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'They treat you like you are not a human being': Maltreatment during labour and delivery in rural northern Ghana

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ABSTRACT

Objective: to explore community and health-care provider attitudes towards maltreatment during delivery in rural northern Ghana, and compare findings against The White Ribbon Alliance's seven fundamental rights of childbearing women.
Design: a cross-sectional qualitative study using in-depth interviews and focus groups.
Setting: the Kassena-Nankana District of rural northern Ghana between July and October 2010.
Participants: 128 community members, including mothers with newborn infants, grandmothers, household heads, compound heads, traditional healers, traditional birth attendants, and community leaders, as well as 13 formally trained health-care providers.
Measurements and findings: 7 focus groups and 43 individual interviews were conducted with community members, and 13 individual interviews were conducted with health-care providers. All interviews were transcribed verbatim and entered into NVivo 9.0 for analysis. Despite the majority of respondents reporting positive experiences, unprompted, maltreatment was brought up in 6 of 7 community focus groups, 14 of 43 community interviews, and 8 of 13 interviews with health-care providers. Respondents reported physical abuse, verbal abuse, neglect, and discrimination. One additional category of maltreatment identified was denial of traditional practices.
Key conclusions: maltreatment was spontaneously described by all types of interview respondents in this community, suggesting that the problem is not uncommon and may dissuade some women from seeking facility delivery.
Implications for practice: provider outreach in rural northern Ghana is necessary to address and correct the problem, ensuring that all women who arrive at a facility receive timely, professional, non-judgmental, high-quality delivery care.
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Introduction

Every year in low- and middle-income countries, 275,000 women die due to pregnancy-related causes, and 3 million babies die in first 4 weeks of life (The Lancet, 2005; Oestergaard et al., 2011; WHO, 2012). Facility-based delivery – or births that occur outside the home in any health-care setting – has been identified by the World Health Organization as a critical strategy for reducing these deaths (WHO, 2004). Nonetheless, many things prevent women from giving birth in a health facility, including logistical factors such as cost (Spangler and Bloom, 2010), distance to facilities (De Allegri et al., 2011; Gabrysch et al., 2011), and unexpected, rapid, or ill-timed onset of labour (Galaa and Daare, 2008). Social factors, such as the need to seek permission from others before going to a health facility (Mills and Bertrand, 2005; Bazzano et al., 2008; Moyer et al., 2013), can also prevent women from giving birth anywhere but at home.

One important factor that is not well-documented but can have profound effects on women's choices regarding where to give birth is maltreatment at the hands of providers at a health facility. Maltreatment has been described or alluded to as part of larger studies in

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Ghana (D'Ambruoso et al., 2005; Mills and Bertrand, 2005; Bazzano et al., 2008), Nigeria (Asuquo et al., 2000; Ejembi et al., 2004; Onah et al., 2006), Swaziland (Uyirwoth et al., 1996; Thwala et al., 2011), Tanzania (Kruk et al., 2009; Spangler and Bloom, 2010), and Uganda (Kyomuhendo, 2003). There is no uniform definition of maltreatment, and there is no standardised instrument to measure its prevalence. Maltreatment has been conceptualised as general abusive treatment towards women (Asuquo et al., 2000), negative or unfriendly staff attitudes (Asuquo et al., 2000; D'Ambruoso et al., 2005; Mills and Bertrand, 2005), verbal abuse (Mills and Bertrand, 2005), or sexual abuse (d'Oliveira et al., 2002). Maltreatment has also been described as encompassing neglect, detention at facilities if women are unable to pay for services, non-consented care, discrimination based on patient attributes, and health-care workers delivering services in exchange for bribes (FIDA-Kenya, 2007; Bowser, 2010; Human Rights Watch, 2011).

The drivers of maltreatment, which is most often discussed in the context of midwife or nurse interactions with pregnant or labouring women, are not well understood. In many developing countries, nurses in the public sector are working long hours in harsh conditions, and there are extreme power differentials between them and their predominantly poor, illiterate patients (Jewkes et al., 1998). 'In these situations nurses have been reported to employ humiliation, verbal coercion, and even physical violence to assert their authority and control patient behavior' (Jewkes et al., 1998, p. 1781). Anecdotal reports from midwives in rural Ghana suggest that they will do whatever it takes to help a woman give birth to a healthy baby—even if that means hitting her to help her focus on pushing during delivery.

In 2011, the advocacy organisation The White Ribbon Alliance for Safe Motherhood published a charter to formally recognise seven fundamental rights of childbearing women, which map to seven categories of disrespect originally put forth by Bowser and Hill (Bowser, 2010). These include: physical abuse, non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in facilities (Respectful Care Advisory Council, 2011). Notably, these categories are not meant to be mutually exclusive as many types of maltreatment encompass multiple categories.

This study sought to explore the issue of maltreatment in rural northern Ghana using a broad cross-section of community respondents. The study included the following aims: (1) to determine whether maltreatment was mentioned by community members without prompting when discussing issues surrounding childbirth, (2) to determine the types of maltreatment reported to be occurring in facilities in rural northern Ghana, and (3) to compare the categories of maltreatment described in the existing literature against those identified in this region of Ghana.

Methods

This study grew out of the Stillbirth And Neonatal Death Study (SANDS) in northern Ghana from July through October 2010 (Aborigo et al., 2012; Engmann et al., 2012; Moyer et al., 2012; Moyer et al., 2013). This study focuses on cross-sectional interview and focus group data spanning the antenatal and perinatal period and excludes interactions solely focused on an infant's first seven days of life. The cross-sectional nature of the study design allowed for a broad exploration of the issue of maltreatment across a variety of respondents, as well as the opportunity to let respondents spontaneously discuss elements of childbirth in this setting.

Study setting

We conducted all data collection in the Kassena-Nankana District of the Upper East region of northern Ghana, a region known for subsistence agriculture and widespread poverty. Approximately 90% of the district's 150,000 inhabitants live in rural settlements. The district has six health centres that refer to one major hospital in the district capital of Navrongo.

Data collection

We conducted in-depth interviews and focus group discussions among a wide cross-section of individuals, illustrated in Table 1. We used several variants of a semi-structured interview tool that we developed based on previous published guidelines (Parlato et al., 2004). The tool varied based upon the type of interaction (interview versus focus group) and the type of respondent.

Selection of participants

The Kassena-Nankani District is divided into four zones for enumeration purposes: two were randomly selected for data collection in this study.

Community Key Informants (CKIs) provided a list of women who delivered infants within the previous 29 days in each selected zone. CKIs live within the community and work with the Navrongo Health Research Center (NHRC) to routinely collect information on such events as births, deaths, pregnancies, and marriages. The list of mothers was categorised by literacy, place of delivery, and number of previous deliveries to maximise the variability of the sample. On the basis of recommendations from the CKIs, we purposely selected traditional birth attendants (TBAs), herbalists, and other local healers. Researchers conducted in-depth interviews with all of these types of respondents.

Focus group participants were recruited from 10 randomly selected community clusters across the two selected zones. CKIs identified grandmothers with relevant experience in neonatal health, and the NHRC database generated a random list of 20 household heads and 20 compound heads from the same communities. We contacted individuals in the order that they appeared on the list and invited the first 12 to grant consent to participate in the discussions.

The research team also selected a purposive sample of health-care providers working in the region, including nurses, midwives, nurse/midwives, medical assistants, and clinicians. Medical doctors practice in the only hospital in the district, thus interviewers selected and recruited doctors at the district hospital. All health-care providers were interviewed individually.

The interviewers

Four trained field staff employed by the NHRC conducted all community-based interviews in one of the two local languages. (Two were undergraduates and two were graduate students at a nearby university; three were male, one was female; all were Ghanaian.) Two graduate students from the United States conducted health-care provider interviews in English, the official language of Ghana. (Both were female medical students.) All participated in nearly 25 hours of instruction and mock interviews. The Ghanaian interviewers did not come from the communities where the interviews were conducted, and there were no known relationships between interviewers and participants.

In-depth interviews (IDIs)

Interviewers conducted hour-long in-depth interviews with community members, relying upon a semi-structured instrument and detailed probes to guide the discussion. All interviews were audio-recorded, and a second field team member took field notes. Interviews conducted in one of the local languages were transcribed into English, with unique words and phrases – or those that were

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