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"We Beat Them to Help Them Push": Midwives' Perceptions on Obstetric Violence in the Ashante and Western Regions of Ghana

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Abstract: Obstetric violence has been recognized as a major impediment to facility-based delivery, increasing the risk of preventable complications and maternal mortality. In Ghana, studies on women's birth experiences reveal enormous and brutal acts of violence during delivery; however, inquiries into why midwives abuse women have not been extensively studied. This study explored the perspectives of midwives on the drivers of obstetric violence in the Western and Ashante Regions of Ghana. A qualitative study was conducted involving 30 in-depth interviews with midwives in eight health facilities. The data were analyzed thematically using NVivo 12. The results of the study reveal a normalization of violence in the delivery room and the intensity of violence is heightened during the second stage of labor. Midwives reported perpetrating or witnessing physical violence, abandonment of women, stigmatization of HIV women, verbal abuses such as shouting, and the detention of women in the health facilities. Midwives abuse women as a result of the pressures of the midwifery profession, poor maternal efforts of women, disrespect of midwives, women's disobedience, and uncooperative attitudes. The culture of acceptability of obstetric violence is a major driver, contributing to its normalization. Midwives do not consider obstetric violence as abuse, but rather, as a delivery strategy which aids a successful delivery. It is therefore justified and viewed as a necessary part of the delivery process. There is a critical need for retraining midwives on alternative birthing strategies devoid of violence.

Keywords: obstetric violence; midwives; mistreatment and abuse; childbirth; women; Ghana

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1. Introduction

Ghana is one of the countries where maternal mortality and morbidity remain a great threat to women's lives and health. According to the World Health Organization (WHO) [1], Ghana ranks high in maternal mortality with a ratio of 310 deaths per 100,000 deliveries. Reducing the maternal mortality ratio to 70 deaths per 100,000 births forms a major component of the Sustainable Development Goals (MDG Goal 5) as well as the Ghanaian government's maternal health policies. Increasing Skilled Birth Attendance has been at the center of global and national strategies to reduce maternal deaths as demonstrable evidence reveals that up to 70% of all maternal deaths could be prevented if all deliveries were conducted by skilled birth attendants [2,3]. Women have a higher risk of maternal or neonatal morbidity and mortality when they give birth at home without a skilled birth attendant to manage clinical complications [3–5]. In Ghana, efforts to reduce maternal mortality have emphasized increasing institutional deliveries through the implementation of the Free Maternal Healthcare Policy in 2008 and improving community-based health services to increase care for women in the rural parts of Ghana. However, these efforts have not translated into quality healthcare for women, as a considerable number of women still do not utilize facility-based services for delivery. Current data on institutional deliveries indicate that out of about 95% of women who attend antenatal care (ANC) services, only about 65% deliver in healthcare institutions [6,7], with 35% of women giving birth at home with unskilled birth attendants. In addition, only 21% of women use all

three WHO-recommended components of maternal healthcare—antenatal care, skilled birth attendance, and postnatal care [8]. This poses a danger to Ghanaian women and underpins the current high mortality rate.

Without doubt, midwives are highly pivotal in the fight against maternal mortality in Ghana. They are the mainstay of providing maternity care and support for women and undertake 80% of all institutional deliveries in Ghana [9]. Beyond their skilled knowledge and professionalism, their disposition, behavior, and attitudes towards women are equally critical and influence delivery outcomes. Investigations into women's delivery experiences in health facilities have revealed enormous abuses and sometimes brutal acts of violence from healthcare professionals. Violence in this context involves the deliberate use of physical force (actual or threats) including aggressive behaviors on women which could result in pain, injury, psychological damage, and maldevelopment [10]. Violence could also be acts of neglect or deprivation. Bohren et al.'s [11] and Bowser and Hill's [12] review of women's experiences of institutional deliveries found that women found the delivery process highly medicalized and dehumanized. These abuses, widely conceptualized as obstetric violence, is gaining widespread attention as a critical and pressing public health concern. Chadwick [13] (p. 504) defines obstetric violence as "the disrespectful, aggressive and humiliating treatment of women and girls during labor and birth". Perez D' Georgio [14] (p. 201) extensively defines obstetric violence as "the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women." Obstetric violence manifests in diverse torturous and abusive acts of physical violence in the form of beatings or stitching without anesthesia as well as forced medical procedures, including forced episiotomies, verbal abuse, and breach of privacy or confidentiality. The WHO classifies obstetric violence to include "physical violence, humiliation and verbal abuse, intimidation, forced medical procedures, neglect, lack of confidentiality, failure to seek consent, refusal to administer pain medications, avoidable complications, refusal of medical admission, and detention of women after delivery based on their inability to pay medical bills" [15] (p. 1). Abuse and maltreatment during labor and delivery is a major health problem which is associated with women's right to quality healthcare and freedom from violence and compromises the bodily integrity of women. It particularly affects women's decisions to deliver in facilities where birth-related complications could be managed appropriately. Studies on the barriers to institutional birthing have established that obstetric violence is a major impediment to skilled birthing as women are likely to avoid skilled birth attendance if they perceive mistreatment and abuses in health facilities [4,16–18]. Obstetric violence also heightens trauma and could lead to birth-related complications and poor health outcomes. In their research on public health in India, Raj et al. [19] found that women who experienced obstetric violence also experienced higher complications during childbirth and in the postpartum period. Particularly women who have experienced sexual violence in the past are more vulnerable to psychological trauma as experiences of violence during delivery trigger traumatic memories of sexual abuse [20,21]. These negative impacts of obstetric violence have been recognized by global health actors, and the WHO has called for proactive measures to reduce the use of violence during delivery.

In recent years, a number of studies have reported on women's experiences of obstetric violence in some parts of the world with varying prevalence rates. With a prevalence rate of 33% in Mexico, 44% in Argentina, and 17% in the United States [22–24], the phenomenon of obstetric violence is gaining attention. A multi-country study involving four Sub-Saharan African countries found that about four out of every ten women who delivered in health institutions experienced obstetric violence [25]. Other studies in Ghana have found obstetric violence to be highly pervasive in institutional deliveries with a prevalence rate of 83% and a significant enabler to women's use of unskilled birth attendants [16,26–29]. The literature also reveals healthcare professionals are aware of the occurrence of obstetric violence and

associate it with poor working conditions of caregivers [30,31]. Women have reported physical abuse, humiliation, verbal abuse, neglect, and sometimes detention in health facilities [16,25,26]. Teenage mothers, single mothers, and women with HIV were found to be more vulnerable to obstetric violence [25,26]. This pervasive abuse in the delivery rooms has raised concerns over the safety of women in the birthing process but the critical question of why midwives abuse women remains crucial to dealing with this problem. This is particularly important because previous research has found the odds of abuse by midwives to be higher than by medical doctors [26]. However, the greater majority of the studies on obstetric violence in Ghana has been based on women's perspectives and experiences [25–29]. The few studies involving health professionals were conducted in other regions and only in urban facilities. There is currently limited evidence on why midwives abuse laboring women in the Ashante and Western Regions, the first and third most populous regions in Ghana with a continuous decline in skilled birthing [6,32]. This study, therefore, aims to critically investigate why midwives employ violence in the delivery process and their perspectives on obstetric violence, in order to understand the dynamics of the phenomenon and the measures that could reduce the mistreatment and abuse of women during delivery.

2. Materials and Methods

2.1. Study Setting and Design

This was a qualitative phenomenological study conducted in eight health facilities in the Western and Ashante Regions in Ghana. Results of the 2021 Population and Housing Census indicate that Western and Ashante Regions have about 8 million inhabitants [32]. About 85% of women in the Western Region utilize antenatal care services, with 54.8% of births occurring in health facilities, while in the Ashante Region, 75% of women attend antenatal care and 53.4% deliver in health institutions [6]. Ghana's health system is categorized into primary, secondary, and tertiary levels. The main point of delivery for most Ghanaian women is the primary and secondary healthcare institutions, while the tertiary level handles obstetric complications. The data were collected in eight public health facilities in both urban and rural settings. The health facilities were purposely selected and included if they were public health facilities, were either primary or secondary-level health facilities, provided obstetric care and maternal services, and had a high client flow for maternity services. Empirical data in the Western Region were collected in the Kwesimintsim Polyclinic and Essikado Government Hospital (the two main hospitals that deal with maternal care in the Sekondi-Takoradi metropolis) and the Agona Nkwanta Health Center and Dixcove Government Hospital located in the rural part of the Western Region. In the Ashante Region, the study was conducted in two health facilities located in the Kumasi Metropolis (urban)—the Maternal and Child Hospital and the Tafo Government Hospital—and two hospitals serving the rural communities in the Ashante Region—Nkenkaasu Government Hospital and Ejura District Hospital.

2.2. Study Participants and Sampling

In-depth interviews were conducted with midwives to gather comprehensive data and information on how women are treated during delivery and the factors that drive obstetric violence in health facilities. Carter et al. [33] contend that in-depth interviews are most appropriate for exploring a particular phenomenon thoroughly and for gaining comprehensive information and understanding of people's experiences and perspectives. A total of 30 midwives, including junior and senior midwives who work in the maternity wards in the selected hospitals, were purposively selected for the study. All midwives who participated in the study were licensed practitioners who had conducted deliveries. Student midwives were excluded from the study. The selected sample size was based on the principle of saturation, a technique where the researcher discontinues gathering data because no new information emerges from the data [34]. Hence this sample size was deemed sufficient for unraveling all the nuances of obstetric violence from midwives' perspectives.

2.3. Data Collection Procedure

Two research assistants (one for each region) were adequately trained to conduct the interviews with the midwives. The research assistants were both females, non-clinical staff, possessed a minimum of a bachelor's degree, and had extensive experience in conducting qualitative interviews. All the research assistants were trained on the study protocol, recruitment procedure, ethical issues, and techniques for conducting qualitative interviews before the data collection. In addition, mock interviewing exercises in English and Akan languages were arranged for the research assistants to ensure consistency in the data collection procedure. The selection of the midwives was made in the maternity wards after a prior meeting with the hospital administrators, where the rationale of the study and the ethical approval letter had been presented. In the maternity wards, the chief midwives were first approached, and midwives who were on duty and were willing to participate in the study were interviewed. Although most midwives were willing to participate, a few others declined participation and time constraint was the major reason. A semi-structured interview guide was used to collect data on the experiences of midwives in the delivery process and the provision of maternity care for women, their knowledge about obstetric violence, witnesses of the use of violence, their acceptance of violence, reasons for the use of violence in the delivery process, as well as the sociodemographic information of the participants. Obstetric violence was measured based on the seven performance indicators developed by Bowser and Hill [12]. These include physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities. The interviews were conducted in either English or Akan and digitally recorded with an audio recorder. The research team had no prior relationship with the participants and no contact was made after the interviews were completed. This study was conducted between August 2021 and February 2022.

2.4. Data Management and Analysis

All the recorded interviews were first transcribed, and the interviews conducted in Akan were transcribed directly into English language. The data analysis was carried out using Braun and Clarke's [35] framework for conducting thematic analysis. The thematic analysis involves the identification of patterns and themes emerging from qualitative data to answer the research questions. Following the framework of Braun and Clarke [35], all the transcribed data were thoroughly read for familiarity and inconsistency checks. The data were exported into the NVivo Qualitative Data Analysis Software, Version 12 for coding and analysis. Codes and subcodes were generated for all the interview data by the lead researcher using the inductive approach which entailed a repeated reading of the transcribed data for the identification of common or emerging themes. The codes were further reviewed for sub-themes. The emerging themes, sub-themes, and results of the study were validated by the research assistants.

The rigor of the findings was ensured through reflexivity, debriefing, transferability, and audit trail. The purposive sampling method utilized for the study ensured that only participants who had the required knowledge and experience were interviewed. Furthermore, regular meetings of all the research assistants and the principal investigator were organized for debriefing while the diverse backgrounds of the research team promoted objectivity. The protocol of the study was strictly adhered to while the robust description of the research methodology and procedure promotes transferability and the future replication of the study.

2.5. Ethical Considerations

The study was approved by the Ethics Committee of the University of Konstanz, Germany (IRB Statement 37/2021) and the Ghana Health Service Ethics Review Committee (GHS-ERC 010/06/21) before the commencement of the study. Further administrative consent was sought from all the directors of medical services in all the hospitals and health centers where the study was conducted. In addition to these, individual consent was

sought from all the midwives who participated in the study after a thorough explanation of the research purpose. To ensure confidentiality, individual details, such as the names and telephone numbers of the midwives, were not collected.

3. Results

The sociodemographic characteristics of the participants were diverse. A total of 30 in-depth interviews were conducted with midwives in all the selected hospitals. All the midwives interviewed were women and were of different levels in their midwifery careers—staff midwives, senior staff midwives, midwifery officers, and principal midwives. The majority of the participants were aged between 20 and 49 years with two participants aged more than 50 years. Their professional experiences ranged from 0 to 23 years. The number of deliveries conducted by the midwives was from 1 to 100 with the majority of them indicating the number of deliveries conducted was uncountable. In total, 20 of the midwives worked in urban hospitals while 10 worked in rural hospitals and health centers.

Diverse perspectives emerged from the interviews with the midwives and these were classified into major themes and sub-themes. The major themes were supportive care, normalization of violence in care services, violence and mistreatment of women during delivery, factors behind the use of violence during delivery, and perspectives on obstetric violence. Figure 1 presents the major themes and sub-themes.

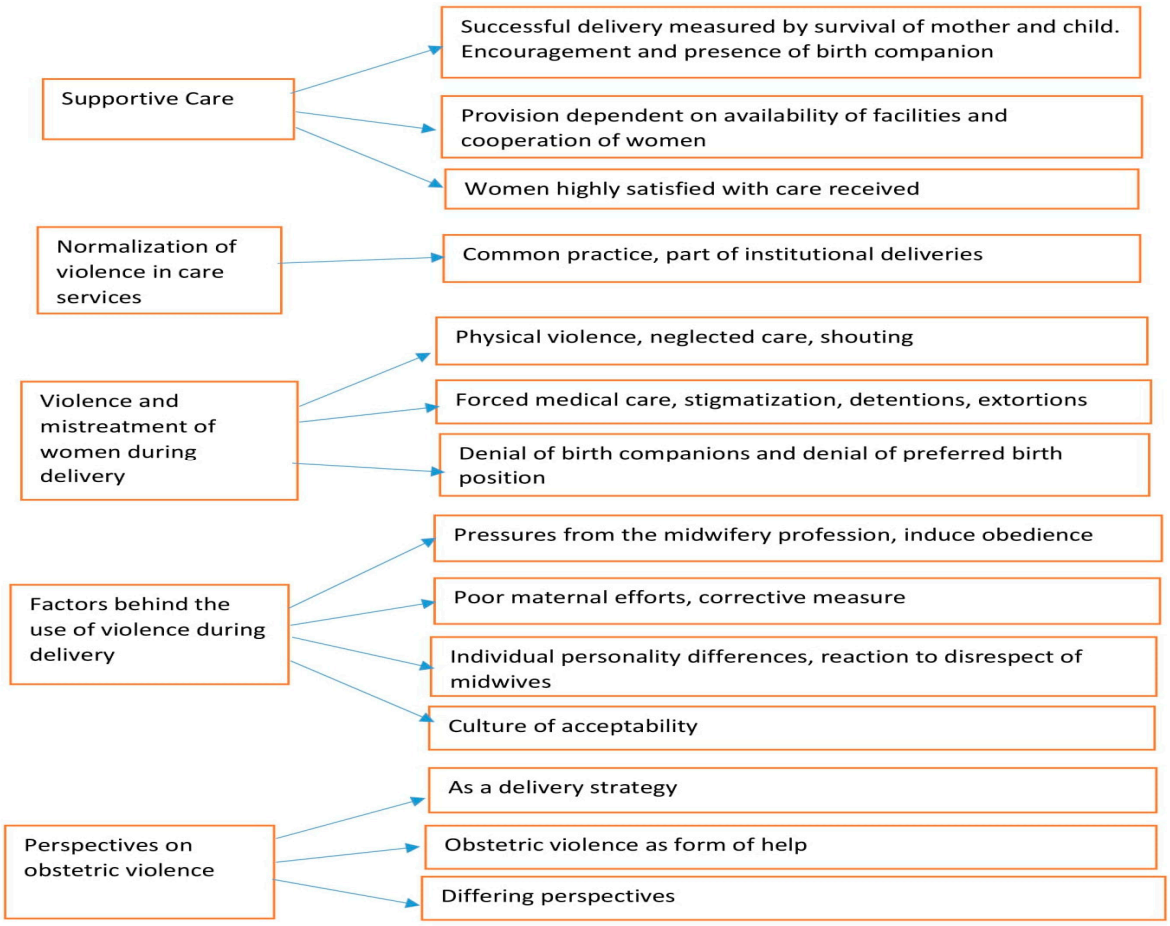

Figure 1. Major themes and sub-themes.

3.1. Supportive Care

Midwives gave diverse opinions on what supportive care for women means to them. The dominant perception of supportive care for most midwives is being able to deliver a woman's baby successfully, measured by the survival of the child and mother. Others

cite granting women the opportunity to have birth companions, encouraging women and providing women with the required information, and being empathetic as supportive care.

> *Supportive care is taking care of the mother, delivering them and the baby being alive, and the mother too being saved. Yes, skillfully*. (Midwife, Essikado Government Hospital, Urban)

> *Supportive care for me is like giving women information concerning the delivery or maybe if there is time you give her a sacral massage. You can engage her in a conversation which is a kind of diversional therapy*. (Midwife, Ejura District Hospital, Rural)

Most midwives perceive that they are providing supportive care just by the mandate of their jobs, while others opined that the provision of supportive care is dependent on the cooperation of women and the facilities available for midwives to work with. This indicates that supportive care for women is not guaranteed.

> *We have a standard mode of practice. We create rapport with the client, we provide antenatal care, and we ensure privacy during delivery and explain findings to the client. So, we are providing supportive care*. (Midwife, Kwesimintsim Polyclinic, Urban)

> *I think that depends on the patient because there've been so many instances where some patients exaggerate their symptoms and so we don't waste so much time on such cases.* (Midwife, Tafo Government Hospital, Urban)

> *If we have the logistics, yes, but if the logistics are not there, sometimes you know what to do for the client but what you will need to do it, you don't have it. If the logistics are there, yes, services are provided satisfactorily. But if there are no logistics, which is usually the case, definitely, the person will not get a satisfactory service. But I believe that we do give them a very good service*. (Midwife, Ejura District Hospital, Rural)

The narratives of midwives reveal that although the provision of supportive care is not a guarantee, women were satisfied with the care they were receiving. Women's satisfaction was based on the huge client flow in the maternity wards and the absence of negative reports of misconduct.

> *Oh very good! That one is exceptional. 80% satisfaction. In this hospital, we are baby and mother-friendly, which is why it used to be called the children's hospital. Women are satisfied with the care they receive which is why we have so many clients that visit this particular hospital*. (Midwife, Maternal and Child Hospital, Urban)

> *Anytime I come on duty I go around to ask the mothers how they were treated and if any midwife behaved rudely in my absence and I don't get any negative feedback. So, we treat them well*. (Midwife, Kwesimintsim Polyclinic, Urban)

3.2. Normalization of Violence in Care Services

The findings of the study reveal that there is a normalization of violence during delivery. A great number of midwives admitted that abuse during delivery is a common practice in the delivery process in Ghana. Many described it as 'very common', others described it as happening 'severally' while some estimate its occurrence at 80%. A few others admitted that although obstetric violence is a common practice in many Ghanaian hospitals, it rarely occurs in their hospitals, thus alienating mistreatment from their domain. The following narratives from midwives reveal a normalization of violence.

> *Severally, sometimes here we even beat the client when they are in labor, during labor, it is normal to do that because the baby's head has come, and instead of the client pushing, she will be relaxing, and the baby too will be asphyxiated. So, unless you beat the client's thighs, the baby might die. Some become relaxed, they think you the midwife should pull it for them. So, during labor, we do that*. (Midwife, Agona Nkwanta Health Centre, Rural)

> *Oh, the shouting is normal and necessary, but we don't insult them*. (Midwife, Kwesimintsim Polyclinic, Urban)

> *It is normal. There are some women, they like to make noise and shout, those people, we are hard on them not because of anything but because of their well-being. So, for the shouting at clients, it can't stop*. (Midwife, Tafo Government Hospital, Urban)

> *I've witnessed such incidence, not in this hospital but in other settings because they (women) can't endure pain, they also misbehave.* (Midwife, Ejura District Hospital, Rural)

Although midwives admitted that abuse is a normal occurrence in the maternity wards, there were some concerns about the legal implications of abuse. Two midwives expressed concern over possible legal repercussions from victims due to education and human right awareness, demonstrating some consciousness that obstetric violence is a human rights violation. However, this consciousness was only among a few midwives (two).

> *It is common, but we can't go away with it anymore because nowadays people are getting educated and legal issues can arise. Everybody is advising herself, so, if you are a midwife, you should also advise yourself not to get in trouble with those things*. (Midwife, Nkenkaasu Government Hospital, Rural)

> *There is a law about negligence. When you come to the hospital and feel that you have been abused in any way, you can go to court and then sue the midwife. Sometimes, they can even take the midwife's license, so she won't be able to work as a midwife in Ghana. A lot of people do that now. Right now, we are being careful*. (Midwife, Tafo Government Hospital, Urban)

3.3. Violence and Mistreatment of Women during Delivery

The narratives of the midwives interviewed reveal clear evidence of obstetric violence perpetrated by the midwives themselves or other midwives. The typical ones include direct physical violence, verbal abuse, neglect of women, the performance of medical procedures without women's consent, detention of women in health facilities, stigmatization, extortion, refusing women their right to birth companions, as well as denying them their choice to a preferred birth position. Many midwives admitted to perpetrating such violence in a bid to ensure successful delivery. From the midwives' perspective, the use of violence is inculcated in the delivery process and this is more intense during the second stage of labor. Violence was viewed as a necessary part of the birthing process, which many declared 'can't end'.

3.3.1. Physical Violence

A good number of midwives narrated detailed incidences where laboring women were hit, slapped, and sometimes tied down in the labor wards. The pain was intentionally inflicted on women as a way of compelling them to cooperate with the birthing process. As a reaction to the pain of the abuse, women forcefully push the babies, making birth easier for the midwives. Many describe the physical violence used as 'harmless' and in the best interest of the laboring woman. From the narratives of the midwives, the use of physical violence was perceived to yield positive birth outcomes, and women who reacted negatively to the abuse (by refusing to push in response to the pain of the abuse) had negative birth outcomes, measured by a cesarean section. The following extracts from the data declared instances of physical violence:

> *Sometimes we even tie them to their beds. That one, too, is there. When their blood pressure rises, they have eclampsia and they become aggressive, so we tie them*. (Midwife, Maternal and Child Hospital, Urban)

> *One of our colleagues was having challenges with a laboring woman, and when we went, the client complained to us that the midwife did this and that, but it was not true. Then, we now saw the head of the baby was there and the client was not pushing, so we decided to give a little pain so that she will push out of the pain. We hit her but it was not intentional to cause harm.* (Midwife, Nkenkaasu Government Hospital, Rural)

Some women don't put so much effort when they are asked to push because of the pain they feel, so the midwives have to cause them pain sometimes by blocking their nostrils, so they would know how the baby feels as a result of their low effort in pushing. (Midwife, Tafo Government Hospital, Urban)

3.3.2. Neglect

Neglecting women's requests for assistance was described as an incessant practice in the labor wards. Midwives admitted ignoring women who were constantly requesting interventions that they perceive to be unnecessary based on their medical knowledge. They described such calls as 'disturbances'. Others also mentioned ignoring women based on their disobedience to the midwives' instructions.

We ignore clients based on their reactions. Maybe when we review clients and it's just 1 cm dilatation, but the client is insisting the baby is coming. And you do the vaginal examination again and it's still 1 cm and she would be shouting and crying and making a whole lot of fuss. Most often we ignore such people. (Midwife, Maternal and Child Hospital, Urban)

Last two weeks, I was right here writing. A woman was brought in just like this one was brought in. I asked her to lie down, and I did all I could, but she did not mind so I just ignored her. Later I heard someone scream, I turned around and saw her standing there. She was pushing the baby out and I didn't mind her. (Midwife, Maternal and Child Hospital, Urban)

3.3.3. Shouting

Shouting at women is the most dominant form of mistreatment in the data. Most midwives confirmed shouting was a regular action to keep women in check and the acceptance of indulgence was high compared to other forms of mistreatment.

As for the shouting, we have shouted at them. If you don't shout at them, you will end up writing a death note because of their negligence. (Midwife, Maternal and Child Hospital, Urban)

Usually, it's just shouting in this hospital, but I've witnessed incidences of midwives hitting pregnant women in labor because they wanted them to push. (Midwife, Tafo Government Hospital, Urban)

We don't normally beat them, but shouting, yes. For some clients, you will talk to them politely and they will still misbehave, we are all humans, so we shout at them. (Midwife, Essikado Government Hospital, Urban)

3.3.4. Failure to Seek Consent for Medical Intervention and Stigmatization

Giving adequate information on all medical procedures that will be conducted on people's bodies and seeking their approval before the administration of any medication or intervention is a basic right for all humans within the medical practice. Thus, failure to give adequate information and seek the approval of women before any medical procedure becomes an abuse of their human rights. Critical analysis of the data revealed that midwives in Ghana adequately inform women about medical procedures, but the question of consent or approval is not a prerogative of women. Consent is denied based on the ignorance of women regarding childbirth.

We inform them. Especially those who have not delivered before. For them, their perineum is very tight, so before delivery, we tell them because they haven't delivered before, we might give them a cut (episiotomy). So, we tell them beforehand. (Midwife, Agona Nkwanta Health Centre, Rural)

Whatever we do, we tell them. During the delivery point, we have to do what is best, so, when we are cutting (episiotomy), we tell them and comfort them when they are feeling

> *the pain. We also tell them we have to stitch the place so that it will go back to normal*. (Midwife, Kwesimintsim Polyclinic, Urban)

> *In cases where the woman does not agree, we use our discretion, because we have knowledge in childbirth more than the woman and so we know what's best to do so we just go ahead and do it.* (Midwife, Essikado Government Hospital, Urban)

Although most midwives declared that they treated all women equally, one midwife admitted that women with HIV were stigmatized. This discrimination is exhibited through acts of extreme avoidance and rejection. During the interview, she noted:

> *For instance, for HIV patients, when they come to the hospital, some of the nurses and midwives are too careful with them and this makes them feel awkward and rejected. But that is when the person needs us more to talk and counsel her and let her know about the procedures she will go through so that her child will not be infected. However, some healthcare professionals will rather be rejecting the person*. (Midwife, Maternal and Child Hospital, Urban)

3.3.5. Detention and Extortion

Detention of women in health facilities after delivery occurred for two main reasons: inability to pay for medical bills and/or for owing midwives. Women detained for owing medical bills are usually women who delivered through cesarean sections and this is because the National Health Insurance Scheme (NHIS) does not cover the cost of C-sections. In addition, many midwives engage in the trading of birth items in the maternity wards, including items such as mackintosh, infant formulas, baby diapers, and toiletries, among others. Women who are unable to pay for the items they bought are detained for such purposes, and those who seek to pay at later dates have their medical records seized until payment has been made. The following extracts from the data give insights into detention:

> *Detention happens, yes, for cesarean sections because it is costly. So, if they do not pay their bills they will not be discharged*. (Midwife, Kwesimintsim polyclinic, Urban)

> *We have detained several women, they will be here until they settle their bills. They can't go. They can go and settle the bills they owe the hospital but still, we have a reason why we are keeping them here and no one can come and tell us otherwise. They bought something from us and they are supposed to pay but they did not. Sometimes, we seize their ANC cards before releasing them. Because this new card has the medical information of the babies which they will need for subsequent checkups. So, when they come, they will be asked to pay before it is released.* (Midwife, Nkenkaasu Government Hospital, Rural)

There were also cases of extortion from women, termed 'Egg Money'. This unauthorized 'Egg Money' is supposed to be a free-will gift, mainly given to midwives in appreciation for their assistance. However, it has become almost compulsory for women, adding to the financial burden women have to bear for facility-based delivery.

> *Some of the midwives behave as if they have a monetary target when they come to work. They want to benefit from every delivery by taking money from the client. At the end of the month, they will still take their salary. Usually, if you treat the client well and they are leaving they can say take this ¢10 but some nurses demand from the client and they termed it "egg money", egg money for what? The client is supposed to give to you from her heart, but not that you demand it.* (Midwife, Tafo Government Hospital, Urban)

3.3.6. Denial of Birth Companions and Preferred Birth Position

The data analysis revealed that many women prefer to have their husbands or family members with them during labor and delivery. However, birth companions were not allowed in the health facilities due to infrastructural deficits. Maternity wards were usually big halls filled with multiple women. Midwives cited the protection of the privacy of other women in the ward as a major hindrance to birth companions. Others also cited cases of

misbehavior from women when their husbands were present as reasons for the denial of birth companions.

> *In labor, we don't allow birth companions because we don't want another person to be exposed. If we had private wards, we would have allowed it. In labor women sometimes expose themselves and if we allow birth companions, someone's husband will be standing by his wife and will be looking at another woman's nakedness, it's not nice.* (Midwife, Essikado Government Hospital, Urban)

> *Mostly we don't allow them to be there because most of the women when they see their husbands they misbehave. Like maybe assuming there is no contraction or the contraction comes and goes, the moment the woman sees the husband she begins to shout "daddy I'm tired, I want to do CS" and so on, so mostly we don't allow them to go there*. (Midwife, Maternal and Child Hospital, Urban)

Women are also denied the choice of a preferred birth position. In all eight health facilities, women were strictly mandated to deliver in one position: the lithotomy position. Midwives are aware of other birth positions such as squatting or kneeling, etc., but restrict women to only one position. This happened despite midwives' acknowledgment of the fact that other birth positions make labor easier for women.

> *The women cannot choose which position they want to deliver, no. We tell them to lie in the lithotomy position. The squatting position is distressing and stressful for us although I learned that it is easier for women to deliver squatting than the lithotomy*. (Midwife, Dixcove Government Hospital, Rural)

> *They're allowed to deliver in only one position. The women here are made to deliver in the lithotomy position*. (Midwife, Essikado Government Hospital, Urban)

3.4. Factors behind the Use of Violence during Delivery

3.4.1. Pressures from the Midwifery Profession

The dominant reason behind the use of abuse during delivery is heavily related to the pressures on midwives to ensure successful deliveries. Common keywords such as 'blame', 'fear', 'frustration', 'accountable', 'audit', and 'trouble' dominated the narratives of midwives. Midwives are blamed for every negative delivery outcome and are made to face disciplinary measures (termed 'audit'), including the termination of their professional licenses. To avoid this, midwives employ abuse and force in the delivery process. Many describe the frustration that comes with this expectation and view women's attitudes as obstacles to their career success.

> *Sometimes out of frustration some midwives shout at the client because as per our practice there is something known as auditing, that is when you would be called to answer questions when either a baby or a mother dies during delivery. So sometimes the midwives would want to avoid that. Although is not good but she has to save the mother and the baby to avoid auditing.* (Midwife, Dixcove Government Hospital, Rural)

> *As for the shouting, it will not end. Because if the client is misbehaving and you don't shout at them and there is a fetal death you will go for an audit about it, and your certificate will be at risk. So that time you are doing everything possible so that the client will not put you in trouble*. (Midwife, Tafo Government Hospital, Urban)

> *There are laws governing these cases because if a midwife becomes the reason for the loss of either the mother or baby; She'll have to face the law. She might even lose her license to ever practice as a midwife*. (Midwife, Tafo Government Hospital, Urban)

Some midwives also stated that stress, huge numbers of patients, and lack of equipment contribute to obstetric violence. It makes it difficult for them to ensure proper care without abusing the rights of women.

> *I think it's because of the stress we go through to care for all the patients. Also, I think it's because we lack the basic things we need to work with. Sometimes it's a transfer of anger from the problems we face.* (Midwife, Essikado Government Hospital, Urban)

> *Sometimes the drugs are not available, so we can't give them the drug to numb the area where we'll have to suture after episiotomy. So, they feel pain when the suture needle touches their skin*. (Midwife, Ejura District Hospital, Rural)

3.4.2. Inducing Obedience

Midwives employed mistreatment and abuse to induce obedience from women. Hitting women, shouting at them, and abandoning them were used as strategies to get women to obey them and follow instructions.

> *It happens because some of them don't comply with the things we tell them not to do. There are some women when you shout once then they become sturdy*. (Midwife, Essikado Government Hospital, Urban)

> *When it gets to a point and we don't apply those things, we don't know what will happen. If you hit and shout at the person, it will put some kind of fear in the person to push.* (Midwife, Tafo Government Hospital, Urban)

3.4.3. Poor Maternal Effort

Midwives cite poor maternal effort as part of the factors that facilitate the use of abuse on women in labor. Losing concentration and being reluctant to take responsibility in the birthing process, especially in pushing out the baby, was considered a poor effort, and women were abused for such reasons. Mistreatments and abuse were therefore tools to ignite good maternal efforts in women.

> *Some women too have poor maternal efforts so unless you shout at her, she will be relaxing. Maybe she is in labor but her mind is elsewhere so when you shout at her she will focus. All these are done to improve the quality of child delivery in hospitals. I wouldn't be happy if my patient loses her life or that of her baby.* (Midwife, Maternal and Child Hospital, Urban)

> *Some women when you tell them to push, they will be relaxing, and the baby too will be asphyxiated, so unless you beat the client they won't push. If they don't push too the baby might die. Some become relaxed they think you the midwife should pull it for them. So, during labor, we use to do that (beat them).* (Midwife, Essikado Government Hospital, Urban)

3.4.4. As a Corrective Measure

Obstetric violence was also viewed as a corrective measure. Midwives employed mistreatment and abuse to correct women who are acting in ways that could cause harm to their babies. In such circumstances, inflicting pain on the women is considered essential.

> *When the person is in labor sometimes if the person is doing something that will cause harm to herself and the child, we will shout at her.* (Midwife, Nkenkaasu Government Hospital, Rural)

> *Sometimes the women fail to comply with all we ask them to do. For instance, we educate them on how they'll feel when they have contractions and ask them to lie on their left side or try to breathe through their mouth whenever they experience the pain but some of them get aggressive and try to do things they're not supposed to do because of the intensity of pain they feel. When the midwives try to correct her and make her understand why she wasn't supposed to do that, they misinterpret it as maltreatment, they think we're maltreating them. After a successful delivery, they tell their families a different story to make them think we maltreat them*. (Midwife, Dixcove Government Hospital, Rural)

3.4.5. Individual Personality Factors

Personality differences was a major theme that emerged in the data. Individual differences among midwives and also women were factors contributing to obstetric violence in health facilities. The midwives noted that some midwives are impatient and abusive by nature and such people are quick to abuse women for even the slightest reasons. Furthermore, individual attitudes of women also influenced abusive treatment.

> *Individual differences count, some midwives are like that. They will shout at the patient over the slightest thing. But if you are calm with the patients and talk to them, they are cooperative.* (Midwife, Maternal and Child Hospital, Urban)

> *I think that individual differences also contribute—a person's character. For some clients, you will have to force them because most of them can't handle pain. Some people will just feel reluctant to push and if you don't do that you will end up losing the baby or both.* (Midwife, Essikado Government Hospital, Urban)

> *Some patients can be very annoying. They will come to labor and the things they will do will make you shout at them. Some patients come here and sleep on the floor. Somebody too will intentionally deliver on the floor. Imagine if care is not taken and the baby's head hit the floor, she will be the one to blame you. So, I don't think it's intentional that they are shouted upon, it's their own fault. Their behavior will make you shout at them.* (Midwife, Maternal and Child Hospital, Urban)

3.4.6. Obstetric Violence as a Reaction to Disrespect

Disrespect of midwives and the midwifery profession was a major driver of abuse. Narratives of disrespectful behaviors from women and their relatives were dominant in the data, and this provoked midwives to retaliate with either disrespectful or abusive behaviors.

> *There was a time when one woman came to the hospital for delivery, she kept defecating on the floor of the labor ward and so in such a case, the midwives would be upset. Some women even say it's our job to clean up after them.* (Midwife, Dixcove Government Hospital, Rural)

> *Women themselves push you to do those things. One day come and work with us and you see that midwives are doing very well. The things that they do, they will throw their pad on the floor, they will be touching you, vomiting around. Some people too their relatives will come and curse. They will come and be dictating to you and all sorts of things.* (Midwife, Maternal and Child Hospital, Urban)

3.4.7. Culture of Acceptability of Violence

Obstetric violence was not only accepted by the midwives but was also accepted by some women as yielding positive results. There were accounts of women thanking midwives for using violence on them to help them deliver. This culture of perceived acceptability is a driver of obstetric violence.

> *A woman who showed no effort to push was beaten and this made her push. And after she delivered her baby, she apologized to the midwife for all she did and even thanked the midwife for slapping her thighs when she didn't want to push. She said had it not been for the slaps she wouldn't be compelled to push hard enough.* (Midwife, Tafo Government Hospital, Urban)

3.5. Perspectives on Obstetric Violence

3.5.1. Obstetric Violence as a Delivery Strategy

There is a general acceptance of violence as a delivery strategy for safe delivery. Obstetric violence is viewed as an important part of the birth process that aids both midwives and women in achieving a safe delivery. As a strategy, midwives declared that it facilitates pushing. Torture, particularly inflicting pain by cutting women's vaginas, works for the delivery by instilling fear in women to cooperate. In addition, using violence was

a means to prevent unconsciousness throughout the delivery process. Many midwives considered this violent strategy right from such a perspective because the motive of the abuse is not to disrespect or hurt women but to aid delivery. The use of violence was also perceived as the only option to ensure safe delivery.

> *Some clients have been over-pampered at home so when it's time for them to push they will be telling you that they are tired. At that time, you have to hit the person just to let the person know that they are not in their comfort zone. Even some people faint during delivery so when you are hitting the person, she will be conscious*. (Midwife, Tafo Government Hospital, Urban)

> *If the person is fully dilated, and the person doesn't push the baby can die or the mother can end up with a C-section. The first thing I will do is either I will shout or I will beat your thighs, if you don't push, I will give you an episiotomy. I will cut your vagina but that one they are afraid, if you take the scissors and they see it they suddenly get the energy to push. You will think I am abusing the client because I am stepping on the client's rights. But to me, I am doing the right thing. So, these are some of the abuses when I am caught, I can defend it and it is acceptable because in the end I will end up successfully with the baby and the mother all doing well*. (Midwife, Nkenkaasu Government Hospital, Rural)

> *We don't shout to show disrespect, we are saving the baby's life. The labor ward is between life and death. And at that time, when the baby is coming, the baby does not get blood oxygen supply from the mother again., So when it is time for you to push and you relax, you are decreasing the oxygen supply to the baby and if care is not taken the baby can die. I have to shout at you to be on track that you are delivering, you should push till the baby comes out, that's why we shout*. (Midwife, Agona Nkwanta Health Centre, Rural)

> *It is not good but there is no option because if the baby dies during that process, she will say it's the midwife that killed the baby*. (Midwife, Dixcove Government Hospital, Rural)

3.5.2. Obstetric Violence as a Form of Help

Midwives' use of violence on women during delivery was perceived as a form of help to women, therefore making obstetric violence a positive phenomenon. Desisting from violence was therefore perceived to be unhelpful for women, leading to negative birth outcomes, thus making the acceptance of violence extremely high among the midwives in Ghana.

> *Oh, I don't think that is bad in itself, we shout at them just to help them. They mostly do not cooperate when they are in labor because of the pain*. (Midwife, Dixcove Government Hospital, Rural)

> *It has a positive side, if we have to shout to save a client it is a positive thing*. (Midwife, Dixcove Government Hospital, Rural)

> *If a midwife shouts at you for your baby to come and you don't want but you want to lay down for her to pamper you to lose your baby, then it is your fault. Next time you will wish she shouts at you for you to get your baby. We do that to save the baby. Pampering them gives a lot of complications*. (Midwife, Nkenkaasu Government Hospital, Rural)

> *I do not think it is mistreatment; it helps them to push in order not to lose their babies. A midwife must exhaust all means to get the needed results so with that, they will shout at you and that is good for the client*. (Midwife, Dixcove Government Hospital, Rural)

3.5.3. Differing Interpretation of Abuse

Midwives' conceptualization of abuse differed from the general conception of abuse. For example, abandoning women's calls for assistance was considered abuse only when the required duration for checkup had elapsed and this duration is solely determined by the midwives and not the women. Ignoring women's spontaneous calls for assistance was

therefore not considered abuse. Furthermore, any form of abuse that yields positive birth outcomes was also not considered abuse.

> *Imagine all the beds being full and one person who is not having contractions or progressing will be complaining about the pain and giving a false alarm. That one the client will be ignored, you get me. But if the contraction is there and 4 h have elapsed and the client is not attended to, it means the client has been ignored and that's our negligence. So, when the time is due and we don't attend to the person that is an abuse*. (Midwife, Maternal and Child Hospital, Urban)

> *They will say I am physically abusing them. But for a midwife, my expectation is to help the mother and the baby to be alive. We don't have the mission or vision to lose a baby. So, if you are at the second stage of labor, and you misbehave I need to put in actions, one of my actions is either, I will shout, "madam, push because the place your child's head is it's not good". Some I need to go to the extent of beating the client, for the client to know that in fact I am aggressive. They will think I am abusing them, but to me, in the end, I will be successful because in the end the baby and the mother will be alive. Their source of abuse differs, some clients will say they were abused, but when you come to my side, it is not an abuse, I am being aggressive for me to end up successfully*. (Midwife, Ejura District Hospital, Rural)

Two out of the thirty midwives interviewed found the use of violence wrong.

> *It is inhumane. You can't be beating someone who hasn't done anything to you. I think it's better you talk to the person than beat the person because you don't know why the client is doing that. Sometimes some of them just need a little pampering so you don't have to be harsh on the client*. (Midwife, Nkenkaasu Government Hospital, Rural)

> *I feel sad because inflicting pain on a woman who is already in pain is really not cool. I've personally not maltreated any pregnant woman but like I said it's due to the differences in personality that makes some midwives do that*. (Midwife, Tafo Government Hospital, Urban)

4. Discussion

This study interrogated midwives' perspectives on obstetric violence and examined the key drivers of mistreatment and abuse of women during childbirth in eight health facilities in Ghana. Although the midwives perceived supportive care to involve providing encouragement and adequate information to women and granting them access to birth companions, the dominant view of supportive care was mainly tied to providing successful delivery—a live mother and child. Similar views are held in India where healthcare professionals interpreted supportive care as ensuring the survival of the mother and baby after the delivery [36]. There were mixed feelings about the provision of supportive care for women but a general perception that women were satisfied with the care and treatment they received. This could partly be due to the low expectations women have regarding maternity services in Ghana [16,37] and the fact that there are no formal channels established by the health authorities where women can express their dissatisfaction, making provider engagement for quality care impossible. Consistent feedback, auditing, and engagements with women regarding their experiences with care have shown a significant impact on healthcare professionals' compliance with desired care [38,39].

Like other studies in Nigeria, Mozambique, Guinea, and Myanmar, there was a general awareness among the midwives of the occurrence of obstetric violence associated with facility-based deliveries in Ghana [37,40–42]. There is a culture of violence inculcated in the delivery process and this is normalized and culturally accepted by both midwives and women. Due to this normalization of violence, the perceived level of obstetric violence is high in Ghana. This parallels a quantitative study on obstetric violence in Ghana where the prevalence rate was exceedingly high (83%) compared to other countries such as Mexico (33%), the United States (17%), and Italy (21%) [21–24,26]. Thus, the normalization of violence and cultural acceptance explain the high prevalence of obstetric violence in Ghanaian

health institutions, demonstrating how obstetric violence is deeply embedded in the social norms of the society. Dealing with obstetric violence, therefore, requires a multifaceted approach that targets the change of social norms that drive abuse during childbirth.

Midwives admitted either abusing or witnessing the abuse of women and the dominant abuse was verbal abuse. The findings of this study are consistent with similar studies on obstetric violence in Ghana where women were subjected to numerous forms of abuse with shouting being the dominant abuse [11,16,28]. Like many third-world countries, Ghanaian women were denied birth companions in all eight health facilities included in this study. However, scientific evidence on labor companions has demonstrated that women who receive personal support from their spouses/partners, family members, or doula (birth educators) are more likely to have positive birth outcomes, limited forceful interventions, and reduced trauma [43]. Birth companions also reduce women's chances of being mistreated. Singh et al.'s [44] quantitative study in India revealed that women with birth companions were less likely to experience obstetric violence. From these bases, it is apparent that there is a need for concrete measures to facilitate accompanied delivery in Ghana.

There were reports of extortion which increased the financial burden of facility-based delivery on Ghanaian women. The demand for unauthorized money could discourage poor women from using health services, and promotes discriminatory practices [45,46]. Despite the National Health Insurance Scheme which provided free maternity care services to women, women are still detained for their inability to pay for the cost of cesarean sections. The NHIS does not cover the cost of cesarean operations, and this is a great setback of the scheme for poor women with pregnancy and birth-related complications. The maternity wards have become commercial joints where birthing items are sold and women who cannot pay for items bought are detained by the midwives. In this study, participants revealed that women with HIV are particularly stigmatized and discriminated against. This could be partly due to the high level of stigmatization of people with HIV within the Ghanaian society. Women with HIV are particularly vulnerable and stigmatization from health workers could hinder them from seeking healthcare during pregnancy or delivery [47]. The delivery process was midwife-centered with women perceived as ignorant of their bodies and the birthing process. Based on these assumptions, laboring women's calls for interventions are ignored, their right to consented medical procedures overruled, and their right to choose their preferred birth positions denied. Women's position in the delivery room is often a replica of their status in society. The conceptualization of healthcare systems, especially obstetric care, is built on patriarchal and sexist ideologies and practices [48,49]. When women have no autonomy over their bodies and no voice in decision-making process and other sectors in society, they are less expected to wield such powers in the medical atmosphere. Therefore, women–caregiver relations are often characterized by unequal power dynamics, where the laboring woman occupies the lower vulnerable position with the caregiver being in authority [50].

Obstetric violence is mainly caused by the pressures of the midwifery profession. Midwives are under excessive pressure to produce successful deliveries and are blamed for all negative birth outcomes. The healthcare system in many parts of the world has been subjected to the 'pressures of performance and efficiency' which has led to stress and burnout with negative consequences on obstetric care delivery [36,41,51] (p. 08). The Ghanaian context, however, is particularly peculiar due to the strict sanctions attached to negative birth outcomes: termination of midwifery licenses. With this, women were therefore viewed as obstacles to the career success of midwives and therefore the midwives employ all measures to force a successful delivery, which often results in gross abuses of the women. Other job-related factors such as stress due to limited staff capacity and lack of equipment contribute to the burnout of midwives. With a midwife–patient ratio of 2.7 per 1000 patients in Ghana [52], midwives work under undue stress and this increases their aggression which is then transferred to the laboring woman. This requires an intense effort from the Ghanaian government to increase the midwifery workforce to reduce the pressure on midwives as higher staffing has been demonstrated to be highly associated with timely

care, supportive care, and kind treatment of women during delivery [53]. Participants also blame women's poor maternal efforts as another major cause of obstetric violence. Women are therefore shouted at, slapped, beaten, or tortured if they fail to push hard enough and quickly because the baby could die as a result of delayed pushing. Therefore, there is a lot of pressure on women to deliver quickly. However, recent studies reveal that the second stage of labor could last up to three hours without any negative consequences for the mother or child [54,55]. This study also found a skewed conceptualization of a successful birth outcome or safe delivery which is limited to a live mother and a live baby. This contradicts the WHO Safe Childbirth Checklist which emphasizes the provision of high-quality care, routine and spontaneous checks, prompt response to women's calls, women's right to preferred birth position, and the encouragement of birth companions [56]. The Ghanaian health authorities, therefore, have limited concern for the actual process of birthing, which is vehemently violent, unsafe, unhealthy, and detrimental to women's well-being, and this greatly fueled the use of abuse. Obstetric violence is also employed as a response to the disrespectful attitudes of women and their relatives. Midwives abuse women if they or their relatives disrespect them. Similar findings were reported in India and Nigeria where midwives admitted societal disrespect for the midwifery profession contributed to poor treatment of women [36,41].

Midwives understand and interpret obstetric violence from different angles and these perspectives influence either acceptance or non-acceptance of obstetric violence. Most midwives do not consider obstetric violence to be acts of mistreatment or abuse, making it highly problematic. Obstetric violence is merely perceived as a delivery strategy that aids a successful delivery. This reveals a poor perception of this phenomenon which is highly problematic because it fuels its acceptance and justification. The poor perception of obstetric violence among healthcare professionals is a major driving force for its perpetration because perceptions and outlooks drive actions [57]. This study points out that midwifery training is outdated in Ghana as many midwives lack contemporary and efficient delivery strategies. There is therefore a critical need for retraining midwives on alternative safe delivery strategies devoid of violence. Furthermore, the curriculum of midwifery colleges in Ghana should be reviewed to incorporate contemporary delivery practices. Finally, education on obstetric violence should be made a compulsory part of the midwifery training curriculum.

5. Conclusions

This study set out to investigate the major reasons why midwives abuse laboring women in Ghana. The study found that obstetric violence was normalized and highly internalized by midwives. Many midwives admitted to engaging in or witnessing their colleagues use acts of physical violence on women, which included beatings, hitting, holding the mouth or nose, and sometimes tying women down. Women were also constantly shouted at, and this was the most dominant form of mistreatment. Women were abused due to the pressures of the midwifery profession, their refusal to push when instructed, and the lack of respect for midwives. In addition, obstetric violence was employed as a corrective tool to correct and induce obedience. This study also found that obstetric violence was widely accepted and justified. Midwives do not view obstetric violence as abuse, but rather a delivery strategy that facilitates successful delivery and is beneficial to women. This study therefore brings to the fore the need for an urgent policy on obstetric violence and an intervention that aims at reorienting midwives on the dangers of obstetric violence and retraining them on alternative safe delivery methods devoid of violence.

6. Limitations of the Study

This study was conducted in two regions out of the 13 regions in Ghana and therefore the findings may not reflect the perspectives of all midwives in Ghana. However, midwives receive their training from different parts of Ghana and the training received shapes their perceptions, attitudes, and practices. The interviews were also conducted in the health facilities and therefore there is a probability of a social desirability bias, hence midwives may

underreport mistreatments and abuses. Nonetheless, the study found obstetric violence to be highly endemic in midwifery practice and this compromises the health of women in Ghana. Future studies could explore intervention approaches that could help reduce obstetric violence in Ghana.

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Institutional Review Board Statement: The study was approved by the Ethics Committee of the University of Konstanz, Germany (IRB Statement 37/2021) and the Ghana Health Service Ethics Review Committee (GHS-ERC 010/06/21) before the commencement of the study.

Informed Consent Statement: Informed consent was obtained from all the midwives who participated in the study after a thorough explanation of the purpose of the research.

Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available due to ethical principles of the University of Konstanz and the Ghana Health Service Ethics Committee which guided this study.

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