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Forms of Support and Experiencing Maltreatment and Disrespect During Childbirth at a Health Facility: A Self-Reported Cross-Sectional Study in Ghana

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Abstract

One method to enhance maternal health outcomes in underdeveloped nations is to help women and encourage them to give birth in medical facilities (skilled delivery). Yet, impediments to facility birth have reportedly included fear of abuse and contempt during labour and delivery. The purpose of this study was to evaluate the self-reported experiences of postnatal women and the types of abuse and disrespect they encountered during delivery. One hundred and thirteen (313) women were chosen at random from three healthcare facilities in the Greater Accra area for a cross-sectional study. STATA 15 was used to analyze the data. According to the study, more than half of the postnatal women (54.3%) were urged to have support people present during labour and delivery. Approximately 75.7% said they had been mistreated in some way, with physical violence accounting for 19.8% and undignified care for 9.3%. About 7.7% (n = 24) of the women were detained or confined against their will. The study's findings indicate that labour-related abuse and disrespect are common. Without improving the birthing experience for women, expanding medical facilities might not result in the skilled or facility-based deliveries that are intended. The quality of maternal health care should be monitored, and hospitals should train their midwives in providing excellent patient care (customer care).

Keywords

maltreatment, women, childbirth, experience, Ghana

Introduction

Maternal mortality remains in challenge globally. The majority (99%) of these avoidable deaths occur in low-income countries.[1] Maternal death has disastrous outcomes for families, communities and country with significant economic effect resulting in broken homes and motherless children.[2] The crucial hurdle to the utilization of health services for women that contributes to maternal death is a delay in the decision to seek care, delay in arrival at a health facility and lack of provision of satisfactory care.[3] The lack of provision and adequate care buttress the need to improve women's access to maternity care and promote birth in health facilities with skilled attendants.[4]

According to Souza et al., the majority of maternal deaths have been found to be avoidable.[5] Maternal and neonatal health can improve and complications avoided when women access skilled respectful care during pregnancy and childbirth from health care providers.[6] Women's experiences and their perceptions of maternity care are formed principally on client-provider interpersonal relationship.[7] The major drawback to accessing skilled care for routine and complicated births is poor interactions between the patient and the health provider.[8,9] Furthermore, the Respectful Maternity Care Charter as published by White Ribbons Alliance recognizes that women's perceptions of childbirth are an essential component of quality health care and their autonomy, dignity, feeling, choices and preferences must be respected.[10]

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In accordance with international human rights law, childbearing women have the right to information, informed consent, privacy and confidentiality, respect for themselves and others, and freedom from physical violence and discrimination. The care received during childbirth must emphasize these and not solely on the prevention of death of mother and baby.[11] Disrespect and abuse during pregnancy and childbirth have been identified as an important indicator of poor quality care and a barrier to improved maternal outcomes with inadequate data on the scope and magnitude, especially in urban areas of low-income countries.[12]

According to Bohren et al., the facilitators and barriers to future facility-based delivery are dependent on experience during child birth and pregnancy outcomes.[3] Also, women who experience negative interactions in a facility are reluctant to report back for subsequent deliveries.[13] According to Okafor, the high rates and contributions of disrespect and abuse continue to favour home deliveries with no skilled attendance in Nigeria.[14] This can lead to poor maternal and neonatal health outcomes and encourage the use of traditional birth attendants. In Earlier study conducted in rural community in Ghana, it was reported that women experience maltreatment during delivery which tends to favour the use traditional birth attendants (TBA).[15] Such an encounter can be a barrier to future facility-based delivery in a setting where women view TBAs as more dependable than health facility personnel, as providing high-quality care in terms of supportive care, skill and emotional help during childbirth.[3]

At La-Nkantanang Madina Municipality in Accra where the study was conducted, supervised deliveries have marginally improved from 45.3% to 62.8% for the first half of the year from 2012 to 2017. However, this is below 92.1% reported in the Greater Accra in a nationwide survey.[16] Given the reported correlate between maltreatment and accessing skilled delivery, this study was conducted to document self-reported experiences of maltreatment.

Methods and Materials

Study Design

A quantitative cross-sectional study was conducted at three selected health facilities in La-Nkwantenang-Madina Municipality (LNMM) in the Greater Accra region of Ghana. The choice of study design was informed by an earlier study conducted in 2016 on the prevalence of disrespect and abuse during facility-based child birth and associated factors in Jimma University Medical Center, Southwest EthiopiaSouth West Ethiopia.[17]

Study Settings

The study was conducted at the three facilities mentioned earlier in La-Nkwantanang Madina Municipality: Pentecost Hospital, Madina Polyclinic at Kekeli and Madina Polyclinic at Rawling circle. These facilities render maternal and child health care to residents of the Municipality and beyond.

Study Population

This study was conducted among postnatal women within the reproductive ages of 15–49 years who delivered at these selected facilities and were attending postnatal clinic at the time of the study.

Inclusion and Exclusion Criteria

Women who have delivered either vaginally or by emergency caesarean section, reporting for their sixth-week postnatal review were included in the study. However, the study excluded women who had induction of labour as well as mothers in critical medical condition or experienced stillbirths. This was because the process of induction may be misconstrued as abuse. Women who had experienced stillbirth were excluded because they may be going through emotional distress.

Sample Size Determination

A single population proportion formula was used to estimate the sample size with an assumption of 5% precision and 95% confidence. An assumption that 72% of labouring mothers would face at least one form of disrespect and abuse during childbirth was used based on earlier study.[18] Based on this, a minimum sample size of 309 was determined. In studies using postnatal women, it has been reported that a non-response rate of 2% to 10% should be expected. The minimum non-response rate was adopted, and the sample size increased to 316.

Sampling Technique

The allocation of the sample to the three health facilities was made proportionately, based on the number of clients who received childbirth services at each facility in the month preceding the data collection period. The average number of deliveries per month in Pentecost Hospital, Madina Polyclinic (RC) and Madina Polyclinic Kekele were 310, 40 and 108, respectively. Proportionate allocation to the three facilities was done (Pentecost hospital = 215, Madina Polyclinic, RC = 28, Madina Polyclinic, Kekele = 73)

The postnatal clinics run every week hence the sample size of mothers to be interviewed per week for Pentecost Hospital, Madina Polyclinic (RC) Madina Polyclinic Kekele were 36, 5, and 13, respectively. A simple random sampling without replacement was conducted at the selected facility to obtain the participants for the study. At each facility, a list of mothers attending postnatal clinic per week was obtained from the medical records and assigned numbers from one to the last number. Each number was written on a paper of the same size and put in a bowl with a blindfolded person to pick 36, 5, and 13 papers at Pentecost Hospital, Madina Polyclinic (RC) Madina Polyclinic Kekele respectively. The mothers whose names corresponded to the

numbers selected at each facility were recruited into the study. If a client declined to participate, a replacement was done.

Study Variables

Disrespect has seven categories: (1). Physical abuse: slapping/hitting or physical force on the mother; (2). Non-dignified care: mother experience rudeness, scolding or insults; (3). Non-consented care: No informed consent or information dissemination; (4). No privacy: curtains or other visual barriers not used; (5). Discrimination: mother prejudiced on grounds of clinic state; (6). Neglect: mother was left alone or unattended to; (7). Detention: mother delayed in health facility against her will.

A woman was considered to have received disrespectful care if she experienced at least one of the seven categories of disrespect and abuse. For a specific category of abuse and disrespect with more than one verification criterion, a woman was labelled "abused and disrespected" in that category if she was abused and disrespected in at least one of the verification criteria during childbirth. The rest of the variables were socio-demographic such as age, marital status, education, religion, parity, mode of delivery.

Data Collection and Tools

A self-administered structured questionnaire was used for data elicitation. For participants who could not read, the Research Assistants interpreted the questions and helped them fill in the questionnaire. The questionnaires were administered on a one-on-one basis to each participant. The first part of the questionnaire elicited participants socio-demographic characteristics/ client-related factors. The second part assessed disrespectful care and during labour and childbirth. The tool was adapted from the Maternal and Child Health Integrated Program (MCHIP) tool kit instrument that assesses and improves respectful maternity care.[19] The tool covers a variety of areas including the right to information and privacy; confidentiality; consent and preference in care; choice of a companion during labour and birth; freedom of movement during labour; non-separation of mother and newborn and prevention of institutional violence, abusive and disrespectful care. It took on an average of 40 min to complete or administer a questionnaire.

Data Processing and Analysis

Data was entered, cleaned, and analysed using STATA software version15. Frequency and percentages were used to describe the demographic characteristics of the study participants. The forms of disrespect and abuse were also summarized descriptively using frequency and percentages. The Pearson's chi-square test of association was used to assess socio-demographic factors and experiencing at least one of the forms of disrespect. The multivariable logistic regression model was used to estimate the crude and adjusted odds ratio of the factors significantly associated with the experience of at least one form of disrespectful care from Pearson's chi-square test. All statistical tests with p-values below .05 were considered statistically significant.

Results

Socio-Demographic Characteristics of Respondents

A total of 316 questionnaires were administered, however, 313 were retrieved (response rate of 99%). About half (49.8%, n = 156) were within the age range 25 to 34 years, 22.0% (n = 69) were single while 43.8% (n = 137) were married, 17.9% (n = 56) had no formal education while 12.5% (n = 39) had tertiary level of education, 22.4% (n = 70) were unemployed. Most (68.7%, n = 215) of the women delivered at PHM (Supplementary file 1).

Forms of Support Received During Labour and Childbirth

Over half (54.3%, n = 170) of the women were encouraged to have a support person present during delivery while 76.7% (n = 240) liked the idea of support persons being present. A third (33.2%, n = 104) had their mothers as labour companions, 22.4% (n = 70) had their husband or partners present while 10 (3.2%) had no one present during delivery (Table 1).

Self-Reported Experience and Forms of Disrespect During Labour and Childbirth

Figure 1 shows the frequency distribution of the number of women who experienced the various forms of disrespect during the delivery at the health facilities. About a fifth (19.8%, n = 62) of the women experienced physical abuse and 9.3% (n = 29) were discriminated against. About 38.9% (n = 122) of the women experienced undignified care, 7.7% (n = 24) of the women were detained or confined against their will, 60.4% (n = 189) did not receive consented care, the privacy, or the confidentiality of 109 (34.8%) women were not protected and 17.9% (n = 56) of the women were left unattended to when they needed care (Figure 1). In overall, 75.7% (n = 237) of the women experienced at least one form of disrespectful care during their delivery at the health facility.

Association Between Socio-Demographic Characteristics (SCD)/Reproductive Factors (RH) and Experience of Disrespectful Care

The experience of at least one form of disrespectful care was 85.5% (59/69) among single women, 64.9% (89/137) among married women, 80.3% (65/81) among cohabiting women,

Table 1. Forms of Support Received During Labour and Childbirth.

Forms of support	Frequency (n)	Percentage (%)
Woman encouraged to have support person		
No	143	45.69
Yes	170	54.31
A woman likes the idea of a support person		
No	73	23.32
Yes	240	76.68
Labour companion		
Mother	104	33.23
Husband/partner	70	22.36
Friend	31	9.90
Others	98	31.31
None	10	3.19
The woman had freedom of movement during labour		
No	151	48.24
Yes	108	34.50
Don't know	54	17.25
Encouraged to eat food		
No	173	55.27
Yes	140	44.73
Encouraged to take fluids		
No	156	49.84
Yes	157	50.16
Labour analgesia		
No	152	48.56
Yes	161	51.44
Episiotomy/laceration		
No	221	70.61
Yes	92	29.39
The baby was given to the mother immediately after birth		
No	62	19.81
Yes	251	80.19

and 92.3% (24/26) among divorced or widowed women. There was statistically significant association between marital status and the experience of at least one form of disrespectful care ($\chi^2 = 17.01$, $p = .001$).

Experience of some form of disrespectful care was higher among women who visited PHM (86.5%, 186/215) compared to those who visited MPK (58.6%, 41/70) and MPR/C (35.7%, 10/28). There was a significant association between health facility delivered at and the experience of at least one form of disrespectful care ($\chi^2 = 49.19$, $p < .001$). Highest level of education ($\chi^2 = 15.05$, $p = .002$), employment ($\chi^2 = 10.97$, $p = .012$), religion ($\chi^2 = 10.63$, $p = .001$) and mode of delivery ($\chi^2 = 13.54$, $p < .001$) were also significantly associated with the experience of at least one form of disrespectful care. The woman is encouraged to have a support person ($\chi2 = 17.31$, $p < .001$), the woman liking the idea of a support person ($\chi2 = 24.03$, $p < .001$), the labour companion present ($\chi2 = 13.56$, $p = .009$), having the freedom of movement during labour ($\chi2 = 23.92$, $p < .001$), encouraged to eat food ($\chi2 = 22.79$, $p < .001$), encouraged to take fluids ($\chi2 = 15.39$, $p < .001$), having labour analgesia ($\chi2 = 20.32$, $p < .001$) and the baby given to mother immediately after delivery ($\chi2 = 11.06$, $p = .001$) were the forms of support significantly associated with the experience of at least one form of disrespectful care (Table 2).

Predictors of Disrespect and Maltreatment During Labour and Delivery

Table 3 shows a multivariable analysis of the factors associated with the experience of at least one form of disrespectful care towards women delivering at the health care facility. The simple logistic regression model was used to estimate the unadjusted odds ratio while the multiple logistic regression

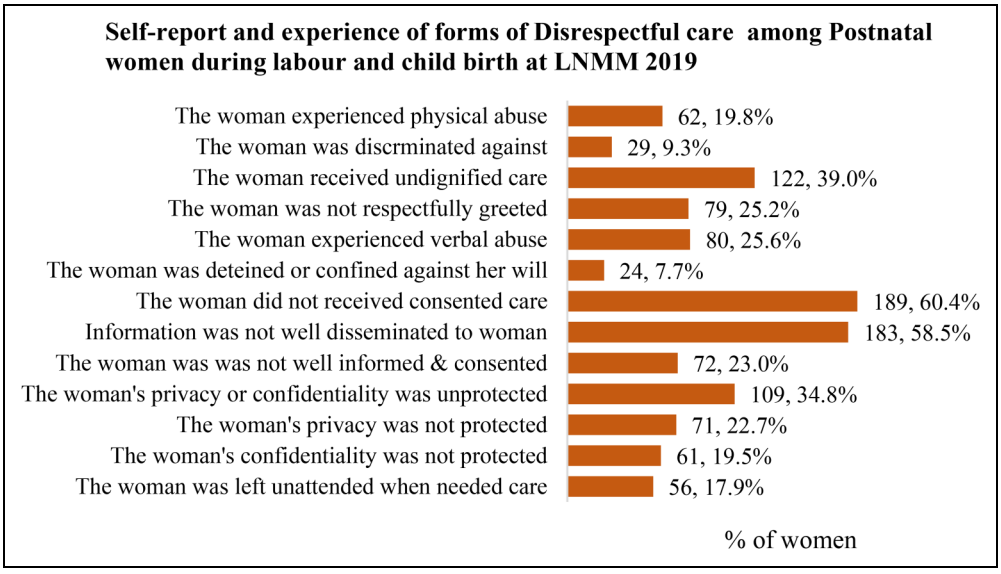

Figure 1. Self-reported and experience and forms of disrespect experienced during labour and childbirth.

Table 2. Association Between Socio-Demographic Characteristics and Reproductive History of Participants and Experience of any Form of Disrespect.

SCDs/RH Variables	Total n	Experience of any form of disrespect: No n (%)	Experience of any form of disrespect: Yes n (%)	χ^2-value	p-value
Age group				4.14	.126
<25	111	20 (18.02)	91 (81.98)		
25–34	156	45 (28.85)	111 (71.15)		
35–44	46	11 (23.91)	35 (76.09)		
Marital status				17.01	.001**
Single	69	10 (14.49)	59 (85.51)		
Married	137	48 (35.04)	89 (64.96)		
Co-habiting	81	16 (19.75)	65 (80.25)		
Divorced/Widowed	26	2 (7.69)	24 (92.31)		
Highest education				15.05	.002**
No education	56	7 (12.50)	49 (87.50)		
Primary	107	33 (30.84)	74 (69.16)		
Secondary	111	20 (18.02)	91 (81.98)		
Tertiary	39	16 (41.03)	23 (58.97)		
Employment				10.97	.012*
Unemployed	70	7 (10.00)	63 (90.00)		
Civil servant	44	15 (34.09)	29 (65.91)		
Traders	146	40 (27.40)	106 (72.60)		
Others	53	14 (26.42)	39 (73.58)		
Income				3.71	.294
None	18	2 (11.11)	16 (88.89)		
<500	113	32 (28.32)	81 (71.68)		
500–1000	88	23 (26.14)	65 (73.86)		
>1000	94	19 (20.21)	75 (79.79)		
Religion				10.63	.001**
Muslim	115	16 (13.91)	99 (86.09)		
Christians	198	60 (30.30)	138 (69.70)		
Parity				1.19	.552
P1–2	229	52 (22.71)	177 (77.29)		
P3–4	71	20 (28.17)	51 (71.83)		
P4 +	13	4 (30.77)	9 (69.23)		
Mode of delivery				13.54	<.001***
Emergency Caesarean Section (Em. CS)	68	5 (7.35)	63 (92.65)		
Spontaneous Vagina Delivery (SVD)	245	71 (28.98)	174 (71.02)		
Facility of delivery				49.19	<.001***
MPK	70	29 (41.43)	41 (58.57)		
MPR/C	28	18 (64.29)	10 (35.71)		
PHM	215	29 (13.49)	186 (86.51)		
Support person encouraged				17.31	<.001***
No	143	19 (13.29)	124 (86.71)		
Yes	170	57 (33.53)	113 (66.47)		
Likes the idea of a support person				24.03	<.001***
No	73	2 (2.74)	71 (97.26)		
Yes	240	74 (30.83)	166 (69.17)		
Labour companion				13.56	.009**
Mother	104	20 (19.23)	84 (80.77)		
Husband/partner	70	24 (34.29)	46 (65.71)		
Friend	31	3 (9.68)	28 (90.32)		
Others	98	29 (29.59)	69 (70.41)		
None	10	0 (0.00)	10 (100.00)		
Had the freedom of movement during labour				23.92	<.001***
No	151	33 (21.85)	118 (78.15)		
Yes	108	41 (37.96)	67 (62.04)		
Don't know	54	2 (3.70)	52 (96.30)		

(continued)

Table 2. (continued)

SCDs/RH Variables	Total n	Experience of any form of disrespect: No n (%)	Experience of any form of disrespect: Yes n (%)	χ^2-value	p-value
Encouraged to eat food				22.79	<.001***
No	173	24 (13.87)	149 (86.13)		
Yes	140	52 (37.14)	88 (62.86)		
Encouraged to take fluids				15.39	<.001***
No	156	23 (14.74)	133 (85.26)		
Yes	157	53 (33.76)	104 (66.24)		
Labour analgesia				20.32	<.001***
No	152	54 (35.53)	98 (64.47)		
Yes	161	22 (13.66)	139 (86.34)		
Episiotomy/laceration				0.59	.441
No	221	51 (23.08)	170 (76.92)		
Yes	92	25 (27.17)	67 (72.83)		
The baby was given to the mother immediately after birth				11.06	.001**
No	62	5 (8.06)	57 (91.94)		
Yes	251	71 (28.29)	180 (71.71)		
Staffs present during labour				8.93	.003**
Less than three (<3)	227	45 (19.82)	182 (80.18)		
Three or more (≥3)	86	31 (36.05)	55 (63.95)		
Staffs present during delivery				1.26	.262
Less than three (<3)	223	58 (26.01)	165 (73.99)		
Three or more (≥3)	90	18 (20.00)	72 (80.00)		
Staff overwhelmed				3.07	.216
No	125	36 (28.80)	89 (71.20)		
Yes	43	7 (16.28)	36 (83.72)		
Don't know	145	33 (22.76)	112 (77.24)		

χ^2: Pearson's chi-Square. P-Value Notation: *: $p < .05$. **: $p < .01$. ***: $p < .05$.

model was used to estimate the adjusted odds ratio. From the adjusted logistic regression model, the odds of a woman experiencing at least one form of disrespectful care was 5 times higher for those visiting PHM compared to those visiting MPR/C (AOR: 5.01, 95% CI: 1.18–21.35, $p = .029$). The odds of experiencing at least one form of disrespectful care were 2.5 times among women who were not encouraged to have a support person present compared to women who were encouraged to have a support person present during delivery (AOR: 2.48, 95% CI: 1.12–5.49, $p = .026$). Also, women who did not like the idea of support person present during labour had 5-times increased odds of experiencing at least one form of disrespectful care compared to those who did not like the idea of support person present (AOR: 5.38, 95% CI: 1.08-26.81, $p = .040$). (Table 3)

Discussion

Forms of Support Received During Labour and Childbirth

More than half (54.3%) of the postnatal women were encouraged to have support persons during labour and delivery. This may be as a result of inadequate space at the labour wards to allow effective execution of labour companion at these facilities or the value of the labour support underestimated. More than two-thirds (76.7%) of the women confirmed their preference for the idea of a support person during labour and delivery. This affirms the assertion that women like to be supported during labour.[20] The companions may provide psychological support to endure labour and childbirth, but also provide logistics and assistance to the staff where necessary.[21] One out of every four (22.4%) labour companions were husbands or partners which reveals a low male involvement during labour and childbirth while their mothers formed a third (33.2%) of the support persons. About a third (34.5%) of the postnatal women had freedom of movement during labour which is not encouraging. This could be because of either the respectful maternity care guidelines are not complied or inadequate space available at the labour ward discouraged the practice of unrestricted movement during labour.

About half of the women were encouraged to drink fluids (50.2%) and eat food (44.7%) during labour. This is also not encouraging because the process of childbirth may lead to maternal exhaustion especially if the labouring women are denied this support. The woman starved and or dehydrated, may lack the energy to expel the baby at the second stage. As a result of exhaustion, increasing her risk of instrumental or caesarean deliveries. Mothers may become dissatisfied

Table 3. Predictors of Experiencing Abuse and Maltreatment During Childbirth.

Predictors of disrespect and maltreatment	Unadjusted logistic regression		Adjusted logistic regression	
	UOR [95% CI]	P-value	AOR [95% CI]	P-value
Marital status				
Single	1.00 [reference]		1.00 [reference]	
Married	0.31 [0.15–0.67]	.003**	1.10 [0.39–3.06]	.857
Co-habiting	0.69 [0.29–1.64]	.398	1.90 [0.60–5.96]	.272
Divorced/Widowed	2.03 [0.41–9.98]	.382	2.91 [0.50–17.02]	.236
Highest education				
No education	4.87 [1.76–13.46]	.002**	3.70 [0.78–17.64]	.101
Primary	1.56 [0.73–3.33]	.251	1.97 [0.55–6.97]	.295
Secondary	3.17 [1.42–7.05]	.005**	2.72 [0.81–9.16]	.107
Tertiary	1.00 [reference]		1.00 [reference]	
Employment				
Unemployed	1.00 [reference]		1.00 [reference]	
Civil servant	0.21 [0.08–0.58]	.003**	0.50 [0.12–2.17]	.354
Traders	0.29 [0.12–0.70]	.005**	0.65 [0.22–1.94]	.434
Others	0.31 [0.11–0.83]	.020*	1.16 [0.31–4.35]	.830
Religion				
Muslim	1.00 [reference]		1.00 [reference]	
Christians	0.37 [0.20–0.68]	.001**	0.88 [0.38–2.02]	.764
Mode of delivery				
Emergency Caesarean Section	1.00 [reference]		1.00 [reference]	
Spontaneous Vagina Delivery	0.19 [0.08–0.50]	.001**	0.63 [0.17–2.33]	.486
Facility of delivery				
MPK	2.54 [1.03–6.31]	.044*	1.36 [0.42–4.41]	.611
MPR/C	1.00 [reference]		1.00 [reference]	
PHM	11.54 [4.85–27.46]	<.001***	5.01 [1.18–21.35]	.029*
Woman encouraged to have support person				
No	3.29 [1.85–5.87]	<.001***	2.48 [1.12–5.49]	.026*
Yes	1.00 [reference]		1.00 [reference]	
A woman likes the idea of a support person				
No	15.83 [3.78–66.24]	<.001***	5.38 [1.08–26.81]	.040*
Yes	1.00 [reference]		1.00 [reference]	
Labour companion				
Mother	1.00 [reference]		1.00 [reference]	
Husband/partner	0.46 [0.23–0.91]	.027*	1.28 [0.45–3.65]	.645
Friend	2.22 [0.61–8.05]	.224	1.12 [0.22–5.60]	.891
Others	0.57 [0.29–1.09]	.088	0.72 [0.30–1.76]	.475
The woman had freedom of movement during labour				
No	1.00 [reference]		1.00 [reference]	
Yes	0.46 [0.26–0.79]	.005**	0.84 [0.39–1.79]	.642
Don't know	7.27 [1.68–31.44]	.008**	3.66 [0.70–19.30]	.126
Encouraged to eat food				
No	1.00 [reference]		1.00 [reference]	
Yes	0.27 [0.16–0.47]	<.001***	0.68 [0.24–1.91]	.467
Encouraged to take fluids				
No	1.00 [reference]		1.00 [reference]	
Yes	0.34 [0.20–0.59]	<.001***	0.88 [0.31–2.46]	.806
Labour analgesia				
No	1.00 [reference]		1.00 [reference]	
Yes	3.48 [1.99–6.09]	<.001***	2.05 [0.82–5.10]	.123

with service and may influence their health-seeking behaviour at subsequent births when deprived of meals and food.

Half of the women (51.4%) received labour analgesia with a third (29.4%) having episiotomy or laceration at childbirth. This number is significant especially when an episiotomy is not a recommended routine procedure, the experience of pain may affect the overall birthing experience for the women. The majority (80.2%) of the postnatal mothers had their babies with them within an hour of birth as a recommended practice by WHO, and mothers who were denied, may have their babies requiring additional support or critically ill after delivery.[22] The study revealed that women

encouraged to have a support person, a woman interested with the idea of a birth companion, freedom of movement during labour, encouraged to eat during labour, labour analgesia and early bonding of mother and baby after delivery were significantly associated with the level of satisfaction of postnatal women towards the care received.

There was also a significant association on the forms of support received thus the woman encouraged to have a support person, liking the idea of a support person, the presence of labour companion, freedom of movement during labour, intake of fluids and meals labour analgesia and early bonding of mother and baby immediately after delivery with the experience of at least one form of disrespectful care. Therefore, a woman in labour denied movement, intake of fluids, meals, pain relief support person and early bonding of mother and baby has not received respectful maternity care.

Experience and Predictors of Disrespect and Maltreatment During Childbirth

The majority (75.7%) of the women reporting for labour and delivery experienced at least a form of disrespectful care. This is similar to what was identified in studies done earlier in some parts of the country.[13,15] One in five of the women (19.8%) experienced physical abuse, about one in ten (9.3%) were discriminated against, about four in ten (38.9%) had undignified care, six in ten (60.4%) received unconsented care, about four in ten (34.5%) received non-confidential care, about one in five (17.9%) felt neglected and one in ten (7.7%) experienced detention against their will. The high prevalence of disrespectful care coupled with the representation of all the seven categories of disrespect and abuse in the study indicates that it is a problem requiring strengthening of the policy of respectful maternity care and institutional reforms. Failure to address this menace will cause clients to mistrust the healthcare system leading to poor health-seeking behaviour and the loss in battle against maternal morbidity and mortality. Also, dissatisfaction with labour and delivery may result in an increased risk of Postpartum depression, anxiety[23] post-traumatic stress disorder[24] compromised maternal and neonatal bonding[25] and anxiety during subsequent delivery.[26] The Ministry of Health should strengthen and enforce the policy on Respectful Maternity Care through advocacy by the agencies of the Ministry of Health (Ghana Health Service and Christian Health Association of Ghana) in health service delivery.

From the adjusted logistic regression model, the odds of a woman experiencing at least one form of disrespectful care was 5 times significantly high for those visiting PHM compared to those visiting MPR/C (aOR: 5.01, 95% CI: 1.18–21.35, $p = .029$). The odds of experiencing at least one form of disrespectful care were 2.5 times among women who were not encouraged to have a support person present compared to women who were encouraged to have a support person present during delivery (aOR: 2.48, 95% CI: 1.12–5.49, $p = .026$). Also, women who had less than three health care providers present during labour had 3-times increased odds of experiencing at least one form of disrespectful care compared to those who had at least three health care workers present (aOR: 3.31, 95% CI: 1.47–7.42, $p = .004$). The shortage of health staff during a shift puts pressure on them and can lead to a disrespectful attitude towards clients. In Tanzania, it has been reported that disrespect and abuse scores increased with an increase in working hours per week and number of staff on duty.[27]

There was a significant association between marital status, the highest level of education, employment, religion mode of delivery and health facility where childbirth occurred with the experience of at least one form of disrespectful care. The findings of significant association of marital status, educational level to disrespectful care confirms the study by Siraj, Teka, and Hebo (2019).[17] The experience of at least one form of disrespectful care was 1.3 times higher among single women (85.5%) than the married women (64.9%) and 1.4 times higher among the divorced/widowed (92.3%) than the married. There was no significant association observed in the study of adolescent girls and women less than 25 years with the experience of at least a form disrespectful care and hence contradicts with earlier studies of mistreatment among adolescent girls during childbirth.[28,29]

Conclusion

According to the study, women did receive certain forms of assistance during labour and childbirth, but it was only slightly above average, particularly in partners' attendance during the birthing process. For all the groups represented, the majority of the women encountered disrespectful treatment across all categories. Without improving the birthing experience for women, expanding medical facilities might not result in the skilled or facility-based deliveries that are intended.

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Ethical Approval

This study protocol was reviewed and approved by the Ghana Health Service Ethics Review Committee (GHS-ERC 020/03/18).

Statement of Human and Animal Rights

All procedures in this study were conducted in accordance with the Ghana Health Services Ethics Review Committee (GHS-ERC020/03/18) protocol.

Statement of Informed Consent

Written informed consent was obtained from the patient(s) for their anonymized information to be published in this article.

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Supplemental Material

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