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# Manifestations of Abuse of Women in Childbirth in Public Hospitals in Ivory Coast: Case of Hospital Center Regional from Divo

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## Abstract

The aim of this study is to describe the manifestations of abuse of women in childbirth. The techniques and tools for collecting data are documentary research, observation, questionnaire and interview. The study was based on a sample of 72 people determined according to the method of reasoned choice. As for data analysis, the method of processing is qualitative and quantitative. In terms of results, it should be noted that the average age of women in childbirth is 23 and those aged 16 - 24 represent the largest segment of the survey population. Most of these women are illiterate or drop out very early. They belong to several religious communities and are of various nationalities. Regarding the manifestations of mistreatment, we retain that they are of several types the most significant of which are verbal abuse, physical abuse, neglect and psychological abuse. These abuses have taken place for some women at their first or last delivery, at all their deliveries or at a single delivery. In general, young women between the ages of 16 and 25 are the most victims of mistreatment in childbirth. Various authors are at the origin of the mistreatment of women in childbirth. They are young midwives often single and childless.

## Keywords

Abuse, Woman in Childbirth, Midwife, Manifestations, Divo, Ivory Coast

## 1. Introduction

Over the past two (2) decades, maternity service benefits have changed significantly in order to adapt to the new health policy, which is part of a perspective of continuous improvement in the quality of care and service to patients. Because the woman who carries a pregnancy expresses a vulnerability and an extreme

sensitivity that deserve everyone's attention. To this end, the WHO [1] states that pregnancy is a particularly risky period. Indeed, in a study on a population of 19,545 pregnant women carried out in six (6) West African countries, 87% of deceased women gave birth in a health facility, including 45% in a regional referral hospital (WHO) [1]. According to United Nations Population Fund (UNFPA) [2], in Côte d'Ivoire 16 women die every day from complications related to pregnancy or childbirth. Another 20 suffer from injuries and disabilities following childbirth, while 15% of pregnant women experience fatal medical complications. Other sources from the Ministry of Health and Public Hygiene report maternal mortality at 614 per 100,000 live births between 2005 and 2011, and neonatal mortality at 38 per 1000 live births (EDSCI-III) [3]. For the French Development Agency (AFD), the rate would have increased from 543 to 720 deaths per 100,000 live births. The extent of this phenomenon highlights not only breaches of professional ethics, but also violations of patients' rights, the mistreatment of women in childbirth, although a recurrent phenomenon, remains a taboo in some public hospitals in Côte d'Ivoire. The socio-professional constraints make it difficult to denounce an abusive Midwife, or to question her professional model.

Several studies have focused on the mistreatment of women in childbirth in health systems. These studies have often focused on physical and psychological causes and suffering as well as their consequences on physical and mental health. Lahaye [4] to this effect, underlines that this mistreatment is explained by any behavior, act, omission or abstention committed by a health worker which is not medically justified and/or carried out without the free and clear consent of the woman pregnant or parturient. Along the same lines, Sannié [5] asserts that this behavior is closely linked to breaches of the health code by health workers. Because for the author the mission of the midwife is to provide care without harming the patient, respecting and ensuring respect for her dignity. This amounts to saying that the midwife must take care of the parturient and not mistreat her. Ilboudo [6], noted that the ill-treatments are due to certain insufficiencies noted at the level of the health services. The author then makes a statement of a set of insufficiencies of health services, in particular the lack of information, talks and debates in health facilities and in communities, which means that some women are unaware of the legal number prenatal consultations during pregnancy. The WHO [7] tells us that these shortcomings can also be explained by the lack of courtesy of health personnel.

Other studies have approached the explanation of mistreatment of women in childbirth by examining shortcomings in prenatal follow-up. Going in the same direction, the Demographic and Health Survey (DHS) [8], affirms that the level of education, decision-making power and geographical location influence the prenatal monitoring of pregnant women. Such a situation is likely to have consequences for the smooth running of the pregnancy and the detection of illnesses or possible complications during childbirth. A lack of information could also endanger the life of the pregnant woman. Baki [9] argues that this lack of infor-

mation is one of the causes of misunderstanding of the risk factors, timing and benefits of prenatal consultation. Otherwise, other variables account for shortcomings in the prenatal follow-up of pregnant women. Dieye [10] asserts that women aged over 34 and women under 18 were more numerous in terms of delay in the first prenatal consultation than the other age groups. Traore *et al.* [11] confirm these results by highlighting the socio-demographic aspects and the prognosis of unattended pregnancies in pregnant women. Ndiaye *et al.* [12] for their part emphasize the influence of sociocultural factors in the shortcomings of prenatal follow-up. These authors state that the unexpected nature of pregnancy, the discretion that must surround pregnancy, ignorance of the risks and the refusal to be examined by male providers, had a statistically significant influence on late antenatal care. Going in the same direction, namely the explanation of the determinants of the insufficiency in prenatal follow-up, Ima [13] showed that illiteracy is one of the limits to the use of health services by women. Sanou [14] meanwhile, showed in a study that 55% of pregnant women surveyed found the waiting time long. For Emile [15], more pregnant women (35.71%) in urban areas had gone to prenatal consultation in the 1st trimester of pregnancy against 04.65% in rural areas. For Fournier & haddad [16], the Christian religion appears as a factor of change and adaptation; Christians are more inclined to use modern health care. On the other hand, the Muslim religion which is a little conservative, tends to favor the use of traditional medicine.

In addition, other explanatory studies of mistreatment of women in childbirth have highlighted the relationship between health personnel and patient. Thus, according to the WHO [17] the difficulties noted in the relationship between doctor and patient are due to psychological factors such as long queues, poor reception and the feeling of frustration likely to be explained by the lack of courtesy of the staff. Added to these factors is the shortage of personnel. These reasons seriously affect the quality of services and the hospital environment. Kronlund [18] thinks that patients and medical staff encounter difficulties because of socio-economic factors. WHO [19] in fact, believes that the doctor to whom the patient comes to confide tends to be inattentive, even expeditious, indifferent to the concerns of the patient. Moreover, the explanations he gives him and which are supposed to reassure him seem to him confused and the treatments prescribed are not very effective in this situation. Clearly, the patient leaving the medical office feels more helpless and worried than before entering it. Moreover, there is no care without the establishment of relationships between health personnel and patients. Dumont *et al.* [20] in a situational analysis, revealed the main obstacles to quality emergency obstetric care: inconstant availability of essential drugs and consumables, dilapidated and sometimes non-functional equipment and low transfusion capacity in most maternities of reference. Unsuitable professional behavior also affects the quality of care. Sawadogo [21] in the same vein showed that more than 93% of women have experienced more or less violent acts and gestures from healthcare providers. The most recurrent are verbal

attacks which represent 56%. He concluded that poor reception is one of the factors explaining the loss between coverage in prenatal consultation and more and coverage in assisted deliveries in the health district of Yako. All these facts underlined by these studies generate in certain patients a bad design of the health services. This is likely to dissuade some of them from having constant recourse to health services. *Ronsmans et al.* [22] reveal that the perception of pregnancy, maternal complications and health services by the populations, certain beliefs and practices of the populations around pregnancy play a very important role in the use of health services. Abundant in the same direction, Rouamba [23] in his study, underlines that the caregiver/patient relationship is often incriminated and decried by the populations. This constitutes a very important barrier because bad memories of health services can lead some people to no longer use them and demotivate those who would like to use them. The WHO [24] in its maternal death surveillance guide, uses the International Classification of Diseases and Related Health Problems (ICD 10) to specify the causes of these deaths. These are the reliability of information, the correctness of diagnosis and treatment, lack of supplies and equipment, organizational and functional infrastructure constraints, etc. This grid helps to identify the problems, the causes of the problems, the causes of death, as well as the avoidable factors in the management of the case. All these elements show the importance of the quality of the relationship between health personnel and pregnant women, lack of supplies and equipment, organizational and functional infrastructure constraints, etc. This grid helps to identify the problems, the causes of the problems, the causes of death, as well as the avoidable factors in the management of the case. All these elements show the importance of the quality of the relationship between health personnel and pregnant women. At the end of this literature review, it appears that most of the writings have focused on the impact of the quality of relations between health workers and patients. Also, shortcomings in prenatal follow-up were addressed. For work on exchanges between health personnel and patients, these authors argued that communication between doctor and patient in the health structure is decisive. These explanations also insisted on the nursing staff in the health establishments. However, these writings did not focus on the manifestations (typology of abuse and victims, circumstances of abuse, etc.) of the abuse of women in childbirth in hospitals. In view of this aspect not taken into account by these authors, we decided to study the manifestations of the mistreatment of women in childbirth in the CHR in Côte d'Ivoire precisely at the CHR of Divo.

In Côte d'Ivoire, abuse and violence against women are a significant phenomenon in terms of frequency and consequences. Indeed, in Côte d'Ivoire, 16 women die every day from complications related to pregnancy or childbirth. Another 20 suffer injuries and disabilities following childbirth, while 15% of pregnant women experience fatal medical complications [2]. To do Faced with this mistreatment of women in childbirth and with a view to improving the quality of the provision of health care and services to the population, the Ministry in

charge of Health has adopted policy documents, in this case the National Plan for Health Development (PNDS), the National Policy for Hospital Hygiene (PNHH) and the National Strategy Document for Hospital Reform (DNSRH) [25]. Many tools have also been developed to improve the quality of services. These include, among others, the manuals for the minimum package of activities for First Contact Health Establishment (ESPC), the manual of symptoms-diagnosis and treatment algorithms, the health district accreditation guide, the national supervision guide, the national guidelines for the organization of referral and counter-referral and emergencies, the directives for the management of chronic pathologies, the 2013 law creating a National Order of Midwives and Maieuticians in Côte d'Ivoire, and the code of ethics for midwives. However, it is clear that despite these measures implemented to guarantee to all citizens, and in particular women in childbirth, a quality of care in terms of effectiveness and efficiency, women in childbirth die because they are victims of abuse. So how are women in childbirth being mistreated despite these measures?

It is therefore to answer this question that we conduct this research to describe abuse of women in childbirth. This is a specific way of presenting the socio-demographic characteristics of women in childbirth and the mistreatment they suffer, to identify the circumstances of these abuses and determine perpetrators of abuse of women in childbirth.

## 2. Materials and Methods

The methodology presents the following elements: the study site, the study population, the sample, the data collection techniques and tools and the data analysis methods.

### 2.1. Study Site

The survey took place from January to september 2022 in the city of Divo, our study area. Capital of the Lôh Djiboua region, Divo is located 600 km from Abidjan. Its population is estimated at 179,455. The department is surrounded by the towns of Oumé to the north, Lakota to the west, Tiassalé to the east, and Fresco and Grand Lahou to the south. This population is spread over 165 villages, approximately 4170 camps and 4 administrative districts, namely Divo, Guitry, Hiré, and Fresco [26]. It should be noted that the population with a large rural component is estimated at 63% of the total population, of which 2/3 live in camps. Road infrastructure, in addition to being insufficient, is degraded and impassable during the rainy season, thus making it difficult for rural populations to access the city [26]. Investigations into the mistreatment of women in childbirth are conducted at the Regional Hospital Center (CHR) of Divo. It is a Public Hospital (dispensary) built in 1928 and erected as a General Hospital in 1956, then as a Regional Hospital Center in 1978. This Hospital Center acts as a Reference Center for the Lôh Djiboua region. Because it covers emergencies and evacuations of the four (4) departments that are Divo, Lakota, Guitry and Hiré;

an area that extends over 10,650 km$^2$ for an estimated population of 1,024,376 inhabitants [26]. For evacuations, the Center has a functional ambulance. As a public service, services are free except for medication. At the CHR of Divo, there are several services and specialties including paediatrics, ophthalmology, geny-co-obstrtrical, the burili ulcer service, and the ENT service. In terms of services, it is one of the health facilities where the rate of attendance by the population is high with an average of 12 to 15 deliveries per day. However, the CHR does not have enough capacity to take care of patients from the town and surrounding villages. The Centre's pharmacy unit is not sufficiently and regularly supplied with medicines. It should also be noted that Divo, like Daloa, Adzopé, Angré, Marcory, Yopougon, Abobo, etc., is one of the cities and towns that have experienced altercations between the medical profession and the patients.

### 2.2. Target Population and Study Sample

As part of this study, we opted for a survey population directly concerned by the object of study. The surveys of this population took place from January to September 2022. The choice of these different categories met three criteria, in particular working in this CHR, having given birth in this CHR or having accompanied a woman for a childbirth in this CHR. By doing so, we hoped to have a clearer reading of the difficulties encountered by women during childbirth in the CHR. To do so, our survey population concerns health, administrative and technical staff but also parturients (old and new) of the CHR and their relatives to have their testimonies and opinions on the object of study. The following social categories were interviewed:

- **Midwife:** her role is to assist and provide care to the parturient because she knows better the difficulties related to the profession;
- **Waitress:** she is in charge of the maintenance of the delivery room and of remaining at the disposal of the midwife in case of need. Generally, she witnesses cases of disputes and abuse;
- **Caregiver:** he or she is available to the midwife if needed. Its role is to prepare the pregnant woman for childbirth;
- **Obstetrician:** he is the childbirth specialist. He ensures compliance with work instructions and sometimes receives threats related to the job;
- **Administrative staff:** we chose to question the general supervisor because it is he who is responsible for controlling and ensuring the smooth running of the work of the health workers;
- **Parturient and other relatives:** they are directly concerned and have a better knowledge of the realities, types and forms of abuse;
- **Private security guard:** they are the ones who monitor the entrances and exits of the CHR. To this end, we therefore believe that they may have information on the phenomenon.

Thus, the perceptions and opinions collected from this survey population on the mistreatment of women in childbirth in the CHR of Divo, allowed us to bet-

ter understand the object of study. In the current state of our knowledge, there is no database on women in childbirth in the CHR of Divo. We could therefore consider this target as a population that is difficult to obtain. Thus, to reach the sample necessary for the present study, we opted for a non-probabilistic method by choosing sampling by reasoned choice or by judgment.. The choice of this method was motivated by the freedom it gives the researcher to interview people with the characteristics required for the survey. Thus, 72 people were surveyed.

### 2.3. Data Collection Techniques

The data collection techniques used are: documentary research, observation, questionnaire and interview. These various techniques proved by their differences and their complementarity necessary to the collection of the data to better apprehend our object of study. To obtain useful and diversified information, we resorted to documentary research. With this in mind, we consulted reports from certain institutions at the Center de Recherche de l'Action pour la Paix (CERAP) and press articles on the Internet. Regarding observation, she consisted on the one hand in noting in the answers to the questions put to the respondents the indicators of mistreatment (injuries, assaults, intentional blows, incivilities, insults, threats, etc.) circumscribed in space and time; and on the other hand, to observe clashes between health workers and patients, or between health workers and parents of patients on the site. After having received authorization from the managers of the CHR of Divo and the various maternity services, we went to their services where we were able to administer a questionnaire to the technical and administrative staff of this structure. This technique made it possible to see the difference between what is said and the reality of the phenomenon, in order to better understand it in all its contours and dimensions. So we collected information on their realities, opinions and listened to the recommendations they made to understand the phenomenon. It is also important to note that this stage lasted six (06) months. The questionnaire proved during our preliminary surveys to be one of the data collection techniques best suited to achieve our objectives. The choice and number of questions respond to a need to take into account the specificities of our survey population. Composed of open and closed questions, the questionnaire was administered indirectly or directly. The open questions were used to grant a fairly large margin of freedom to our respondents, while subjecting them to specific questions related to the object of study. On the other hand, the closed questions were intended to restrict the freedom of the respondents, by asking them to make choices in a set of proposed answers. The questionnaires were administered to the technical and administrative staff of the departments visited. The questions relating to several specific aspects of our subject made it possible to know the actions implemented by certain state actors to guarantee better care for women in childbirth. The interview in the case of our study, was intended as an individual and semi-directive interview and the tool used is the interview guide. It is semi directive in the sense that it is

neither entirely open nor channeled by a large number of specific questions. This approach has the advantage of allowing the interviewee to express themselves freely, in the words they wish and in the order that suits them without dispersing themselves and without deviating from the main subject. Thus, during our various interviews, our respondents freely confided in us. They shared with us their perceptions, their interpretations, their experiences, and their concerns. The interviews were structured as follows: The socio-demographic characteristics of pregnant women, the typology and perpetrators of mistreatment of women in childbirth.

### 2.4. Data Analysis Methods

To analyze the data collected, we used qualitative and quantitative analyses. It is research that produces and analyzes descriptive data, such as the words spoken or written and the behavior of people [27]. This method was useful because it made it possible to analyze the opinions, attitudes, behaviors, meanings, opinions and ideas expressed by the respondents in order to better understand the logic of the actors [28]. We have therefore emphasized the experience of individuals in relation to the phenomenon studied. According to Marchand [29], the purpose of quantitative analysis is the description and analysis of social phenomena by means of methods borrowed from statistics by quantifying them in order to determine the meaning and the force uniting the different variables. This method made it possible to process the information collected on the mistreatment of women in childbirth in the CHR of Divo. It was a question of exploiting our data in terms of numbers (frequency distribution tables or data) and distribution of factors on a quantitative level. The processing of these data was possible using the software Statistical Package for Social Sciences (SPSS) release 22.

## 3. Results

The presentation of the results is articulated around three (3) axes, in particular the socio-demographic characteristics of women in childbirth, the manifestations of women in childbirth and perpetrators of abuse of women in childbirth.

### 3.1. Sociodemographic Characteristics of Women in Childbirth

The study of the characteristics of women in childbirth makes it possible to know their age, their level of study, their nationality, their ethnic group and their religion.

#### 3.1.1. Age and Level of Education of Women in Childbirth

- **Women's age**

Analysis of the data in Table 1 shows that the age of women in childbirth who have suffered abuse falls essentially into three age brackets, namely 16 - 24 years, 25 - 33 years and 34 - 40 years. The first category represents 53.33% of the target population. As regards the second age category, it represents 33.33% of the target population. Finally, the last age category, is 13.33% of the target population. The

Table 1. Distribution of women in childbirth according to their age groups.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | ]16 - 24[ | 16 | 53.33 | 53.34 |
| | ]25 - 33[ | 10 | 33.33 | 33.33 |
| | ]34 - 40[ | 4 | 13.33 | 13.33 |
| | Total | 30 | 99.99 | 100 |
| Missing | System | 0 | 0.0 | |
| Total | | 30 | 100.0 | |

Source: Our investigation 2022.

Table 2. Distribution of women by level of education.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | No schooling | 6 | 20 | 20 |
| | Primary | 11 | 36.66 | 36.67 |
| | Secondary | 9 | 30 | 30 |
| | Superior | 4 | 13.33 | 13.33 |
| | Total | 30 | 99.99 | 100 |
| Missing | System | 0 | 0.0 | |
| Total | | 30 | 100.0 | |

Source: Our survey, 2022.

average age is 23 years old. Generally speaking, the data in Table 2 show that women aged 16 - 24 represent the largest segment of the survey population. We therefore note at the level of these young women surveyed that they are characterized by their young age.

- **Educational level of women in childbirth**

13.33% of the women surveyed have reached higher education and 30% have reached secondary level. Only 20% have no schooling. Better 36.67% of women have reached the primary level. The level of education of the women in the study is low. Indeed, it emerges from the analysis of Table 3 that the majority of women are illiterate or have dropped out of school very early (cumulative percentage of uneducated and primary level is 53.67%). Through our interviews, we found that this low level of education is mainly due to poverty.

### 3.1.2. Religion and Nationality of Women in Childbirth

- **Women's religion**

The majority of women belong to a religious community: Catholic, Protestant, Evangelical, Muslim, and Animist. The most represented religions are respectively: the Muslim religion 40%, Catholic 20%, Evangelical 13.33% and Protestant 10% or 99.99%. Such a high cumulative percentage could testify to the presence of strong religious influence among these women. The majority of these

Table 3. Distribution of women according to religion.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | Catholic | 6 | 20 | 20 |
| | Protestant | 3 | 10 | 10 |
| | Evangelical | 4 | 13.33 | 13.33 |
| | Muslim | 12 | 40 | 40 |
| | Animist | 5 | 16.66 | 16.67 |
| | Total | 30 | 99.99 | 100 |
| Missing | System | 0 | 0.0 | |
| Total | | 30 | 100.0 | |

Source: Our survey, 2022.

Table 4. Distribution of women by nationality.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | Ivorian | 10 | 33.33 | 33.33 |
| | ECOWAS nationals | 17 | 56.66 | 56.67 |
| | Non-ECOWAS nationals | 3 | 10 | 10 |
| | Total | 30 | 99.99 | 100 |
| Missing | System | 0 | 0.0 | |
| Total | | 30 | 100.0 | |

Source: Our survey, 2022.

women refused to denounce to the health authorities the midwives who exercised acts of mistreatment on them.

- **Nationality of women in childbirth**

According to the data in Table 4, 56.67% of the women surveyed are ECOWAS nationals. On the other hand, 33.33% of the women questioned are Ivorians. 10% of women surveyed are non-ECOWAS nationals. Ivorian women are less represented than ECOWAS nationals. This less significant presence of Ivorian women compared to that of ECOWAS nationals is explained by the fact that foreign women are the only ones, according to respondents, not to observe family planning.

## 3.2. Manifestations of Abuse of Women in Childbirth

### 3.2.1. Victimization of Women in Childbirth

The various surveys carried out have made it possible to collect data on the mistreatment of women in childbirth. These collected data show the proportion of women victims of abuse in our survey sample. The types of abuse suffered, the frequency and the groups at risk are also presented. These different elements make it possible to understand both the existence of this mistreatment and the

circumstances of their manifestations in Divo.

### 3.2.2. Proportion of Women Who Have Experienced Abuse

On a sample of 30 women, whose age varies from 16 to 40 years, the proportion of people who have been victims of abuse is recorded in the following table:

According to the results in Table 5, 90% of respondents claim to have been victims of abuse. On the other hand, 10% of respondents said they had not been victims of abuse. In general, it appears that more than the majority of the women surveyed, *i.e.* 90%, claim to have been victims of abuse. However, during our interviews, we noticed that the women who claimed not to have been victims of ill-treatment in a personal way, nevertheless witnessed the victimization of certain women in a direct way. In view of this information, the existence of mistreatment of women in childbirth in Divo is reinforced. In addition, in order to better understand their existence, we studied the types of abuse suffered by these women. The data is recorded in the following tables:

According to the data in Table 6, the respondents affirmed that women in childbirth experience several types of abuse. The most significant are constituted by verbal violence (37.50%), physical violence (27.78%), negligence (20.83%) and psychological violence (13.89%).

### 3.2.3. Frequencies of Mistreatment of Women in Childbirth

The data in Table 7 show the frequency of victimization of the women surveyed.

Table 5. Personal victimization of the respondent.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | Yes | 27 | 90 | 90 |
| | Nope | 3 | 10 | 10 |
| | Total | 30 | 100 | 100.0 |
| Missing | System | 0 | 0.0 | |
| Total | | 30 | 100.0 | |

Source: Our survey, 2022.

Table 6. Types of abuse suffered by women in childbirth.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | physical violence | 20 | 27.77 | 27.78 |
| | Verbal abuse | 27 | 37.50 | 37.50 |
| | Negligence | 15 | 20.83 | 20.83 |
| | Psychological violence | 10 | 13.88 | 13.89 |
| | Total | 72 | 99.98 | 100.0 |
| Missing | System | 0 | 0.0 | |
| Total | | 72 | 100.0 | |

Source: Our survey, 2022.

**Table 7.** Frequencies of ill-treatment suffered by women in diapers.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | At all births | 10 | 33.33 | 33.33 |
| | At their first birth | 9 | 30 | 66.70 |
| | At their last birth | 5 | 16.66 | 16.67 |
| | At a single birth | 6 | 20 | 20 |
| | | 30 | 99.99 | 100.0 |
| Missing | System | 0 | 0 | |
| Total | | 30 | 100.0 | |

Source: Our survey, 2022.

**Table 8.** Groups most victimized according to respondents.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | young women (16 - 25 years old) | 60 | 83.33 | 83.33 |
| | older women (26 - 40 years old) | 12 | 16.66 | 16.67 |
| | Total | 72 | 99.99 | 100.0 |
| Total | | 72 | 100.0 | |

Source: Our survey, 2022.

First, 66.70% of women claim to have been victims of abuse during their first childbirth. And 33.33% of women declare for their part that they have been victims of abuse at all their births. Then, 16.67% say they were victims of abuse during their last childbirth. Finally, 20% of women claim to have been victims of abuse at a single birth. This information reflects the recurrence of abuse suffered by these women. They are of various shapes. It is this aspect of the phenomenon that leads us to determine the groups most at risk for the occurrence of this mistreatment among our respondents. The table below presents the opinions of the respondents.

According to the data in Table 8, the women who run the greatest risk of being victims of abuse during childbirth according to our respondents are young women (83.33%) and elderly women (16.67%). In general, it appears that young women (83.33%) whose age is between 16 and 25 are the most victims of abuse. This is explained by the fact that this category has limited experience, since most of them are at their first birth. Also, this category of women at risk are mostly illiterate and do not have enough knowledge of their rights as parturients.

### 3.2.4. Perpetrators of Abuse of Women in Childbirth

The observations and interviews carried out revealed that the abuse suffered by women in childbirth in Divo involves different perpetrators. The data relating to the perpetrators of abuse suffered by women in childbirth are recorded in the following table:

**Table 9.** Perpetrators of abuse according to respondents.

| | | Frequency | Percentage | Valid percentage |
|---|---|---|---|---|
| Valid | Midwives with less than 5 years of practice | 40 | 55.55 | 55.55 |
| | Midwives with less than 10 years of practice | 20 | 27.77 | 27.77 |
| | Midwives with more than 10 years of practice | 12 | 16.66 | 16.67 |
| | Total | 72 | 99.99 | 100.0 |
| Missing | System | 0 | 0.0 | |
| Total | | 72 | 100.0 | |

Source: Our survey, 2022.

The analysis of Table 9 shows that various perpetrators are at the origin of the ill-treatment exercised against women in childbirth. These are midwives with less than 5 years of practice (55.55%), midwives with less than 10 years of practice (27.77%), and midwives with more than 10 years exercise (16.67%). It generally emerges from the analysis of the data in this table that midwives with less than 5 years of practice (55.55%) are the main perpetrators of abuse suffered by women in childbirth at the CHR of Divo. They are mostly young women, often single and childless.

## 4. Discussion and Conclusion

### 4.1. Discussion

The results of the study present the identity characteristics of women in childbirth such as their age, their level of education, their nationality and their religion. Their average age is 23 and those aged 16 - 24 represent the largest segment of the survey population. Most of these women are illiterate or drop out very early. Their low level of education is mainly due to poverty. These results confirm those of Dieye [10] who claims that those women in childbirth who are abused are those who are under the age of 18. But unlike Dieye [29], our study provides more details about these women. Indeed, those aged between 16 and 24 appear to be the most vulnerable. Their young age is perceived as a criterion of vulnerability. According to Traoré *et al.* [11] and Ndiaye *et al.* [12], this vulnerability is explained by the unexpected nature of pregnancy, the discretion that must surround pregnancy, ignorance of the risks and the refusal to be examined by male providers. Otherwise, our results confirm those of Lahaye [4], Sannié [5] and Ghadi [30]. Indeed, Lahaye [4] points out that this mistreatment is explained by any behavior, act, omission or abstention committed by a health worker which is not medically justified and/or carried out without the free and clear consent of the pregnant woman or the parturient. Sannié [5] attests that this phenomenon is closely linked to breaches of the health code by health workers. For the author, the mission of the midwife is to provide her care without abandoning an attack on the patient, to respect and ensure respect for her

dignity. This amounts to saying that the midwife must take care of the parturient and not mistreat her. Ghadi [30] for his part by highlighting three forms of ill-treatment in hospitals, also distinguishes three types of factors, in particular those linked to the behavior of health workers (verbal abuse and reprisals), those linked to institutional factors and the third form is linked to the lack of information. Contrary to these authors, our work brings more precise details on these forms of these mistreatments, the circumstances of their commission and the perpetrators.

### 4.2. Conclusion

In terms of results, it should be noted that the description of women in childbirth was based on their characteristic identity traits such as their age, level of education, nationality and religion. Thus, the average age of women in childbirth is 23 and those aged 16 - 24 represent the largest segment of the survey population. Most of these women are illiterate or drop out very early. Their low level of education is mainly due to poverty. In terms of religion, they belong to several religious communities: Catholic, Protestant, Evangelical, Muslim, and Animist. These women have various nationalities including ECOWAS nationals, Ivorians and non-ECOWAS nationals. Regarding the manifestations of this mistreatment, we believe that they are of several types the most significant of which are verbal abuse, physical abuse, neglect and psychological abuse. These abuses have taken place for some women at their first or last delivery, at all their deliveries or at a single delivery. Also, the results show that, in general, young women between the ages of 16 and 25 are the most victims of mistreatment in childbirth. Finally, various authors are at the origin of the mistreatment of women in childbirth. These are midwives with less than 5 years of practice, midwives with less than 10 years of practice, and midwives with more than 10 years of practice. They are mostly young women, often single and childless. Among the solutions envisaged, we propose at the level of the CHR of Divo to organize periodically awareness sessions and training of midwives and to organize training relating to the care of women in childbirth. Concerning the Ministry of Health and the State, we suggest creating a National Observatory on the mistreatment of patients, strengthening childbirth equipment, publishing the list of procedures for free care in CHRs and fight against family poverty. The solutions for patients and populations are to inform patients in order to help them exercise their rights, to make women aware of respecting the therapeutic instructions of midwives and to make remarks of courtesy and respect towards health personnel.

## Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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