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Original Research Article

Mistreatment in the gynaecology and obstetrics units of health facilities: community women's experiences in Guinea

Alpha Oumar Sall[1]*, Ramata Diallo[1], Mamadou Dioulde Balde[1], Sadan Camara[1], Kabinet Kourouma[2], Madeleine Toure[1], Aissatou Diallo[1], Tiany Sidibe[1], Felix Millimono[2], Ousmane Balde[3]

[1]Center for Research in Reproductive Health in Guinea (CERREGUI), Conakry, Guinea
[2]Amref Guinée, Conakry, Guinea
[3]Department of Gynecology and Obstetrics, Gamal Abdel Nasser University of Conakry, Conakry, Guinea

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***Correspondence:**
Dr. Alpha Oumar Sall,
E-mail: asall6988@gmail.com

ABSTRACT

Background: Improving maternal and child health helps to ensure women's well-being. However, despite many efforts, women are still subjected to mistreatment and abuse in health facilities such as gynaecology and obstetrics units. Data on women's mistreatment in gynaecology are scarce and insufficient in obstetrics departments. This study therefore analyses women's experiences of mistreatment in these services in Guinea.
Methods: This study is based on a qualitative approach using in-depth individual interviews and group discussions with community women. The data was subjected to thematic analysis.
Results: This study revealed a high prevalence of mistreatment of women in health facilities, both during provision of gynaecological services and in obstetric units (pregnancy, prenatal consultations and childbirth). They are mainly victims of verbal abuse, negligence and informal payment, and to a lesser extent physical violence. Victims generally have few means of redress. This mistreatment is encouraged above all by the lack of training for health care providers, the inadequacy of services and the absence of sanctions. To prevent and combat this phenomenon, it is necessary to organise training courses on respectful maternal care for healthcare providers, make patients aware of their rights and the culture of consent, and apply disciplinary sanctions.
Conclusions: This study has enabled us to understand the types and extent of mistreatment suffered by women in obstetrics and gynaecology units. It identified measures to be taken to prevent and combat mistreatment in these units in order to ensure respectful healthcare and improve relations between healthcare providers and their clients

Keywords: Community women, Guinea, Gynaecology, Mistreatment, Obstetrics, Violence

INTRODUCTION

Improving reproductive, maternal and child health contributes to women's well-being. This improvement is reduced by delay in seeking appropriate medical care, delay in accessing an appropriate health facility and delay in obtaining appropriate care once at the health facility. These delays are considered to be the reasons why women and girls die or are traumatised during pregnancy and childbirth.[1] Discriminatory practices fuel the root causes that prevent women from accessing the services they need.[1] A 2015 formative study provided an in-depth understanding of how women are treated during childbirth in four countries and the perceived factors associated with this mistreatment.[2] Such Mistreatment of women is

common in both private and public sector facilities in India.[3]

A systematic review in Ethiopia specifically described mistreatment of women as an obstacle to institutional delivery.[4] A similar situation was found in Brazil, where a cross-sectional study of obstetricians' perceptions of "obstetric violence" showed that 73.9% of participants considered the term "obstetric violence" to be harmful or detrimental to their professional practice.[5] Overall, disrespectful and abusive behaviour undermined the use of healthcare facilities for childbirth and created a psychological distance between women and healthcare provider.[6]

In Guinea too, studies have highlighted the practice of mistreatment in the delivery room.[7,8] However, these practices are not limited solely to the delivery period, but also exist during obstetric periods (pregnancy, antenatal consultation) and during services in gynaecology departments.

This is why the present study was initiated to cover Mistreatment, including the violence perpetrated in the gynaecology and obstetrics units of health facilities in Guinea. This article focuses on the experience reported by community women.

This analysis aimed to explore women's experiences of mistreatment in gynaecology and obstetrics units in health facilities in Guinea.

Located on the western coast of the African continent, Guinea covers an area of 245,857 km2 and has a population of around 13.5 million, 24.3% of whom are women of childbearing age (15-49).[9] Guinea's socio-economic situation is marked by persistent poverty. In 2012, 55.2% of the population lived below the poverty line[10] and the Human Development Index (HDI) ranked Guinea 182nd out of 195 countries in the world and 45th out of 54 in Africa. Despite the interventions implemented, maternal health indicators remain worrying.

METHODS

Type of study

This was a cross-sectional qualitative analysis involving in-depth individual interviews and group discussions.

Study sites

The study was conducted in four administrative regions of the country: Labé, Faranah, Boké and N'Zérékoré. It therefore covers a wide range of the country's geographical, socio-economic and cultural diversity, and includes both urban and rural sites to ensure a greater diversity of viewpoints on the subject.

Sampling, study participants and recruitment

The data were collected through 30 individual in-depth interviews (IDIs) and 20 focus group discussions (FGDs) with community women. Participants were identified and recruited with the help of community health workers, taking into account their age (between 18 and 49) and their place of residence (urban or rural).

Data collection and management

The data collection team, composed of 15 interviewers and supervisors, were trained on the research protocol and data collection tools during a workshop in Conakry in December. Data collection took place between January and February 2023.

The individual interview and group discussion guides developed for data collection in the field were translated into local languages (Soussou, Pular, Maninka and Kissi), then pre-tested and amended. Data collection was conducted in the language spoken by the participant. The data was recorded on tape-recorders, then transferred to audio files and transcribed into French using Word files.

Data analysis

The data were analysed using a thematic approach, as described by Braun and Clark.[11]

The study protocol was approved by the Guinea Health Research Ethics Committee. Detailed information about the study was provided to participants. Confidentiality was ensured. Free and informed consent was obtained from participants prior to the interviews.

RESULTS

Socio-demographic characteristics of participants

The results show that slightly more than a third of the participants (37%) were in the 20-24 age group. More than 4 out of 5 participants were married (83%) and four-tenths of the women (42%) had not attended school. One third of the women were sellers or housewives. Slightly more than half of the participants (53%) lived in urban areas (Table 1).

Frequency of mistreatment in gynaecology and obstetrics units

In gynaecology, mistreatment was observed mainly during consultations and gynaecological care, as reported by a teenage girl from an urban commune:

"We are often neglected by health workers when we go for consultations, sometimes we suffer...". (IDI 19-year-old girl, urban)

In obstetrics, this happens mainly during prenatal consultations and childbirth in local health facilities, as reported by these adult women in an urban commune:

"Women who come for consultations during pregnancy are sometimes abandoned by certain health workers, who may ask you for money that you are unable to pay. They give you neither medicines, nor treatment if you have no money. Some women die for lack of money". (IDI Woman 30, Urban))

Table 1: Socio-demographic characteristics of women in the community.

Variables	FGD	IDI	Total	
	Number	Number	Number	%
Age (in years)				
15-19	24	5	29	15
20-24	65	8	73	37
25-29	31	8	39	20
30-34	12	2	14	7
≥35	36	7	43	22
Total	168	30	198	100
Marital statuts				
Single	22	3	25	13
Married	140	24	164	83
Widowed	3	2	5	3
Divorced	3	1	4	2
Total	168	30	198	100
Education level				
None	71	12	83	42
Primary	59	5	64	32
Secondary	31	5	36	18
Higher	6	3	9	5
Professional	2	4	6	3
Total	169	29	198	100
Profession				
Housewife	50	11	61	31
Dressmaker	37	6	43	22
Saleswoman	61	8	69	35
Pupil/student	13	3	16	8
Civil servant	2	2	4	2
Other	4	1	5	3
Total	167	31	198	100
Number of children				
0	12	3	15	8
1-2	72	13	85	43
3-4	52	7	59	30
≥5	32	7	39	20
Total	168	30	198	100
Residence				
Urban	85	20	105	53
Rural	83	10	93	47
Total	168	30	198	100

Types of mistreatments

The main types of mistreatments reported in both gynaecology and obstetrics were verbal abuse, negligence, informal payment and long waiting times. One example of verbal abuse was given by a woman during an FGD in urban area:

"During my last childbirth, I came across these cases sometimes, they shout, nag, scold, and take you out, telling you that when you will be with your mind, we will take care of you". (Adult woman aged 36, FGD Women 25-49, Urban)

There is also physical violence, indiscretion on the part of some providers, as well as stigmatisation.

"When they come for childbirth, they are neglected; they are beaten, pinched and they put pressure on their stomachs; they scold at you saying that you lack courage" (IDI, 19-year-old girl, Rural).

Verbal violence was the most reported type of violence in obstetrics, both in individual interviews and group discussions with women. In several cases, combined types of mistreatments are cited. Some women complain that healthcare providers abandon women in labour

"When you resort to them during pregnancy or to give birth, if you are not cooperative, they humiliate you and abandon you until you are forced to give birth without assistance; we have suffered this. (IDI Woman 49, Urban)

Complaints to the authorities

The majority of participants who had suffered mistreatment during gynaecological consultations and care did not respond to this mistreatment. An adult woman living in an urban area said:

"We did not say anything because we had nowhere to complain, we told ourselves to be patient because it had already happened''. (IDI Woman Age 32, Urban)

According to the women interviewed, more of them complain to the health authorities when they are victims of mistreatment in obstetrics. Sometimes, health authorities responded to their complaints, as illustrated a participant in a rural area:

"The parents informed the village notables. Finally, the person accountable for this incident was punished by the hospital authorities". (Adult woman aged 34, FGD Women 25 -49, Rural)

There are also victims who do themselves justice, as this young woman from a rural area testifies:

"My sister, who had suffered this prejudice, said she was not going to forgive me after her baby's baptism, so she

went back to hospital and slapped the midwife back. So she took justice into her own hands". (Adult woman aged 20, FGD Women 18-24, Rural)

Factors contributing to the occurrence of mistreatment

Several factors are thought to be at the root of this mistreatment. Insufficient financial resources on the part of healthcare providers are a factor often cited as leading to patients being held to ransom. As one young woman put it:

"We will say it is because we don't have the financial capacity, it's because we don't have money, no one will consider you but if you have money, the person will welcome you and give you seat and then ask you what is hurting you, because they know you have something but if you have nothing, they tell you It are not aware, someone who has nothing can't be hard of character". (Adult woman, age 35, FGD 25-49, Urban)

Another contributing factor is the lack of training for healthcare providers and lastly, the lack of materials and equipment was also mentioned by women.

"That is what I said straight away, it is because there is a lack of training; if you are very well trained, when you work, you will not put your money first, you will treat your patient well, and if he or she is cured, you will talk to them until you all come to an agreement, but if you don't know your job and why you're working, you'll treat people badly". (Young woman aged 20, FGD Women 18-24, Urban)

Failure to punish health workers who perpetrate this mistreatment was also reported as an important factor. Young women in rural areas witnessed:

"The persistence of this mistreatment is because there are no sanctions, some women varied but the same behaviour still persists if we had contact with those in charge at a higher level to inform them of what is happening in our centre perhaps they could change their behaviour but unfortunately we don't have this possibility". (Young woman aged 23, FGD Women 18-24, Rural).

Suggestions for preventing and combating this mistreatment

Supplying medicines, materials and equipment, training providers and raising their awareness on the one hand, and raising the awareness of clients of gynaecology and obstetrics services on the other, could prevent and combat the mistreatment that women suffer in gynaecology and obstetrics units. A young woman living in a rural area suggested:

"The government should make enough medicines available in health facilities and increase the salaries of health workers so that when we go to hospital, they do not take money from us. There is also need to raise awareness to put an end to mistreatment and reduce the cost of treatment in health facilities". (IDI Young woman, aged 20, Rural)

Participants felt that by using qualified staff and appropriate equipment, women's mistreatment could be reduced. A woman in an urban area asked:

"All they have to do is help us get doctors who can help women. Our health centre is also there, but there is no electricity, no water, no medicine, and not enough equipment. When you go there, sometimes you have to deal with things, even if you know your job, but if you do not have any equipment, it is nothing, all they have to do is really help us. (Adult woman aged 26, FGD Women 25 - 49, Urban)

Participants also suggested that staff should be made more aware of how to welcome patients, and that patients should be made more aware of how to behave in health facilities

Lastly, many participants also felt that sanctions should be applied against offending healthcare providers and that an appeal mechanism should be set up in health facilities. One woman we met in an urban area suggested raising awareness in the community and setting up a toll-free number; she explains:

"In certain cases, if I have such a number I can call and explain to them how the situation unfolded and even show them the perpetrators if possible. But if you don't have anywhere to complain, you don't have the strength... That's why they do what they want to us because we do not have any strength, we do not have anywhere to complain, we do not have anyone to complain to and if you inform their superiors, they will also shout at you. So, all you can do is submit and stand by what they tell you. They need to be made aware of this and also help us understand what to do if one or two of them are caught and brought before the law, the others will take their cues from them. But if nothing is done, they will continue their behavior. It is all because we have got nothing to complain about; if we have something to complain about, we will complain about them. (Adult woman aged 33, FGD Women 25-49, Urban).

DISCUSSION

This study revealed that women are frequent victims of mistreatment in healthcare facilities. This is perpetrated during provision of gynaecological and obstetric services, mainly during consultations and gynaecological care, as well as during labor and delivery.

In terms of extent, our study shows that women's mistreatment in gynecology and obstetrics is frequent in health facilities in Guinea. The results are similar with other findings in many other countries, reporting mistreatment during childbirth and in the post-partum period, but mainly in obstetrics. In a multi-country study

(Myanmar, Guinea, Ghana and Nigeria) involving 2672 women, more than a third (35.4%) of these women said they had been mistreated.[12] A cross-sectional study with healthcare providers in one hospital and three health centers in Ethiopia also showed that a quarter (25.9%) of participants said they had already witnessed physical violence (physical force, slaps or blows) in their healthcare establishment.[13] A study carried out a year later in Ethiopia confirmed the high prevalence of mistreatment, showing that out of a total of 379 women surveyed, three quarters (74%) reported mistreatment.[14]

A study of 1914 postpartum women in Tanzania found that 15% of participants reported experiencing at least one incident of violence/mistreatment during childbirth. This number was considerably higher in community follow-up interviews, where 70% of women reported having experienced mistreatment during childbirth.[15]

Several types of mistreatments were reported by community women in obstetric and gynaecological units in Guinea, ranging from physical and verbal abuse to neglect and stigmatization. The same types have been reported in another studies from Nigeria including slapping, physical restraint of a delivery bed, detention in hospital, shouting and threatening women with physical violence.[16] The results of a previous study in Guinea on mistreatment during childbirth also reported in 2017 as types, physical violence, verbal violence, abandonment and neglect.[8]

In a study conducted in India in 2015, verbal abuse was the most frequently described form of violence. It was followed by neglect and informal payment respectively.[3] A cross-sectional study conducted in 4 countries showed that verbal abuse was also the most common form of mistreatment, particularly among teenage girls during childbirth.[17] In a review including 14 studies, the most frequently reported type of mistreatment was non-dignity in the form of a negative, mediocre and hostile attitude on the part of the provider; physical violence and detention in institutions were the least frequently reported forms of mistreatment.[6]

In terms of complaints/recourse to the authorities, it should be noted that the majority of participants who had been victims of mistreatment during gynaecological consultations and care had not reacted to the acts they had suffered, unlike the victims of obstetrical care, who were more likely to lodge complaints with the authorities. Those who do file complaints often have no feed-back. According to a systematic review carried out in Nigeria in 2017, there is a lack of accountability and legal redress mechanisms regarding mistreatment.[6] A study in Myanmar also found that most women did not accept the various types of abuse. However, some justified slapping and shouting at women as encouragement during work.[18]

As for the factors favoring the occurrence of mistreatment, our study with community women reported that shortcomings in the training of healthcare providers, their poor living and working conditions and the lack of sanction of providers by the authorities are the main factors favoring the presence and persistence of women's mistreatment in gynecology and obstetrics. In the study carried out in Nigeria, which targeted both providers and clients, the participants identified three main factors contributing to abuse: poor provider attitudes, women's behavior and health system constraints.[16] Furthermore, a systematic review reveals that mistreatment has been influenced by low socio-economic status, lack of education and empowerment of women, poor training and supervision of providers, weak health systems, lack of accountability and legal redress mechanisms.[6]

Lastly, to prevent and combat this mistreatment, health care providers need to be trained on respectful maternity care, working conditions need to be improved and sanctions applied where necessary. It is also necessary to educate clients to adopt respectful attitudes towards providers. A study conducted in Tanzania also reported that to promote respectful care for women, the following areas are essential: pre-employment and in-service training, improving working conditions and the working environment, empowering pregnant women and strengthening health policies.[19]

This study is the first to explore women's mistreatment in gynecology units in Guinea and reinforces the knowledge about it in obstetrical units. But the limitation of the study is that it covered a limited number of health districts in Guinea. It did, however, endeavor to diversify the study sites by reaching referral structures, urban and rural health facilities in all regions.

CONCLUSION

This study has made it possible to understand the extent of women's mistreatment in gynaecology and to increase knowledge of all aspects of obstetrics. Victims of these acts, for which healthcare providers are held accountable, very rarely file complaints, which often go unheeded. To prevent and combat these bad practices, it is important to strengthen training on respectful maternal care, improve care providers' working conditions and apply rigorous sanctions against perpetrators of these practices in health facilities. In addition, clients need to be aware of the rules of conduct in health facilities.

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