Health worker attitudes; its influence on pregnant women's decision and implications on quality of maternal care in the Greater Accra Region

Policy Brief **April 2016**

Linda L. Yevoo

Thirty-six years old senior secondary school graduate Dufie; was the only client the midwife assisted with her delivery the entire shift. In her history Dufie had informed the midwife she was a mother of three. She suddenly began to bleed thirty minutes after delivery of the baby. The midwife re-examining the placenta, said aloud checking over possible causes for the bleeding: "There is no missing lobe, she had no tear, her uterus is well contracted and I administered cytotec tablets per rectum. What is making this woman bleed profusely?" Then she massaged Dufie's lower abdomen gently and instructed the researcher to fetch her an ampule of oxytocin. Dufie's bleeding ceased about an hour later, after receiving nine more ampules of oxytocin injections. Shortly, a gentleman came into the labour ward and said: "My wife just telephoned accusing me of practicing witchcraft." The midwife exploded with anger: "Papa, are baby girls not human beings?. Because she disliked the baby's sex, she started bleeding suddenly!"
Dufie's husband's reply provided the missing piece of the puzzle. "She has a boy child amongst the three children from her previous marriage. But she insisted she wants another boy child." The midwife became angrier – but this time at this revelation. She asked the man "You mean your wife is a mother of seven instead of three?. She nearly killed herself because she lied to us"[..]

INTRODUCTION

Our introductory story is one of several incidents observed in the research reported in this study, of pregnant women withholding information critical to inform care decision making from frontline health care workers. The withholding and distortion of medical and reproductive information can have severe consequences on the appropriateness of care providers' decision making and management. This study explored medical and social information provision to care givers by pregnant women; why pregnant women with hold or distort information and the effect on care providers' decision making and clinical management.

METHODS

This study was conducted in two municipal hospitals in the Greater Accra Regions of Ghana over a period of nineteen months. It employed ethnographic methods of participant observations, focused group discussions with pregnant and post-natal mothers; interviews with front-line healthcare providers and interactions between providers and pregnant women at first antenatal registry and at delivery.

KEY FINDINGS

During history taking at first antenatal registry, women sometimes distorted or withheld the following information from their healthcare provider:

- Number of self-induced abortions
- Number of children
- Maternal and Gestational age

The reasons pregnant women gave for with holding or distorting medically relevant information provided to care providers was that it was a way of avoiding reprimands and humiliations. This is because during

UNIVERSITY OF GHANA COLLEGE OF HEALTH SCIENCES · Ghana Health Service · WAGENINGEN UR · NWO · UMC Utrecht

history-taking, healthcare providers often showed anger and /or made negative and sarcastic comments when pregnant women's reproductive information did not meet healthcare providers' standards and expectations. Also, pregnant women used this strategy to protect the confidentiality of their personal information. This was because the history taking areas and consultations rooms did not provide pregnant women with adequate privacy during the clinical consultation process.

Unfortunately, this coping and protective behaviour of pregnant women practices sometimes affected the quality of care they received; as gaps were created in care providers' awareness about the potential risks of pregnant women. Care providers' clinical decision making and management of pregnant women during antenatal and at delivery is dependent on the information disclosed (or not disclosed) to them.

IMPLICATIONS AND RECOMMENDATIONS

- It is necessary to improve healthcare providers' attitudes and interactions with clients. This can be achieved by introducing and teaching customer-relations skills as part of their basic training; and regularly update this skills through continuous learning to maintain the right standard. This skill acquisition will make care providers more sensitive and aware of clients' aspirations and preferences during the interactional process and its implications on trust relations between clients and providers.
- Improving the level of privacy and confidentiality of the client-provider consultation process in health facilities is essential because it would instil confidence in pregnant women to provide the right reproductive and medical information to care providers without feeling embarrassed.

  This requires eliminating the practice of open consulting rooms and desks shared by multiple providers and clients. In turn requires the provision of adequate consulting room and focused antenatal care infrastructure space in public facilities.
- Each midwife's consulting room should be equipped with the basic equipment— weighing scale, sphygmomanometer, height measure etc. This will also prevent them from reorganizing focused antenatal care into fragments by moving clients into shared spaces to have access to equipment, tools and supplies and in the process, gather clients medical and reproductive histories in the open.
- There is the need to empower clients to ask questions and seek clarification in a non-confrontational way, when dissatisfied with care providers.
- Pregnant women need to be educated on the importance and use of the personal medical information they provide and the potential personal negative consequences of withholding and distorting information.

-Linda L. Yevoo; Irene A. Agyepong; Trudie Gerrits and Han van Dijk. "If I tell and I will be humiliated; I will not tell": Misinformations as a Strategy against Domination and Humiliation in Maternal Care Decision Makings in Ghana. (forthcoming)