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Women's perspectives of mistreatment during childbirth at health facilities in Ghana: findings from a qualitative study

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Abstract: *Mistreatment of women during childbirth at health facilities violates their human rights and autonomy and may be associated with preventable maternal and newborn mortality and morbidity. In this paper, we explore women's perspectives on mistreatment during facility-based childbirth as part of a bigger World Health Organization (WHO) multi-country study for developing consensus definitions, and validating indicators and tools for measuring the burden of the phenomenon. Focus group discussions (FGDs) and in-depth interviews (IDIs) were used to explore experiences of mistreatment from women who have ever given birth in a health facility in Koforidua and Nsawam, Ghana. Interviews were audio-recorded, transcribed and thematic analysis conducted. A total of 39 IDIs and 10 FGDs involving 110 women in total were conducted. The major types of mistreatment identified were: verbal abuse (shouting, insults, and derogatory remarks), physical abuse (pinching, slapping) and abandonment and lack of support. Mistreatment was commonly experienced during the second stage of labour, especially amongst adolescents. Inability to push well during the second stage, disobedience to instructions from birth attendants, and not bringing prescribed items for childbirth (mama kit) often preceded mistreatment. Most women indicated that slapping and pinching were acceptable means to "correct" disobedient behaviours and encourage pushing. Women may avoid giving birth in health facilities in the future because of their own experiences of mistreatment, or hearing about another woman's experience of mistreatment. Consensus definitions, validated indicators and tools for measuring mistreatment are needed to measure prevalence and identify drivers and potential entry points to minimise the phenomenon and improve respectful care during childbirth. DOI: 10.1080/09688080.2018.1502020*

Keywords: Mistreatment of women, abuse and disrespectful care, facility-based childbirth, verbal abuse, physical abuse, Ghana

Introduction

Global efforts to improve maternal health care include strategies to reduce maternal mortality, increase the proportion of births attended by a skilled provider, and ensure access to quality reproductive health services for all women.^{1,2}

Addressing preventable maternal and newborn mortality and morbidity is a key component of the sustainable development goals.¹ Although there was a substantial reduction (43%) in maternal mortality from 1990 to 2015 globally, still 99% of maternal deaths occur in developing countries.³ Ghana has recorded improvements in its maternal health indicators, with a decline in the maternal mortality ratio from 634 in 1990 to 319 per 100,000 live births in 2015³ while the rate of

This article has been republished with minor changes. These changes do not impact the academic content of the article.

facility-based deliveries increased from about 42% in 1988⁴ to approximately 73% in 2014.⁵ However, a significant proportion of women still do not access health facilities for childbirth services.

Women's reluctance to give birth in health facilities may be partially attributed to a fear of mistreatment by healthcare providers.^{6–9} In 2015, a systematic review by Bohren and colleagues proposed an evidence-based typology of what constitutes mistreatment during childbirth, including: physical abuse (hitting, slapping, pinching), verbal abuse, stigma and discrimination, and systemic issues in health facilities and systems that contribute to poor experiences of care.^{7,9} Mistreatment during childbirth violates the human rights and autonomy of women¹⁰ and may constitute a major disincentive for seeking maternity care services at health facilities. A recent WHO statement regarding this public health and human rights issue called for more proactive action, dialogue, research and advocacy to improve maternal health globally.¹¹

Mistreatment of women during facility-based childbirth in Ghana has been documented, albeit in few studies.^{12–14} D'Ambruoso et al. presented women's accounts of their interaction with birth attendants during facility-based childbirth in semi-urban suburbs of Accra.¹² Their findings showed that women were deeply concerned about health provider attitudes and refused to attend health facilities where they were not treated kindly. A study among student midwives across Ghana also confirmed occurrences of mistreatment during childbirth.¹⁴ Similarly, a study by Moyer et al.¹³ in rural northern Ghana noted that mistreatment during facility-based childbirth was pervasive, and could serve as a disincentive for attending health facilities in the future. These studies did not specifically assess views of acceptability of mistreatment during childbirth, or the perceived factors influencing mistreatment. Previous studies relating to disrespectful care during childbirth tackled different aspects of the mistreatment of women in health facilities without recourse to standardised definitions and methodologies. This has resulted in different descriptions and estimations of the true burden of the problem with diverse propositions for eliminating the mistreatment of women during childbirth, and promoting respectful maternity care.

Although the occurrence of mistreatment of women and disrespectful care during childbirth in health facilities is increasingly well-documented

in both resource-rich and resource-poor countries, consensus definitions including standardised categorisations and measurement tools are lacking globally.⁹ The lack of consensus on definition, classification and specific indicators for measurement of disrespectful care during the birthing process impede accurate prevalence estimation and development of effective interventions.^{7,9,15}

WHO is coordinating a two-phased, multi-country, mixed-methods study on measuring the mistreatment of women during facility-based childbirth in four countries: Ghana, Guinea, Myanmar and Nigeria.¹⁶ The overall objective of this study is to develop an evidence-based definition, identification criteria and two measurement tools to better understand and measure mistreatment, based on the experiences and perceptions of women, healthcare providers and administrators in maternity care settings.

The first phase of this study is a formative phase, including a multi-country qualitative study to inform the development and components of the two measurement tools (direct observations of labour and a community survey with women). These measurement tools will then be used to measure the burden of mistreatment in different settings, and permit standardised comparisons across settings and over time. The qualitative evidence from the first phase will also improve understanding of the context in which mistreatment during childbirth occurs, the contributing factors, and also identify potential entry points to reduce mistreatment and promote respectful care. This paper explores women's perspectives of mistreatment during facility-based childbirth in the Ghanaian context specifically.

Methods

The study was carried out in two different towns in Ghana, a country with a population of about 25 million in 2010 and a population growth rate of about 2.5% per annum.¹⁷ Most women in Ghana give birth in government institutions where maternity care is free due to complete coverage by national health insurance. The health system in Ghana comprises primary, secondary and tertiary levels of care. Women with pregnancy-related complications are referred to a higher level of care based on clinical urgency and expertise.

The study was conducted from May to July 2015 in the towns of Koforidua and Nsawam in the Eastern region of Ghana which has a population of

about 2.6 million.¹⁸ Approximately 97% of pregnant women in the region attend antenatal care, and 68% of births take place in health facilities.⁵

We employed an exploratory qualitative design using in-depth interviews (IDIs) and focus group discussions (FGDs) to gain comprehensive knowledge on how women are treated during facility-based childbirth.

The study involved women of reproductive age (15–49 years) in Koforidua and Nsawam who had recently given birth in any health facility, as well as health care providers and health service administrators working in two public health facilities. The focus of this paper is to share findings of qualitative research on women of reproductive age only. The perspectives of healthcare providers and administrators will be published separately.

To explore individual experiences and perceptions regarding mistreatment during childbirth, IDIs were conducted with women who had given birth in any health facility within 12 months prior to the study. Secondly, to explore community norms regarding mistreatment during facility-based childbirth, FGDs were held with women who had given birth in any health facility within the previous two to five years.

Recruitment, sampling and data collection procedures

Participants for the study were purposively selected by the community health nurses and midwives who live in the communities and therefore had knowledge about the locations of the potential study participants. Women for the FGDs were contacted through face-to-face interaction with a community health nurse within their respective communities. Those for the IDIs were approached by midwives from child welfare clinics at their

respective facilities. Following recruitment by the community health nurses and the midwives, research assistants then approached and informed them about the study. All the women who were approached agreed to participate in the study. They were given a date, time and location for the interviews. Participants were stratified according to age (Table 1).

Before each IDI or FGD, participants provided written informed consent and had their demographic information taken. Each IDI and FGD was conducted by two experienced research assistants; a moderator and a note taker. Field workers (research assistants) adept in qualitative interviews were recruited and trained for the purpose of the study. The social scientist in the team communicated constantly with the interviewers in the field and responded to any issues that arose during data collection. There were six research assistants per site; 12 in all. The research assistants were non-healthcare providers who worked mainly as research assistants and had social science backgrounds with at least a first degree from a recognised university. Non-healthcare providers were used to avoid response or social desirability bias in the data collection, as the research team hypothesised that people with clinical training may interact with the research participants in a different way, or that research participants may share their experiences with healthcare providers differently from with non-healthcare providers. None of the research assistants originated from the study areas, or had relatives or friends in communities or health facilities in the study area. Due to the sensitive nature of childbirth issues, all the research assistants were females. A training session was organised for the research assistants during which a mock interviewing exercise was conducted

Table 1. Age distribution of women in IDIs and FGDs

Age groups	IDIs (<i>n</i> = 39)		FGDs (<i>n</i> = 10)	
	Koforidua	Nsawam	Koforidua	Nsawam
Women aged 15–19 years	6	6	1	1
Women aged 20–34 years	7	8	2	2
Women aged 35–49 years	5	7	2	2
Total	18	21	5	5

by each participant in English and the local language (Twi).

Semi-structured IDI (Appendix 1) and FGD (Appendix 2) guides were used to guide data collection. The primary domains of interest were: (1) expectations of care during childbirth at health facilities (2) experiences and perceptions of mistreatment during childbirth (3) perceived factors influencing mistreatment (4) decision-making processes to give birth at a facility (5) views of acceptability of different scenarios of mistreatment during childbirth.

The IDIs and FGDs were conducted either in English or Twi and audio recorded. The moderator and assistant debriefed immediately after each interview and recorded the debriefing so as to capture their observations and comments on the discussion. The field notes were also incorporated into the debriefing. Each IDI and FGD lasted between 45 and 60 minutes and 60 and 90 minutes, respectively. All the interviews and discussions were conducted in a quiet community centre in the study sites, outside participants' homes and health facilities with only the study participant(s) and interviewers involved. Each interview was conducted only once.

Data management and analysis

The audio recordings were transcribed in English by the interviewers soon after each interview. The transcripts were checked for completeness and accuracy by the field supervisor and the social scientist in the research team. In preparation for the data analysis, the researchers (a social scientist, public health specialists and obstetricians) and research assistants participated in a three-day workshop on qualitative data analysis facilitated by researchers from WHO. A codebook was developed based on the interview guides, findings from a systematic review⁹ and themes emerging from the data. During the coding process, each member read each transcript several times to ensure in-depth familiarity. Three of the research assistants who completed the qualitative training workshop independently coded different transcripts manually based on the thematic content. Thereafter, the codes and emerging findings were discussed as a group until consensus was reached. After coding and categorising the codes, a working analytic framework was developed based on consensus from all the researchers and this was applied to all the transcripts to obtain the final output. Thus, the framework method of qualitative

research, with inductive and deductive analytic approaches, was systematically employed during the analysis of this study. In the inductive analytic approach themes were allowed to emerge from the data, whilst the systematic review and interview guides were used in the deductive approach. The final analysis and presentation of the results were performed by the social scientist in the team with contribution from all other authors. The data was enriched by triangulation of IDIs and FGDs. Differences among team members regarding interpretations of the findings were discussed until consensus was reached.

Technical and ethical considerations

Scientific and technical approval for the study was obtained from the World Health Organization Human Reproduction Programme (HRP) Review Panel on Research Projects (RP2). Ethical approval was obtained from the WHO Ethical Review Committee (Protocol ID, A65880) and the Ethical Review Committee of the GHS (Protocol ID GHS-ERC-13/01/15).

Written informed consent was obtained from the respondents just before the interviews. They were assured of confidentiality of any information provided. To ensure anonymity, no identifiable participant information was taken. The participants were not compensated for taking part in the study but were given a token of GHC 30.00 (USD 8.00) to cater for their time and transportation.

Findings

Overview

Forty-one IDIs and 10 FGDs were conducted with a total of 110 women (Table 1). None of the women approached declined participation in the study. Most women were 30–34 years (33) or 15–19 years old (29), married (75), and residing in urban communities (82). Almost all the participants were Christian (109) and most were of Akan ethnicity (71) (Table 2).

Prominent themes which emerged on the subject of mistreatment included (1) experiences and perceptions of mistreatment during childbirth (2) perceived factors influencing mistreatment, (3) views of acceptability of different kinds of mistreatment during childbirth and (4) influence of mistreatment on preferences for choice of facility-based childbirth. Although not all women recounted personal experiences of mistreatment,

Table 2. Socio-demographic characteristics of participants: women of reproductive age							
	FGDs n = 69	IDIs n = 41	Total n = 110		FGDs n = 69	IDIs n = 41	Total n = 110
Age (years)				Highest level of education attained			
20-24	4	1	5	Primary	3	7	10
25-29	8	9	17	JHS/MSLC**	42	17	59
30-34	27	6	33	SHS/SSS**	15	10	25
35-39	13	8	21	Tertiary	6	4	10
40+	3	2	5	Vocational	0	2	2
Marital Status				None			
Married	55	20	75	Employment			
Single	12	8	20	Trader	27	21	48
Cohabiting	2	12	14	Hairdresser	8	4	12
Widowed	0	1	1	Teacher	8	0	8
Location				Caterer			
Urban	54	28	82	Dressmaker	5	1	6
Peri-Urban	15	13	28	Other	6	3	9
Religion				Unemployed/None			
Christian	68	41	109	Total number of children living			
Muslim	1	0	1	1	20	17	37
Ethnicity				2 to 3			
Akan	48	23	71	4 to 5	9	5	14
Ewe	14	13	27	6+	3	2	5
Ga/Ga-Adangbe	2	2	4	Total number of deliveries			
Gruisi/Fafra/Dagomba	5	3	8	1	23	18	41
				2 to 3	37	16	53
				4 to 5	8	5	13
				6+	1	2	3
				Total	69	41	110

**MSLC (Middle School Leaving Certificate) **JHS (Junior High School) **SHS (Senior High School).

it was a phenomenon that participants commonly associated with facility-based childbirth, and they shared stories that they had heard from friends or family members.

Mistreatment during childbirth described by women

With regards to forms of mistreatment experienced, there were themes on verbal and physical abuse, as well as psychological stress resulting from neglect and lack of supportive care, along with the critical influence of mistreatment on preferences for choice of facility-based childbirth.

Verbal abuse

Women detailed experiences of verbal abuse, including shouting, yelling, insults and derogatory remarks from healthcare providers. They identified these experiences as demeaning, and explained that verbal abuse happened across the duration of their stay in the health facility, from the initial contact with the healthcare providers, through labour and childbirth, as well as during discharge.

I: *How were you received by the health workers when you got to the hospital?*

R: *When I got there, I went there with a sister and I was asked what I am coming to do and I told them I am in labour. I was actually in pains so I couldn't even talk hard and they were shouting at me that I should talk for them to hear. Why? Am I a baby? How they received me I even felt sorry for myself for going there. It made me feel so bad. (IDI, Married woman, 32 years, Nsawam)*

I = Interviewer R = Respondent

Those who experienced shouting and yelling in the early stages of labour described it as scary and intimidating. Women acknowledged that health care providers often yelled at them because they did not arrive at the health facility with the required items for childbirth (e.g. sanitary pads, mackintosh, soap and baby dresses) or they did not assume the “required” position for childbirth (to lie on their back with legs apart).

When we were going to the hospital, I knew my pregnancy was eight months so I told my sister not to take my things for delivery. When we got to the

hospital, the nurse we met said “villager, hmmm ... foolish girl...” I didn't talk because I was in pain. Then the nurse asked me to go and sit on a chair there, then the other nurse said she has to go and lie down. The other nurse said this villager sitting there which bed is she going to lie on, so the second nurse took a cloth and spread it on the bed for me to lie on. I didn't know when you lie down you have to lie on your right side, one nurse saw me turning myself and she said I'm stubborn. (IDI, Married woman, 30 years, Koforidua)

Some women recounted experiences of midwives shouting at them when they were ready to bear down during the second stage of labour. These derogatory remarks usually targeted the woman's inability to push as expected.

I: *How was the shouting like?*

R: *Hey Ewura (lady), you are not the only one to give birth here. You have given birth before. Are you coming to show your arrogance to me, the nurse?*

I: *... at what time of the delivery process did this happen?*

R: *During the pushing period before the delivery. When the baby was about to come I shouted “auntie nurse please it is coming oohh”. But because she was angry, she shouted at me. (IDI, Widowed, 40 years, Koforidua)*

Although, verbal abuse was experienced by women across all age groups, abusive remarks directed at younger women (15–19 years) often touched on the issue of teenage pregnancy.

When you get pregnant and you go to the hospital they would insult you because you are a teenager, so when you are fifteen or fourteen and you go there you will never be happy until you deliver your child. They [healthcare providers] have an age when you can get pregnant, that is from 20-30. (FGD, Married woman, 19 years, Koforidua)

Physical abuse

Participants also recounted physical abuse they endured during childbirth at health facilities. Physical abuse included pinching and slapping of their thighs and sometimes their backs. In some instances, such acts were accompanied by derogatory remarks about their progress through labour or ability to push.

I: *Did you like how you were treated in the facility?*

R: *Please no... When I was pushing there were three nurses around me, when I couldn't push one nurse pinched me and said I should force and push, the other also slapped my thighs and also said I should push but I didn't push, because of that I will not go there again. I wasn't happy; it made another madam insult me and even said that they are not here to help people like me. She even went further to use the word "nasty person".* (IDI, Single, 19 years, Koforidua)

These experiences were evident among women of all ages, and often occurred during the pushing stage of the childbirth process. Women sometimes described these gestures positively, viewing them as corrective measures taken by the healthcare providers to ensure safe childbirth. Although women were displeased with being hit, they believed that such gestures were necessary due to their inability to effectively push:

R: *When I was due for labour and was asked to push, I couldn't push and the nurse beat me very well. She used a cane to whip me so I could push, but I told her I was tired but she insisted I should push. So she really whipped me with the cane and later used her hand to hit my thigh. There I became conscious and was able to push.* (FGD, Married woman, 35 years, Koforidua)

Failure to meet professional standards of care (neglect and lack of supportive care)

Women's experiences suggested psychological stress during labour and childbirth resulting from instances of neglect, lack of support, and health workers' unresponsiveness to their needs. Although women acknowledged that the number of skilled attendants was inadequate to meet the demands of women, they felt that attendants focused on other activities rather than showing interest in the women. In extreme cases women gave birth in the facility without the presence of a healthcare provider, and believed that this was due to poor monitoring and assessment of women during the labour process:

I: *Why did you think you did not get the kind of support you anticipated?*

R: *The nurses were not enough... Also even though the nurses were not enough they sat by their table too much. If they could move around the labour ward, they will know who needs help. One woman delivered on the bed alone in the labour room because we are not well monitored.* (IDI, Married woman, 30 years, Koforidua)

Some women recounted their personal experiences of typical displays of disrespectful care and lack of clinical support during critical moments of maternity care. They described mistreatment by healthcare providers as psychologically disturbing and making them feel helpless and powerless, as enumerated below by a respondent in a FGD:

R: *When the nurse came to look at me, just seconds after she left, then I saw that the thing was coming, and I couldn't do anything about it. And I called the nurse to come. At that time she had already reached her table and was conversing. One said, "did you not just leave that place? and what?, are you the only one coming to deliver here"? So the security personnel who was passing saw my state and called out to the nurses that my baby's head was showing so they should hurry up. But the nurse angrily came and wheeled me away. Truly speaking I was disturbed, but my hand was in her mouth so I kept quiet.* (FGD, Married woman, 35 years, Koforidua)

Acceptability or non-acceptability of types of mistreatment

Women were also asked about their views on the acceptability or non-acceptability of specific acts by healthcare providers that could be considered mistreatment. Their responses were nuanced, showing variations in perceptions and norms among different age groups, reactions to different forms of mistreatment, as well as conditions and timing within which such acts occur. In general, several women expressed strong beliefs, with some indicating that all acts of mistreatment, irrespective of the type or time committed, were unacceptable. The conversations below indicate strong

convictions among women against any form of mistreatment

- I: *If a woman is shouted at by the midwife during labour when do you think [it] is acceptable?*
- R: *For that one it is not acceptable. Slapping her, pinching her, shouting at her all is not acceptable. If you will shout at her, it should be after delivery, even that, excuse me, she is somebody's wife, uh huh and you have also delivered before and you know how it is and people behave differently during labour so it not acceptable for you to shout on the person. (IDI, Married Woman, 39 years, Nsawam)*

In contrast, a few women believed that mistreatment during childbirth was acceptable under certain situations. For example, some women believed it was appropriate for clients who do not follow instructions given by health workers. For a few women “pinching” and “beating” are corrective measures to alert mothers to assume the right position during birth or to enable them to push”:

- I: *So when they (health workers) pinch a pregnant woman to open the legs for the baby to come, is it acceptable?*
- R: *When they pinch them it means they don't obey the instructions of the nurses. Maybe the baby is coming and you are closing your legs so the nurse must pinch you to open them up. Yes it is acceptable. (IDI, Single, 18 years, Nsawam)*

Most women did not hold strong opinions about mistreatment during childbirth. Their responses suggest dilemmas regarding the usefulness of specific acts of mistreatment and their contextual interpretations, compared to the harms it could cause.

- I: *Will pinching ever be justified in some cases?*
- R: *Come to think of it, yes, because some of us women have difficulty in understanding things, and some because they behave outside just like they do at home sometime their behaviour calls for that. Sometimes when they are told to push, they don't push, they will be lying there doing nothing. So to avoid being tagged that those on duty caused the death of so and so*

number of children they will do whatever it takes ...

- I: *How would you feel if it happens to you?*
- R: *If it's for a reason to save my baby I will accept it, but if for no reason, I will take the matter up (IDI, Married woman, 26 years, Koforidua)*

Women implied that some acts of mistreatment were useful for addressing a woman's misbehaviours, misunderstandings, and miscommunications with health providers during the birthing process. In these instances, acts of mistreatment are not expected to be the “first line” of action used by the health provider, but could be applied as “supportive” practices to help mothers through the birthing process.

- R: *Sometimes is not the fault of the health worker. When it is time for you to push the baby out and you don't push, that one it is not the fault of the health worker. If she doesn't slap you to push the baby out you will not [push]. Sometimes it is our fault.*
- I: *Would this be acceptable?*
- R: *It is not right. You don't need to slap too much because some people do not want to push when they are asked to push. When you slap a bit, she will push, so it is right.*
- I: *So it is acceptable to pinch and slap?*
- R: *Yes, it will force us to push the baby out.*
- I: *How would you feel if this happens to you?*
- R: *It will encourage me to push for the baby to come out. (IDI, Cohabiting woman, 28 years, Nsawam)*

In some cases, women felt that when the provider yelled or slapped a woman during labour, it would help to communicate the gravity of the situation and as a way of “guiding you as to when you should push and when you should breathe in between” (IDI, Married woman, 32 years, Koforidua). These inconsistencies, dilemmas and differences in opinions regarding acceptability were particularly evident during FGDs among women across all ages.

Women's views on acceptability or non-acceptability placed the various forms of mistreatment on a spectrum and depicted some as more acceptable and less harmful than others. Most women believed it was unacceptable for a healthcare provider to refuse to help women during labour and

childbirth, and some women even noted that such an act should be reported.

I: *Is it acceptable for a health care provider to refuse to help a woman in labour?*

R: *It cannot be acceptable because it is their job and so even if I call you and it is not yet time for me to deliver I would want you to come and examine me and tell me that my sister endure the pain because it is not yet time for you to deliver. But if you refuse coming, then it is intentional. And so if you even come and say something I will feel that when the time is up the baby would come out.* (FGD, Married woman, 30 years Nsawam)

Influence of mistreatment on preferences for choice of facility-based childbirth

Some women stated that health workers' attitudes, including mistreatment, are major reasons for non-utilisation of skilled birth attendance. Some women identified previous experiences of mistreatment from healthcare providers as influencing future decisions regarding the use of the facility for childbirth, in which case they prefer to give birth at home:

I: *Why do some also give birth in the house?*

R 1: *Please sometimes it's because of the behaviour of some of the nurses that is why they give birth in the house... Shouting and the intimidation, they are not patient with them.*

R 2: *They insult us very well so when you are pregnant and you give birth in the house you are treated well, [better] than the hospital.*

R 3: *The nurses are not patient with us they will be insulting us especially when you are not married you are treated badly.* (FGD, Women 15-19 years, Koforidua).

R 4: *No, I did not, I had wanted to deliver at home because someone told me that if you go and deliver in the hospital, they mistreat you, they don't have patience for you; so that was the reason why I wanted to deliver at home but the nurses managed to convince me to come and deliver at the hospital.* (IDI, Married woman, 30 years, Koforidua)

Discussion

This qualitative study has demonstrated that multiple forms of mistreatment are experienced by women during facility-based childbirth in Ghana. In this study, most women reported experiencing verbal abuse in the form of shouting, yelling, insults and derogatory remarks, which had a negative impact on their self-confidence. Physical abuse in the form of pinching and slapping was also reported. Other forms of mistreatment included abandonment, lack of support, neglect and unresponsiveness to women's needs. Although mistreatment occurred throughout the birthing process in the health facilities, women reported that it was most common during the second ("pushing") stage.

This study has also shown that mistreatment can disincentivise facility-based childbirth in the future. Our findings are similar to the few previous studies in Ghana, which reported women experiencing physical abuse, scolding, shouting and abandonment during childbirth, as well as health facilities that are unresponsive to their needs, or unable to provide the necessary emotional and physical support during childbirth.^{12–14,19,20} Failure to push, young age and inability to bring all items required for the birthing process were reported in our study as potential triggers for mistreatment, also echoing previous studies in Ghana.^{13,14,20}

Mistreatment during facility-based childbirth is increasingly recognised as a widespread problem. Comparable findings of mistreatment of women, in varied forms, during childbirth in health facilities have been reported in Tanzania, Kenya and Nigeria.^{6,8,21} Other study sites in this WHO-led multi-country study (Nigeria and Guinea) have revealed similar experiences of mistreatment in health facilities.^{22,23}

Such mistreatment may have negative effects on future maternal health-seeking behaviour and choices regarding facility-based childbirth. A recent systematic review determined the existence of a wide range of disrespectful and abusive treatment of women during childbirth in Nigeria.²⁴ The authors suggested that female education and empowerment, strengthening of the health systems and refresher training of healthcare providers represent viable solutions to reducing disrespectful treatment of women during childbirth.²⁴ Disrespectful and undignified care during facility-based childbirth also occurs in higher-income countries^{25,26} but forms and patterns of mistreatment may differ.

These findings buttress the need for concerted efforts (both locally and internationally) to objectively measure and determine the prevalence of mistreatment and abuse during childbirth. This will serve as the necessary contextual information on which any evidence-based measures to eliminate mistreatment and promote respectful maternity care could be based. Elimination of such forms of mistreatment could improve facility-based childbirth rates and ultimately maternal and perinatal health outcomes. Previous studies in Africa have demonstrated clearly the relationship between mistreatment and future childbirth in health facilities.^{13,27,28}

Eliminating all forms of mistreatment and ensuring that women's rights are respected hinges on extensive education, especially in low resource settings, on whether such acts are appropriate or useful. In this study, some women believed that in some contexts, some forms of physical and verbal abuse are needed to ensure the safety of the mother and baby during childbirth. Trainee midwives in Ghana¹⁴ and healthcare providers and women in Nigeria²⁹ and Guinea²³ have also rationalised some mistreatment as ensuring good pregnancy outcomes. This may explain why mistreatment was reported to be more prevalent during the second stage of labour, the terminal and critical phase of the birthing process. Using mistreatment as a means to achieve better outcomes during childbirth may have dire consequences, given that mistreated women may opt for home births in the future, as attested to by this study and others.^{13,30–32} This could in turn derail gains made in reducing maternal mortality and improving quality of care. The cultural normalisation of some forms of mistreatment needs to be considered and addressed when developing interventions.

There is also a need to address systemic failures within health facilities and health systems that contributes towards mistreatment and abuse of women. Although low staff numbers (as indicated by women in our study) can affect the quality of care, women raised concerns regarding staff idleness. This made women feel powerless, and led to negative labour and childbirth experiences. Similar sentiments have been expressed by women in South Africa and Tanzania^{32,33} and can erode the importance of attending health facilities for childbirth.

In Ghana, there are specific health system challenges which influence the optimal provision

of maternal health care including delays in providing care, shortage of healthcare providers, logistics, laboratory supports and effective drugs. Some of these specific issues came up in the health workers' interviews which are not incorporated in this paper as its focus is on women's perspectives on mistreatment during facility-based childbirth. Health system-related issues are described in a forthcoming paper on health worker perspectives. A recent systematic review has highlighted persistent lack of adequate resources, among other factors contributing to the delay in providing emergency obstetric care in developing countries.³⁴ Despite these challenges, significant, although slow, progress has been achieved in key maternal health indicators in Ghana. A recent country-wide survey in 2015 indicated that 97% of pregnant women obtained antenatal care from a skilled provider compared to 82% in 1988. Health facility-based childbirth and supervised skilled-birth provision have increased from 42% and 40%, respectively, in 1988 to 73% and 74% in 2014.³⁵ However, a wide disparity in maternal morbidity and mortality persists compared with resource-rich countries. This variation in clinical outcome indicators could be attributed to differences in the quality of maternity care services where a significant proportion of women in the developing world do not have access to supervised facility-based childbirth, despite remarkable improvements in antenatal care coverage.

The structure of the health system in Ghana is such that most uncomplicated maternal-related cases are managed at primary and secondary health facilities whilst complicated and severe cases are managed at tertiary or teaching hospitals. In cases of obstetric emergencies, patients are usually transferred to tertiary hospitals to access a more complete multi-disciplinary specialist level of care. Obstetric emergencies which present at lower-level facilities are transferred to a higher institution based on the preparedness of the facility for such complications. On the other hand, some clients obtain maternity services from traditional births attendants (TBAs) who have not had formal training in the provision of maternal health care. In Ghana, TBAs still conduct a significant proportion of deliveries, despite several attempts to channel all births to health facilities. The recent Ghana Demographic Health Survey indicated that 16% of births are delivered by traditional birth

attendants.³⁵ The occurrence of a significant proportion of births unsupervised by trained providers in health facilities in the country might be related partly to the persistence of mistreatment of women during facility-based provision of maternity care services as recounted by respondents in the current study. The findings of this study are instrumental in the attempt by WHO to globally estimate the true burden of the phenomenon of mistreatment and its underlying factors using internationally validated measurement tools with subsequent identification of potential entry points to minimise mistreatment and improve respectful care.

Strengths and weaknesses

One of the strengths of this study is being part of a larger WHO multi-country study, which aims to define mistreatment during childbirth, and develop and validate two tools for measuring its occurrence (a labour observation tool and a community-based survey tool). The lived experiences and perceptions of Ghanaian women described in this paper have been synthesised with findings from other participating countries (Guinea, Myanmar and Nigeria), and stakeholder groups (healthcare providers and administrators) and integrated into the design and components of the two measurement tools. This will ensure that the tools address what is actually experienced by women giving birth in health facilities in different settings. For example, while the forms of mistreatment identified in our study have been documented in other settings, the timing, specific actions and terms used by Ghanaian women to describe mistreatment informed how corresponding measurement questions are framed and timed. Quantitative findings on the application of these tools in maternity care facilities in Ghana will be explored in a forthcoming paper.

An additional strength of this study is the inclusion of the views of women purposively sought from all age groups (adolescents as well as adults) in both urban and suburban settings. Grouping women into similar age groups for the FGD allowed the adolescents to express themselves without fear of reprisal from older women, which culturally is the norm. Also, we employed non-clinical research assistants to reduce the risk of social desirability/response

bias and there were regular ongoing discussions with multi-country research teams about emerging findings. This was buttressed with regular monitoring by the social scientist in the team to respond to issues related to the data collection.

This study also has some weaknesses. It is possible that the nurses who recruited the study participants may have influenced their responses to favour providers. Different socio-economic factors, including educational level and women's marital status, that could affect their childbirth experiences, were not stratified. Despite this potential limitation, women in this study reported negative personal experiences or experiences of others within their social network. Given the qualitative methods used in this study, the findings may not be transferable to populations outside of the study settings. We did not compare the occurrence of mistreatment of women during childbirth at the facility to home deliveries by TBAs. However, our findings, indicating a significant burden of mistreatment of women during facility-based childbirth in various typological forms, are aligned with other studies conducted in sub-Saharan Africa.^{23,35–37}

These findings, and forthcoming findings from our research group on healthcare providers' and administrators' views on mistreatment, can help to identify and implement strategies to address the problem of disrespectful facility-based maternity care. Our findings provide the evidence to encourage the Ministry of Health to engage stakeholders and formulate appropriate policies to improve respectful care of women during childbirth in health facilities. Strategies need also to engage pre-service training institutions, to address cultural norms around mistreatment at health facilities during childbirth and to sensitise staff on the occurrence and consequences of mistreatment of women during childbirth. Furthermore, collaborating with women's and community groups to raise their expectations and demands for high quality care will be critical to design and adapt health services to be more woman-centred. Provision of high quality of care by eliminating disrespectful treatment of women at the time of childbirth will improve maternal health in Ghana and ensure that all women have the right to access high quality maternal healthcare.

Conclusion

Mistreatment of women occurs during facility-based childbirth in our study sites in Ghana, with negative impacts on women's care experiences. Conflicting opinions exist amongst women regarding its appropriateness and usefulness. Evidence-based consensus definitions, as well as validated indicators and tools for measuring mistreatment, are needed to help identify the underlying factors and potential entry points to minimise the phenomenon and improve respectful care during childbirth.

The authors declare no conflict of interest in this study. This study represents the views of the named authors only, and not the views of the World Health Organization.

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Résumé

La maltraitance pendant l'accouchement dans les centres de santé viole les droits fondamentaux des femmes ainsi que leur autonomie et elle est peut-être associée à la mortalité et la morbidité maternelles et néonatales évitables. Dans cet article, nous explorons les perspectives des femmes sur la maltraitance pendant des accouchements en institution, dans le cadre d'une étude multinationale plus large de l'OMS pour élaborer des définitions consensuelles, des indicateurs validés et des outils pour mesurer la charge de ce phénomène. Des discussions de groupes d'intérêt et des entretiens approfondis ont permis d'analyser les expériences de maltraitance des femmes ayant déjà accouché dans un centre de santé à Koforidua et Nsawam, Ghana. Les entretiens ont été enregistrés sur bande sonore et transcrits, puis une analyse thématique a été menée. Dans l'ensemble, 39 entretiens approfondis et 10 discussions de groupes d'intérêt avec 110 femmes au total ont été réalisés. Les principaux types de mauvais traitements identifiés étaient : les violences verbales (cris, insultes et commentaires désobligeants), la maltraitance physique (pincements, tapes) et le manque d'attention ou de soutien. La maltraitance était fréquente pendant le deuxième stade du travail, particulièrement chez les adolescentes. L'incapacité à bien pousser pendant ce deuxième stade, le non-respect des instructions données par le personnel supervisant l'accouchement et l'absence des articles demandés pour la naissance (trousseau de la maman) précédaient souvent la maltraitance. La plupart des femmes ont indiqué que les tapes et les pincements étaient des moyens acceptables de « corriger » des comportements désobéissants et d'encourager à pousser. À l'avenir, les femmes risquent d'éviter de donner naissance dans des centres de santé en raison de leurs propres expériences de maltraitance, ou de celles d'autres femmes dont elles ont entendu parler. Des définitions consensuelles, des indicateurs validés et des outils pour mesurer la maltraitance sont nécessaires pour estimer la prévalence et identifier les facteurs et les points d'entrée potentiels de façon à minimiser ce phénomène et améliorer des soins respectueux pendant l'accouchement.

Resumen

El maltrato de las mujeres durante el parto institucional viola sus derechos humanos y su autonomía, y podría estar asociado con morbimortalidad materna y neonatal evitables. En este artículo, exploramos las perspectivas de las mujeres sobre el maltrato durante el parto institucional como parte de un estudio más extenso multinacional realizado por la OMS para crear definiciones de consenso, indicadores validados y herramientas para medir la carga del fenómeno. Se utilizaron discusiones en grupos focales (DGF) y entrevistas a profundidad (EAP) para examinar las experiencias de maltrato sufrido por mujeres que habían dado a luz en una unidad de salud, en Koforidua y Nsawam, en Ghana. Las entrevistas fueron grabadas y transcritas, y se realizó un análisis temático. Se realizaron 39 EAP y 10 DGF con 110 mujeres en total. Los principales tipos de maltrato identificados fueron: maltrato verbal (gritos, insultos y comentarios despectivos), maltrato físico (pellizcos, bofetadas), abandono y falta de apoyo. El maltrato fue frecuente durante la segunda etapa del parto, especialmente entre adolescentes. La incapacidad para empujar bien durante la segunda etapa, la desobediencia de las instrucciones de asistentes del parto, y no traer los objetos indicados para el parto (kit de mamá) a menudo precedían el maltrato. La mayoría de las mujeres indicaron que las bofetadas y pellizcos eran medios aceptables de “corregir” comportamientos desobedientes y motivar a las mujeres a empujar. Es posible que las mujeres eviten tener un parto institucional en el futuro debido a sus experiencias de maltrato, o por haber oído hablar de las experiencias de maltrato de otras mujeres. Las definiciones de consenso, indicadores validados y herramientas para medir el maltrato se necesitan para poder medir la prevalencia e identificar los impulsores y posibles puntos de entrada para minimizar el fenómeno y mejorar la atención respetuosa durante el parto.

Appendix 1

In-depth interview guide for women of reproductive age who delivered at a facility in the past 12 months (phase 1)

In-depth interview guide

Women of reproductive age who delivered at a facility in the past 12 months

Step 1: Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain oral/written consent.

Step 2: Ask the participant to identify herself and fill out the table below on sociodemographic information prior to beginning the interview.

Step 3: Conduct the interview. Please remember to audio record the interview.

Step 4: Complete the form at the end of the interview guide.

on treatment by providers and the facility environment.

4. What were your expectations when you delivered at the health facility?
5. In your opinion, what do you need from your NURSE OR DOCTOR in a health facility in order to receive respectful care during childbirth?
6. In your opinion, how are women treated by staff [administrators, nurses/midwives, physicians] in the facility when they come to deliver [from admission to discharge]?
7. In your opinion, how were you treated by the health workers during your most recent labor and delivery? Please explain.
 - a. Probe: If the participant says that she was treated well, ask her if her family and friends had a similar experience as she did. Please explain.

Participant #	Age group (circle)	Number of deliveries in a facility (write in)	Number of deliveries at home (write in)	Education (circle)	Marital status (circle)
Participant	<30 30-45 >45			< Primary Primary Secondary > Secondary	Single Married/ cohabitating Divorced Widowed

Start time:

Interviewer ID _____

Interview date: ____/____/____

DD / MM / YY

Interview discussion guide

A. Decision-making process to deliver at a facility during the most recent birth

Please take a moment to think about your most recent delivery.

1. Why did you decide to give birth in a health facility?
2. Who was involved in making this decision about where to give birth?
3. Were you planning to deliver in that health facility? [Probe: were you referred to/from another health facility?]

B. Experiences and perceptions of care provided at the most recent facility-based delivery, focusing

C. Elements of disrespect and abuse to inform the development of the identification criteria, including involved parties, timing and frequency of disrespectful or abusive care

Sometimes women are mistreated or poorly treated during childbirth by health workers and health staff at health facilities. This mistreatment may take several different forms. Now, I would like to discuss some of these forms of mistreatment with you.

8. In your opinion, did you experience mistreatment or poor treatment during your most recent childbirth? [Probe: if the participant says no, ask if she has ever experience mistreatment during any of her deliveries. If the participant says no, ask if any of her family or friends have ever experienced mistreatment during their delivery.]

- a. Could you explain the situation?
- b. Who was involved in the situation?
- c. How were you [friend/family] mistreated?
- d. When did it happen? [Probe: time of day, during labor, during delivery or postpartum].
- e. How often did it happen? [Probe: just once or more often].

*** If the participant describes a situation related to verbal mistreatment, physical mistreatment, or poor communication between the patient and provider, then probe the following accordingly:

Verbal mistreatment:	Physical mistreatment:	Poor communication between the patient and provider:
Did the provider raise his/her voice?	Did that include pinching?	Were there any problems with the language of communication?
What types of comments were made?	Did that include slapping?	If so, was a translator available?
Were these comments made to threaten with poor outcomes?	Did that include beating?	Was the poor communication related to lack of consent for a test or procedure?
Were these comments judgmental/ derogatory in nature?	Did that include kicking?	
Were these comments based on her age or her number of children?	Did that include hitting?	
Did the provider blame her for getting pregnant?		

- 9. In your opinion, how common is the situation that you described? [Probe: do situations like this happen often?]

Now I would like to ask your opinion on the treatment of women during labor and delivery.

- 10. Are there any situations where it would be acceptable for a health worker to pinch or slap a woman during delivery? Please explain. [Probe: how would you feel if this happened to you? Explain.]
- 11. Are there any situations where it would be acceptable for a health worker to not ask for the patient’s consent before a test or procedure when the patient is conscious? Please explain. [Probe: how would you feel if this happened to you? Explain.]
- 12. Are there any situations where it would be acceptable for a health worker to tell the woman she will have a poor outcome if she does not cooperate? Please explain. [Probe: how would you feel if this happened to you? Explain.]
- 13. Are there any situations where it would be acceptable for a health worker to physically restrain a woman during labor or delivery? [Probe: how would you feel if this happened to you? Explain.]
- 14. In your opinion, what could be done to improve the treatment of women during labor and delivery?

D. Perceived factors that influence disrespect and abuse in the facilities

- 15. In your opinion, what are the factors that influence the mistreatment of women during labor and delivery? Please explain. Probe:
 - a. Related to supplies (availability of medication, equipment)
 - b. Related to health provider staffing (number of staff, attitude towards patients)
 - c. Related to patient load (number of patients, overcrowding)
- 16. In your opinion, what could be done to address these factors so that women are treated better during labor and delivery?

When the interview appears to have finished, ask participant if there is anything that you have misunderstood or that they would like to add.

Thank the participant for his/her time. Remind them that the information will be kept confidential.

End time: :

Appendix 2

Focus group discussion guide for women of reproductive age who have delivered in a facility in the past 5 years (phase 1)

FGD guide

Women of reproductive age who have delivered in a facility in the past 5 years

Step 1: Introduce yourself to the group. Describe the purpose of the FGD and how

information will be used. Obtain verbal/written consent.

Step 2: Ask each participant to identify herself and fill out the table below on sociodemographic information prior to beginning the discussion.

Step 3: Conduct the FGD. Please remember to audio record the discussion.

Step 4: Complete the FGD form at the end of the discussion guide.

Participant #	Age group (circle)	Number of deliveries in a facility (write in)	Number of deliveries at home (write in)	Education (circle)	Marital status (circle)
Participant 1	<30 30-45 >45			< Primary Primary Secondary > Secondary	Single Married/ cohabitating Divorced Widowed
Participant 2	<30 30-45 >45			< Primary Primary Secondary > Secondary	Single Married/ cohabitating Divorced Widowed
Participant 3	<30 30-45 >45			< Primary Primary Secondary > Secondary	Single Married/ cohabitating Divorced Widowed
Participant 4	<30 30-45 >45			< Primary Primary Secondary > Secondary	Single Married/ cohabitating Divorced Widowed
Participant 5	<30 30-45 >45			< Primary Primary Secondary > Secondary	Single Married/ cohabitating Divorced Widowed
Participant 6	<30 30-45 >45			< Primary Primary Secondary > Secondary	Single Married/ cohabitating Divorced Widowed

Start time: :
 Interviewer ID
 Interview date: / /
 DD / MM / YY
 FGD discussion guide

A. Decision-making process to deliver at a facility and perceptions of delivering at a facility
Please take a moment to think about places where women deliver in your community.

1. Where do women prefer to give birth in your community? (probe: at a health facility or home)
2. Who is involved in making the decision about where to give birth?
3. Why do you think women go to health facilities to give birth?

B. Perceptions of care provided at the facility, focusing on treatment by health workers and the facility environment

4. What do you think of the care that women receive at these health facilities during childbirth? Why do you think this way? Please explain.
5. In your opinion, how are women treated by staff [administrators, nurses/midwives, physicians] in the facility when they come to deliver [from admission to discharge]?

C. Elements of disrespect and abuse to inform the development of the identification criteria, including involved parties, timing and frequency of disrespectful or abusive care

Sometimes women are mistreated or poorly treated during childbirth by health workers and health staff at health facilities. This mistreatment may take several different forms.

6. In your opinion, in what ways could women be mistreated or poorly treated during labor and delivery at health facilities?
 - a. Who is usually involved in these situations [nurses/midwives/doctors]?
 - b. When does it usually happen? [Probe: time of day, during labor, during delivery or postpartum].
 - c. In your opinion, how common is/are the situation(s) that you described? [Probe: do situations like this happen often?]

Now I would like to ask your opinion on the treatment of women during labor and delivery.

7. Are there any situations where it would be acceptable for a health worker to pinch or slap a woman during delivery? Please explain.
8. Are there any situations where it would be acceptable for a health worker to not ask for the patient's consent before a test or procedure when the patient is conscious? Please explain.
9. Are there any situations where it would be acceptable for a health worker to tell the woman she will have a poor outcome if she does not cooperate? Please explain.
10. Are there any situations where it would be acceptable for a health worker to physically restrain a woman during labor or delivery? Please explain.
11. In your opinion, what could be done to improve the treatment of women during labor and delivery?

D. Perceived factors that influence disrespect and abuse in the facilities

12. In your opinion, what are the factors that influence the mistreatment of women during labor and delivery? Please explain. Probe:
 - a. Related to supplies (availability of medication, equipment)
 - b. Related to health provider staffing (number of staff, attitude towards patients)
 - c. Related to patient load (number of patients, overcrowding)
13. In your opinion, what could be done to address these factors so that women are treated better during labor and delivery?

When the interview appears to have finished, ask participant if there is anything that you have misunderstood or that they would like to add.

Thank the participant for his/her time. Remind them that the information will be kept confidential.

End time: :