitutes D&A (**Table 2**). Overall, 57.8% of respondents demonstrated good knowledge of D&A, while 42.2% exhibited poor knowledge.

Table 2: Knowledge of the Forms of Disrespect and Abuse during Facility-Based Childbirth

Variable	Correctly answered Frequency (n=614)	Percent
The following comprises D&A during facility-based childbirth*		
Physical Abuse		
Slapping a woman on the laps to facilitate childbirth	124	20.2
Hitting a woman who refuses to push during labour	207	33.7
Cutting and stitching episiotomy without anaesthesia	307	50.0
Non-dignified care		
Shouting at a woman who refuses to push during labour	161	26.2
Asking a woman to walk around while waiting in labour ward	547	89.1
Non-consented care		
Performing vaginal exam on a woman in labour with her permission	492	80.1
Allowing a woman deliver in her preferred position	464	75.6
Performing a procedure such as C/S on a woman during childbirth without explaining to her/relatives	342	55.7
Giving a woman episiotomy without her permission during labour	329	53.6
Discrimination		
Discussing information of a client in a manner that other people hear without her permission	535	87.1
Non-confidential care		
Encouraging a woman to deliver without the use of screens or curtains	401	65.3
Abandonment		
Leaving a woman unattended during labour is D&A	529	86.2
Inappropriate demand for payment		
Detaining a woman in the healthy facility due to inability to pay for childbirth services rendered	165	26.9
D&A during childbirth violates the basic rights of a woman	434	70.7

*Multiple responses

Attitudes towards Disrespect and Abuse during Facility-Based Childbirth

Respondents’ attitudes toward D&A varied significantly. While 71.8% strongly agreed that

women have a right to be treated with respect and dignity during childbirth, a substantial proportion (37.3%) disagreed that shouting at women in labour is abusive. Furthermore, 43.8% found it

acceptable for healthcare providers to scold women who did not bring essential birthing items. Alarming, 42.7% considered detaining women unable to pay hospital bills as acceptable. In contrast, leaving a woman unattended during labour was deemed unacceptable by 94.3% of respondents (Table 3). The overall attitude scores revealed that 50.5% had good attitudes towards D&A, while 49.5% exhibited poor attitudes, reflecting a troubling normalisation of some abusive practices.

Qualitative Findings: Perspectives on Acceptability of Disrespect and Abuse

The focus group discussion (FGD) provided deeper insight into community perceptions of D&A. Many participants rationalised abusive behaviours, such as shouting, slapping, or pinching, as necessary to ensure compliance during labour, especially in emergencies. For instance, a 29-year-old participant stated, *“If slapping is the only way to save the baby, then it is acceptable.”* However, some participants opposed such practices, advocating for more respectful approaches. A 34-year-old woman shared, *“The nurses were petting me and asking me to breathe; they didn’t beat me, and I delivered safely.”* Mixed opinions also emerged

on detaining women for non-payment. Some viewed it as a deterrent against exploitation, while others emphasised its harm to vulnerable families.

Factors Associated with Knowledge of and Attitudes toward Disrespect and Abuse

Multivariable logistic regression revealed that marital status was the only significant predictor of knowledge. Married women were twice as likely to have good knowledge of D&A compared to unmarried women (adjusted odds ratio [AOR] = 2.253, 95% CI: 1.456–3.486, $p < 0.001$). (Table 4)

Age, education, employment, and knowledge significantly influenced attitudes towards D&A. Older respondents were less likely to accept D&A (AOR = 0.958, 95% CI: 0.921–0.996, $p = 0.032$). Formal education and good knowledge were protective against accepting D&A (AOR = 0.200, 95% CI: 0.073–0.550, $p = 0.002$; AOR = 0.104, 95% CI: 0.067–0.161, $p < 0.001$, respectively). Interestingly, employment increased the likelihood of accepting D&A (AOR = 4.011, 95% CI: 1.448–11.110, $p = 0.008$), possibly reflecting workplace desensitisation to mistreatment. (Table 5)

Table 3: Attitude of respondents towards D&A during Facility-Based Childbirth

Variable	Attitude				
	Strongly Agree n (%)	Agree n (%)	Undecided n (%)	Disagree n (%)	Strongly disagree n (%)
You have a right to be treated with respect and dignity during childbirth	441 (71.8)	171 (27.9)	1 (0.2)	1 (0.2)	0 (0.0)
It is abusive to shout at a woman in labour or during delivery	120 (19.5)	173 (28.2)	27 (4.4)	229 (37.3)	65 (10.6)
It is acceptable to slap or pinch a woman during childbirth	238 (38.8)	190 (30.9)	32 (5.2)	111 (18.1)	43 (7.0)
It is acceptable for health provider to shout at or scold a woman who did not come with her essential birthing items	269 (43.8)	196 (31.9)	31 (5.0)	76 (12.4)	42 (6.8)
It is acceptable for health provider to leave woman in labour unattended when she is busy	9 (1.5)	5 (0.8)	21 (3.4)	220 (35.8)	359 (58.5)
Woman should tolerate being slapped or shouted at during childbirth to ensure good outcome for her baby	160 (26.1)	279 (45.4)	38 (6.2)	96 (15.6)	41 (6.7)
It is acceptable to detain woman in health facility due inability to pay hospital bills	262 (42.7)	193 (31.4)	60 (9.8)	67 (10.9)	32 (5.2)
There should be mechanism for complaining about abusive maternity practices of health care providers	161 (26.2)	246 (40.1)	165 (26.9)	21 (3.4)	21 (3.4)
Health provider who disrespects and abuses women during childbirth should be punished	158 (25.7)	237 (38.6)	166 (27.0)	27 (4.4)	26 (4.2)

DISCUSSION

The findings of this study highlight significant gaps in knowledge and attitudes toward disrespect and abuse (D&A) during facility-based childbirth in Esan Central Local Government Area, Edo State, Nigeria. Despite global advocacy for respectful maternity care (RMC), this study reveals persistent normalization of abusive practices, highlighting systemic

challenges and cultural influences that undermine women's rights to dignified healthcare.

While 37.5% of respondents reported awareness of the term "disrespect and abuse during childbirth," 70.7% recognised it as a violation of women's basic rights. These findings align with similar studies conducted in Nigeria, where awareness of D&A remains low despite widespread occurrence.^{15,20} The limited understanding of specific abusive practices, such

as physical abuse (20.2%) and detention due to unpaid bills (26.9%), reflects societal acceptance of these behaviours. This lack of awareness perpetuates a cycle of mistreatment, as women may not recognise or report such violations.

The findings also reveal disparities in knowledge, with married women being more likely to have good knowledge of D&A compared to unmarried women. This is consistent with literature suggesting that marital status often correlates with increased exposure to maternity care systems and social networks facilitating information sharing.^{7,22,23} However, the study highlights the need for targeted education campaigns to bridge knowledge gaps, particularly among younger and unmarried women.

Attitudes toward D&A revealed a troubling dichotomy: while most respondents (71.8%) strongly agreed that women have a right to respectful care, many normalized abusive behaviours, such as shouting (37.3% disagreed it is abusive) and scolding women for not bringing birthing items (43.8% found it acceptable). These findings are consistent with previous studies in Nigeria and Ghana, where cultural norms often prioritise infant survival over maternal dignity.^{23,24} The acceptance of financial detention by 42.7% of respondents further underscores systemic inequities and the financial vulnerabilities of women during childbirth.

Table 4: Multivariable logistic regression showing predictors of good knowledge of Disrespect and Abuse during facility-based childbirth among respondents

Predictors	β coefficient	Adjusted Odds ratio	95% CI		p-value
			Lower	Upper	
Age (in years)	-0.013	0.987	0.958	1.018	0.404
Marital Status					
Never married		1			
Ever married	0.812	2.253	1.456	3.486	<0.001*
Religion					
Christian		1			
Non-Christian	0.241	1.272	0.789	2.053	0.324
Completed level of Education					
No formal education		1			
Formal education	0.149	1.160	0.621	2.169	0.642
Occupation of respondents					
Unemployed		1			
Employed	-0.408	0.665	0.424	1.043	0.076

*Statistically significant; CI: Confidence Interval

Qualitative findings from focus group discussion (FGD) revealed rationalizations of abusive practices, particularly in emergencies. This perception reflects a deep-seated belief that

certain actions, though harmful, are necessary to ensure safe delivery outcomes. Similar findings were reported in a study from northern Nigeria, where healthcare providers rationalized abusive

practices as a way to manage uncooperative behaviour patients.⁷ However, participants who opposed these practices emphasised the

effectiveness of compassionate care, advocating for alternative approaches that respect women's autonomy while achieving optimal outcomes.

Table 5: Multivariable logistic regression showing predictors of attitude that accept Disrespect and Abuse during facility-based childbirth among respondents

Predictors	β coefficient	Adjusted Odds ratio	95% CI		p-value
			Lower	Upper	
Age (in years)	-0.043	0.958	0.921	0.996	0.032*
Marital Status					
Never married		1			
Ever married	-0.216	0.806	0.443	1.466	0.479
Religion					
Christian		1			
Non-Christian	0.328	1.389	0.746	2.585	0.300
Completed level of Education					
No formal education		1			
Formal education	-1.608	0.200	0.073	0.550	0.002*
Occupation of respondents					
Unemployed		1			
Employed	1.389	4.011	1.448	11.110	0.008*
Monthly income (₦)					
≤ 30000		1			
>30000	-0.341	0.711	0.459	1.101	0.126
Knowledge of respondents					
Poor knowledge		1			
Good knowledge	-2.262	0.104	0.067	0.161	<0.001*

*Statistically significant; CI: Confidence Interval

Multivariable regression analysis identified marital status, education, age, employment, and knowledge as significant predictors of attitudes toward D&A. Formal education and good knowledge emerged as protective factors, reducing the likelihood of accepting D&A. These findings corroborate existing literature that links education to increased awareness of healthcare rights and the ability to challenge mistreatment.^{22,25} Conversely, employment was associated with a higher likelihood of accepting D&A, possibly reflecting workplace desensitisation to abusive behaviours, as noted in

previous studies.^{7,25} Addressing such normalization requires systemic changes, including workplace training and community sensitization.

The normalization of D&A undermines efforts to improve maternal health outcomes and achieve Sustainable Development Goal (SDG) 3, which aims to reduce maternal mortality. Women who experience D&A are less likely to seek facility-based care in subsequent pregnancies, perpetuating high maternal mortality rates in low-resource settings.^{26,27} Addressing these challenges necessitates a multi-pronged

approach, including the integration of RMC principles into healthcare training curricula, community advocacy campaigns, and the enforcement of legal protections against D&A.

The role of healthcare providers is pivotal in transforming care practices. Studies have shown that training providers in RMC can significantly reduce instances of D&A, enhancing patient satisfaction and trust in healthcare systems.^{10,28} Policies that ensure accountability, such as grievance mechanisms for reporting abusive practices, are also essential to safeguarding women's rights during childbirth.

This study contributes to the growing evidence base on D&A in Nigeria, providing both quantitative and qualitative insights. However, its generalizability is limited by its focus on a single local government area. Additionally, the reliance on self-reported data may introduce recall bias, particularly in assessing past experiences of D&A. Future research should consider longitudinal designs to explore the long-term impact of D&A on maternal health-seeking behaviours.

CONCLUSION

The findings highlight the urgent need for interventions to address knowledge gaps and

challenge the cultural acceptance of D&A. Strategies should prioritise community education, healthcare provider training, and policy reforms to ensure that all women receive respectful, dignified care during childbirth. Implementing culturally sensitive and sustainable policies is essential to eliminating D&A and promoting respectful maternity care, ultimately contributing to improved maternal health outcomes and trust in healthcare systems.

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Author's contribution: EOC conceptualised the study, collected data, analysed data, prepared the manuscript and contributed to the manuscript writing. OEO contributed to the manuscript writing and editing. OOI contributed to data analysis and manuscript writing. All authors reviewed and approved the final manuscript.

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