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Original Research Article

Mistreatment of women during gynecological care in health facilities in Guinea

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ABSTRACT

Background: Many women are victims of violence in healthcare facilities around the world. This problem remains under analysed in gynecology departments in Guinea. The aim of this study was to determine the frequency and identify the factors associated with the occurrence of client mistreatment in gynecology units.
Methods: This was a descriptive cross-sectional study conducted in 15 health facilities in five prefectures of the Republic of Guinea between January 20 and February 16, 2023. Women aged 18 to 49 who agreed to participate in the interview constituted the study population. A total of 276 clients were surveyed at the discharge from gynecological consultations and care. Multivariate logistic regression was used to identify factors associated with the occurrence of mistreatment among gynecology clients, using Stata 16.0 software.
Results: Acts of mistreatment were frequent in gynecology departments, including several types, essentially physical violence (28%), verbal violence (25%) and especially neglect (40.6%). Factors associated with mistreatments included the number of children, the time of occurrence and age of the client. Having 2 or more children increases the risk of abuse. At the time of occurrence, risk of exposure to physical violence, verbal abuse and all types of mistreatments during surgery/postoperative care. Being between 25 and 29 reduces the risk of exposure to mistreatment, comparing to adolescents.
Conclusions: This study suggests training providers in respectful care and sensitizing them to the need to discontinue this practice in order to reduce mistreatment in gynecological care services in Guinea, while taking into account the factors highlighted by this study in order to provide clients with effective services and enable them to make better use of them.

Keywords: Clients, Guinea, Gynecology, Healthcare facilities, Mistreatment, Violence

INTRODUCTION

Worldwide, many women are exposed to violence/abuse during their stay in healthcare facilities.[1] One type of violence/abuse is gynecological violence, which consists of disagreeable acts suffered by women during consultations and care in gynecological units.[1] They can discourage women from using health services or seeking advice from qualified health personnel, leading to complications of sexual and reproductive health diseases.[2] They include physical, verbal and psychological abuse, neglect and stigmatization.[2,3] These forms of violence are frequent and are considered a violation of human rights, and are linked to the poor quality and effectiveness of health services.[4]

In previous studies, the existence of mistreatment in healthcare facilities has been demonstrated.[5,6] In Ethiopia, a study reported that 74% of women reported abuse in the family planning service, including 2% physical abuse and 8% verbal abuse.[5] Disrespect for professional standards of care accounted for 29%, and poor relations between women and providers for 72%.[5] In family planning services, research has highlighted violence and mistreatment of women, as in Malawi, where 18% of clients surveyed reported having been verbally abused during FP services.[6] In Kenya, a qualitative study revealed that although family planning services are free, providers ask for informal payments rather than formal facility fees.[7] The study in Chile looked at gynecological violence.[8]

Many factors associated with violence in gynecology have been found in the literature, such as age, parity, religion, place of residence, client's level of education and provider's status.[9]

In Guinea, too, a number of studies have examined the problem of mistreatment in health care facilities.[10,11]

However, these studies have been limited to mistreatment in the childbirth room. To date, we have found no studies on the factors associated with the occurrence of mistreatment in gynecology units in the West African context, which is the reason for the present study. To fill this knowledge gaps, we intend to answer this research question: What is the prevalence of mistreatment and the factors associated with the occurrence of mistreatment in gynecological wards in Guinea?

These results will help fill the data gap in the field of gynecology and improve the quality of sexual and reproductive health service provision. The aim of this study was to determine the frequency and identify the factors associated with the occurrence of mistreatment in gynecology units in Guinea.

Study setting

Guinea is located on the West African coast and had a population of around 13 million in 2020. The country is composed of seven administrative regions and the capital (Conakry). The country suffers from high vulnerabilities among women of reproductive age (15 to 49), particularly adolescents and young girls with little or no access to family planning and sexual reproductive health services (only 10 out of 38 health districts have them), adolescent girls subjected to sexual violence (26.5%) and early fertility rates of up to 178/1000 among adolescent girls in rural areas. The rate of illiteracy among women (68.9%) is particularly high, which prevents them from accessing and understanding information about their health and their sexual and reproductive rights, and therefore from expressing a free choice in terms of healthcare. This is a group of patients who, a priori, would require particularly careful care throughout the family planning and sexual and reproductive health pathway.[12]

METHODS

Study design

A descriptive cross-sectional study conducted in 15 health facilities in five prefectures of the Republic of Guinea.

Study sites

Participants in this study were selected from four different regions of the country (Labé, Faranah, Boké, and N'Zérékoré) in order to ensure geographical, socio-economic and cultural representation of the country and to have urban and rural samples to guarantee a greater diversity of viewpoints on the theme.

Study population

The study population comprised all clients who came to the health facilities for gynaecological consultations or care. Women aged 18 or over who came for consultation or care to the gynecology units during the study period and who gave their consent to participate were included in this study. The exclusion criterion was refusal to participate in the study.

Sampling, study participants and recruitment

The study was carried out in the rural health centre of the most populated sub-prefecture in each prefecture. We chose Sannoun (Labé), Banian (Faranah), Kolaboui (Boké), Bissikrima (Dabola) and Guendembou (Guéckédou). These rural health centres were selected on a purposive basis. Urban health centres were selected by random selection using Random Generator software. In addition, there were the regional hospitals of Boké, Labé and Faranah and the prefectural hospitals of Dabola and Guéckédou.

The sample size of women interviewed was calculated using Schwartz's formula $n = z^2 \times p(1-p)/e^2$, where n: sample size, z: confidence level, e: margin of error, p: prevalence of abuse (16% for physical violence) in Guinea, as reported in a previous study.[13]

So, it took at least 206 women to do the study. To anticipate the non-response rate, this sample size was maximized by 33%, for a total of 276 women interviewed.

These women were selected exhaustively were interviewed on their discharge from gynecological consultations and care after obtaining their consent to participate in the study.

Study variables

The dependent variables in this study were physical violence, verbal violence and other types of mistreatments (neglect, lack of consent, informal payment, lack of pain relief, lack of communication, perceived lack of hygiene,

etc.), which were dichotomous variables with yes or no modalities. The independent variables related to the clients included age, religion, place of residence, level of education, occupation (physician, midwife, nurse/technical health worker), number of children, the woman's history of mistreatment, the time of the mistreatment, the status of the of the care provider who mistreated her and the type of health facility where the woman used the services (regional hospital, prefectural hospital, urban health center, rural health center) (Table 1).

Table 1: Description of study variables.

Mistreatments/ violences	Definition
Physique violence	Use force or physical constraint (pinch, kick, slap, hit, tie, press on abdomen, painful gynecological examination)
Verbale violence	Yell, grunt, insult, mock, negative remarks about the woman, threats or reproaches
Negligent	Left unattended, ignored when needed, abandoned and long delays, absence of staff for the service requested
Informal payment	Corruption and extortion, unclear pricing and unreasonable demands by health workers, Institutional detention for non-payment, demand for bribes for services
Lack of confidentiality	Treated in a way that violates privacy Treated in a way that violates confidentiality
Lack of hygiene	Unsanitary premises, have women cleaned for body fluid/waste
Lack of communication between the providers and the woman	Difficulty in establishing communication between provider and patient

We used a tool developed by Vogel and Warren for violence in the childbirth room, which we adapted to the gynecology department.[14,15] The tool was pre-tested with a small group of women with characteristics similar to those of the study population. The questionnaire focused on the frequency, different forms and factors associated with gynecological violence/mistreatment. The questionnaire was translated into local languages, and the pilot test ensured that the local language translations were accurate and comprehensible.

Data collection and management

Data collection was carried out over a 15-day period from January 20 to February 16, 2023. To do this, 15 data collectors were recruited, including doctors and sociologists with experience of quantitative data collection. These investigators received 3 days of structured training, followed by a pre-test of the data collection tools. Using a structured electronic questionnaire on tablets, data were collected. Women were approached and interviewed just as they were discharged left the health facilities.

Statistical analysis of data

The statistical analysis was carried out using Stata software version 16.0. A descriptive analysis of all the selected variables constituted the first stage of our analysis. The univariate analysis consisted of measuring the association between the dependent variable and each of the selected independent variables using simple logistic regression. The variables included in the multivariate model were those for which the significance level of the p value in the univariate analysis was less than 20%. This analysis enabled us to obtain the crude odds ratios with their confidence intervals.

In the multivariate analysis, a significance level of 5% was used. Using multivariate logistic regression, adjusted odds ratios were estimated with their p-values and confidence intervals. For the specification of the final model, goodness-of-fit and specification tests were performed. At each stage of the analysis, data clustering and the weight of the statistical unit in the sample were taken into account.

Ethics considerations

The study protocol was approved by the Guinean Health Research Ethics Committee under number 162/CNERS/21 of November 01, 2021. Confidentiality was ensured and the free and informed consent of participants was obtained before the start of the interviews, with detailed information provided to respondents through the application of consent forms. Participants in this study were informed of their right to withdraw from the study at any time without having to justify their decision.

RESULTS

Socio-demographic characteristics of participants

Table 2 presents the socio-demographic characteristics of the clients at discharge from the health facilities. A total of 276 women were included in this study.

Of the 276 clients who came to the gynaecology departments, 32.24% were in the 20-24 age group and 28.6% were housewives. More than a third (38.40%) had no formal education, and the vast majority lived in urban areas (84%). Also, 55.80% had two or more children (Table 2).

Table 2: Socio-demographic characteristics of exit-clients.

Socio-demographic characteristics	Hospitals (n=231)		Urban health centers (n=24)		Rural health centers (n=21)		Total (n=276)	
	N	%	N	%	N	%	N	%
Age (in year)								
18-19	26	78.79	4	12.12	3	9.09	33	12.00
20-24	71	79.78	8	8.99	10	11.24	89	32.24
25-29	68	89.47	3	3.95	5	6.58	76	27.54
30 and more	66	84.62	9	11.54	3	3.85	78	28.26
Religion								
Muslim	185	84.86	22	10.09	11	5.05	218	78.98
Christian	46	79.31	2	3.45	10	17.24	58	21.01
Place of residence								
Urban	208	89.66	24	10.34	0	00	232	84.00
Rural	23	52.27	0	00	21	00	44	16.00
Education level								
None	85	80.19	13	12.26	8	7.55	106	38.40
Primary	57	79.17	5	6.94	10	13.89	72	26.09
Secondary	57	89.06	4	6.25	3	4.69	64	23.19
Higher/professional	32	94.12	2	5.88	0	00	34	12.32
Profession								
Housewife	56	71.79	10	12.82	12	15.38	78	28.26
Tailor	50	87.72	4	7.02	3	5.26	57	20.65
Saler/shopkeeper	59	84.29	6	8.57	5	7.14	70	25.36
Pupil/student	27	87.10	3	9.68	1	3.23	31	11.23
Others	39	97.50	1	2.50	0	00	40	14.49
Number of children								
0-1	108	88.52	7	5.74	7	5.74	122	44.20
2 and more	123	79.87	17	11.04	14	9.09	154	55.80

Table 3: Types of gynecological violence reported by clients.

Types of violences/ mistreatment	Hospitals (n=231)		Urban health centers (n=24)		Rural health centers (n=21)		Total (n=276)		χ^2 (P value)
	N	%	N	%	N	%	N	%	
Physical violences	55	23.8	5	20.8	17	80.9	77	27.9	31.9 (0.001)
Verbal violences	51	22.1	6	25.0	12	57.1	69	25.0	12.6 (0.002)
Neglect	101	43.7	8	33.3	17	80.9	126	40.6	12.4 (0.002)
Informal payment	59	25.5	3	12.5	17	80.9	79	28.6	32.3 (0.001)
Lack of confidentiality	51	22.1	3	12.5	12	57.1	66	23.9	14.9 (0.001)
Lack of hygiene	65	28.1	4	16.7	11	52.4	80	29.0	7.4 (0.024)
Lack of communication between the providers and the woman	41	17.7	1	4.2	5	23.8	47	17.0	3.6 (0.167)

Types of violence/mistreatments in gynecology

Table 3 shows that 28% of clients (i.e. more than a quarter) said they had been victims of physical violence. This type of violence was much more common in rural health facilities and hospitals. Verbal abuse was reported by 25% of clients, with a greater emphasis on rural health centres and hospitals. Among the other types of mistreatments, 40.6% of respondents had been neglected, especially in rural health centres, with a frequency of 80.9% (χ^2=12.4 and p value=0.002). Another 28. 6% had been victims of informal payment, again mainly in rural health centres. Lastly, there was also a lack of confidentiality (24%) (Table 3).

Factors associated with the occurrence of violence/mistreatment

Table 4 presents the results of the multivariate analysis. Factors statistically associated with physical and verbal abuse and other types of mistreatments were: age, profession, number of children, time of occurrence of mistreatment, health worker status and type of facility care. The young clients aged 25-29 had a lower risk of

mistreatment (adjusted OR=0.27; CI 95%=0.07-0.1) compared to their 18-19-year-old counterparts. In terms of profession, pupils or students had an 81% reduced risk of mistreatment compared with housewife clients (adjusted OR=0.19; CI 95%=0.05-0.7).

Table 4: Multivariate analysis of factors associated with violence/mistreatment among clients.

Variables	Physical violences			Verbal violences			Other types of mistreatments		
	Adjusted OR	CI 95%	P value	Adjusted OR	CI 95%	P value	Adjusted OR	CI 95%	P value
Age (in year)									
18-19=ref									
20-24	0.72	0.5-2.3	0.870	1.69	0.5-5.5	0.384	1.431	0.5-4.2	0.513
25-29	0.41	0.2-1.6	0.308	1.27	0.3-5.0	0.725	0.27	0.07-0.1	0.047
30 and more	0.50	0.2-4.6	0.999	2.45	0.6-9.9	0.208	0.668	0.2-2.4	0.541
Religion									
Christian=ref									
Muslim	0.63	02-1.6	0.352	0.25	0.1-0.6	0.002	0.2	0.1-0.5	0.001
Place of residence									
Urban =ref									
Rural	2.48	0.7-8.5	0.147	1.166	0.3-3.7	0.797	2.730	0.6-11.4	0.168
Education level									
None=ref									
Primary	1.06	0.5-2.3	0.870	1.12	0.5-2.4	0.773	0.710	0.3-1.5	0.376
Secondary	0.59	0.2-1.6	0.308	0.84	0.3-2.2	0.734	0.846	0.3-1.1	0.703
Higher/ Professional	0.99	0.2-4.6	0.999	1.50	0.4-5.6	0.539	3.080	0.8-11.0	0.085
Profession									
Housewife=ref.									
Tailor	0.87	0.3-2.3	0.798	0.819	0.3-2.2	0.695	1.089	0.4-2.6	0.851
Saler/shopkeeper	1.46	0.6-3.4	0.395	1.109	0.4-2.6	0.809	1.11	0.5-2.5	0.799
Pupil/student	0.63	0.1-3.0	0.576	0.868	0.2-3.4	0.839	0.19	0.05 - 0.7	0.016
Others	0.78	0.2-2.68	0.700	1.09	0.3-3.3	0.877	0.584	0.2-1.7	0.344
Number children									
0-1=ref									
2 and more	1.74	0.7-4.1	0.206	0.810	0.3-1.8	0.601	2.1	1.0-4.5	0.049
Time of the mistreatment occurrence									
Gynaecological consultation and care =ref									
Surgery/post-operative care	8.5	2.8-26	0.001	3.7	1.3-10.4	0.010	4.0	1.4-11.7	0.010
Family planning and gynaecological consultation	0.47	1.2-18	0.271	0.77	0.2-2.6	0.679	0.804	0.2-2.7	0.729
Status of the health worker who committed the mistreatment									
Physician=ref									
Midwife	0.90	0.3-2.1	0.811	0.860	0.3-2.0	0.734	0.32	0.1-0.7	0.012
Nurse	0.29	0.7-1.1	0.080	0.494	0.1-1.7	0.268	0.27	0.07-0.9	0.040
Type of health facility									
Regional hospital=ref									
Prefectural hospital	3.2	1.4-7.6	0.007	1.221	0.5-2.8	0.642	4.1	1.9-8.7	0.000
Urban health centers	2.07	0.5-8.0	0.295	2.246	0.6-7.9	0.206	2.248	0.7-7.3	0.177
Rural health centers	14.0	2.4-82.4	0.003	5.4	1.0-28.6	0.044	5.779	0.9-36.9	0.064

*p<0.05, **p<0.01, ***p<0.001; Note: adjusted OR: 95% CI: 95% confidence interval; *Other types of mistreatments: Neglect, Informal payment, Lack of confidentiality, Lack of access to water and fluids.

However, the risk of mistreatment was 2.16 times higher for clients with 2 or more children (adjusted OR=2.16; CI 95%=1.03-4.51) compared with other women. Also, clients seen by midwives and nurses were 68% and 73% less likely to be victims of other types of mistreatments compared to clients seen by doctors, with respectively (adjusted OR=0.3; CI 95%=0.1-0.8 and adjusted OR=0.2; CI 95%=0.1-0.9). Clients who came for surgery or surgical and post-operative care were more susceptible to endure all types of violence/mistreatments (adjusted OR=8.5; CI 95%=2.8-26); for physical violence, adjusted OR=3.7; CI 95%=1.3-10.4) for verbal violence and adjusted OR=4.0; CI 95%=1.4-11.7) and for other types of abuse compared to their counterparts who came for gynecological

consultations or care. Secondly, having consulted a prefectural hospital increased the risk of violence/mistreatment (adjusted OR=3.2; CI 95%=1.4-7.6) for verbal abuse and adjusted OR=4.1; CI 95%=1.9-8.7) for other types of mistreatments or especially in rural health centre's (adjusted OR=14.0; CI 95%=2.4-82.4 for physical abuse and adjusted OR=5.4; CI 95%=1.0-28.6) for verbal violence comparing to other clients (Table 4).

DISCUSSION

This study revealed the existence of violence/mistreatment of women during gynecological consultations and care in health facilities in Guinea. The main factors associated with mistreatment of women in Guinea were age, profession, number of children of the client, time of occurrence of mistreatment and type of facility. These results highlight questions about interventions to combat these practices in facilities in Guinea.

Most women have suffered mistreatment in health facilities in Guinea. Most women have suffered violence/ mistreatment in health facilities in Guinea. A study carried out in Chile in 2023 revealed that more than half (57.9%) of women had suffered violence during gynecological consultations.[8] Similar findings were made by other authors in Kenya and Malawi.[6,7,16] Physical abuse, verbal abuse, neglect and informal payment were the types of abuse most reported by clients. In Ethiopia, however, the results showed that physical and verbal violence were not significant.[5]

The reason may reside in differences between study populations, samples and type of study, but also the use of violence in care facilities is perceived as legitimization by staff to control patient behavior and maintain a privileged and powerful position in relation to their patients. To resolve this, it would be appropriate to fill the training gap in academic and continuing education, while introducing respectful care modules.

The study also showed that young women were less likely to be mistreated. This is contrary to findings in Kenya, Ethiopia and Malawi, which show that young and adolescent women are more exposed to violence in gynecology units (as in family planning units).[5,7,17] Being young, these women submit to the demands of the health staff, which means that they are not subjected to these practices. It would therefore be important to encourage empathy on the part of healthcare staff through awareness-raising campaigns, in order to improve gynecological service provision.

As for the number of children, customers with two or more children were more exposed to physical violence. These results are similar to those found in Ethiopia.[5] The fact that these women have repeatedly been confronted with the behavior of health staff sometimes leads them to oppose the actions of health workers, as well as the fact that they are aware of the lack of recourse in the event of bad experiences in these gynecology units. This would contribute to a reduction in the number of visits to health facilities. It would be advisable to consider the introduction of recourse procedures in the facilities for cases of mistreatment.

The results show that clients seen by midwives and nurses were less likely to be mistreated. These results are contrary to Honduras and Tanzania which revealed that women were mistreated by doctors and nurses but also by midwives. Victims reported being ridiculed, berated and ignored.[18,19] The fact that women who are seen by midwives and nurses are less likely to be abused merits a mixed study to elucidate this finding further. Improving health workers' skills in communicating with gynecology service users would be an asset in improving the quality-of-service provision.

The type of health facility is a factor statistically associated with the occurrence of abuse among clients. According to our results, clients who consulted rural health centers were more likely to experience physical violence and any other type of maltreatment in gynecology. The reasons for this could be a lack of training and awareness among healthcare providers of the impact of such disrespectful treatment on women in their search for solutions to their problems, but also on the use of gynecological units. In Kenya, studies have shown that clients experience more violence in public health services than in private facilities.[6,16,20]

To address this problem of client mistreatment in gynecological wards, the country's health and administrative authorities should implement interventions in the healthcare system, such as sensitizing healthcare providers to sexual and reproductive health and respectful care, and implementing sanctions against staff responsible for care against such mistreatment.

This study is based on data from a cross-sectional survey, which makes it impossible to establish a causal link between verbal violence, physical violence and other mistreatment and the various explanatory variables. Participants in this study were asked about their history of mistreatment, which may introduce the possibility of recall bias. Despite these limitations, this study has its strengths. To the best of our knowledge, it is the first to study the factors associated with the occurrence of mistreatment in gynecology in the West African context. It could also provide a basis for planning evidence-based strategies to prevent and combat these practices in health facilities.

Implications for research and practice

The results of this study will help to put in place promising strategies in the prevention and fight against mistreatment. One of these strategies would be to train and sensitize health care providers to respect women's rights, but also to ensure that this fight is a priority for the authorities in order to provide quality services in health care facilities. Future

research should take a broader angle at national level to better understand this practice by healthcare providers.

CONCLUSION

This study explored the factors associated with the occurrence of mistreatment during gynecological consultation and care in Guinea. The main associated factors were age, level of education and type of health facility. The study recommends that, in addition to training providers in respectful care and raising awareness of the need to abandon the practice, there is also a need for joint action involving health providers, health facility managers and Ministry of Health decision-makers to combat this practice in gynecology departments.

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