Parturients Perception of Care Providers Attitude Towards Women During Labour And Delivery In Southwest Cameroon

Clovis Achassi Tankeng
Faculty of Health Sciences, University of Buea
Gregory Halle-Ekane
Faculty of Health Sciences, University of Buea
Alfred Awa Mokom
Faculty of Health Sciences, University of Buea
Yannick Lechedem Ngunyi (yanlech25@gmail.com)
Faculty of Health Sciences, University of Buea
André Gaetan Simo Wambo
Faculty of Health Sciences, University of Buea
Hermann Ngouakam
Faculty of Health Sciences, University of Buea
Emmanuel Vubo Yenshu
Faculty of Social and Management Sciences, University of Buea

Research Article

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Abstract

Background: The period of labour and childbirth for women is a delicate moment and predisposes them to disrespectful care which has been reported in many countries. In Cameroon, data which could help in formulating policies to modify these attitudes is rare.

Objectives: To assess parturients' perception on the respect and disrespect of women by care providers as well as determining the prevalence, types and predisposing factors of physical and verbal abuse during labour and delivery, in the Buea and Limbe Regional hospitals, Cameroon.

Methods: It was a hospital based cross-sectional study carried out in Buea and Limbe Regional hospitals from February 15th to April 20th 2021. It involved parturients aged between 15 and 45 in their first eight weeks post-delivery. Data was collected using a structured questionnaire, and the collected data was entered into and analyzed with SPSS version 25. Dependent variables were dichotomized and a bivariate logistic regression model was fitted to obtain the determinants of mistreatments during labour and delivery, while Chi-squared test was used to establish association between socio-demographic characteristics and care categories. A *P*-value <0.05 was considered statistically significant.

Results: We sampled 274 parturients aged between 15 and 42 (mean=26.69yrs and SD=$\pm$ 5.34). Sixty-nine (25.18%) of the respondents reported at least a physical and/or verbal mistreatment. The most common physical and verbal mistreatments were abdominal fundal pressure to facilitate expulsion and scolding. Muslims were more likely to report insult. Parturients perceived both respectful and disrespectful forms of care.

Conclusion: Disrespectful care during labour and delivery may not be uncommon in our country as suggested by the findings in this study. There is need for development of interventions to address the drivers of disrespect and abuse which will encourage clients' future facility utilization. More studies are needed in other areas of the country to support this evidence.

Background

Studies and reports worldwide have revealed a rise in mistreatments by care providers during labour and delivery and this has increased researchers interest on the issue [1–3]. In our hospitals, it is not uncommon for women to complain that they are ill-treated by the personnel during labour and delivery, despite these anecdotal findings, in Cameroon published data is rare. Disrespect and abuse during labour is a human right abuse, which reduces effective collaboration between the care providers and the parturients. This affects the quality of care negatively, posing a barrier to achieving improved maternal and fetal health outcomes[4–7]. WHO, in order to ensure quality care, recommends that parturients are treated respectfully with informed choices and continuous support during labour and delivery while maintaining their dignity, privacy and confidentiality, ensuring freedom from harm and mistreatments[3, 8]. Health care policies in most low- and medium-income countries including ours usually focus on process and coverage outcome interventions such as increasing numbers of skilled personnel, material resources, health facilities with less focus on the quality of care offered by the personnel. This is probably insufficient as materno-fetal morbidity and mortality persist[6, 7, 9, 10]. It is therefore important to carry out studies of this kind in our context in order provide objective evidence that there is mistreatment. This will facilitate and promote the development of policies that will address drivers of mistreatments and improve the care quality. The mistreatment of women during childbirth has been reported in many other countries, both low and high income countries as explained in reviews by Bohren et al in 2015 and Bowser and Hills in 2010 (including 150 studies in 18 different countries)[1, 11]. Some of the most reported mistreatments include racism, discrimination, detention in medical or immigration facilities, abandonment of care, lack of privacy and informed consent, hitting etc. Although the manifestations were different for the studies reviewed; the most vulnerable women were the poor, refugee, young, uneducated, and the racial/ethnic minority group [1, 11]. However, it has been difficult to compare studies of this kind due to differences in definition, tools, methodologies and typologies of interest[1–2, 11]. A cross sectional household survey at Tehsil Kharian in Gujrat health district, Pakistan, involving parturients within 8 weeks post-delivery; had an observed prevalence of 99.7% and a reported prevalence of 27.2% of mistreatments. The most reported mistreatments include; lack of informed choices (99.7%), abandonment of care (72.5%), and non-confidential care (58.6%). The determinants of disrespect and abuse was; facility birth and low socio-economic status[3].

A study in East and Southern Africa, involving five countries (2015) on the prevalence of respectful maternity care and abusive behaviors at health facilities; revealed reports of abandonment of care, neglect and lack of informed care, although many parturients also reported to have been treated with dignity and support[12]. In Kenya (2015), a study on the prevalence of disrespect and abuse had a reported prevalence of 20%. Mistreatments reported include; non-confidential Care (8.5%), non-dignified care (18%), neglect or abandonment (14.3%), nonconsensual care (4.3%), physical abuse (4.2%) and, detainment for non-payment of fees. The determinants of mistreatments in this study were Age, Parity and lack of birth companion [13]. In Cameroon, there is paucity of data, however, maternal morbidity and mortality is still a major concern, as Cameroon is ranked 169th out of 185 countries with highest maternal mortality rate. Although maternal mortality from 2000 to 2017 has dropped by 35% (from 782 to 529 per 100,000 live births), it is still far from the target of less than 70 deaths per 100,000live births by 2030[14]. There is therefore need for additional strategies apart from process and coverage outcome interventions to help reduce this mortalities, one of which is improving quality of care, through adjustment of health personnel attitude towards their parturients[1, 15, 16–18]. This study aimed to assess parturients' perception of care-providers attitude, the prevalence, types and predisposing factors of physical and verbal abuses in view of enacting policies that would lead to improved quality of care in the aforementioned hospitals in the southwest region of Cameroon.

Methods

Study design and setting

This was a hospital-based cross-sectional study carried out in the Buea and Limbe Regional hospitals from February 15th to April 20th 2021. The Buea and Limbe regional hospitals are located at the centres of these two cities and are the major referral hospitals of the entire Southwest Region of Cameroon. The Maternity unit of Buea regional hospital at the time of the study had a bed capacity of 22. A staff capacity of 21 personnel comprising 3 obstetricians, 8

midwives, 7 nurses and 2 assistant nurses, with an average of 90 deliveries per month. The maternity unit of Limbe regional hospital had a total bed capacity of 31. A staff capacity of 19 personnel comprising 1 obstetrician, 11 midwives, 3 state registered nurses and 3 nurse assistance, with an average of 92 deliveries per month (vaginal and cesarean delivery included).

Study population and sampling

The Regional hospitals of Buea and Limbe in the southwest region of Cameroon were chosen purposively and by convenience for the greater numbers of monthly childbirth. Furthermore, they serve as referral hospitals for healthcare delivery in this region. The participants were met at the maternity, neonatology and vaccination units of these two hospitals. All women met at the study site who were illegible and provided consent were surveyed. All women aged between 15–45 who delivered either by emergency cesarean section or through spontaneous or induced labour and were within eight weeks post-delivery, were included in the study. Parturients who did not provide consent or decided to quit during the survey were excluded from the study. Women with comorbidities or health conditions that hinder them from participating in the study were also excluded.

Sample size calculation

The participants included parturients who were within 8weeks post-delivery; aged 15 to 45. To obtain the sample size we used the Cochran formula ($N^o=Z^2pq/e^2$)[19] with a P value of 0.02 derived from a 2015 study in Kenya[13] at 95% confidence interval. This gave us a minimum sample size of 271 participants at a 10% error rate.

Data collection

Data was collected using a structured questionnaire, designed with options, including a five-point Likert scale. This permitted us to quantify respondents' responses. The participants were interviewed in the postpartum period on their experience of any abuse and disrespect during labour and postpartum period by healthcare providers (midwives, nurses, Doctors or any health personnel offering delivery services). Collected data included, socio-demographic characteristics, experience of any physical abuse, verbal abuse, and their perception on the level of privacy, satisfaction of care and approach of care by care-providers towards them.

Statistical analysis

The collected data was entered into and analyzed with SPSS version 25. Descriptive statistics was performed to obtain frequencies and proportions of categorical variables (respectful and disrespectful care) while mean and standard deviation were used for continuous variables (age). Dependent variables were dichotomized and a bivariate logistic regression model was fitted to obtain the determinants of mistreatments during labour and delivery. Chi-squared test was used to establish association between socio-demographic characteristics and care categories. Statistical significance was set at a 95% confidence interval, with a *P*-value < 0.05.

Ethics considerations

The ethical clearance for this study was issued by the institutional Review Board of the Faculty of Health Sciences, University of Buea (ref. N°: 202/1045-01/UB/SG/IRB/FHS). An administrative approval was obtained from the regional delegation of Public Health for the Southwest Region (ref. N°: R11/MINSANTE/SWR/RDPH/PS/540/780) and the Directorate of Buea, and Limbe Regional Hospitals, Cameroon (ref. N°: MPH/SWR/RHL/DO/343). To ensure confidentiality, all patient information was coded.

Results

A total of 274 parturients were surveyed. More than half (58%) were met at the Buea Regional Hospital (BRH), while 115(42%) were met at Limbe Regional Hospital (LRH). Amongst them, 158(57%) were surveyed at the maternity unit, 94(34.3%) at the vaccination unit, and 22(8%) at the neonatology unit. Out of the 274 participants, a majority, 127 (46.4%) were met in their first 2days postpartum. The minimum duration from delivery was from the day of delivery to a maximum of 56days postpartum (range = 56days, mean = 9.81days, SD = 14.06).

Parturients socio-demographic characteristics

The parturients were aged from 15 to 42 years (range = 27), most of whom were between 25–29 years (31.8%). The mean maternal age was 26.69years (SD = 5.34). A majority the of respondents (36.9%) were non-civil servants, married (39.1%) and Christians (97.4%). More than two-thirds (71.5%) of the respondent's delivered vaginally, while 78 (28.5%) delivered by emergency cesarean section.

Table 1: Parturients socio-demographic characteristics

Socio-demographic characteristics		Number of participants	Percentage (%)
Age of baby	0-2days	127	46.4
	2days -2weeks	96	35.0
	2-6weeks	46	16.8
	6-8weeks	5	1.8
Maternal Age(years)	<20	17	6.2
	20-24	83	30.3
	25-29	87	31.8
	30-34	69	25.2
	≥35	18	6.6
Occupation	Civil servants	64	23.4
	Housewife	38	13.9
	Student	71	25.9
	Applicant/non civil servants	101	36.9
Religion	Christian	267	97.4
	Muslim	6	2.2
Marital status	Married	107	39.1
	Single	66	24.1
	cohabiting	101	36.9
Number of children alive (including most recent)	1	129	47.1
	2	65	23.7
	≥3	80	29.2
Mode of delivery of recent delivery	Vaginal	196	71.5
	Emergency c/s	78	28.5

Physical and verbal mistreatments

A total of 69(25.18%) of the 274 parturients reported to have experienced at least a physical and or verbal mistreatment during labour and delivery. forty-one (15%) reported at least a verbal abuse while 28(11%) reported at least a physical abuse. The most reported verbal abuse was scolding (6.2%) followed by threats to have a bad pregnancy outcome (2.9%) and then threats to withhold care (2.9%). The most reported physical abuse was downward pressure on the abdomen (4.4%) followed by pinching on the thigh (2.6%) (Table 2).

Table 2
Verbal and physical abuse reported by respondents

Mistreatment	Count (from the 274 parturients)	Percentage (%)
Scolding	17	6.2
Down pressure on the abdomen	12	4.4
Threatened with bad outcome	8	2.9
Threatened to withhold care	8	2.9
Pinched	7	2.6
Blamed for poor outcome	7	2.6
Held down forcefully	4	1.5
Threatened with procedure	4	1.5
Slapped on the thigh	3	1.1
Insulted	3	1.1
Mocked	2	0.7
Other verbal abuses	2	0.7
Physically tied on the delivery bed	1	0.4
Negative comment on medical status	1	0.4

Amongst the parturients who reported verbal abuse, 78.04% of them reported a single type of abuse, while 19.51% and 2.4% reported two and 3 or more different types of verbal abuses respectively. Amongst those who reported physical abuse, 23(82.14%), 4(14.29%) and 1(3.57%) reported a single type, two types and 3 or more different types of physical abuse respectively. About 23% of the 69 cases reported to have experienced the two types of mistreatments (verbal and physical) during labour and delivery. More than half, 41(59.4%) of the respondents who reported to have experienced a physical or verbal abuse reported to have experienced a particular type of abuse more than once, while 6 (8.7%) could not remember the number of times they experienced a given mistreatment. Also, 61(88.40%) of the 69 parturients reported to have experienced this mistreatment before delivery, while 10 (14.49%) experienced it after delivery. About 4% experienced mistreatment both before and after delivery while 5.8% of them could not remember when they experienced the abuse. In 95.65% of the cases, the mistreatment was reported to have been done by the midwife or nurse while in 10.14% of the cases by the Doctor (general practitioner, obstetrician). The trainees and non-staffs were incriminated in 7.24% and 1.45% of the cases respectively.

Vaginal examinations

Out of the 274 respondents sampled 272 (99.3%) parturients received vaginal examination. Seventy-five respondents (27.57%) reported that vaginal examinations were not private while 70.96% of respondents reported that privacy conditions were respected during the process.

About one-fifth (20.59%) of the 272 parturients reported that the vaginal examinations were not comfortable, with 4 to 5% reporting that it was very uncomfortable.

Pain relief

Of the 274 parturients, 248(90.5%) received one or more forms of pain relief. Only 41 (15%) requested pain relief, while 12 (4.4%) were refused pain relief.

Birth companion

Out of 274 parturients 149 (54.4%) of them were allowed to have a birth companion before or during childbirth. Amongst the 149, 52(35.86%) of them had companion from labour till after childbirth, 50(34.48%) had during labour only, 3(2%) had a companion from childbirth till after delivery. Only 1–2% had a birth companion during childbirth only. Of the 149 parturients who had birth companions, Close to 50% had a personnel while about 40% had a family member as companion during labour and delivery respectively. Husbands and friends were companions in 10.47% and 3.36% of the cases respectively.

Unreasonable demands

Of the 274 respondents 5 (1.8%) of the participants reported to have been asked to clean the examination/delivery bed, while 11(4.0%) reported to have been asked informal payments.

Supportive care

Thirty-three (12.04%) of the 274 participants perceived to have been ignored (with up to 36.4% of the 33 agreeing strongly to have been ignored). Also, 15.69% of the 274 parturients felt neglected (25.58% amongst them feeling strongly neglected) while 5.87% felt as if they were a nuisance to the personnel. About 6% of the participants felt to have waited for long periods of time before being attended to by the personnel when they arrived the health facility (BRH, LRH), while 8.76% of the 274 participants felt that their questions and concerns were not listened to and/or addressed. However, a majority, 242 (88.3%) of the 274 respondents felt that they were supported emotionally by the personnel. Only 4.38% felt strongly that they were not supported emotionally.

Childbirth

During childbirth, the personnel was always present for 40.1% of the times, 51.1% most of the time and 8.8% sometimes. The personnel most present during labour and childbirth were midwives and nurses. The midwives were present in 46.7% and the nurses in 23.0%. The other personnel who attended to the delivery, medical students (10.2%), midwifery/nursing students (5.8%) and doctors (3.3%). Only 2 (0.7%) of the 274 respondents reported that no personnel was present when the baby came out. Also, 193 (70.4%) reported that there were measures of confidentiality in the labour room. On the other hand, 69 (25.2%) reported that no measures for confidentiality were used in the labour room during their own time (free movements of persons into and out of labour room, lack of shields, parturients health information easily heard by others and sometimes care-givers present).

Detainment in the hospital for inability to pay medical bills

Four (1.5%) of the 274 respondents reported to have been detained or had their discharged period prolonged due to their inability to pay their hospital bills.

Autonomy and informed consent

Of the 274 participants, 75 (27.4%) had a cesarean section, 180 (65.5%) had uterine revision, 12 (4.4%) had an induction of labour and 65(23.7%) had augmentation of labour. On the average, the procedure was explained to 75.11% of the parturients amongst whom 71.52% consented.

Perception of care given

Up to 45.99% perceived that education given was not enough to meet their needs from labour till after birth, with 4.4% perceiving that it was absent. More than two thirds of respondents (82.12%) felt that there was enough privacy in the labour, given the nature of restrictions of entry and exit of persons while about 12.8% perceived that the level of privacy was inadequate (as a patient and sometimes care-givers could see the next labouring parturients' nakedness during examination) with 4.0% of participants perceiving that there was no privacy at all. Closed to 5% of the participants were neutral. Of the 274 participants, only 6 (2.2%) of the participants felt that their religious needs were not respected, while 158 (37.7%) felt that it was respected for their situation. The majority of participants (39.2%) were neutral (as they did not exercise any religious duty). Most of the 274 participants, 260 (94.9%), felt to have been treated with respect, while (7) 2.6% felt to have been treated with no respect. Seven (7) of the participants were equally neutral in their perception of being treated with respect or not. Forty-one (15%), of the participants felt that they were not informed about decisions taken on them concerning their care, meanwhile 16 (5.8%) were neutral. More than a third of respondents, 101(36.9%), felt that they did not make shared decisions during their care, and 32 (11.7%) were neutral (maybe because they trusted the personnel or were not even given the chance or were not aware of their rights). (Tables 3 and 4).

Table 3
Perceived respectful Categories of care reported

Care category	Percentage (%)
Treatment with respect	94.9
Cultural and religious respected	57.7
Had a good relationship and communication with the personnel	91.6
Was treated in a timely, safely and careful manner by the personnel	86.9
Informed about decisions concerning their care	79.2
Were emotionally supported	88.3

Table 4
Perceived disrespectful care categories reported

Care categories	Percentage (%)
Not encouraged to hold and breastfeed baby	39.7
Health education offered did not meet their needs	45.99
Privacy of parturients not respected	12.8
Was passively involved in decision making	36.9
Waited for long periods of time before being attended to by personnel on admission	13.87

Overall satisfaction

Of the 274 participants, 235 (85.77%) felt satisfied with the overall care given to them from arrival till delivery. Seventeen (6.2%) were neutral while 20 (7.30%) were not satisfied. Seven (2.6%) were very unsatisfied with the care given to them by the personnel. (Fig. 1).

Respectful care categories perceived

Out of 274 participants, 251 (91.61%) agreed that they had a good relationship, interaction and or communication with the personnel, with 66.8% participants feeling that they had a very good relationship. On the other hand, 5.8% of the participants felt that they did not have a good interaction, with 1–2% feeling that they had a very poor interaction with the personnel taking care of them during labour and delivery. Also, 238 (86.9%) felt that they were treated safely, carefully and in a timely manner, meanwhile, 30 (10.9%) of the participants felt that they weren't treated safely, carefully and in a timely manner. 6 (2.2%) of the

participants were neutral. In 254 (92.7%) of the respondents, participants felt that the personnel were actively participating in their labour process. On the contrary, 5.8% of participants did not feel this way, while 4 (1.5%) of the participants were neutral to this point. Of the 274 participants sampled, 145 (52.9%) were adequately encouraged to hold and breastfeed their babies as soon as possible after vaginal delivery, or emergency cesarean section. Up to 109 (39.7%) felt that they were not adequately encouraged to do so, with 19.3% reporting that, the personnel did not encourage them at all after they had delivered. Meanwhile, 20 (7.3%) were neutral to that point. More than four-fifths, 242 (88.3%) of the participants felt emotionally supported during labour and delivery against only 4.38% who strongly disagreed to being strongly emotionally supported.

Table 5
The five (5) main disrespectful care categories reported

Categories of mistreatment identified		Percentage (%)
Physical abuse		10.22
Verbal abuse		14.96
Failure to meet professional demands	Absence of measures for confidentiality	25.20
	Uncomfortable vaginal examination	20.60
	Refusal of pain relief	4.40
	Lack of informed consent before procedure	24.89
	Neglect and ignoring of parturients	27.74
	Lack of encouragement of mother baby relationship	39.7
Poor rapport between provider and parturients	Dismissal of the women's concerns	8.80
	Lack of supportive care (no emotional support/lack of birth companion)	49.98
	Loss of autonomy/passive involvement of women in the management (no shared decision making)	36.90
Health system conditions and constraints	Lack of curtains and shields to provide privacy	27.57
	Unreasonable demands (asking parturients to clean examination bed/asking of gift or money informally or illegally)	5.80

Determinants of mistreatments during labour and delivery.

To obtain the determinants of mistreatments during labour and delivery, the dependent variables (disrespectful care categories reported) were aggregated into dichotomous variables (yes, no) and bivariate logistic regression was computed at 95% confidence interval against the independent variables (socio-demographic factors). Only religion was significantly associated with a verbal mistreatment after bivariate logistic regression analysis. There was no significant factor associated with any physical or other verbal mistreatments. Muslim parturients were significantly more likely to be insulted compared to Christian parturients (OR 26.50, 95%CI: 2.05-342.22, P = 0.001).

Table 6: Determinants of mistreatments during labor and delivery (Bivariate logistic regression)

Care category	Determinants	Subcategories	OR (95%CI)	P-value
Insult	Religion	Muslim	26.50 (2.05-342.22)	0.001
Privacy during vaginal exams	Marital status	Cohabiting	3.06 (1.49–6.26)	0.025
Overall satisfaction	Number of pregnancies beyond 7months	Two (2)	5.35 (1.211–23.60)	0.035
	Location/residence	In town of residence	0.27 (0.91 – 0.80)	0.02
	Number of children alive	1 child alive	1.80 (1.14–2.85)	0.032
C. section explained	Health Facility	Limbe regional hospital	0.88 (0.04–0.91)	0.016
Offered emotional support	Religion	Christian	0.22 (0.05–0.90)	0.009
Informed decision making	Health Facility	Buea Regional hospital	2.64 (1.31–5.35)	0.025

OR: odd ratio, CI: confident interval

Discussion

The prevalence of physical and verbal abuse reported in our study was 25.18% and our research hypothesis was at least 20%. This suggests that physical and verbal abuse is not uncommon in these hospitals and this may be the case in most health settings in Cameroon, although more studies need to be done in order to ascertain this. Downwards abdominal pressure was the most reported physical abuse. It was previously used as a means to aid parturition especially difficult deliveries [20]. Perhaps the personnel are not aware that it is a mistreatment as they do this, probably believing it's for the good of the parturients and

their babies. However, WHO doesn't recommend this act as it is painful and may lead to anxiety and risk for materno-fetal morbidity, just as other physical abuses [20]. Muslims in our study were more likely to report to have been insulted. This may be due to religious influence or culture or maybe from an inner perception of discrimination as most or all of the care providers were non-Muslims. However, we cannot say for sure given the few numbers of Muslim parturients enrolled in our study, therefore studies need to be done in Muslim dominated areas of the country to support this finding. The parturients agreed to have experienced both respectful and disrespectful care categories and this suggests that despite the mistreatments reported, care-givers also offered positive and supportive care towards parturients. Although the report is highly subjective as we relied on information from parturients which could be biased by their interaction with the care givers. Overall, most parturients (over 90%) agreed to be satisfied by the level of care received and this may suggest a high level of normalization, acceptance and ignorance. This is supported by the disparity between the proportions of parturients who reported, to those who perceived the lack of privacy. This might be because modern medical practice is foreign to the local population, thus they are ignorant about their rights and accept it the way it is presented to them by the care providers. Many parturients perceived that they were passively involved in decision making during their care, (non-consented care). This is suggested by the disparity between the proportions of women who agreed to informed decision making (79.2%) and those who agreed to have made shared decision (51.1%) and supported by the disparity between the proportions to whom explanation was given before a procedure, to those who reported to have agreed to the procedure (71.52%). This violates their rights to autonomy and informed consent, therefore not fostering the SDG 5 of women empowerment, affecting care quality negatively.

The prevalence of physical abuse reported(10.22%) is consistent with the results from a study in four African countries by Bohren et al, who reported 10.7% physical abuse during labour and delivery[2]. Downward abdominal pressure was also the most reported physical in the study. This is probably due to the fact these studies where in low-income countries like ours with similar health challenges. On the contrary, verbal abuse in their study was twice higher compared to ours probably due to the fact that higher numbers of health facilities at different levels were involved, and the fact that those respondents were interviewed in the community, thus reducing fear of future poor interaction with the personnel[12]. Studies done in Kenya reported a lower prevalence of physical abuse (4.2%) but with a verbal abuse (grouped under non-dignified care in the study, 14.3%) being consistent to our findings, while another study done in Pakistan reported 12.2% of non-dignified care, with no physical mistreatment reported[3, 13]. These findings although with some differences probably due to differences in definition of abuse and disrespect, tools used, sample size and numbers of study sites, cultural and religious backgrounds etc. suggests that, Cameroon just as other low- and medium-income countries already faced with similar challenges in their healthcare systems is not an exemption as far as the mistreatment of women during labour and delivery is concern. In our study Muslim parturients were significantly more likely to report insult compared to Christian parturients. This could be due to religious and cultural influence and the fact that most personnel were Christians, thus giving them an inner perception of discrimination although they might not have overtly reported. This is supported by a similar study in Pakistan, a Muslim dominated society where non-dignified care was the most reported abuse and disrespect, suggesting that Muslims may be more likely to report insult[3]. Insult during labour and delivery has also been reported in studies done in Nigeria and Tanzania[21–23]. Insults creates an inhospitable environment for the parturients and a poor maternal-provider interaction. It is against the basics of respectful maternal care, thus having a negative impact on the quality of care and effective utilization of health services for labour and delivery [10, 24]. However, the number of Muslims in our study were too small compared to Christian parturients. We therefore recommend a similar study to be done in areas of the country dominated by Muslim to support our findings.

According to report from Observations in qualitative studies done in Nigeria and Tanzania, midwives, admit "mistreatments" and explain that sometimes they carry out these actions (said mistreatments) in attempt to save the life of the baby and or mother, in a situation of a non-cooperating parturients or difficult deliveries. However, this could instead lead to anxiety, poor women-provider interaction, reducing care quality and resulting in a higher risk of adverse materno-fetal outcome. Some parturients reported to be aware that their rights were being abused but remained silent, and avoided the same hospital on subsequent deliveries[25, 26]. The lack of privacy measures in our study settings showed a deficiency of the health settings as there were no curtains or shields to separate the parturients from each other. Lack of privacy has also been observed in studies done by Burrowes et al, Igboanugo et al and Sule et al[22, 26, 27]. This could be due to weaknesses in the health system, promoted by the lack of knowledge of parturients on their rights to privacy, under reporting probably due to normalization, cultural influence or fear of future poor interaction between them and the personnel[13, 26]. Parturients who were cohabiting were significantly more likely to report of vaginal exams being private, compared to women who were single. This is probably due to the high importance single ladies give to their intimacy. A study done in one emergency obstetric unit in south Colombo teaching hospital showed a remarkable increase in the perception of privacy after the introduction of curtains, shields into the labour room suggesting the importance of curtains/shields in the perception of privacy amongst parturients[28]. The majority of parturients perceiving that there was privacy despite the absence of curtains could be due to normalization, and/or ignorance. This is supported by the high proportion of parturients reporting satisfaction of care despite the high prevalence of perceiving disrespectful care. This is also a health system weakness which is a major issue in health settings of low- and medium-income countries where there are insufficient resources needed to ensure respectful maternity care. While close to two-fifths of the respondents (39.7%) perceived that they were not encouraged enough or at all to hold and breastfeed their babies, 45.99% of parturients perceived that health education did not meet their needs. To hold and breastfeed a baby as soon as possible after delivery has many maternal and fetal advantages and not encouraging this relationship will therefore affect care quality negatively as it increases the risk of poor materno-fetal outcome[5, 10]. In this study, up to 39.7% perceived an inadequate or lack of encouragement of mother-baby relationship after delivery. From the qualitative study done in urban Tanzania, researchers observed midwives encouraging parturients to hold and breastfeed their babies in many instances[25]. However, we cannot compare with the study because of the difference in methodology. Closed to 46% of the participants perceived that health education given to them by the personnel after delivery did not meet their needs. Education and information on health issues are very important in primary care. It helps the parturient and baby to live a healthy life, detect and report promptly in case of any complications. It is also a fundamental right of patients. Inadequate information leads to ignorance and disfavours empowerment of women and further affects their right to information, thus affecting the quality of care negatively. A considerable proportion of the parturients agreed to have perceived some categories of respectful care. The observational study in urban Tanzania also reported these respectful care categories except for lack of emotional support and informed decision making which were not observed in their studies probably because it was not one of their typologies of interest[25]. Another qualitative observational study involving five (5) African countries reported dignified and supportive care as respectful categories most observed[2]. Each of the studies above had different respectful categories reported probably because of differences in components of interest measured and environmental context where these studies were carried out. Respectful care during

labour and delivery creates a hospitable environment for the parturients and therefore promotes effective utilization of health services for delivery[29]. It is also respect for human rights, and thus fosters the respectful maternal care domains. This improves the quality of care, and thus help to reduce adverse materno-fetal outcome indirectly[7, 10, 30]. A good maternal-provider relationship has been shown to result in lesser materno-fetal complications, and WHO emphasizes on it as a pre-requisite to positive childbirth outcome[7, 31]. Mistreatments during labour and delivery affects the quality of care negatively and this increases the risk for adverse materno-fetal outcomes[4–7]. The data above is clinically relevant as it suggests that mistreatments during labour and delivery in these settings are not uncommon. The relationship between care-provider and the parturient is vital and has an effect on the women. A good relationship brings a positive birth experience while a poor relationship may leave a lasting damage[8, 29]. Women need to be treated right and with respect of their autonomy and privacy, but from the data obtained this might not be the case in these two hospitals. Although we cannot say for sure, this might be a similar situation in other health settings of the country and might be a partial contributor to the persistent maternal morbidity and mortality[9]. It is thus important to do more studies of this kind in our setting so as to identify and address drivers of these mistreatments in order to improve clinical care, and create a conducive environment that respect parturients' autonomy/rights, privacy and confidentiality. This forms the basis of respectful maternity care[10]. This will affect the quality of care positively, create a positive birth experience and probably help to reduce the risk of adverse materno-fetal outcomes.[9, 20]

Limitations Of Our Study

Purposive and convenience non-probability sampling was used to select the study sites (health facilities) and this may be a weakness to the study. Data was collected during the postpartum period, increasing the likelihood of recall bias and false information. Also, this study was a hospital-based study, involving two regional hospitals, thus may not be a true representation of what is happening in other hospitals such as tertiary hospitals, district hospitals, and health centers. More studies involving different hospitals at different levels of care are therefore needed in order to obtain results that can easily be generalized to the whole country.

Strengths Of The Study

This is the first known study of its kind from Cameroon. We used an evidence based typology and measurement tool from a review and similar study by Bohren et al.[1, 11]

Conclusion

This study's findings suggest that abuse and disrespect of women during labour and delivery is not uncommon in these hospitals. More studies however need to be in done in other areas of the country and involving other levels and private health facilities for better generalizability. One out of four women reported at least a physical and or verbal mistreatments during labour and delivery. Downward abdominal pressure and scolding were respectively the physical and verbal mistreatments most reported. Parturient perceived both respectful and disrespectful care categories. From the report, we could deduce that parturients are not educated or encouraged enough to hold and breastfeed their babies after delivery. Also, privacy and confidentiality measures available in our setting are inadequate and most parturients probably due to normalization, acceptance and/or ignorance still under report it. The high proportion of satisfaction of care and emotional support, supports this fact. Muslims in our study were more likely to report insults during labour and delivery. It is important to develop interventions at national, health facility and community levels to address the drivers of disrespect and abuse (normalization, acceptance, and ignorance), so as to encourage effective future facility utilization. Maternal health policies need to be revised based on respectful maternal care and SDG 3 and 5, as this summarizes most of the interventions needed to improve the quality of care during labour and delivery through modification of personnel attitude. This will improve quality of care, hence curbing materno-fetal morbidity and mortality that has remained a major issue over the years in Cameroon and many other developing countries.

Abbreviations

ANC: Antenatal clinic

BRH: Buea Regional Hospital

CS: Caesarean section

LRH Limbe Regional Hospital

PPH: Post-partum hemorrhage

SDG: Sustainable Development Goals

VD: Vaginal delivery

WHO: World Health Organization

OR: Odd Ratio

CI: Confidence Interval

Declarations

Ethics Declaration

Ethics approval and consent to participate

The ethical clearance for this study was issued by the institutional Review Board of the Faculty of Health Sciences, University of Buea (ref. N$^{o:}$ 202/1045-01/UB/SG/IRB/FHS). An administrative approval was obtained from the regional delegation of Public Health for the Southwest Region (ref. N$^{o:}$ R11/MINSANTE/SWR/RDPH/PS/540/780) and the Directorate of Buea, and Limbe Regional Hospitals, Cameroon (ref. N$^{o:}$ MPH/SWR/RHL/DO/343). A written informed consent was obtained from all participants. All methods were performed in accordance with ethical guidelines as outlined in the Declaration of Helsinki.

Consent for publication

Not applicable

Availability of data and material

The data sets supporting the findings of this study are available, and can be provided by the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

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None.

Authors' contributions

CAT wrote the research proposal and designed the study; GH, AAM, HN and AGSW reviewed and corrected the research proposal. CAT & YLN collected the data, analysed it and wrote the initial manuscript. GH, AAM, AGSW, EVY and HN proof-read and corrected the final manuscript. All authors approved the final manuscript.

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Authors' information

Affiliations

Faculty of Health Sciences, University of Buea, Buea, Cameroon

Clovis Achassi Tankeng, Gregory Halle-Ekane, Alfred Awa Mokom, Yannick Lechedem Ngunyi, André Gaetan Simo Wambo, Hermann Ngouakam.

Obstetrics and Gynaecology service, Douala General Hospital, Douala, Cameroon

Halle Ekane Gregory.

Mbonge District Hospital, Mbonge, Cameroon.

Yannick Lechedem Ngunyi.

Faculty of Social and Management Sciences, University of Buea, Buea, Cameroon.

Emmanuel Vubo Yenshu.

Corresponding author: Yannick Lechedem Ngunyi (yanlech25@gmail.com).

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Figures

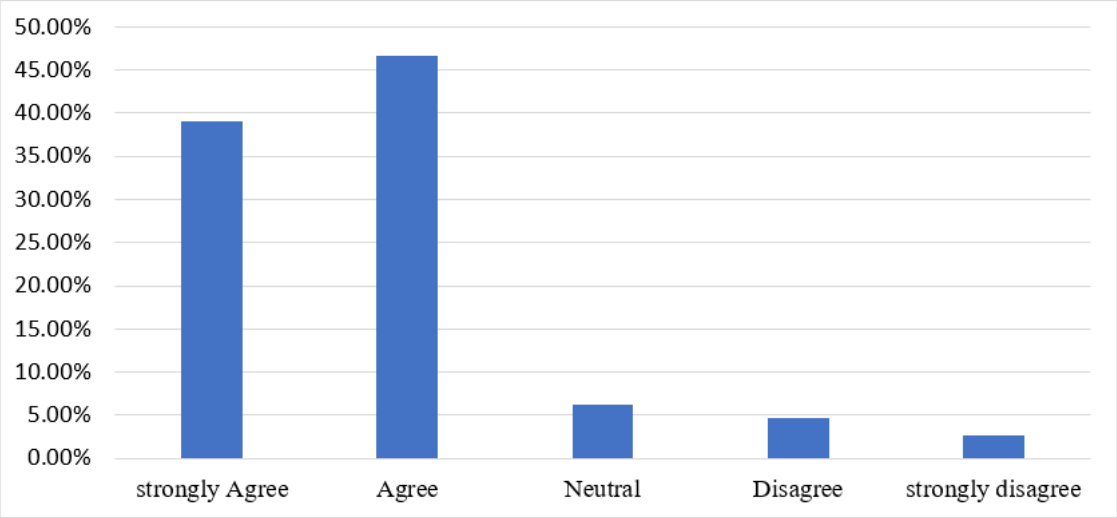

Figure 1

Parturients satisfaction for the care received