EXPLORING EVIDENCE FOR DISRESPECT AND ABUSE IN FACILITY-BASED CHILDBIRTH AT A TERTIARY FACILITY IN GHANA

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ABSTRACT

Background: Pregnant women's decisions to seek maternity care are influenced by the poor quality of health care they receive, as well as their fears of being disrespected and abused during childbirth, which are perpetuated by health workers. Physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in facilities are some of the most common manifestations of disrespect and abuse. Maternal mortality interventions have primarily targeted facility-based delivery, but the proportion of births in facilities has remained persistently low

in many low-resource settings, despite the fact that facility-based birth rates have increased in recent years.
Purpose: The purpose of this study was therefore to explore women's views on disrespect and abuse in childbirth in the Tamale Teaching Hospital.
Methods: Analytical cross-sectional design was used to collect data for this study, and a purposive sampling technique was used to select the respondents from the study area. A total of two hundred and forty respondents were surveyed for the purpose of gathering information for the study. The majority of the primary data was gathered through the use of administered questionnaires. The information gathered was analyzed with the help of Microsoft Word Excel.
Results: The study revealed that, 23 percent of respondents identified insulting as a form of abuse and disrespect during childbirth, and that 91% of respondents believed that abuse and disrespect during childbirth could never be stopped. A further finding was that 86% of respondents viewed abuse and disrespect during childbirth as negative, whereas 51.6% of respondents viewed the absence of abuse as a means of improving the overall quality of health care during childbirth.
Conclusion: On the basis of the study's findings, a number of recommendations were also made, including the intensification of interventions that could help prevent neglect or isolation among new mothers in the study area.

Key Words: *Disrespect, Abuse, Childbirth, Maternity Care, Facility-Based Birth*

INTRODUCTION

The relationship that a woman has with her maternity care providers is critical to her overall well-being [4]. Furthermore, not only do these encounters serve as a conduit for essential lifesaving health services, but women's interactions with caregivers can either empower and

comfort them or cause them long-term harm and emotional trauma [16]. However, women's memories of their childbearing experiences last a lifetime and are frequently shared with other women, contributing to a climate of confidence or doubt surrounding childbearing and health-care utilization [5]. Obstetrics and obstetrical care continue to put women at risk for significant morbidity and mortality, particularly in sub-Saharan Africa [2].

Pregnant women require access to the infrastructure, equipment, and personnel necessary for routine and emergency obstetric and newborn care in order to exercise their right to readily available, easily accessible, acceptable, and of high-quality care [28]. Despite the advancements, many pregnant women, particularly in developing countries, continue to face challenges in obtaining high-quality services [34]. Although services are available, care may be compromised by social, ethnic, and cultural barriers; a chilly reception at the health care facility; a lack of privacy and limited information sharing between the client and the provider; and, in some cases, outright neglect or abuse [1].

According to international law, the right to health necessitates the provision of health services that are readily available, easily accessible, acceptable, and of high quality [24]. While numerous official interpretations and guidance documents have been issued in support of the application of this right to childbirth, reports of disrespectful or abusive treatment during labour and delivery continue to appear in many parts of the world [2]. Recently published data from low-resource settings revealed a widespread practice of disrespectful and abusive treatment by health-care workers when pregnant women seek childbirth, as well as the ability of such experiences to undermine access to childbirth care during subsequent deliveries [6].

The World Health Organization (WHO) recently issued a call for action to put an end to disrespectful behaviour during skilled birth, from policy to practice [8]. According to the call, women from low socioeconomic status, migrant women, and women from ethnic minorities are particularly vulnerable to disrespect and abuse during pregnancy and childbirth [8]. According to the growing body of anecdotal and research evidence collected in maternity care systems around the world - from the wealthiest to the poorest countries - it appears that disrespect and abuse of women seeking maternity care are becoming increasingly serious issues [15]. Taking a stand against disrespect and abuse, WHO states that every woman has the right to the highest

attainable standard of health, including the right to dignified and respectful care during pregnancy and childbirth [6].

MATERIALS AND METHODS

Study design: The study employed a cross-sectional design that was primarily analytical in nature.

Study Area: The study was conducted in the Tamale Teaching Hospital which is located in Tamale Metropolis.

Target Population: The study participants were primarily post-partum women who had been in the Postnatal Ward for no more than three days at the time of the study's implementation. The study population consisted of women of reproductive age (15 to 49 years) who had given birth in the hospital within the previous (0-3) days and who had been attended by a skilled birth attendant during their delivery.

Exclusion Criteria: Participants who does not fall within the reproductive age.

Data Collection Instrument: For the purpose of gathering information, a structured questionnaire consisting of both closed- and open-ended questions was used as the primary tool. Primary and secondary data sources were used to gather the information. When collecting primary data, the researchers used structured questionnaires to gather as much information as they possibly could. Individually administered questionnaires were given out by the researchers at the Tamale Teaching Hospital's Post-Natal Ward. Obtaining secondary information was accomplished through a review of related literature, which included books, journals, and internet articles.

Sampling Technique and Size: The respondents for the study were selected using a technique known as purposive sampling. The Fisher's method was used to narrow down the pool of potential respondents. The numbers used as identification were given to post-partum women who had delivered between (0-3) days prior and were written on pieces of paper that were then folded in half. Using a clean rubber bucket, the folded papers were thoroughly mixed and kept together. To obtain the required sample size of 240 folded papers, the technique of sampling without

replacement was used to pick the folded papers out of the rubber bucket one by one until the required sample size formula was obtained.

Data Analysis Tools for Statistical Significance: The completed questionnaires were crossed checked for completeness and accuracy. The questions were coded and entered into the excel computer software for analysis using Microsoft Excel Word 2018. The descriptive tools were tables, pie chart, graph and bar charts together with relevant and narrative expression.

The researchers conducted the data collection in order to ensure that the information gathered was trustworthy and valid. This ensured that the questions were consistent throughout. The questionnaires were also pre-tested on a total of fifteen post-partum women before being distributed. The pre-testing was carried out in order to assist in the restructuring of the questionnaire. After double-entry of data was completed, the two data sets were compared at the conclusion of the analysis.

Ethical Consideration: Permission was sought from the hospital administration. This was granted. Before they were administered, the questionnaires were also reviewed by the appropriate authorities. Written informed consent was obtained from the participant.

RESULTS

This chapter presents the results from the data that was collected from the respondents.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

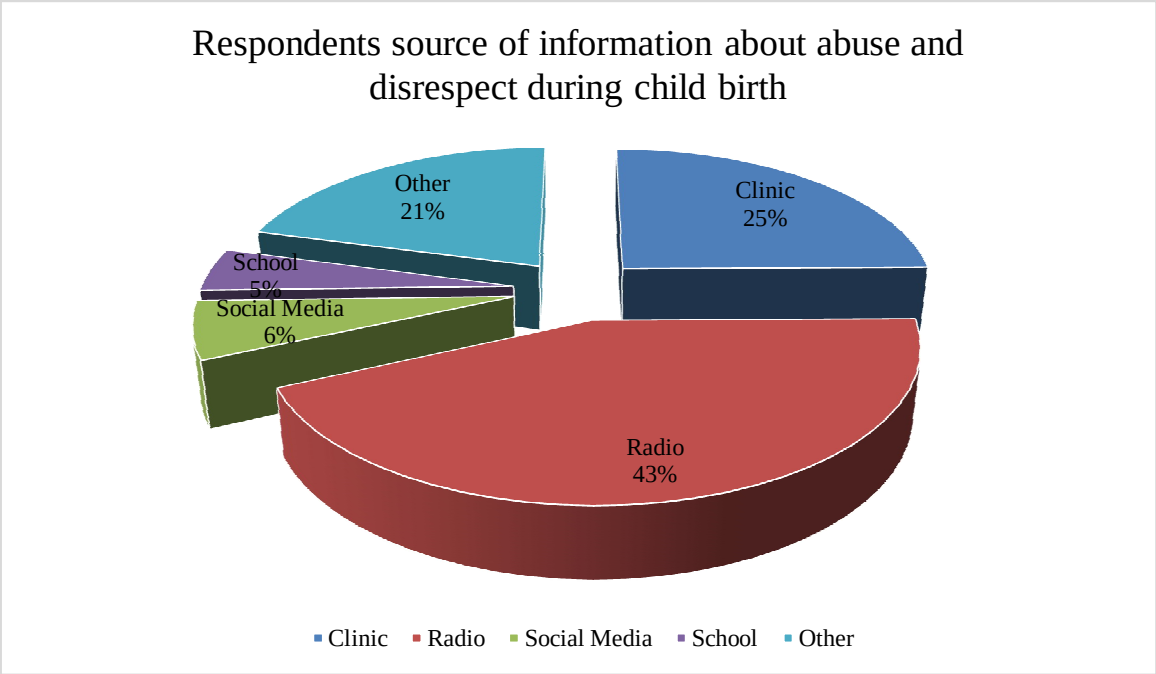
The age distributions of respondents who formed part of the study. Most of the respondents representing 52% were within the age of 31-35 years, 19% respondents were within 26-30 years, 8% respondents were within 20-25 years whiles 21% respondents were 36 and above years. Majority of the respondents (90%) were married whiles (10%) respondents were single or in consented relationship none of the respondents however stated divorce, separated or widowed. Most of the respondents (62.5%) were practicing Islam with 37.5% respondents practicing Christianity. 66.7% of the respondents were self-employed, 14.2% respondents said they were students whiles 8.3% respondents stated they were unemployed. 10.8% respondents were gainfully employed hence salaried workers. Also, 60% of the respondents were Dagombas, 42

(17%) respondents were Gonja, 28 (12%) respondents were Dagarti, 8 (3%) respondents were Akans and 8 (18%) of the respondents were Bimoba. In terms of education, 47.4% of the respondents had no formal education with 11.2% and 13.6% respondents having primary and secondary education respectively. 16.2% respondents had tertiary education whiles 11.6% said they had vocational education.

Regarding parity of respondents, 53.3% of the respondents had 3-4 children, 25.8% had 5 and more children and 20.8% had 1-2 children at the time of conducting the research at the study area.

The number of times of pregnancy of respondents, 52.5% respondents had conceived for three and above times, 39.2% respondents conceived for the second time whiles 8.3% respondents however were primigravidae. Moreover, 91% respondents' mode of delivery was Spontaneous Vagina Delivery (SVD) whiles 9% respondents said by Caesarean Section (C/S).

Figure 1.1: Sources of respondent's knowledge of abuse and disrespect



23% of the respondents identified insulting as a form of abuse and disrespect during childbirth, 21% respondents mentioned non-dignified care, 8% respondents stated non-confidential care with 6% respondents stating physical beating. 2% respondents and 40% respondents respectively identified buying of things and shouting as abuse and disrespect during childbirth.

All the respondents (100%) identified the midwives and nurses as the most frequent health workers who abused pregnant women during child birth probably because they are directly involved in the art and process of child birth. All the respondents (100%) stated that the negative effect of abuse and disrespect during childbirth is the emotional instability they usually experienced

From this, majority of the respondents (91%) were of the opinion that abuse and disrespect during childbirth can never be stopped whiles 9% respondents expressed a contrary view.

PERCEPTION AND VIEWS ON ABUSE AND DISRESPECT IN CHILDBIRTH

Majority of the respondents (86%) perceived abuse and disrespect during childbirth as bad whiles 14% respondents perceived it not to be bad. Among the latter, they mentioned factors such as; some pregnant women are always too reluctant to comply to basic issues during labour and during labour most pregnant women become emotional unstable and unnecessary angrily and need to be controlled. From the responses, most of the respondents have had one form of abuse or disrespect before or otherwise in childbirth. 94.1% of the respondents said they have been abused before whiles 5.9% said they have never been abused before.

Table 1.1: Respondents perception of quality of health care

VARIABLE	FREQUENCY	PERCENT
proper communication	89	37.1
Friendly care	27	11.3

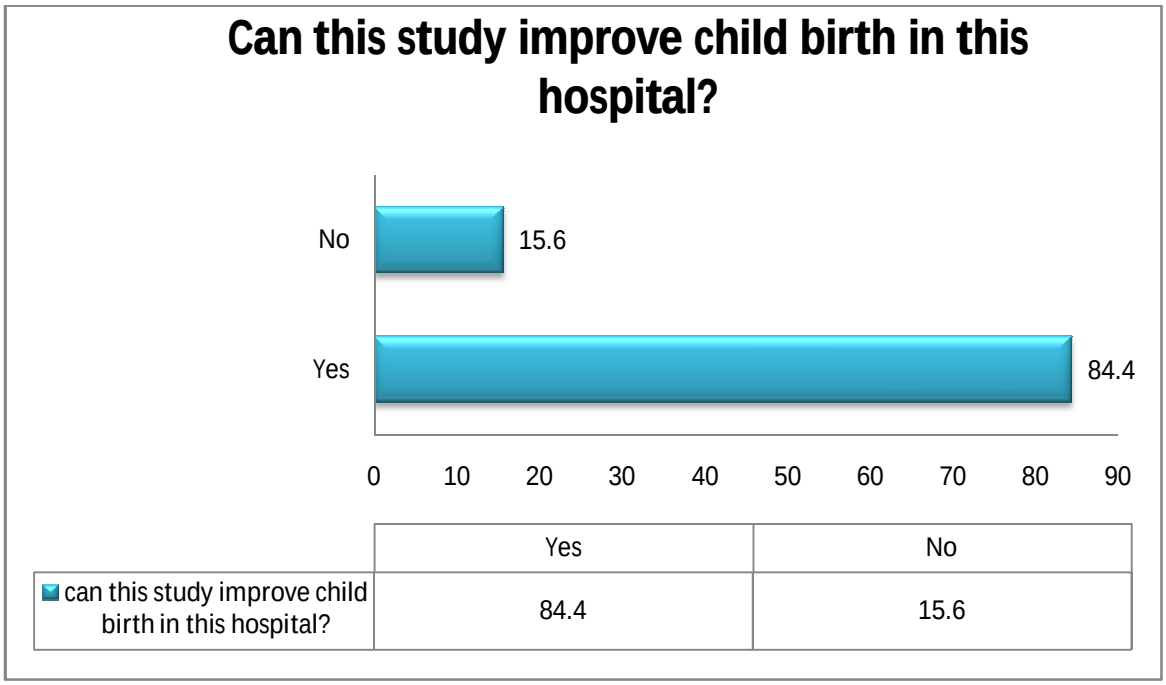
Absence of abuse	124	51.6
TOTAL	**240**	**100**

In terms of education and abuse during child birth, 72.3% respondents said educational level of pregnant women determines whether the person was going to be abused or disrespected whiles 27.7% respondents however, stated that educational level was not linked to abuse and disrespect during childbirth.

Moreover, 56% respondents said financial status of pregnant women is a contributory factor to abuse and disrespect during child birth as poor pregnant women were more likely to suffer abuse than the rich whiles 44% respondents said there was no relationship between abuse and financial status of pregnant women during child birth.

76% respondents strongly agreed that lack of policies that support respectful and non-abusive maternity care are contributory factors to abuse and disrespect during child birth whiles 15% respondents agree to that assertion 9% respondents however disagree. Eight-seven percent respondents strongly agree that lack of standard and leadership for respect and non-abusive in child birth are contributory factors to abuse and disrespect whiles 13% respondents disagree.

Figure 1.2: Respondents assessment of the study on the impact of childbirth



DISCUSSION

According to the findings of the study, 72.3% of respondents stated that the educational level of a pregnant woman determines whether or not the person will be abused or disrespected during childbirth, while 27.7 percent of respondents stated that educational level was not associated with abuse and disrespect during childbirth. This finding of the study is in contrast to the findings of Warren et al. studies conducted in Kenya, which found that there was no significant relationship between education and any form of abuse or disrespect among post-partum women. According to the findings of the study, those who took part in it stated that education and abuse during child labour were inversely related [33].

The findings of the study are not surprising, given that the majority of the respondents lacked formal education and had previously experienced abuse during childbirth in one form or another, depending on their own understanding of the term. It is important to remember that these respondents took into consideration not only physical abuse during childbirth, but also non-

verbal abuse during childbirth. It is possible to engage in nonverbal abuse in a variety of ways, including puffing, ignoring during labour and shouting at the woman to push. 90% of the respondents were married, with 62.5% identifying as Muslims.

The Dagomba ethnic group was the most prevalent, with a percentage of 60 having three or four children at the time of the study's conduct. According to the study's findings, 56 percent of respondents believe that a pregnant woman's financial situation is a contributing factor to abuse and disrespect during childbirth, and that poor pregnant women are more likely than rich pregnant women to suffer abuse and disrespect. 44 percent of those who answered the survey said there was no link between abuse and the financial situation of pregnant women during pregnancy and childbirth. This finding from the study is consistent with the finding made by Vedam et al., who found that pregnant women with high household income are more than six times more likely than pregnant women with low household income to access birth care, with fewer abuses and disrespect at health facilities, than pregnant women with low household income in Addis Ababa, according to the study [32].

FORMS OF ABUSE AND DISRESPECT

The risk of dying during pregnancy or shortly after delivery is measured by the maternal mortality ratio, which is primarily used to assess the safety of childbirth in the United States. Most maternal deaths occur in developing countries, with sub-Saharan Africa having the highest maternal mortality ratio in the world (900 deaths per 100 000 live births), according to the World Health Organization [21].

According to the findings of the study, all of the respondents have ever heard of abuse or disrespect during childbirth, which lends support to the findings of Mrisho et. al., who found that abuse and disrespect in facility-based care are extremely common among post-partum women [19]. According to the responses gathered from the respondents, it is clear that there is no single, definitive definition for disrespect and abuse perpetrated against post-partum mothers.

Once again, this finding supports the findings of Ratcliffe, who found that disrespect or abuse toward pregnant women during childbirth in health-care facilities is multidimensional and difficult to define [22]. The results, on the other hand, indicate that some respondents attempted

to define abuse or disrespect. Maltreating a pregnant woman during childbirth, the way a pregnant woman is received and handled during childbirth, and is the way a pregnant woman is received and handled during childbirth are some of the highlights. According to Bowser & Hill, yelling during labour, insulting, beating, and providing less care during labour are some of the measures that have been used to describe what pregnant women have actually labelled as abuse and disrespect during childbirth, and this range and variety of explanations is consistent with their findings [6].

According to the findings of the study, 23% of respondents identified insulting as a form of abuse and disrespect during childbirth, while 21 percent mentioned non-dignified care, 8 percent stated non-confidential care, and 6 percent stated physical beating. During childbirth, 2 percent of respondents and 40 percent of respondents, respectively, identified the purchasing of items and shouting as forms of abuse and disrespect. In accordance with Ratcliffe, the findings of this study confirm the findings of a previous study conducted in Boston, which revealed that the most common abuse experience described across respondents was that of feeling ignored or neglected [22]. In addition, verbal abuse was common, but it appeared to be less disconcerting among those who responded. As previously stated by Watson-Jones et. al., 79 percent of postpartum women identified insulting as a common form of abuse and disrespect, 16 percent reported being shouted at during labour, and 5 percent of postpartum women reported receiving non-dignified care during the delivery process [34]. Even in a normal situation, insults are the most common thing that causes a pregnant woman to become enraged while in labour. A person has a tendency to retaliate in response to what they perceive as insults. As a result, these respondents were subjected to verbal or nonverbal abuse during their time at work.

PERCEPTION AND VIEWS ON ABUSE AND DISRESPECT IN CHILDBIRTH

Facility delivery rates in Sub-Saharan Africa are among the lowest in the world, with only 47% of women in 28 sub-Saharan African countries giving birth in a health facility, according to recent surveys. It was discovered through the study’s findings that 86% of the respondents believed abuse and disrespect during childbirth were harmful, while only 14 percent did not believe these things to be harmful. That this study's findings support previous research conducted

by Watson-Jones et. al., who found that post-partum women admitted that abuse and disrespect during childbirth are harmful [34].

The study's findings also revealed that 94.1% of respondents had experienced abuse in the past, with only 5.9 percent reporting that they had never been abused before. This finding from the study confirms the findings of Watson-Jones et al., who found that in Kenya, all post-partum women interviewed admitted to having been abused during childbirth in the previous year or two [34]. Even when pregnant women are in severe pain, the instructions given to them by nurses and midwives to follow are often interpreted as abuse by the majority of pregnant women who are in labour [3]. It should be noted that the overwhelming findings of the study, which indicated the majority of respondents had experienced some form of abuse during childbirth, were due to the various forms of abuse identified as a result of the respondents' diverse cultural and ethnic backgrounds, as abuse is always relative. A situation that one person may consider abusive may not even be considered abusive in other contexts, and vice versa.

CONCLUSION

Many of the post-partum women who took part in this study reported that they were subjected to unfavorable conditions while giving birth in the hospital. One approach to addressing this issue could be to improve the status of women in the community. Some of the structural barriers that contribute to abuse and disrespect, as well as poor maternal care services for these populations during childbirth. Respondents provided a variety of explanations for abuse and disrespect, making it difficult to define. The findings revealed that the most common forms of abuse and disrespect in the hospital are: being yelled at, being insulted, receiving substandard care, and purchasing items.

References

1. Awuah, T. Farouk, G. & Thomas, O. (2010). Assessing evidence of disrespect in public hospitals in Ghana, 45.50
2. Baer. H. Singer, M. Johnsen, J. (2019). Toward a critical medical anthropology. Soc Sci Med, Vol. 23:95-98.
3. Bartu, D. (2019). Client Satisfaction: Why bother? Journal of Substance Abuse, Vol. (1): pp20 – 26.
4. Berry, N. S. (2017). Who's judging the quality of care? Indigenous Maya and the problem of "not being attended". Med Anthropol, Vol.27:164-189
5. Bowser, D. & Hill, K. (2018). Exploring evidence for disrespect and abuse in facility-based childbirth. USAID-Traction Project, Harvard School of Public Health.
6. Bowser, D. & Hill, K. (2020). Exploring evidence for disrespect and abuse in facility-based childbirth: report of a landscape analysis. USAID-Traction Project, Harvard School of Public Health and University Research Co.
7. D'Ambruoso, L,.Abbey, M. Hussein, J. (2019). Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana.BMC Public Health, Vol. 5:140.
8. D'Oliveira, A.; Diniz, S. G.; Schraiber, L. B. (2018). Violence against women in health-care
9. Eric Amakwah (2007). Assessing patients' satisfaction level in Ghana: A case study of Komfo Anokye Teaching Hospital, pp45.
10. Filippi, V. Ronsmans, C. Campbell, O. Graham, W., Mills, A. Borghi, J. Koblinsky, M. Osrin, D. (2011). Maternal health in poor countries: the broader context and a call for action. Lancet, Vol. 368:1535-1541.
11. Frisch, A. (2010). Principles of post-operative patients care Nursing Standards. Vol. (5): pp 43-52.

12. Jewkes, R. Abrahams, N. Mvo, Z. (2010). Why do nurses abuse patients? Reflections from South African obstetric services. Soc Sci Med , Vol. 47:1781-1795.
13. Kruger, L. Schoombee, C. (2010). The other side of caring: abuse in a South African maternity ward. J Reprod Infant Psychol, Vol.28:84-101
14. Kruk, M. Kujawski, S. Mbaruku, G. Ramsey, K. Moyo, W. Freedman, L. (2014). Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. Health Policy Plan. doi:10.1093/heapol/czu079
15. Kruk, M.E. Paczkowski, M. Mbaruku, G. de Pinho, H. Galea, S (2019). Women's preferences for place of delivery in rural Tanzania: a population-based discrete choice experiment. Am Public Health, Vol. 99:1666-1672.
16. Kumbani, L.C. Chirwa, E. Odland, J. Bjune, G. (2012). Do Malawian women critically assess the quality of care? A qualitative study on women's perceptions of perinatal care at a district hospital in Malawi. Reprod Health,Vol. 9:30.
17. Mamdani, M. Bangser, M. (2010). Poor people's experiences of health services in Tanzania: a literature review. Reprod Health Matters, Vol. 12:138-153.
18. Moyer, C. Adongo, P. Aborigo, R.A. Hodgson, A. Engmann, CM. (2014). 'They treat you like you are not a human being': maltreatment during labour and delivery in rural northern Ghana. Midwifery, Vol. 30(2):262-268.
19. Mrisho, M. Schellenberg, J. Mushi, A.K. Obrist, B. Mshinda, H. Tanner, M. Schellenberg, D. (2015). Factors affecting home delivery in rural Tanzania. Trop Med Int Health, Vol. 12:862-872
20. Mselle, L. T., Moland, K. M., Mvungi, A., Evjen-Olsen, B. & Kohi, T. W. (2013). Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania. BMC Health Serv Res, Vol. 13:174
21. Radoff, K.A. Levi, A. Thompson, L.M. (2012). From home to hospital: mistreatment of childbearing women and barriers to facility-based birth in Nicaragua. Int J Childbirth, Vol. 2:40-50.
22. Ratcliffe, H. (2013). Creating an Evidence Base for the Promotion of Respectful Maternity Care. Boston, MA: Harvard School of Public Health

23. Reichenheim, M. Zylbersztajn, F. Moraes, C., Lobato, G. (2009). Severe acute obstetric morbidity (near-miss): a review of the relative use of its diagnostic indicators. Arch Gynecol Obstet , Vol. 280:337-343.
24. Rosenfield, A. & Maine, D. (2016). Maternal mortality–a neglected tragedy. Where is the M in MCH? Lancet, Vol.2:83-85.
25. Schroll, A.M. Kjærgaard, H. Midtgaard, J. (2013). Encountering abuse in health care; lifetime experiences in postnatal women-a qualitative study. BMC Pregnancy Childbirth, Vol.13:74.
26. Shimpuku, Y. Patil, CL. Norr, KF. Hill, PD. (2013). Women's perceptions of childbirth experience at a hospital in rural Tanzania. Health Care Women Int , Vol. 34:461-481.
27. Souza, J. Gülmezoglu, A. Vogel, J. Carroli, G. Lumbiganon, P. Qureshi, Z.(2013). Moving beyond essential interventions for reduction of maternal mortality (the WHO Multicountry Survey on Maternal and Newborn Health): a cross-sectional study. Lancet; Vol. 381(9879):1747–55. http://dx.doi.org/10.1016/S0140-6736(13)60686-8 pmid: 23683641
28. Thaddeus, S. & Maine, D. (2019). Too far to walk: maternal mortality in context. Soc Sci Med.
29. Turan, J. Nyblade, L. (2013). HIV-related stigma as a barrier to achievement of global PMTCT and maternal health goals: a review of the evidence. AIDS Behav;17:2528–2539.
30. UNICEF (2013). The State of the World's Children. New York, NY: United Nations Publications.
31. United Nations High Commissioner for Human Rights (2012). Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality [A/HRC/21/22]. New York: United Nations. Vol. 38:1091-1110.
32. Vedam, S., Stoll, K., Taiwo, T.K. *et al.* (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health* 16, 77 (2019). https://doi.org/10.1186/s12978-019-0729-2
33. Warren, C. Njuki, R. Abuya, T. Ndwiga, C. Maingi, G. Serwanga, J. Mbehero, F. Muteti, L. Njeru, A. Karanja, J. (2015). Study protocol for promoting respectful maternity care

initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya. BMC Pregnancy Childbirth, Vol. 13:21.

34. Watson-Jones, D.; Balira, R. & Ross, D. A. (2018). Missed opportunities: poor linkage to ongoing care for HIV-positive pregnant women in Mwanza, Tanzania.