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# When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out: justification of disrespectful and abusive care during childbirth among midwifery students in Ghana

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## Abstract

Despite global attention, high levels of maternal mortality continue to plague many low- and middle-income settings. One important way to improve the care of women in labour is to increase the proportion of women who deliver in a health facility. However, due to poor quality of care, including being disrespected and abused, women are reluctant to come to facilities for delivery care. The current study sought to examine disrespectful and abusive treatment towards labouring women from the perspective of midwifery students who were within months of graduation.

For this study, we conducted focus groups with final year midwifery students at 15 public midwifery training colleges in all 10 of Ghana's regions. Focus group discussions were recorded and transcribed. A multi-disciplinary team of researchers from the US and Ghana analysed the qualitative data.

While students were able to talk at length as to why respectful care is important, they were also able to recount times when they both witnessed and participated in disrespectful and abusive treatment of labouring women. The themes which emerged from these data are: 1) rationalization of disrespectful and abusive care; 2) the culture of blame and; 3) no alternative to disrespect and abuse.

Although midwifery students in Ghana's public midwifery schools highlight the importance of providing high-quality, patient-centred respectful care, they also report many forms of disrespect and abuse during childbirth. Without better quality care, including making care more humane, the use of facility-based maternity services in Ghana is likely not to improve. This study provides an important starting point for educators, researchers, and policy makers to re-think how the next generation of healthcare providers needs to be prepared to provide high-quality, respectful care to women during labour and delivery in low-resource settings.

**Keywords**: Disrespect and abuse, Ghana, midwifery

**Key Messages**

- Midwifery students in Ghana's public midwifery schools report witnessing and participating in many forms of disrespect and abuse during deliveries as part of their education. While they are clear as to why respectful care is important and necessary, they are able to justify and explain reasons for disrespectful and abusive care. This poor treatment of labouring women was explicitly and tacitly supported by these students' teachers and preceptors.
- All study materials and methods were reviewed and approved by the Ghana Health Service Ethical Review Committee, the Kwame Nkrumah University of Science and Technology Committee on Publication and Human Ethics, and the University of Michigan Institutional Review Board.
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## Background

Despite global attention, high levels of maternal mortality continue to plague many low- and middle-income settings. Increasing the proportion of births that occur in a health facility with skilled birth attendants is one of the most important and impactful interventions to reduce maternal mortality, especially in low and middle-income countries where rates of facility-based delivery are the lowest and rates of maternal mortality are the highest (Campbell and Graham 2006). Beginning twenty years ago, Thaddeus and Maine (1994) described barriers women experience when deciding where to deliver. Since then, much work has been conducted to conceptualize and test ways to increase skilled birth attendance in the world's poorest countries (Moyer and Mustafa 2013). Many of the barriers to facility-based delivery have been supply-side; poor geographic coverage of facilities and high costs, for example (Bohren *et al.* 2015).

Out of the research to identify barriers have come many interventions to increase the proportion of women who deliver in facilities with a skilled attendant, and these efforts have been successful; in developing countries, the proportion of birth attended by a skilled provider rose from 56% in 1990 to 68% in 2012 (UN, 2014). However, efforts to increase facility-based delivery rates often fail to reach their desired full impact due to women's reluctance to deliver in facilities based on the treatment they receive by health staff, including midwives (Kruk *et al.* 2009; Abuya *et al.* 2015). Previous efforts' exclusive focus on increasing facility-based delivery rates without sufficiently addressing process and quality of care concerns is problematic (Freedman and Schaaf 2013). The impact of disrespectful and abusive care during childbirth on women's utilization of facilities is gaining increased attention as Millennium Development Goal #5, to reduce maternal mortality by three quarters between 1990 and 2015 was not reached in many low- and middle-income countries, especially in sub-Saharan Africa (UN 2014) and we turn toward new targets for the Sustainable Development Goals.

Women's human rights, which include a right to health, have been outlined by international law and adopted by such bodies as the United Nations and the World Health Organization (Freedman *et al.* 2014). This right to health requires health services that are available, accessible, acceptable and of good quality, and extends to respectful care during labour and delivery (Hulton *et al.* 2014). Disrespect and abuse during childbirth in facilities is an important component of quality of care and is often associated with other markers of poor quality of care including poor clinical outcomes, and poor patient satisfaction with care (Bowser and Hill 2010). Apart from the immediate outcomes, poor patient satisfaction may also lead to a woman choosing to deliver elsewhere for subsequent deliveries, as well as encouraging members of her social network to avoid facilities for delivery (Gilson 2003). Disrespectful and abusive treatment by providers may be due partly to a low number of providers compared to workload, poor quality facilities, lack of supplies and equipment, absent or inadequate enforcement of human rights policies and lack of leadership in the health system (Bowser and Hill 2010). It may also be due to providers' negative view of their patients (Andersen 2004) and their desire to exert their role in society as superior to that of illiterate or poor women (Jewkes *et al.* 1998).

In Ghana, while the vast majority of pregnant women attend antenatal clinics at facilities, just over half deliver their baby in a facility (GSS 2009b). The Government of Ghana and the Ministry of Health have implemented initiatives to increase the facility-based delivery rate, including making antenatal care (ANC) and delivery free (Population Council 2006) and waiving enrollment fees into the National Health Insurance Scheme for pregnant women (GSS, 2009a). Recent data from Ghana show that while women in the highest income quintile deliver with skilled birth attendance at rates of over 90%, only 46% of those in the lowest wealth quintile receive skilled birth attendance (GSS 2015). Differential treatment of women based on their income or socioeconomic status (Andersen 2004) may be part of why women with higher economic means are more likely to deliver in facilities. Reasons for low levels of facility-based care in Ghana, especially among the poorest women, are many and include informal costs, such as needing to bring delivery materials with you to the facility when you deliver, poor transportation availability, long distance between a woman and a facility and the treatment women receive at the facility (Moyer and Mustafa 2013; Moyer *et al.* 2014). While there have been a few studies on disrespect and abuse from the perspective of the mother (Moyer *et al.* 2014), there are fewer studies that investigate service provision from the viewpoint of the providers, especially in low-resource settings (Fujita *et al.* 2012).

The current study sought to examine disrespectful and abusive treatment towards labouring women from the perspective of their caregivers. Specifically, we aimed to 1) discuss the various domains of disrespectful and abusive care with midwifery students to assess their experience with them and 2) assess how these future providers contextualize and conceptualize the treatment they have witnessed and participated in during their educational program.

## Methods

For this study, we conducted focus groups with final year midwifery students at 15 public midwifery training colleges in all 10 of Ghana's regions (see Figure 1 for a map) between September 2012 and February 2013. The focus group guide was developed based on authors' previous work (Moyer *et al.* 2014) and Bowser and Hill's (2010) domains of disrespectful and abusive care. These domains include physical abuse, non-consented care, non-confidential care,

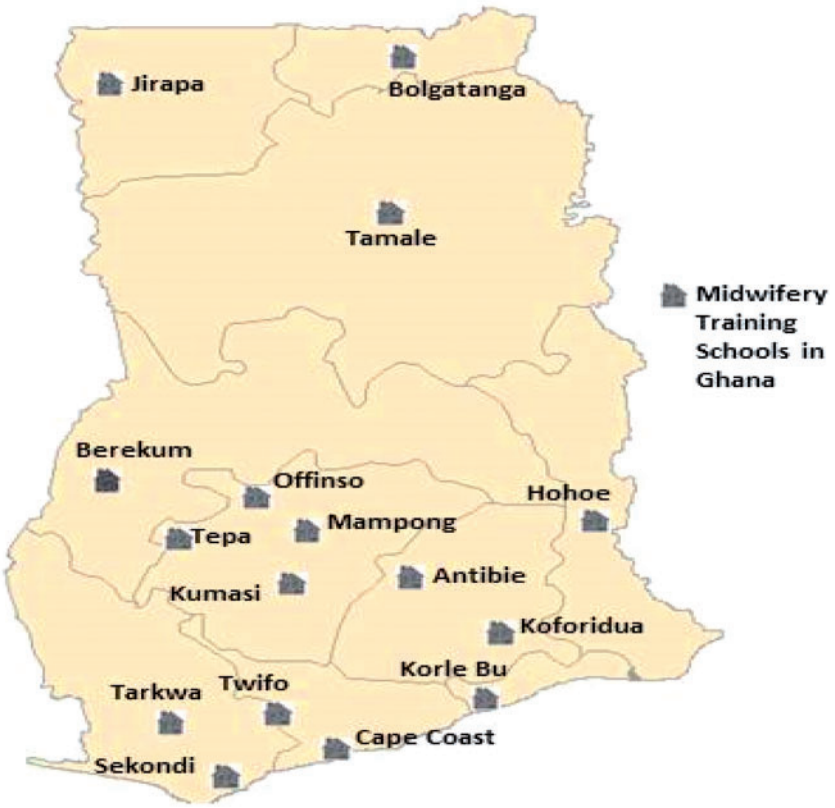


**Figure 1.** Locations of public midwifery training schools in Ghana.

non-dignified care, discrimination based on specific patient characteristics, abandonment of care, and detention in facilities. The focus group discussions aimed to elucidate participants' perceptions of the delivery care they had observed and participated in during their training.

Participants for the focus groups were recruited from the pool of participants for a related quantitative study. All final year students were invited to take part in a computer-based survey (for more details, see Rominski *et al.*, 2016). Depending on the size of the school, either one or two focus groups were conducted at each. Focus groups were convened at each school to hear and include different perspectives from different areas of the country. Students interested in taking part in the focus groups were taken to a private classroom near the computer lab where the survey was taking place. Focus group discussions were conducted by a member of the study team in English. Participants were taken through an informed consent procedure, where the nature of the study was explained to them. They then completed and signed consent documents. No names were collected during the interviews, and all participants were given a number. No identifying information is linked to the data.

Initial questions posed to the group included demographic information including age, marital status, number of children and birth location. Students were then asked for the reason or reasons they had decided to study midwifery. Questions about births they had participated in as part of their education were introduced with a question about how they define respectful patient care. Individual questions about disrespect and abuse were posed to the students (Has anyone seen a nurse, doctor or midwife slap or hit a woman during labour before?), as well as broader question (Some people say as long as a mom and baby make it through labour and delivery alive, that is all that matters. What do you think about this?). Students were first asked about how they conceptualize respectful care, why it is important, and about the forms of disrespect and abuse they have witnessed or taken part in. While the discussions were steered by the written guide, many of the groups took place as conversations in which the facilitator asked spontaneous questions following statements by the participants.

All focus groups were digitally recorded and transcribed verbatim. Data were analysed using a thematic analysis approach. Transcripts were read and re-read repeatedly. Initial categories for analysing data were drawn from the interview guide and themes and patterns emerged after reviewing the data. The transcripts were coded by the research team and then cross checked for coder variation. The data were then reviewed for major trends and crosscutting themes were identified. Issues for further exploration were prioritized for final analysis. All coding discrepancies were discussed among the research team and consensus was reached. Ethical approval was obtained from the authors' institutions.

## Results

Due to audio files being corrupted, 11 of the 17 focus group discussions from 9 of the 15 participant schools were included in the analysis, although field notes were compared from the missing schools and the research team agreed that the issues and factors discussed were similar across sites. There were between 6 and 9 participants in each focus group. A total of 83 students participated in these focus groups. The results below are presented as the ways students think about respectful care, followed by the three themes which emerged from the data; 1) Rationalization of disrespectful and abusive care; 2) Culture of blame; and 3) No alternative to disrespect and abuse.

Midwifery students discussed eloquently and at length how they conceptualize respectful care and why respectful care of women during labour and delivery is important. They also described freely many kinds of disrespect and abuse which they had both observed and, in some cases, participated in. The discussion around these two topics followed each other immediately, with the importance of respectful care coming first, followed by questions about disrespectful and abusive care. The students often followed their statements about the importance of why respectful care is imperative with examples of times abusive and disrespectful care was necessary.

## Respectful patient care

There were several ways that participants conceptualized respectful care. Some students conceptualized respectful patient care as treating each woman as an individual and not treating women differently due to class or socioeconomic position. For example, a student from the Bolgatanga Nurse Training College said,

> The basic knowledge I have about respectful patient care, is irrespective of the race, the social status, the background, or whatever of the client. You . . . must not discriminate against them because of who they are. So when we say respectful client care, you are supposed to respect the person as she is . . . As you provide to others, provide to her the same. That is how I understand the respectful client care.

Other students thought of respectful care as being supportive of the patients. For example, a student from Twifo Praso said,

> When we talk about respectful patient care I think it means caring for the patient in a respectful manner like not insulting the patient, or beating her or teasing her, you care for her emotionally and everything so that she can deliver safely.

Others noted the reciprocal nature of respectful care. As one student from Berekum said, "I will say respectful patient care is when you subject yourself to what the patient wants you to do and when the patient also subject his or herself to what you are also requiring from the patient." In response to the question, "What is respectful patient care?" a student from Koforidua said, "[a] patient who obeys instructions."

Students also discussed reasons why this is important. For example, a student from Hohoe said,

> To me, it matters so much because, the attitudes of the health work(ers) makes the pregnant women go to the TBAs and other places. From an experience, I was at a hospital, observing a delivery and the attitude of that midwife towards the client was so appalling; she beat the woman, even though she wanted to save the life of the baby it was too much. At that moment I said to myself if I want to deliver, I will rather go to a TBA, because, she will not beat or shout at me but will rather help me to deliver successfully. So it matters so much.

## Types of disrespectful and abusive care witnessed by midwifery students

Students reported witnessing, and sometime participating in, many forms of disrespectful care, including physical abuse; non-dignified care including intentional humiliation, scolding, blaming, and shouting; discrimination based on specific patient attributes; abandonment of care; and detention in facilities. See Table 2 for examples of Bowser and Hill (2010) domains of disrespectful and abusive care witnessed and participated in by study participants.

From these questions came more open-ended discussions which flowed from the interview guide into topics raised by the groups. The themes which emerged from these data are: 1) how students rationalize disrespectful and abusive care; 2) the culture of blame and; 3) no alternative to disrespect and abuse.

## Rationalization of disrespect and abuse

Students explained the behaviour they witness or participated in and rationalized this behaviour in many ways. Some students questioned why they witnessed the behaviour they did. For example, one student from Koforidua said,

> I got the opportunity to ask the staff nurse . . . why is it that when the patient is in the first stage room she is been treated well and when she gets to the second stage and the time comes for her to push (you) yell at them . . .? She said sometimes you need to push the patient a little bit otherwise . . . the woman might even lose the baby because some don't push unless you yell at them. So it is not that they do it on purpose but they do that to let them do what they are supposed to do to have their baby and their lives back.

***Workload/Stressed*:**

Students note that midwives are often overworked and under-resourced, which can lead to disrespectful and abusive care. For example, one student from Atibie said,

> If you are due and they tell you to push and you are not pushing and the situation is let's say one midwife to about five clients so if you are not ready to push it is either she hits you or something so that brings about those things.

Other students said similar things;

> I think sometimes it is not the intention of the midwife to disrespect, but sometimes it is due to stress for instance you are just a one-man staying at a district, you are the only person, sometimes you work so hard that you become so tired, so some of the things you do is not intentional, you don't intend to disrespect them.—Tamale

In order to reduce abusive behaviour on the part of the midwives, these students felt there needed to be more personnel. For example, from a focus group at Atibie:

Interviewer- Is it justified . . . to hit a (labouring) woman?
All: No.

> Participant three: It all bores back to this thing . . . they don't get enough people to work, like, one midwife to five clients, by the time they will be delivering the babies will be falling, like that, so they should train more midwives. I think that will be better.

**Some midwives have personalities that preclude them to commit abusive behaviours:**

Students said that there are midwives who have personalities that make it hard for them to provide respectful care. For example, a student from Bolgatanga said,

> If it happens to be a quick tempered person . . . the appearance of the person alone, looking at the tattered clothing of the person, it already annoys me, I go like, "you yourself crying, what is the problem, you went and got pregnant again?" . . . If I am a quick tempered person, then it would be a little bit difficult for me to provide this kind of respectful care, and if from the background I am coming from, like we relate hostilely to one another, it would

> be very difficult for me to come to understand that even the status of the person is, she needs more respectful care or, she needs more care than ever, and very difficult for me to provide it. So, yeah, I would say that the temperament . . . will also be a factor to aid or to make it impossible for her to provide this care.

**Midwives are disrespected:**
Students noted that sometimes the midwives themselves are disrespected by their patients, or by other service providers. For example, a student from Atibie said,

> I also think that some of the doctors especially look down on the nurses and midwives, the doctor comes to the ward they don't even consider what you are doing, they just shout on you as if you don't know what you are doing, you don't know your left from your right and that is not the best at least they should respect each other's work so that's what I will say.

Some students also noted that being young, they are often younger than their patients, which can lead to the patients not respecting them. For example, a student from Twifo Praso said,

> Sometimes it becomes difficult because . . . we the young ones . . . - when some of the old ones [patients] come and they see us, they think that we are young and for that matter everything that you tell them to do . . . they don't comply; they see you as their kid so . . . when you talk to them the way and manner they behave to you, it is like they tend to pick a bone with you and . . . you tell them do . . . they will be quarreling with you and everything becomes messed up.

***Patients bring it on themselves*:**
Students reported that often it was the patients who were responsible for the behaviour. As a student from Koforidua said, it is not all the patients that are being yelled at; it depends on how you the patient will act that will bring about the yelling. And a student from Berekum said, So I think sometimes when they [midwives] beat them [women], they [women] deserve it.

There were various reasons that patients bring on this disrespect and abuse. One of the reasons was that the labouring women do not listen. For example, a student from Jirapa said,

> In the instance that the patient is not . . . cooperating with you, sometimes the midwives just get angry and neglect that patient and go to the next patient who is ready for her.

Other times the patients do not do what they are supposed to. For example, they are not pushing, they are closing their legs or they will not lie down.

> The midwife told her to push. She was tired, exhausted and said that she could not push. The midwife had to give her some small beatings for her to comply.—Jirapa
>
> The woman was in labor and the midwife asked her to push. She was not cooperating, and she slapped her. (Interviewer: and what do you think about that?) Respondent: I think it was right at that moment because she was trying to help her out.—Tamale
>
> They gave the woman an episiotomy and she has to cooperate for the midwife to suture but she was not cooperating, she was closing her thigh so, the midwife has to hit and yell at her before the woman open her thighs for her to suture.—Korle Bu
>
> I have experienced some before. Actually, the woman was pushing and she was getting out from the bed, we were telling her to lie down but she was not complying and the baby's head was coming. So one midwife had to slap her so that she can comply ≪laughing≫ with that slapping she slept.—Tamale

The following quotes highlight the final part of this theme, that patients will understand the reason for the disrespectful or abusive treatment and will learn something from it, so the maltreatment is justified in the end.

> I also think that when the mother is doing something that will affect the mother and the baby you must use a bit of force but after that you explain the rationale behind what you did because you want to save both the mother and the baby's life and you want both of them to go home healthy so a bit of force with an explanation will let them know what you want to do to help them.—Koforidua
>
> So I think midwives, after they harm, I think you should open up and tell the woman that, listen, listen, this is what you have done, and it is not right, so the next time the woman is coming to deliver, she will bear it in mind.—Tamale
>
> And it [yelling] is far, far better than the beating. So, instead of midwives beating, I think we should yell, and after yelling, you let the woman understand why you yelled at her, next time she wouldn't repeat it again.—Tamale

***No justification for abuse*:**
Not all participants were comfortable with the justifications they heard their classmates making. A student from Korle Bu said, after many of her classmates talked about times when they had seen a patient being yelled at or hit,

> I think, yelling and hitting is an abuse, no matter how well you justify it is an abuse. We document everything, if a client does not want something to be done; you just document everything she refused for you to do for her so, that if anything should happen you cannot be blamed for it. Yelling and beating is an abuse, so, I am not in support of that.

## Culture of Blame

In this setting, students mentioned that midwives will be blamed if there are negative outcomes, meaning a woman or a baby dying during childbirth. This fear of being blamed was noted as a reason for midwives engaging in disrespectful and abusive care.

> The women don't cooperate, they refuse to bear and some will be like they are tired and if you are tired the baby will die and if the baby dies they will be like, the midwife has killed my baby.—Atibie
>
> A woman came and then needed to open her to see the extent of cervical dilation. This woman would not open her legs, but she [midwife] also knew that if anything happened like maternal death they would have to call the midwife to book, so the woman was hit to open her legs.—Jirapa

For some students, because midwives are held responsible for the outcome of births, it was not that midwives had to engage in disrespectful and abusive care, but that it was actually a good thing. For example,

> I also think it is good for her [midwife] to do that [shouting] because at times the patients, whatever you said they don't cooperate and maybe they will end up losing their baby and they will be blaming you that you are the one who have done that. So I think in a way it's better.—Korle Bu

It is not just the patients who will blame the midwives, according to these students. The midwife on duty may be blamed by the Director of Nursing Services (DNS), or other administrators.

> So if something happens, instead of the authorities calling the midwife and asking her what happened sometimes they will even come and insult her in front of the client. (Interviewer: Which people are they?) The DNS and the heads, the people from the top will come and blast you meanwhile it is the client's fault.—Atibie

The other part of this theme was that student midwives blame the patients for the treatment they receive.

> Sometimes when you tell them (women) to do something and they refuse, you are **forced to neglect them** because you would tell them to push . . . and they would not mind you . . . so you are forced to neglect them and go and sit somewhere . . . until they are willing to do what you want them to do. –Tamale
>
> Sometimes it is not the [midwives'] fault. Let's say the woman is in second stage, the head is in the vagina and you are telling the woman to push and she does not want to push; sometimes you have to shout. –Atibie

**Table 1.** Number of participants in each focus group, by school

| School Name | Number of Participants |
|---|---|
| Atibie Midwifery | 8 |
| Bolgatanga Midwifery | 8 |
| Cape Coast Midwifery | 6 |
| Hohoe Midwifery | 7 |
| Jirapa Midwifery | 9 |
| Korle Bu Midwifery (1) | 8 |
| Korle Bu Midwifery (2) | 8 |
| Tamale Midwifery (1) | 8 |
| Tamale Midwifery (2) | 7 |
| Koforidua Midwifery | 7 |
| Twifo PRASO | 7 |

### No alternative to disrespect and abuse

Students' note that disrespectful and abusive behaviour is resorted to if the woman is not doing what she is supposed to and there is no other way to get them to cooperate. While they would rather not treat women badly, they feel that sometimes there are simply no other options, if you want to save the woman and baby's lives. For example, a student from Tamale said,

> One time I was conducting a delivery and the woman was not pushing. I have said everything. I have done everything, she would not push. And I don't know what else to do, so I just called the in-charge, she came, shouted at her some few minutes, beat her, then she started pushing. In some few minutes, the baby came out. So, if I have just left her, after explaining everything to her, I have just left her like that, the baby would have come out asphyxiated, and I could not do anything about it. So sometimes, we just have to use a little bit of force, and then they will comply.

If a patient will not do what she is supposed to, a midwife is forced to abuse her. For example, a student from Tamale said, "the midwife has no choice, [no] option, but just to beat . . . she delivered. She delivered perfectly"

## Discussion

The current study investigated how midwifery students from all 10 regions in Ghana, across both urban and rural settings, experience, conceptualize, and justify or explain disrespect and abuse of patients

**Table 2.** The domains of disrespect and abuse from Bowser and Hill (2010)

| | |
|---|---|
| Physical abuse | "They will shout on the person, hit the person and immediately the person will deliver. So I saw that and I thought it was okay." – Atibie Midwifery<br>"She doesn't want anyone to do her vagina examination so we decided to hit her so that she opens up her leg to do the V.E."—Twifo Praso |
| Non-consented care | "We too have to communicate well with the patient and tell her all that we will do for her to understand, but we do not."—Korle Bu<br>"Once a woman came, and when she saw the midwife she was like, 'This woman she restricted me to my bed that I should sleep.' . . . Yes sometimes if the membrane raptures, you do not want them to be walking around."—Korle Bu Midwifery |
| Non-confidential care | "From the district that I worked in, the client came from another district, it was a referred case. They could not speak her language and they had to call her mother-in-law to the labour ward, so in that case her privacy has not been protected."—Koforidua Midwifery |
| Non-dignified care | "It was in the second stage, when this woman was to push, she was shouting . . . and she was passing stool, so after the delivery, the midwife went to her and was teasing her, "You said you would never get pregnant again and you were shitting on us.'"—Tamale Midwifery |
| Discrimination based on specific patient characteristics | "The appearance of the person alone, looking at the tattered clothing of the person, it already annoys me, I go like, 'You yourself crying, what is the problem, you went and got pregnant again?'"—Bolgatanga Midwifery<br>"I was on the ward yesterday and this lady walked in and was complaining about abdominal pain and she said she was on her way to Takoradi when she felt the pain, so she came to the hospital. But the midwife did not treat her well because she . . . (thought she) was one of those women who sleep by the street. Later . . . her brother-in-law came with everything she need(ed) including her (antenatal) card and from the records, she was attending her antenatal clinics and she has a good record. She was not treated well when she first came."—Korle Bu Midwifery<br>"So we didn't give her the care she needed because we thought she was one of those who sleep outside. They come and terrorize and you say, 'I left my (antenatal) card,' so we never treat them."—Korle Bu Midwifery |
| Abandonment of care | "Sometimes when you tell them (women) to do something and they refuse, you are forced to neglect them because you would tell them to push, or it is even like at the left lateral and they would not mind you because they are in pain, so you are forced to neglect them and go and sit somewhere. Until they are willing to do what you want them to do, we will not come there."—Tamale Midwifery |
| Detention in health facilities | "I had an experience at the Government Hospital, a lady went to deliver and she was not able to pay for the bills so she was asked to sweep the place and mop the place." Atibie Midwifery<br>"One midwife detained one patient because they said they are collecting some soap, paper and those things, then the patient couldn't give it out, so they detained the patient."—Jirapa Midwifery |

during childbirth. In this qualitative study, participants were able to identify reasons why it is important to treat women with respect during labour and delivery. These reasons were eloquently elucidated and participants talked about intrinsic reasons for respectful care, such as women's rights, as well as extrinsic reasons, such as psychological distress and the impact on future health-seeking behaviour. This perspective is supported by evidence from multiple locations; how women perceive they will be treated determines to a large extent where they choose to deliver (Kruk *et al.* 2009; Leonard 2014).

However, participants in this study also talked about disrespectful and abusive treatment being widespread and normal. In all of the focus groups, many forms of disrespect and abuse were described as being witnessed or perpetrated by the students. This was sometimes explained as resulting from the behaviour of a few quick tempered midwives, or as a result of the high levels of stress midwives are under. While it is natural to want to blame a few individuals for this kind of behaviour, prevalence studies have indicated that disrespect and abuse are widespread (Kruk *et al.* 2014; Abuya *et al.* 2015) and indicative of health systems which not only tolerate but even enable maltreatment (Freedman and Kruk 2014). Students in the current study were willing to discuss times when they had themselves treated a patient in an abusive or disrespectful manner, without shame and without fear. This willingness to discuss these actions is indicative of both the normalization of this behaviour as well as a lack of processes for redress (McMahon *et al.* 2014). None of the students talked about instances when disrespectful and abusive care was punished through disciplinary actions, although this was not asked about directly. To the contrary, the participants talked about the reasons for disrespectful and abusive care being understood and accepted by the victims, and it being better than the alternative of losing the life of a baby or a mother. In contexts where abusive and disrespectful care is widespread and tacitly accepted by professional and facility leadership, individual midwives can hardly be blamed for assuming their actions have at least partial support from their supervisors, hospital management and even the professional societies in the country (Jewkes *et al.* 1998). In settings where abusive care has been normalized, it becomes routine, accepted and expected (Kruk *et al.* 2014). It is these professional norms, more so even than policies and procedures, which are decisive in shaping both individual behaviour and organizational culture (Freedman and Schaaf 2013). To reverse the normalization of this behaviour, the organizational and professional culture will need to be changed.

There are indications that some women are treated worse than others due to their backgrounds or socio-economic status (McMahon *et al.* 2014). The students in this study alluded to this phenomenon in how they conceptualize respectful care. Many of them define respectful care as not treating women differently because of their background or socio-economic status. In a companion quantitative paper, this issue was investigated more fully and proves to be an area of promising future research (Moyer *et al.*, under review).

Previous work has suggested that practicing nurses and midwives who engage in disrespectful and abusive care during childbirth do so because they learned or observed this during their pre-service training (Jewkes *et al.* 1998; d'Oliveria *et al.* 2002). Our current study supports these assertions and stresses the importance of how professionals are socialized. Many of the participants noted times when they had been instructed to be hard on patients because if you are extra nice, the patients will not listen and follow instructions. These results suggest that one key area of intervention is ensuring supervisors are treating women with respect and modelling good behaviour for students to emulate. Students are learning from the midwives who precept them, both in the clinical care they provide and in the way they interact with patients. There is a need to increase training in interpersonal skills in the curricula of health service providers (Ouedraogo *et al.*, 2014; Jewkes *et al.*, 1998) and for accountability measures to ensure clinical preceptors are teaching students appropriate ways to engage with patients. It is not clear from this study if midwifery students are being taught humanistic practices during their schooling. This is an important area for future investigation.

In a time when maternal and neonatal mortality are the focus of increased attention, audits or other facility-based investigations are often conducted to explore the root cause of poor outcomes. Although the World Health Organization defines a facility-based maternal death review as a qualitative, in-depth investigation of the causes of, and circumstances surrounding, maternal deaths which occur in health care facilities, (WHO 2004), in some areas these reviews can feel as though management is looking for someone to blame (Kongnyuy and van den Broek 2008). Some of the participants in our study reported that the fear of being blamed for a death was a major justification for disrespectful and abusive behaviour. Thus, identifying the root cause of poor outcomes must be handled in such a way that individuals can learn from previous situations without feeling personally vilified. Assigning blame can be counterproductive, and as seen in these data, can lead midwives to blame the victims of disrespectful and abusive care.

Another major reason why midwifery students reported they or their preceptors engaged in disrespectful or abusive behaviour was because they did not know how else to motivate or communicate with their patients. Participants felt that there are no other ways to get women to open their legs or push when they are exhausted and in pain. This is in a setting where anaesthesia for labouring women is rare and where resources used in high income settings to improve women's comfort, such as birthing balls, bathtubs, and doulas, are nonexistent. A clear implication of this research is the need for a midwifery curriculum that focuses on respectful motivational practices. Further, there is a need for in-service training for practitioners on motivational practices that are respectful as they are the ones modelling behaviour to midwives in-training. A further intervention to improve the ability of health workers to motivate women to push during labour could be the introduction of a labour companion. Although not the policy of the Ghana Health Service, labour companions have been shown to be effective in praising, comforting and supporting the women during childbirth (Hodnett *et al.* 2003). However, implementing this kind of intervention in low-resource settings has proven to be more difficult than anticipated, and there is a need to test whether it is feasible and beneficial (Brown *et al.* 2007). We have also conducted research in Ghana that indicates only half of pregnant women desire a labour companion, suggesting this intervention may not be sufficient to change the dynamic in the labour in delivery ward. (Alexander *et al.* 2013)

An additional reported reason for disrespect and abuse was due to an understaffed and over-stressed health system. In previous studies, women who have been the victims of disrespect and abuse during childbirth empathized with midwives who were over-worked who had perpetrated the abuse (McMahon *et al.* 2014). Ensuring health systems are adequately resourced, both with human resources and supplies and equipment, is imperative for improving the quality of care women receive. Where resources are severely limited, as they are in Ghana, minimum standards of quality of care, including respectful care, are hard to attain (Ouedraogo *et al.* 2014). Healthcare workers need to be well-supported if they are to be held accountable for their actions. There are very real resource limitations facing the health system in Ghana which may impact the quality of care

midwives are able to provide (Banchani and Tenkorang 2014). While women have a right to high quality and respectful care, providers have a right to the means to deliver this care (Hulton *et al.* 2014). If the health system is not well financed and providers are not well supported, it is difficult to expect them to deliver high quality care.

In the WHO's 2015 document, "Strategies Toward Ending Preventable Maternal Mortality," it is noted that care for women must emphasize the framework of availability, accessibility, acceptability and quality of services (AAAQ), and further human rights demand standards of care which emphasize such factors as participation, information and accountability (WHO 2015). Efforts to increase the utilization by pregnant women of facilities for delivery must address issues of disrespect and abuse to preserve women's human rights and ensure future utilization (Kruk *et al.* 2014).

WHO states, "Experience of care includes firstly effective communication—a woman (or her family if required) should feel that she understands what is happening, what to expect and knows her rights. Secondly, she should receive care with respect and dignity. Thirdly, she should have access to the social and emotional support of her choice." (Tuncalp *et al.* 2015, pg. 2) It seems clear that the care envisioned in this statement is not the norm for many of the midwifery students who participated in this study.

Another potential intervention to reduce disrespectful and abusive care during childbirth supported by this research would be to ensure women know what to expect during labour and delivery. There are indications from previous work that there are "rules" they are expected to follow, although they are often not made aware of these rules (McMahon *et al.* 2014). Andersen (2004), working in a Bolgatanga hospital, noted, "The authority of staff at the hospital is vigorously expressed and 'disobedient' patients are openly reprimanded most often verbally and at times physically." (pg. 2006) To begin to address a situation where women do not know how they are expected to behave, women could be prepared during ANC visits, through a hospital visit while still pregnant and through communication during health visits.

Health systems are deeply embedded in society's broader social and political dynamics, which can contribute to disrespect and abuse of women giving birth (Freedman and Kruk 2014). Violence against women is common in Ghana where one in three women reported being the victim of violence at the hands of an intimate partner (Appiah and Cusack 1999). Since the establishment of a Women and Juvenile Unit of the Ghana Police Service in 1998, there has been exponential growth in reports of violence against both women and children (Amoakohene 2004). Intimate partner violence has been so ingrained that women feel it is normal and only register it as problematic if it causes serious injury or death (Amoakohene 2004). Health professionals in Ghana are afforded a position of power and may wield that power in ways which are deemed abusive and disrespectful (Prytherch *et al.* 2013). Therefore, addressing violence against women at a societal level is an important line of inquiry in order to begin to combat abuse during childbirth.

Changing ingrained clinical practice is difficult and requires multifaceted approaches, such as ensuring cooperation and collaboration from both opinion leaders and those implementing the change (the health workers), involving health providers in objective setting, and ensuring both evaluation and feedback are timely and appropriate (Grol and Grimshaw 2003). Interventions to influence practitioner practice have not been tested extensively in low- and middle-income settings, and little is known about what works in resource poor settings and why (Siddiqi *et al.* 2005). In one small study in Benin, humanized care was introduced to the maternity services in a referral hospital with positive results which were found to change the hospital culture (Fujita *et al.* 2012). Due to the complexity of interventions to improve quality of care, these interventions are often evaluated using phased or non-experimental designs that provide information about context and critical success factors, as well as the likelihood that change will be sustained beyond the study period (Campbell *et al.* 2000; Garner *et al.* 2004; Brown *et al.* 2007). One notable set of interventions to address disrespectful care is known as the Heshima Project, an initiative in Kenya that included both facility-level and community-level interventions. (Abuya *et al.* 2015A). Facility-level interventions included provider trainings, quality improvement teams, counselling for healthcare providers, monitoring of disrespect and abuse, on-the-job mentorship, and maternity open days where community members were invited to visit the facility to meet the providers and learn about maternity procedures. Community-level interventions included community workshops, mediation and dispute resolution mechanisms, and counselling for community members. Taken together, overall disrespect and abusive behaviours decreased between 20 and 13% at 13 facilities in Kenya using a pre- and post-test exit-interview and observational design, with most sub-categories of disrespect and abuse dropping by 40 to 50 percent. (Abuya *et al.* 2015A) However, the project design precludes determination of the effectiveness of individual components of the multiple interventions.

Given the sparse literature on interventions, there has not yet been a systematic review of interventions to improve the quality of care women receive when seeking delivery services (Bohren *et al.* 2015). Yet Filby *et al.* (2016) recently published a systematic mapping of barriers to the provision of quality midwifery care, indicating that midwives are subject to significant social, cultural, economic, and professional barriers that can ultimately lead to burnout and poor quality care provision. (Filby *et al.* 2016) For example, midwives are often women, and thus are subject to gender-related challenges, such as being expected to maintain their fulltime domestic and reproductive duties while working as a midwife, or being vulnerable to sexual violence when going out late at night to visit labouring women. Young midwives stationed in rural areas risk social isolation and few opportunities for marriage or starting a family, let alone professional advancement. In addition, the perception that the tasks associated with midwifery are 'unclean' may contribute to the low societal value that many places on midwifery as a profession. (Filby *et al.* 2016) Clearly, the issues facing midwives in low and middle income countries are complex, and more work is needed to design, implement and evaluate interventions to improve the quality of care women receive during facility-based delivery and the impacts of disrespect and abuse during childbirth on women's willingness to deliver in facilities and the clinical quality women receive.

## Limitations

This study has several limitations. First, there may have been cultural norms which biased the reporting of disrespect and abuse by the participants in a focus group setting. However, given the breadth of responses given and the open nature with which respondents discussed the issues, we do not believe this was a significant problem. As a qualitative study, there was also no objective measure of disrespectful or abusive behaviours and reported anecdotes cannot be confirmed. However, this is a limitation common to all qualitative research and we do not believe this to be a significant limitation. This study was also limited in its ability to explore every possible facet of maltreatment due to time constraints associated with conducting focus groups among active students during school hours.

For example, the interviewers were not able to delve into additional detailed questions regarding the differences between traditional birth attendants and midwives, perceived contradictions between how some preceptors behaved versus how others behaved, and subtle inconsistencies in how respondents conceptualized disrespect and abuse. All of these are important areas for future research. Despite these limitations, this study offers an in-depth investigation into how midwifery students from across Ghana conceptualize and justify disrespectful and abusive care in childbirth.

## Conclusion

Although midwifery students in Ghana's public midwifery schools highlight the importance of providing high-quality, patient-centered respectful care, they also report many forms of disrespect and abuse during childbirth. They have both experienced and participated in disrespectful and abusive care and while they are clear as to why respectful care is important and necessary, they are able to justify and explain reasons for disrespectful and abusive care. These seemingly contradictory stances highlight the complexity of discussing and addressing these issues. These young women are dedicated to providing a safe birthing experience for their patients and felt that yelling, shouting, and even hitting women in order to ensure a positive outcome was justified and understood, and maybe even appreciated, by women. The healthcare and social contexts in which these midwives practice and live is multifaceted, and so are the issues surrounding disrespectful and abusive care during childbirth (Warren *et al.* 2015). This study provides an important starting point for educators, researchers, and policy makers to re-think how tomorrow's healthcare providers need to be prepared to provide high-quality, respectful care to women during labour and delivery in low-resource settings.

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