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Article

"*By slapping their laps, the patient will know that you truly care for her*": A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria

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ABSTRACT

Background: Many women experience mistreatment during childbirth in health facilities across the world. However, limited evidence exists on how social norms and attitudes of both women and providers influence mistreatment during childbirth. Contextually-specific evidence is needed to understand how normative factors affect how women are treated. This paper explores the acceptability of four scenarios of mistreatment during childbirth.

Methods: Two facilities were identified in Abuja, Nigeria. Qualitative methods (in-depth interviews (IDIs) and focus group discussions (FGDs)) were used with a purposive sample of women, midwives, doctors and administrators. Participants were presented with four scenarios of mistreatment during childbirth: slapping, verbal abuse, refusing to help the woman and physical restraint. Thematic analysis was used to synthesize findings, which were interpreted within the study context and an existing typology of mistreatment during childbirth.

Results: Eighty-four IDIs and 4 FGDs are included in this analysis. Participants reported witnessing and experiencing mistreatment during childbirth, including slapping, physical restraint to a delivery bed, shouting, intimidation, and threats of physical abuse or poor health outcomes. Some women and providers considered each of the four scenarios as mistreatment. Others viewed these scenarios as appropriate and acceptable measures to gain compliance from the woman and ensure a good outcome for the baby. Women and providers blamed a woman's "disobedience" and "uncooperativeness" during labor for her experience of mistreatment.

Conclusions: Blaming women for mistreatment parallels the intimate partner violence literature, demonstrating how traditional practices and low status of women potentiate gender inequality. These findings can be used to facilitate dialogue in Nigeria by engaging stakeholders to discuss how to

Abbreviations: ACASI, audio computer assisted self-interview; COREQ, consolidated criteria for reporting qualitative research; DHS, Demographic and Health Survey; FGD, focus group discussion; HRP, World Health Organization Human Reproduction Programme; IDI, in-depth interview; IPV, intimate partner violence; LMIC, low- and middle-income country; RP2, Review Panel on Research Projects; SDG, Sustainable Development Goals; USAID, United States Agency for International Development

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challenge these norms and hold providers accountable for their actions. Until women and their families are able to freely condemn poor quality care in facilities and providers are held accountable for their actions, there will be little incentive to foster change.

1. Background

A growing body of research suggests that many women experience mistreatment during childbirth in health facilities across the world (Bohren et al., 2015), including physical abuse (such as pinching or slapping) (Stop Making Excuses, 2011; McMahon et al., 2014; Moyer, Adongo, Aborigo, Hodgson, & Engmann, 2014), verbal abuse (Chadwick, Cooper, & Harries, 2014; D'Ambruoso, Abbey, & Hussein, 2005; Hatamleh, Shaban, & Homer, 2013) and discrimination by healthcare providers (Stop Making Excuses, 2011; Janevic, Sripad, Bradley, & Dimitrievska, 2011; Small, Yelland, Lumley, Brown, & Liamputtong, 2002). Mistreatment during childbirth can amount to a human rights violation, as all women have the right to respectful and dignified sexual and reproductive healthcare, including during childbirth (World Health Organization, 2014; Resolution 11/8, 2009; Technical guidance, 2012; UN General Assembly, 1948, 1976, 1993; White Ribbon Alliance, 2011). The importance of acknowledging and addressing this important area of women's health has gained traction since the publication of Bowser and Hill's (2010) report on disrespect and abuse during childbirth (Bowser & Hill, 2010). Most research has focused on descriptive qualitative analyses of experiences of mistreatment, with some small measurement studies (Kruk et al., 2014; Okafor, Ugwu, & Obi, 2015; Sando et al., 2014). Mistreatment during childbirth is a multi-dimensional issue, and prevention requires understanding the root causes that can include behavioral norms, professional ethics, facility environments and accountability mechanisms. To better understand how and why mistreatment during childbirth occurs, it is important to reflect on societal tolerance of violence and power dynamics.

1.1. Gender inequality, patient inferiority and violence against women

Jewkes, Abrahams & Mvo (1998) published findings from a qualitative study on why nurses abuse patients on South African maternity wards. The authors concluded that an "underpinning ideology of patient inferiority" was a primary driver of mistreatment, compounded by a complex relationship between "organizational issues, professional insecurities…[and the] perceived need to 'control' a woman's behavior" (Jewkes et al., 1998). Jewkes and Penn-Kekana (2015) draw a parallel between the typology of mistreatment during childbirth developed through a systematic review conducted by Bohren et al. (2015) and violence against women more broadly. They argue that violence against women in obstetric settings results from gender inequalities that place women in subordinate positions compared to men, thereby enabling the use of violence and promulgating disempowerment of women (Jewkes & Penn-Kekana, 2015).

Similarly, research evidence on attitudes towards intimate partner violence (IPV) suggests that IPV is often considered normal in the context of marital relationships, and is justifiable in different scenarios, such as if a woman refuses to have sex, or is perceived as neglecting children, committing infidelity or burning food (Hindin, 2003; Krishnan et al., 2012; Rani, Bonu, & Diop-Sidibe, 2004a; Uthman, Lawoko, & Moradi, 2009). Some research on mistreatment during childbirth suggests that providers and women may consider mistreatment to be justifiable, such as when women cry out or fail to comply with a provider's requests. Likewise, social norms around power dynamics and control influence both IPV and mistreatment during childbirth. As such, women in labor may be disempowered to speak out for their right to respectful care from healthcare providers, just as women are disempowered from standing up to abusive intimate partners. In low- and middle-income countries (LMICs), women often deliver at hospitals without birth companions who could advocate for their rights, and bear witness to occurrences of mistreatment. Furthermore, these facilities often lack accountability and redress mechanisms to address mistreatment that does occur. In these settings, healthcare providers may use their position (sometimes unintentionally or unknowingly) to exert power over and gain compliance from women, and women may have little choice but to submit to their demands.

1.2. Social norms and attitudes towards mistreatment during childbirth

Attitudes towards IPV are well documented in the literature (Hindin, 2003; Heise, Ellsberg, & Gottemoeller, 1999; Kim & Motsei, 2002; Koenig et al., 2003; National Population Commission (NPC) [Nigeria] & ICF International, 2014), and a set of questions has been incorporated into the Demographic and Health Survey (DHS) (Attitudes toward wife-beating). This work has demonstrated that where societies accept and tolerate violence against women, eradication is complex, as those perpetrating abuse may not recognize their actions as abusive (Rani, Bonu, & Diop-Sidibe, 2004b). Similarly, Freedman and Kruk argue that during childbirth, "practices that to the outside advocate or trained observer seem unambiguously disrespectful or abusive are often normalized" (Freedman & Kruk, 2014). Therefore, understanding how both women and providers perceive different acts that could be classified as mistreatment by an independent observer, researcher or advocate is a crucial step to be able to measure accurately and develop preventive measures (Vogel, Bohren, Tunçalp, Oladapo, & Gülmezoglu). However, limited research has been conducted globally on the influence of societal norms and attitudes towards the mistreatment of women during childbirth, and contextually-specific evidence is needed to understand how social and normative factors influence how women are treated during childbirth.

With growing recognition of the mistreatment of women during childbirth, there is a demonstrated need to better understand why it is occurring and to develop measurement tools to quantify the burden and contributing factors. As such, a two-phased, mixed-methods study is underway in Nigeria, Ghana, Guinea and Myanmar. In short, the first phase is a formative phase consisting of a multi-country primary qualitative study (Vogel et al., 2015). Findings from the formative phase will improve understanding of factors contributing to mistreatment during childbirth, identify potential entry points to reduce mistreatment, and inform the development of measurement tools to be used in the second phase.

This paper explores the acceptability of four scenarios of mistreatment during childbirth, as presented to women, midwives and doctors in north central Nigeria. Participants were presented with each scenario and asked if the scenario was acceptable, when (if ever) it would be acceptable, and how they would feel if it happened to them (or their wife or sister in case of a male provider). These four scenarios were developed based on a prioritization activity with the research team to

consider the types of mistreatment during childbirth women commonly experienced based on a systematic review (Bohren et al., 2015) and scenarios that would be clear to concise to explain to both women and providers. The first scenario was if it was acceptable for a health worker to slap or pinch a woman at any time during her labor or childbirth. The second scenario was if it was acceptable for a health worker to yell or shout at a woman at any time during her labor or childbirth. The third scenario was if it was acceptable for a health worker to refuse to help a woman at any time during her labor or childbirth. The fourth scenario was if it was acceptable for a health worker to physically restrain a woman during her labor or childbirth; for example, using ropes or linen to tie the woman to the delivery bed. Previous research has suggested that women were slapped, pinched or shouted at to encourage them to cooperate with the providers and open their legs to give birth (Bohren et al., 2015). Research conducted with women in South Africa (Stop Making Excuses, 2011), Tanzania (McMahon et al., 2014), and Ghana (D'Ambruoso et al., 2005) concluded that health workers both ignored and actively refused to help women during labor and childbirth. Furthermore, evidence from Tanzania (Mselle, Kohi, Mvungi, Evjen-Olsen, & Moland, 2011), Nigeria (Okafor et al., 2015), and Brazil (Teixeira & Pereira, 2006) suggests that some women are physically restrained during labor with bed restraints and mouth gags, in order to control a disobedient woman. The selection of these scenarios was also supported by findings from a measurement study conducted in southeastern Nigeria, where 7.2 percent of women reported being "beaten, pinched or slapped" during childbirth, 17.3 percent of women reported being "restrained or tied down during labor", 29.6 percent of women reported non-dignified care (blame, intimidation, threats, slanderous remarks, shouting at), and 9.2 percent of women reported "being left unattended during the second stage of labor" (Okafor et al., 2015).

1.3. Maternal health services in Nigeria

Human resources for health in Nigeria include doctors, nurses, midwives, public health nurses and community health workers (including community health officers, community health extension workers and health assistants). Healthcare providers working in public facilities are paid by the level of government responsible for their employment; for example, the state ministry of health is responsible for paying healthcare providers in state-level hospitals. Most doctors and nurses work in state- or tertiary-level facilities or in private practices, and few work in primary health facilities (Federal Ministry of Health, 2011). Better living and working conditions, including higher salaries, draw most providers to work in urban areas or private hospitals, and many healthcare providers have a secondary source of income as staff salaries are often irregularly paid (Oksakede & Ijimakinwa, 2014). For example, public-sector providers went on a nationwide strike from November 2014 to February 2015 due in part to the government's failure to honor collective bargaining agreements for improved wages and conditions of service, which left some healthcare providers without wages for over nine months (Oksakede & Ijimakinwa, 2014). These strikes paralyzed the health sector, leaving patients to seek care from private hospitals or through traditional medicine.

Poor use of maternal health services in Nigeria is a key factor contributing to high levels of maternal morbidity and mortality, as 2013 data suggests that only 51.1 percent of women completed four or more antenatal care visits and only 36 percent of births took place in a health facility (National Population Commission (NPC) [Nigeria] & ICF International, 2014). In addition to problems related to availability and accessibility, perceived poor quality of care at facilities is a critical barrier (Idris, Sambo, & Ibrahim; Bawa, Umar, & Onadeko, 2004; Esimai, Ojo, & Fasubaa, 2002; Osubor, Fatusi, & Chiwuzi, 2006; Uzochukwu, Onwujekwe, & Akpala, 2004), and poor health worker attitudes contribute to a woman's choice of using a facility or traditional provider (Esimai et al., 2002; Osubor et al., 2006; Uzochukwu et al., 2004). A study from northwestern Nigeria concluded that 23.7 percent of women who did not deliver in a health facility cited negative provider attitudes as the primary reason for not using delivery services, and 52.0 percent of women suggested that improvements in provider attitudes are necessary to increase demand for facility-based deliveries (Idris et al.). Another study in southern Nigeria showed that women viewed government facilities as providing poor quality maternity services and had poor availability of trained staff during childbirth (Osubor et al., 2006).

2. Methods

2.1. Study sites

This study was conducted in two communities in the Federal Capital Territory (one peri-urban/rural and one urban), in the north central region where approximately 45.7 percent of women gave birth in a facility in 2013 (National Population Commission (NPC) [Nigeria] & ICF International, 2014). In the north central region, the median age at first marriage is 19.1 years (among women aged 20–49 years) and the total fertility rate is 5.3 (National Population Commission (NPC) [Nigeria] & ICF International, 2014). Study facilities were chosen in collaboration with the local principal investigator using pre-specified inclusion criteria, including number of deliveries per month, number of staff currently employed, and an existing relationship between the research institution and the selected facilities. Characteristics of the study sites are shown in Table 1.

2.2. Study participants, recruitment and sampling

Three groups of participants were identified for this study: (1) women; (2) healthcare providers; and (3) facility administrators. FGDs were conducted with women of reproductive age (15–49 years) who gave birth in any facility in the past five years and resided in the selected facility catchment area. IDIs were conducted with women of reproductive age (15–49 years) who gave birth in a facility in the past twelve months and resided in the selected facility catchment area. Women were ineligible to participate if they did not reside in the facility catchment area or did not give birth at any health facility in the past twelve months (IDIs) or five years (FGDs). Both IDIs and FGDs were conducted

Table 1
Facility characteristics.
(*Note*: facility characteristics as reported by the head of each facility in personal communication, August 2014).

	Peri-urban facility	Urban facility
Staffing		
Obstetrician/gynecologist	3	4
Medical officer	8	10
Midwife	15	12
Capacity		
# beds on delivery ward	6	4
Health outcomes (2013)		
Total births (n)	3231	2417
Live births (n)	2961	2182
Stillbirths (n)	270	235
Maternal deaths (n)	94	73
Cost of childbirth services		
Vaginal delivery	$0 USD	$0 USD
Caesarean section	$215 USD (42,000 NGN)	$215 USD (42,000 NGN)

with women in order to gain a detailed understanding of experiences of mistreatment during childbirth (IDIs) and to better understand social norms related to mistreatment (FGDs). IDIs were conducted with health care providers (e.g.: nurses/midwives and doctors/specialists) and facility administrators (e.g.: medical director, head of obstetrics, matron-in-charge). Healthcare providers were ineligible to participate if they did not work on the maternity ward of the study facilities. Only IDIs were conducted with providers and administrators, due to concerns that FGDs may breach the confidentiality of study participants through the disclosure of poor practices or "naming and blaming".

An obstetrician and midwife from each selected facility who attended the study training workshop acted as an entry point to connect research assistants to healthcare providers. Community health workers helped to identify women who met the inclusion criteria and research assistants initiated face-to-face contact with women and providers who met the inclusion criteria. Each individual was invited to participate and provide consent.

Quota sampling was used to achieve a stratified purposive sample without random selection using specified parameters to stratify the sample, including setting, religion, age and cadre. Women were sampled from the urban and rural/peri-urban communities in the selected facility catchment area, and were recruited based on their age/parity/religion in order to explore the experiences of both younger/primiparous and older/multiparous women. Although further stratification did not take place across ethnicity or religion in the FGDs due to logistical difficulties of recruiting and hosting a FGD with multiple layers of stratification, interviewers sampled women across a mix of different ethnicities and religions. Healthcare providers were sampled from the study facilities based on their cadre, and across a mix of older/more experienced and younger/less experienced. Facility administrators were sampled from the study facilities.

2.3. Study instruments

All instruments were semi-structured discussion guides, fostering comparability across IDIs/FGDs and allowing participants to guide the discussion based on their experiences. Instruments were pilot tested during a training workshop for research assistants. The domains of interest were explored in the following sequence: (1) decision-making processes to deliver at a facility; (2) expectations of care during childbirth at health facilities; (3) experiences and perceptions of mistreatment during childbirth; (4) perceived factors influencing mistreatment of women during childbirth; (5) views of acceptability of mistreatment during childbirth; and (6) treatment of staff by colleagues and supervisors (healthcare providers only). To build rapport with the participants, research assistants began the IDIs and FGDs with more general questions about childbirth experiences, expectations of care and what constitutes supportive care during childbirth. Then, women were asked if they (or someone they know) experienced anything during their childbirth in a health facility that made them feel unhappy or uncomfortable, and probed regarding who was involved, when it happened, how it made them feel, and how common this type of treatment was. Similarly, healthcare providers were asked if they had ever seen or heard of women being poorly treated during childbirth, and probed regarding who was involved, when and why it happened, and how common this type of treatment is. Using this format, participants first identified what they perceived to be experiences of poor treatment during childbirth. Then, women, midwives and doctors were presented with four scenarios that could be classified as mistreatment during childbirth (Bohren et al., 2015) including (1) a provider slapping or pinching a woman during childbirth; (2) a provider shouting or yelling at a woman during childbirth; (3) a provider refusing to help the woman during childbirth; and (4) a provider physically restraining a woman during childbirth (e.g.: tying the woman to the bed with ropes or forcefully pinning her to the bed). Each scenario was presented to the participant and asked if it would be acceptable, under what circumstances it would be acceptable (if any) and how they would feel if it happened to them (or a wife or sister in case of a male provider). These four scenarios were selected based on types of mistreatment during childbirth women may experience, according to a systematic review (Bohren et al., 2015) and consideration of the limited evidence of the context of mistreatment during childbirth in Nigeria (Okafor et al., 2015). Based on these research findings, the research team conducted a prioritization exercise to develop scenarios that were understandable, clear and concise to explain to participants with different backgrounds (clinical and non-clinical), to ensure that responses would be comparable across women and provider participants.

2.4. Data collection and management

Research assistants were female Masters of Public Health graduates with training in qualitative research and maternal health. All research assistants were from Ibadan, Nigeria and underwent a two-day training and piloting workshop in Abuja prior to commencing data collection. Eligible individuals completed a written consent form prior to participation. All FGDs and IDIs took place in a private setting with no non-participants present (e.g.: home for women or private room in the facility for providers), were audio recorded, lasted 60 to 90 minutes and were conducted by research assistants. Participants received 2000 Naira (approximately $10 USD) to compensate for their transportation cost and a refreshment. Data were collected from March to June 2015, until thematic saturation was reached. Transcription, translation and recording of field notes occurred in parallel, and transcripts were shared and reviewed on an on-going basis to ensure data quality. IDIs and FGDs conducted in English were transcribed in English, and those conducted in a local language (Pidgin English, Hausa, Igbo or Yoruba) were translated and transcribed simultaneously by the research assistants. De-identified transcripts were stored on a password-protected computer.

2.5. Data analysis

This analysis employs a thematic analysis approach, as described by Braun and Clarke (2006). Thematic analysis is inherently a flexible method and is useful for identifying key themes, richly describing large bodies of qualitative data and highlighting similarities and differences in experiences (Braun & Clarke, 2006).

After transcription, line-by-line coding was performed on a subsample of transcripts by two independent researchers to develop an initial thematic framework. Codes are tags or labels used to assign meaning to a unit of qualitative data (words, phrases, sentences, paragraphs or question/answer sequences), and are a critical component of the qualitative analysis process to organize, retrieve, assemble, reduce and determine patterns in the data. These codes emerged inductively from the data and were initially structured as ideas and notes emerging from the data, with no established link between them or to other transcripts. These codes were synthesized with questions from the discussion guide and systematic review findings (Bohren et al., 2015) into a coding scheme transferable to other transcripts. The coding synthesis yielded a hierarchical codebook to explore higher-level concepts and themes and organize the codes into meaningful code families (see Appendix 1 for the codebook). Reliability testing of the codebook was conducted in two stages: (1) two researchers jointly coded three transcripts, one from each type of participant; and (2) two researchers independently coded two transcripts and discussed coding decisions until consensus. After reliability testing, the final codebook was developed, which

includes the structure of code families, code names, definitions, and an example of proper use (see Appendix Table 1a). All transcripts were subsequently coded using Atlas.ti (Scientific Sofware Development, 1999). Memos were used to collate emerging thoughts, highlight areas of importance and develop ideas throughout the analysis process. A subset of the coded transcripts was reviewed by an independent researcher to check reliability of the coding.

Transcripts were organized according to meaningful "primary document families" in Atlas.ti (Scientific Sofware Development, 1999), a method of organizing groups of transcripts based on common attributes, and used to restrict code-based searches or to filter coding outputs (Muhr, 1994). Primary document families consisted of: (1) type of participant; (2) facility/catchment area; and (3) religion. Output and reports were generated for specific codes using Atlas.ti (Scientific Sofware Development, 1999) and filtered by primary document family where appropriate. Data from these reports and output were further synthesized into meaningful sub-themes, narrative text and illustrative quotations to draw connections between recurrent patterns and themes. These themes were interpreted within the context of the study and the typology of mistreatment during childbirth developed from the systematic review (Bohren et al., 2015). Data on social norms and acceptability of the presented scenarios of mistreatment were rich and provide an important frame to understand how and why mistreatment during childbirth persists in this context. A four-day data analysis workshop was also held with the research assistants, Nigerian investigators and WHO study team to interpret the findings in the Nigerian context.

Throughout the iterative analysis process, the research team considered questions of reflexivity, including identifying and reflecting on assumptions and preconceptions regarding what specific acts constitute mistreatment, and considering research relationships. For example, this includes the relationship between the participant and the researcher, as well as between the researcher and the research topic, and how relationship dynamics may influence responses and interpretation.

2.6. Technical and ethical approvals

Scientific and technical approval was obtained from the World Health Organization Human Reproduction Programme (HRP) Review Panel on Research Projects (RP2), and ethical approval was obtained from the World Health Organization Ethical Review Committee (protocol ID, A65880) and the Federal Capital Territory Health Research Ethics Committee in Nigeria (protocol ID, FHREC/2014/01/72/28-11-14).

This paper is reported according to the consolidated criteria for reporting qualitative research (COREQ) guidance (Tong, Sainsbury, & Craig, 2007).

3. Results

3.1. Overview

A total of 84 IDIs and 4 FGDs are included in this analysis. Table 2 reports sociodemographic characteristics of participants: women of reproductive age, and Table 3 reports sociodemographic characteristics of participants: healthcare providers and administrators. Three eligible participants declined to participate: one administrator refused to give an audio-recorded interview, one woman did not have sufficient time to be interviewed, and one woman needed her husband's permission but he was unavailable.

This analysis focuses on women's, midwives' and doctors' perceptions of the acceptability of mistreatment during childbirth. Participants were presented with four scenarios of mistreatment during childbirth: (1) pinching or slapping a woman; (2) shouting at a woman; (3) refusing to help a woman; and (4) physically restraining a woman, then were asked whether the scenario was acceptable, under what conditions (if any) the scenario would be acceptable, and how they would feel if it happened to them or their partners.

In this study, all seventeen midwives were female, and of seventeen doctors, five were female and twelve were male. In general, midwives found more of the presented scenarios of mistreatment to be acceptable practices, compared to the doctors. This was particularly true for the scenarios of slapping, pinching and shouting at a woman in labor, where several midwives viewed such behavior as a necessary practice to have a safe outcome for the baby. Both female and male doctors admitted that they had witnessed slapping, pinching and shouting at a woman on their wards, but that these tactics were unethical and primarily used by midwives.

Table 2
Sociodemographic characteristics of participants: women of reproductive age.

	IDIs (n=41)	FGDs (n=4 FGDs*)
Age (years)		
20–24	2	7
25–29	12	11
30–34	14	9
35–39	9	5
40+	4	2
Marital status		
Single	0	0
Married	40	33
Divorced/Widowed	1	1
Location		
Urban	6	0
Peri-urban	21	34
Rural	14	0
Religion		
Christian	21	26
Muslim	20	8
Ethnicity		
Yoruba	13	9
Igbo	6	6
Hausa	2	1
Idoma	1	1
Igala	4	7
Tiv	2	0
Urhobo	0	4
Other**/missing	13	6
Education		
None	1	4
Primary	1	1
Secondary	18	21
Tertiary	21	11
Employment		
Business/private sector	5	3
Civil servant	3	2
Hair dresser	2	5
Housewife	10	8
Tailor	5	0
Teacher	4	5
Trader	7	11
Other	5	0
Number of living children		
0–1	9	8
2–3	17	20
4–5	13	4
6+	2	2

* Three FGDs conducted with 8 women, one FGD conducted with 10 women.
** "Other" includes Akwa-ibom, Angas, Ebira, Igede, Katarf, Ogori, Zuru, Akoko Edo, Bekwarra, Edo, Isoko, Ogoja.

Table 3
Sociodemographic characteristics of participants: healthcare providers and administrators.

	Nurse/midwives n=17	Doctors n=17	Administrators n=9
Age (years)			
30–39	7	5	0
40–49	5	10	3
50+	5	2	6
Marital status			
Single	0	0	0
Married	15	17	8
Widowed	2	0	1
Gender			
Female	17	5	7
Male	0	12	2
Years of experience			
0–4	0	2	0
5–9	2	3	0
10–15	4	6	0
15+	11	6	9
Hospital			
Urban facility	8	9	5
Peri-urban facility	9	8	4

3.2. Scenario 1: acceptability of a provider pinching or slapping a woman

This scenario refers to a healthcare provider slapping the woman during labor or childbirth, for example slapping her thighs to encourage her to open her legs. Both women and healthcare providers agreed that if a woman was slapped "out of malice" or with ill intent, it would never be acceptable. However, opinions were more nuanced if a woman was slapped "to ensure a positive health outcome" for the baby or to help the woman to focus on pushing during the second stage of labor. Conditions where some felt that slapping could be acceptable included "when it was necessary" as a "punishment" for not cooperating, to ensure a good outcome for the baby or when all other means of supporting the woman were exhausted. Slaps were acceptable to signal the woman to become more alert and give her the strength to push.

> *By slapping their laps, the patient will know that truly you care for her. After the delivery, you would tell the woman the reason that you did it for her, even some women will tell you, I'm sorry, thank you.* [IDI female nurse, 39 years old, peri-urban facility]

Furthermore, timing mattered: slapping a woman during the first stage of labor was considered poor practice, but slapping a woman during the second stage of labor, when she is about to deliver, was considered acceptable.

> *R: It depends on the motive, because most, because most of the motive, I told you, okay, is just to encourage her, we are not being wicked, alright, at the end of it, we all smile, she's happy and we'll forget about it, although we would just discuss it jokingly, yes understand. Arhhhh, I slap you, if to say I no slap you, you for no born this pikin,* [if I did not slap you, you would have not given birth to your baby]*…you understand…we are not being wicked, we are just trying to, it's out of passion, no, please we want this thing to be successful, why is this woman delaying, we are not just being, we are not being wicked, it's not in our nature.*
> *I: Okay, so bringing it to a more personal level, how would you feel if this happened to maybe your sister and she told you, or your wife?*
> *R: …I will like to ask at what stage* [of labor], *because if you do that in the first stage, it will be weird, but at the point of, at the second stage, about to deliver, yes, it's acceptable, why? Just to encourage, you understand…it depends on at what point during labor, was this act committed, you understand* [IDI male doctor, 44 years old, urban facility]

Those who felt that slapping was not acceptable under any conditions felt that women suffered enough from the pain of labor and slapping only contributed to that pain. Slapping was "unethical", served no purpose, and women should be treated with respect since they are the customers.

> *I: Is there any situation where this would be acceptable?*
> *P: It is completely wrong for a woman to be pinched or slapped or harassed while in labor, because we all know labor is a painful thing* [IDI male doctor, 42 years old, urban facility].
> *I won't accept it, why would you slap a woman in labor or pinched her, why? You know…it should go with reason, if you are slapping me you should tell me why you are slapping me, okay? I've never been slapped, neither have I been pinched, you don't need slap to do that or pinch me to do it, no. You need to encourage them, give them what will encourage them. Most times they will tell you they're tired but you have to because it is equally your own success that you are helping somebody to bring in a child into the world…at the end of the day you're happy…but if a child dies in your hand you always sad, you don't want it, or if anything goes wrong with the mother; you don't like it, you don't want such things to happen but it's equally the health workers success, so why would you slap a woman in labor or pinch her* [IDI woman, 44 years old, peri-urban].

Generally, women felt that it was acceptable to slap other women who were uncooperative, but it was unacceptable if it happened to them personally. They believed that they would feel "pained" both physically and emotionally if it happened to them.

> *There is some women when they are pushing, when they are pushing the head of the baby will come and they will closing their leg so you have to slap her very well. When you slap her, she will open the leg the baby will come out.* [IDI woman, 30 years old, peri-urban].

3.3. Scenario 2: acceptability of a provider shouting at a woman

This scenario refers to providers shouting at women during labor or childbirth, for example to berate them for disobedience or encourage them to push. Similar to slapping, many women and healthcare providers felt that shouting at a woman out of malice or anger was unacceptable. However, some women and healthcare providers agreed that shouting was acceptable if women were disobedient or arrived without a "mama kit" (safe delivery supplies including a plastic sheet, gauze, gloves, soap, razor blades, and cotton). They described that shouting can be helpful if it communicates the gravity of the situation and ensures a positive outcome. Using a raised voice to communicate the providers' commands was acceptable, provided that the woman was not insulted through name-calling or criticism. Most providers felt that shouting was a "spontaneous" or "impulsive" reaction to working in a stressful environment, but also that shouting is "a normal thing" and a woman needs to "carry her cross".

> *I: So, what if a woman was yelled at or shouted at by a health worker during her childbirth? Will this be acceptable?*
> *R: Well, it could be partially acceptable…When the woman is not cooperative. You are given instruction, she is not even listening, she is just shouting. She is just screaming, rolling in pain, you understand ahaa…. Then, you can actually yell out instruction because if you talk in your normal voice, she will not hear. You will be drowned in the scream. You understand. So, you can yell. The*

yelling could be a good aspect actually [IDI female doctor, 36 years old, urban facility]

I: So even if a woman is shouted at or yelled at by the health worker during labor, you won't find that also acceptable?

R: Why not, you will find it acceptable because you don't have any option than to give birth and get out of there [IDI woman, 28 years old, peri-urban facility]

Some women felt that if they were shouted at, then the healthcare provider was doing their job and served as a reminder that the woman should also do her job and cooperate.

Women felt that shouting was more appropriate than slapping; however, shouting can scare, disempower and disrespect the woman. Healthcare providers felt that shouting was not part of their professional ethics or etiquette and they should take the time to communicate with women more clearly. They also felt that when healthcare providers shout, it is a "failure of the system" because they are transferring their stress from a challenging work environment to the woman.

R: Is not acceptable, because it will affect, it will hamper, you know it will discourage the woman, the woman might not be able to respond to the, you know, instruction given to her. She will not be happy.

I: Okay, okay. Is there any situation where it will be acceptable for a health worker to shout on a woman or to yell at her during delivery?

R: There should not be, there shouldn't be. The health workers are supposed to be like pastors, you know, you know they are supposed to be very courteous, they are suppose be calm, they are supposed to be receptive, and you know very nice to their patients. Because that goes a long way in making them achieve a good result in whatever they are doing [IDI woman, 34 years old, urban].

Like me I will tell the madam, I will call her name, when you call her name she will listen to you. Madam see we know this thing is painful but try to endure, that is the way I do it. If you shout, you're confusing her more…No you don't yell. What you do is, like now if I call your name, you no matter how what how painful, you will relax so that when I talk to you, you will hear. So what you do is don't yell, you call the person like I can call you now, the person will listen to you. By the time you, even if they shout by the time you call the person; even by the time you call two three times, the person would relax then you say; look madam this way now,…just tell the patient to relax they will listen to you, the whole thing will be over. [IDI male doctor, 52 years old, peri-urban facility].

Is okay to shout, if you shout at a person the person will understand, at least the doctor will tell the person or nurse will tell the person to, concentrate so that your baby will come out, not to beat the person. To shout is better than to beat [FGD woman, 30 years old, peri-urban].

Many women felt unhappy at the prospect of being shouted at and desired a feedback mechanism to share their dissatisfaction.

3.4. Scenario 3: acceptability of a provider refusing to help a woman

This scenario refers to a provider refusing to help a woman during labor or childbirth, for example when she asks for support or has a question. Women believed that a healthcare provider refusing to help was an egregious shortcoming, but argued that it does happen in both study facilities and is an explanation for why some women deliver alone in the facility, without a healthcare provider present. Women felt that if this happened to them, they would not attend that facility again and would seek redress from the provider.

It is not acceptable at all, at all. You can be sued for it. You are there as a health worker, you must, is not optional. Is a must, you must support the woman in all the ways, in all ramifications. Whatever the woman needs at that point, at that moment, you must do it. You must be there to support her. Leaving a woman that is in labor to even eat is a crime, you understand? No matter how hungry you are, you must not leave a woman that is in labor, you must be there for her, you must. So it is not acceptable at all that you didn't support a woman that is in labor [IDI woman, 36 years old, peri-urban].

Most healthcare providers from both study facilities did not feel that other providers ever refused to help a woman. They felt that if a provider refused to help, then they should not be called a health worker, as it is their occupation and responsibility to assist. Healthcare providers pondered if women might feel that they were refused help if they were referred to another facility during a period of overcrowding and suggested that improved communication could help to allay this perception.

There is no situation that should arise that a health worker would refuse. Because he knows this is human being, you are dealing with lives not paper. If it is a paper, you can neglect the paper for years it will be there, you'll meet it there, but a life is not like that because any little mistake can lead to another problem, so you don't neglect any patient, we know our count. Have told you experience of where a patient slap a nurse in the process of assisting her during delivery yet we still carry on the delivery we didn't neglect the patient; on no account should we neglect a patient [IDI female nurse, 39 years old, peri-urban facility].

3.5. Scenario 4: acceptability of physically restraining a woman

This scenario refers to physically restraining the woman to the bed during labor or childbirth, for example by tying her to the bed using ropes or linen, or forcefully pinning her to the bed. Most healthcare providers believed that the only conditions under which it was appropriate to physically hold a woman down was if she was having an eclamptic seizure or if she was being uncooperative. In either situation, providers believed that it was their responsibility to clearly explain to the woman and her family why they are holding her down.

It depends on what the person want, what they are experiencing. There…are some women because of pain, they want to jump out of the couch, and some jump out and (laughs) start land on the floor. But if they can restraint, the restraining a patient is acceptable. What we call control restraint of the patient is acceptable. That is when somebody want to jump down. Women that during labour, they'll be struggling that they may even fall down from there and injure themselves hit the, the abdomen on the floor and you know what the danger that can portray, can even result in death of the baby and even rupture of the uterus and the like. So there is there is there is some restraints acceptable. And while they are been restrained, you can now call the attention of co-workers to find out if this woman can continue this labour or not, if she cannot continue, we have to book her for caesarian section straight. That's the practice here. We have to restrain, call the doctor to come and assess, that this person is not cooperating, is is jumping from bed to bed, is better to take her straight and get the baby out [IDI male doctor, 54 years old, urban facility].

Furthermore, both a doctor and a woman agreed that if physically restraining a woman yielded a positive birth outcome, then it was an acceptable practice.

There's nothing wrong there, there's nothing wrong if she's held down and at the end we get the result, a good outcome [IDI male

doctor, 52 years old, peri-urban facility].

If there is a situation, if is to save your life and that of the baby, why not? [IDI woman, 31 years old, urban].

Several women did not understand why healthcare providers would ever physical restrain women in labor, and were in disbelief that this could happen: "Will somebody just come and hold somebody down just like that?" [IDI woman, 35 years old, urban]. Other women interpreted this to mean restraining a disobedient woman. Most of these women believed that physical restraint was unnecessary under any conditions, as it restricted the woman's movement and freedom and demonstrated a lack of empathy from the healthcare providers. Rather than restraining a woman, a provider should communicate, encourage and support a woman to bear down.

Okay hold her down; hold her down to press her down. I don't think it's right, you can tell me to go down, you can talk to me really but not holding you down, pinning you down as if you must, you must do what I say per time, I don't see it as right, but at least you can talk to the person and say you are not doing this right, do this right, do it this way you are not behaving well, it's not right but when you are trying to hold down it's as if you are forcefully telling the person and of course you know we are different set of individuals some might react negatively to it [IDI woman, 28 years old, urban].

The health, the person [healthcare provider] *don't suppose to hold me down when while I'm in labor. You allow me to push by myself. I mean she will be controlling me. Then she's not supposed to hold me down* [IDI woman, 26 years old, rural].

A minority of women believed that a healthcare provider would not do anything harmful to a woman, so physical restraint must have a positive effect.

4. Discussion

This study explored the acceptability of mistreatment during childbirth, according to women, midwives and doctors in the North Central zone of Nigeria, and provides the first known analysis of social norms regarding the acceptability of mistreatment during childbirth. In this area, women and providers reported witnessing and experiencing mistreatment during childbirth, including physical abuse such as slapping and being tied to a delivery bed, and verbal abuse, such as shouting at, intimidating, and threatening women with physical abuse or poor health outcomes. Women, midwives and doctors were presented with four scenarios that could be classified as mistreatment during childbirth (Bohren et al., 2015) and each of these scenarios were considered an appropriate measure to gain compliance and ensure a good outcome for the baby by some of the participants. Both female and male doctors acknowledged that mistreatment occurs on their wards, but that these tactics were primarily used by midwives to gain compliance, and midwives were comparably more accepting of these mistreatment scenarios compared to doctors. Overall, this analysis suggests that mistreatment is perpetrated by all cadres of health providers who care for women during childbirth. However, it is possible that in order to be viewed more favorably by the interviewers, doctors responded to these scenarios in a manner that transferred blame to a lower and more disempowered cadre of providers (social desirability bias).

It is of great concern that both women and healthcare providers commonly blamed a woman's "disobedience" and "uncooperativeness" during labor and delivery for her experience of mistreatment. When a woman is in labor, healthcare providers should support her to make decisions for her body; she should not be mistreated by her healthcare providers. Such situations parallel the IPV literature, which has demonstrated how structural gender inequality "is perpetuated by traditional and customary practices that accord women lower status in the family, workplace, community and society, and it is exacerbated by social pressures" (United Nations, 2010). Such social pressures include the shame and difficulty in denouncing abusive acts towards women, a lack of means to address causes and consequences of violence and a scarcity of laws prohibiting violence (United Nations, 2010; World Bank Group, 2014). Responses to questions regarding acceptability of IPV under certain conditions parallel the acceptability questions asked in this study: women continue to accept physical violence and disempowerment (National Population Commission (NPC) [Nigeria] & ICF International, 2014; United Nations, 2010). For example, the 2013 Nigerian DHS reports that in the North Central Zone of Nigeria, 39.0 percent of women justified wife-beating for at least one reason (National Population Commission (NPC) [Nigeria] & ICF International, 2014). This included for burning the food (20.0 percent), arguing with her husband (26.3 percent), going out without telling her husband (31.8 percent), neglecting the children (31.3 percent) or refusing sexual intercourse with her husband (21.5 percent) (National Population Commission (NPC) [Nigeria] & ICF International, 2014). There are clear similarities between justifications for some acts of mistreatment during childbirth (e.g.: physical and verbal abuse) and justifications for IPV. Both mistreatment during childbirth and IPV are influenced by social norms and pressures, such as punishing women for being disobedient or difficult, and understanding violence against women in the Nigerian context can help to frame the findings of this study.

The systematic devaluation of women is further perpetuated through hegemonic power relations on the maternity ward, leading to the normalization and acceptance of healthcare providers using abusive tactics to gain control and punish disobedience (Jewkes & Penn-Kekana, 2015). Although midwives are the backbone of maternity services in LMICs, they often work in disempowering environments where their contributions may not be adequately recognized, and they may be disrespected and unsupported by their supervisors (Brodie, 2013). Midwives are predominantly women and frequently work in their own communities, facing the same challenges that other women face: low social status, disrespect and gender inequality. Furthermore the health system, particularly in public facilities, can be a disabling environment plagued by chronic low salaries, physical resource constraints, and understaffing. Working in such conditions is clearly disempowering for healthcare providers, and there are limited avenues to alleviate stress and foster motivation. However, such disabling work environments can provide only a partial explanation for mistreating a woman during childbirth, not a justification for such abuse. In Nigeria and other low-resource settings, no redress mechanisms exist to voice complaints over such treatment, and women are often not allowed a labor companion who could act as the woman's advocate and provide her with emotional support.

4.1. Challenges with defining mistreatment during childbirth

The way in which mistreatment during childbirth is defined has a substantial impact on how it is measured and on resulting prevalence estimates, and understanding the acceptability and normalization of behaviors that could be considered mistreatment is an important step. There are two main viewpoints to consider when developing definitions of a phenomenon of interest in the social sciences: emic and etic approaches (Ellsberg & Heise, 2005; Harris, 1976). In the case of mistreatment during childbirth, an emic approach would rely exclusively on a woman's and/or a provider's own definition of mistreatment (e.g.: behaviors determined to be mistreatment by local custom, meaning and belief), whereas an etic approach would rely on an externally derived definition of mistreatment (e.g.: generalizations about human behavior universally considered as true) (Harris, 1976). An emic approach may be helpful if researchers want to understand contextually-specific perceptions of violence, but may be less useful when planning

interventions or conducting cross-cultural comparisons. For example, asking a woman "have you ever been mistreated during childbirth" is likely to underestimate the true occurrence of mistreatment as women may experience poor treatment but not identify this behavior as such, or because poor treatment is normative in their setting. On the other hand, an etic approach may be helpful if researchers want to make cross-cultural comparisons, but may be less useful in understanding what meaning specific acts have on a woman. For example, asking women whether they have experienced a series of specific acts of mistreatment (punching with a closed fist, slapping with an open hand) would provide a response comparable across settings. However, an etic approach would not help a researcher to understand whether these acts have the same meaning to different women or in different cultures (e.g.: calling a woman in labor an "animal" may be more degrading than a slap on the thighs in some cultures).

In this study, we used a combined approach. During the IDIs and FGDs, the research team first asked women to broadly describe their previous birth experience, then if they had experienced anything that made them feel unhappy or uncomfortable during their previous childbirth, and if so, who perpetrated the event, how often it occurred, why they thought it happened and how this made them feel. Similarly, midwives and doctors were asked if they had ever heard of or seen women being poorly treated during childbirth. Participants were therefore able to answer freely and to describe any behaviors or experiences that they considered to be mistreatment. After these broad questions, participants were asked more focused open-ended questions about social norms and acceptability of specific behaviors that were classified as mistreatment in a systematic review (Bohren et al., 2015). This combined approach allowed us to analyze and describe evidence that can be compared to other settings, as well as to understand participants' perceptions of mistreatment in their context.

4.2. Limitations and future research

This study was conducted in two facilities and facility-catchment areas in the Abuja metropolitan area, and may not reflect the experiences of women and healthcare providers across Nigeria. For example, the women included in this study reside in communities in close proximity to the capital city, and therefore may not be representative of all women in Nigeria, such as those living in more rural areas. Similarly, the healthcare providers working in the study facilities may have access to different resources than healthcare providers working in other settings, such as primary health units. However, healthcare providers working in Abuja come from all regions of Nigeria, and their perceptions and experiences of mistreatment during childbirth are shaped throughout their training and careers. Mistreatment and provision of poor quality care are difficult topics to discuss with providers; consequently providers may have underreported the acceptability of such experiences (social desirability bias). This may be particularly true where doctors believed that most mistreatment occurred at the hands of midwives rather than doctors. However, both women and providers in this study were accepting of scenarios that can be classified as mistreatment (Bohren et al., 2015). This study explored acceptability and norms of mistreatment during childbirth using a qualitative approach. As a result, relationships between accepting mistreatment according to gender or cadre of healthcare provider should be viewed as hypothesis-generating.

Future research could explore the acceptability of mistreatment through a quantitative survey of both women and providers, similar to the DHS module focused on attitudes towards wife beating. Such research, particularly if conducted anonymously and without a human interviewer (e.g.: using audio computer assisted self-interview (ACASI)), could help further explore normative behaviors and prevalence of perpetration. Furthermore, future research on measuring mistreatment during childbirth should follow lessons learned from research on violence against women, including asking about specific behaviors of mistreatment (Ellsberg & Heise, 2005). Conducting a mixed-methods study with a qualitative component may be helpful to elucidate women's and providers' perceptions of mistreatment in a culturally appropriate manner. Moving forward into the Sustainable Development Goals (SDG) era, developing tools to measure mistreatment during childbirth can provide the evidence base to measure progress towards several SDG targets, including target 5.1 to "end all forms of discrimination against all women and girls everywhere", target 5.2 to "eliminate all forms of violence against all women and girls," and target 5.3 to "eliminate all harmful practices" (United Nations, 2015).

4.3. Conclusions

Findings from this qualitative study can be used to help facilitate this dialogue in Nigeria by engaging key stakeholders to discuss what can be done to challenge these norms and hold providers accountable for their actions. Jewkes hypothesizes that the construct of the "nursing identity" emphasizes moral superiority and control over the "inferior patient" and lacks a commitment to ethics that precludes mistreating a woman (Jewkes et al., 1998). Until women and their families are able to freely condemn poor quality care in health facilities and healthcare providers are held accountable for their actions, there will be little incentive to foster change. Understanding how and why exerting control over a woman in labor by slapping and shouting at her are acceptable actions requires deeper inquiry into normative attitudes and behaviors on the maternity ward.

Competing interests

We declare that we have no competing interests.

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Author contributions

MAB, JPV, ÖT OTO and AMG designed the study with input from BF, MT and AOO. MAB, BF, MT, AOO, LM, MO, ORO and AAO conducted data collection and management. MAB and MJH led the analysis with input from all authors. All authors read, commented on, and approved the final manuscript.

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Appendix 1. Qualitative codebook

See Table A1 here.

Table A1
Final qualitative codebook outlining the structure of code families, code names, definitions, and an example of proper use.

#	Code	Definition	Example of proper use
A.0	**Childbirth narrative**		
A.01	Childbirth narrative	Miscellaneous code regarding the childbirth experience that doesn't fit the codes below.	*R: Ahh I was in the house when I was in labour. And so when I was in labour my grandmother had wanted me to deliver in the house but my tommy by then was still up it couldn't descend. So I was taken to someone that delivers women in the house to observe my pregnancy. And then the woman said I can deliver but it hadn't descended yet. And then my grandmother said once it hadn't descended she is scared and so I should be taken to the hospital. And so the woman escorted me to the hospital. And so when she took me to the hospital I was admit3ted. And so when they admitted me one nurse came and attended to me. And so when she attended to me she told me that my tommy was still up and so by the time I would push the baby out I can pass away and so I should be patient so that they would go and perform operation on me. And then I said okay if that is what she is saying then I have heard but I said that not wholehearted. And then she went and consulted my grandmother and then she agreed to it. And so a different nurse came when I was there. And so when she came she said "that long time that you were brought you haven't delivered yet"? And then I said Maame nurse please one nurse came and attended to me and said that I will be operated. And then she said no I should not agree to any operation and that I should try and deliver by my self and then I said okay. And so I was there when she brought something and inserted it into my buttocks and then she examined it and said push. Then I said "Maame nurse I can't push". Then she slapped my thigh and said "I say push". Then she said "I say push". So anytime she would say push she would slap my thighs. It was there that the other nurse came and said ahh why are you worrying the girl like that? Look at her tommy. Can't you see that the baby has not descended? And they said that my baby was coming out with his buttocks. And so she insulted the other nurse and they carried me to the theatre for the operation.*
A.02	Decision-making for care seeking	Who is involved in the decision to seek care and what is their role? What other factors influence the decision to seek care?	*R: Please it was my auntie, my grandmother and my father.* *I: What did they do in this decision making process?* *R: Please my grandmother said that she has ever delivered in the house before and so she knows how both delivering at home and at the hospital are. When one delivers in the house it is possible that she would be affected by pains such that its effect would be experienced during another delivery of the woman. She said that she doesn't like home delivery and so I should go to the hospital.*
A.03	Preference for delivery location	Any mention of preference for where delivery would occur (e.g.: home vs hospital, one facility vs another facility), or reasons why women deliver at health facilities	*I: okay, thank you ma. So ma, in your opinion why do women seek care at the during child birth, in your own opinion why do you think women come to hospitals to seek for care during child birth?* *R: My own opinion why I feel they seek for care because they felt eh. the hospital, those that are in the hospital are trained personnels that have knowledge of eh. Pregnancy and how to manage it to a successful end.*
A.04	Mode of delivery	Any mention of the preference for mode of delivery, or reason given for why they had that mode of delivery. Includes reactions, feelings to the decision.	*I: You have indicated that you were operated. Was this what you had wanted?* *R: No.* *I: What did you want?* *R: I wanted to deliver on my own.* *I: Why did you want to deliver by yourself?* *R: Please people say that operation is not good. It is a great worry to the woman that is operated because she will not be able to do the work that she wants. She will not be able to lift heavy objects and so on.*
A.05	Baby health status	If the baby cried or breathed when it was first born	*I: so when you had the baby, was the baby crying immediately when you had your baby* *R: Yes immediately she came out, she cried*
A.06	Labor length	Duration of labor, including how long she was in labor for at home and in the facility	*I: How many hours were you in labour in the house before you went to the hospital?* *R: Oh the labour started on Sunday evening but I didn't know that it was labour and I didn't tell my grandmother too. And so at dawn around 3 o'clock was when I felt the pain till…and so the woman that came and took care of me was saying oh you will deliver, you will deliver! And so it was around 6:30am before we were able to go to the government hospital.* *I: And so from morning till what time did you start feeling the pains?* *R: In the morning around 4am.* *I: Up to 6:30 in the evening?* *R: Yes* *I: How many hours were you in labour at the hospital before you were sent to the theatre for the operation?* *R: I was operated around 1 o'clock.* *I: Was it 1 o'clock in the morning or in evening the following day?* *R: It was 1 o'clock in the afternoon.* *I: So how many hours will that be? If you were there at 6:30am and left for the operation at 1 o'clock then it implies that it was 19 hours?* *R: Yes*
A.07	Length of hospital stay	Duration of hospital stay during/after childbirth	*I: How long did you stay in the hospital after delivery?* *R: Six days.* *I: Why did you stay that long?* *R: I was told after the operation that there was sore there so they were dressing it for me. And so it was when it was getting healed that we were given some of the medicine to go. And also they said that if care is not taken and I go home they would give me heavy meals and so they wanted me to wait for a while and be given lighter meals there so that I will not be affected when I go and eat heavy meals at home.*
A.08	Birth position	Position of delivery, including preferred	*I: okay. But do women what to deliver in a different position when you tell them okay lie.*

Table A1 (*continued*)

#	Code	Definition	Example of proper use
		delivery position, actual delivery location, etc (e.g.: squatting, lying down)	*R: well, some of them when they are in pain they will prefer to turn anyhow, but we keep encouraging them. Yes, because that position makes it better.* *I: so women are not allowed to deliver in a position of their choice? Or are they allowed to?* *R: sometimes they squat, that position too is good we allow them.* *I: okay, so you allow squatting (R: yes), if a woman says she prefers to squat?* *R: yes, we do. we do, we do*
B.0	**Hospital setting and policy**		
B.01	Labor room	All encompassing code used as a double code when the labor room (e.g.: first stage room, or where a woman is before she starts to push) is being discussed/described. Should *be used in conjunction with the B.04-B.10(*)* below	*I: thank you. Can you please give me a description of what this lying in ward looks like?* *R: hmm…it's a ward that compose, we have two rooms there, and compose of three bed each and eh… the one by the passage is just because we are in short of space (I: okay) and em…three bed…two beds there, so comprise of eight beds all in all (I:okay) and three rooms,* *I: okay, only beds that are there nothing else?* *R: we have.no, we have beds, tables, we have cupboards where they will put their neatly, (I: okay), yeah, we have ACs too incase the weather is too hot for them and they are not comfortable they can put it on, they have fan too (I: okay) yeah,*
B.02	Delivery room	All encompassing code used as a double code when the delivery room (e.g.: second stage room, or where a woman is when she delivers) is being discussed/described. Should *be used in conjunction with the B.04–B.10(*)* below	*R: when they're in the late first stage we take them to the labour room they stay there, in their second stage they're also in the labour room (I: okay), yes for delivery in the couch.* *I: ok ma, so you said they…you take them to the labour room (R: hmm labour room) okay.* *R: they'll be on the couch there (I: okay), yes, and they'll be lying in one position either the right or left depending on which one. (I: okay), yes to enable their baby breath well.* *I: thank you. Can you describe what this labour room looks like?* *R: well the labour room as a couch, that is adjustable, either lift it up or down, we have eh… cubicles or cupboards that is meant for them to keep their delivery items, we have eh… monitor, feotal monitor that mea…that monitors the babys' heart rate and we have thermometer, ehh. BP aparatus, we have temperature ehn! thermometer! then the Sphgs then the emm… feotoscope cone in case the machine is not functioning well, we use the fetoscope to check.*
B.03	Unclear if labor or delivery room	All encompassing code used as a double code when it is unclear whether the labor/ first stage or delivery/second stage room is being discussed/ described. Should *be used in conjunction with the B.04–B.10(*)* below	*n/a*
B.04	*Layout/structure	Description of the physical layout, setting, infrastructure, etc of the labor or delivery room.	*I: thank you. Can you please give me a description of what this lying in ward looks like?* *R: hmm…it's a ward that compose, we have two rooms there, and compose of three bed each and eh… the one by the passage is just because we are in short of space (I: okay) and em…three bed…two beds there, so comprise of eight beds all in all (I:okay) and three rooms,* *I: okay, only beds that are there nothing else?* *R: we have…no, we have beds, tables, we have cupboards where they will put their neatly, (I: okay), yeah, we have ACs too incase the weather is too hot for them and they are not comfortable they can put it on, they have fan too (I: okay) yeah,*
B.05	*Mobility	Reference to a woman moving or walking during labor. *Must be double coded with either B.01, B.02 or B.03*	*R: well if she's in the first stage of labour she stays in the eh… lying in ward. She stays there, once in a while if she wants to stroll, if she's fit on her own she goes but we don't ask them, it depends on how they want to do it.*
B.06	*Fluids/food	Reference to a woman eating or drinking during labor. *Must be double coded with either B.01, B.02 or B.03*	*I: okay, when women are in this lying in ward room do they things like eating, or taking fluid. You mentioned they take a stroll if they want to (R: if they want to), what other things do they do also aside from that?* *R: okay they eat, they drink since they're in the latent phase, they eat and drink.* *I: okay* *R: food of their interest, there's no restriction concerning what to eat.*
B.07	*Presence of or preference for birth attendant/ companion	Any mention of birth companion or birth attendant, or mention of being alone during labor/delivery. *Must be double coded with either B.01, B.02 or B.03*	*I: so besides the health workers, you said something like if it's only one patient you allow the husbands to come in, that means that you don't allow non medical persons to come in during…(R: if other women) a woman's labour.* *R: if other women are there, we are not going to allow because of privacy (I: okay), they need… others too need privacy (I: okay), yes, so if we allow relations to be there, the're different people. We have two patients and two different relations are there, they'll be seeing the other patient which is not good, they need privacy too.*
B.08	*Role of birth attendant/ companion	Any mention of specific roles for a birth companion or birth attendant. *Must be double coded with either B.01, B.02 or B.03*	*R: because err…accor…accord…based on what have told you earlier on, I told you that if the space is er., just a woman in the labour room her husband is allowed he supports, we too give our own necessary support, so that is what I feel that actually they've been supported, (I: okay), yeah.*
B.09	*Emotional state	Any mention of the emotional state of either a health worker or woman during labor. *Must be double coded with either B.01, B.02 or B.03*	*I: okay. So how do you feel, that's your emotions during this first stage of labour? How do you feel?* *R: well during the first stage of labour, really I feel good and especially, though the problem is with the primemerch they tend to be more anxious and eh… you know their own takes a bit… a longer time but we counsel them and I feel happy because they adhere to our advise and they are relaxed.*
B.10	*Role of health worker during labor/delivery	Any mention of specific roles for a health worker during labor/delivery. *Must be double coded with either B.01, B.02 or B.03*	*I: okay. So as a health care provider also what roles do you perform during this first stage of labour?* *R: the first stage of labour, as I earlier told you, you need to counsel them to prepare their heart towards labour, because some of them may have the fear of labour, but if you counsel them and encourage them, that actually it might be painful, but the joy of it is that what is coming out of it, is your baby, you see your baby healthy so you need to be strong in heart you need to prepare yourself, it might be painful but not that that…you*

Table A1 (*continued*)

#	Code	Definition	Example of proper use
			will also believe that others have pass through, you too will pass through it. You encourage them to do that.
B.10	*Role of health worker during labor/delivery	Any mention of constraints of the hospital setting (e.g.: not enough space/beds, lack of equipment/drugs, not enough staff, overworked staff, etc).	*I: so besides the health workers, you said something like if it's only one patient you allow the husbands to come in, that means that you don't allow non medical persons to come in during…(R: if other women) a woman's labour.* *R: if other women are there, we are not going to allow because of privacy (I: okay), they need… others too need privacy (I: okay), yes, so if we allow relations to be there, the're different people. We have two patients and two different relations are there, they'll be seeing the other patient which is not good, they need privacy too.*
C.00	**Perceptions and experiences of care**		
C.01	Expectations during labor/delivery	Any mention of expectations about treatment/care, and whether or not they are met by the treatment provided. This code is both for positive and negative expectations	*I: so as a health care provider, what are you expectations during this first stage of labour that a woman comes in what are your own expectations?* *R: okay, as a health car…care provider my expectations is that she will deliver safely if I examine her. Knowing quite well that all the parameters are adequate, I expect that sh… I'll manage her up to the stage of safe delivery, even manage postpartum, eh… third stage of labour actively.* — *R: I was afraid when I entered the room because of the knives and other equipment that I saw there but it was because my grandmother had told me that if they realize that I am scared they would cut my private part carelessly and so I was also quiet and I was just looking at them as they were doing those things.*
C.02	Defining support	How a respondent describes support during labor/delivery (e.g.: holding their hand, making tea, emotional support)	*I: okay could you describe what it means to be supported during labour? What you believe the meaning of supported during labour means?* *R: What I er… understand by supported during labour because anybody that is with a patient could support him, morally, physically, because you will…the patient a time when they are in pain they would like you to rub their back. So if a supporter is there he assists in rubbing the back, if a supporter is there he assists in lifting the leg, sometimes they hardly lift their legs up, so when you help them they will also feel comfortable, they will feel secured, they have somebody with them that can help.*
C.03	What do women need from health workers	Explanation of what women need from health workers in order to experience supportive care during labor/delivery	*R: What I will say is that the nurses should treat us like their children and they should desist from mistreating women at the facility.*
C.04	What is needed from woman/family	Explanation of what a health worker needs from a woman or her family in order to provide supportive care during labor/delivery (e.g.: to provide money and necessary equipment, to be obedient)	*I: thank you ma, in your opinion what would you need from a woman and her family in other to provide this type of supportive care you have given, you know you explained that it involves physical, moral and other aspect, so in your own opinion what would you need from the woman and her family in order to provide this type of supportive care.* *R: okay. in my own opinion what I would need from the woman, the family member is before the labour begins they need to prepare all the necessary things the hospital needs to assist the woman to safe delivery, because in some cases some of them will come even though with a supporter but the things needed are not there, the woman becomes the depressed, but in some you see the relations are there asking what do you need? What we have is it enough we want to get it before she goes into labour. You feel happy even you the health provider. so those things needed not only the hospital things, she might need some drinks too, so some relations actually are up and doing they'll provide all those things that she needs and it makes things easier for the patient and the nurse too nursing the patient.*
C.05	Support and relationship with colleagues	Explanation of what a health worker needs from their colleagues in order to provide supportive care during labor/delivery (e.g.: teamwork or good communication)	*I: okay, thank you ma. What of the things that you will need from your colleagues in order to make this kind of supportive care available (R:okay), now you've told us what the woman and her family can do, now we want to find out what of you colleagues, what can they do?* *R: okay. actually in this issue of delivery it's not a one man business, if you have a supporter, a nurse with you she can assist in some areas because during the delivery she might be getting things ready for you, you too will be preparing with your gown, wearing your gloves ther…and if you've worn your gloves it's a sterile procedure you don't need to be touching some things, but if you colleague is there with you, there with you she would be helping you to give those things or open those things that you can pick in order not to contaminate the patient or the procedure. So actually its' good when you're conducting or when you're taking care of patient you have a professional colleague to assist, to support too.*
C.06	Support and relationship with supervisors	Explanation of what a health worker needs from their supervisors in order to provide supportive care during labor/delivery (e.g.: motivation, second opinion, management of resources)	*I: okay. What of those things that you think you will need from your superi…em supervisor what you need from your supervisor this time? We've spoke about woman and family, we spoke about colleague now we are coming down to the supervisor, what are the things, in your opinion you would need from your supervisor in order to provide this type of supportive care.* *R: okay. In order to provide supportive care, my supervisor I would need all the…the papers to document, I will need her to be around if she as the time so that she can supervise me while am taking care of the patient because there after which… in this unit that is what our supervisor does, our in charge. She is always there for us, she supervises, she gives advice, she makes correction where it's necessary (I: nmmm) and even thereafter, she gives us lectures. So this has been helping us very well.*
C.07	Supportive work environment/needs from hospital	Explanation of what a health worker or woman needs from their facility in order to provide or experience supportive care during labor/delivery (e.g.: drug/blood supply, enough beds). Description of how a work environment is supportive or not, beyond human relationships.	*I: I will do that* *R: You will see that the work environment is so fantastic. As for the staff, they are cool to work with, the equipment, supplies, obviously it is a human institution once a while you will get shortage of certain things like supplies. In total the working environment is amazing.*

Table A1 (*continued*)

#	Code	Definition	Example of proper use
C.08	Overall perception of care received	Explanation of the overall experience of care and how the woman felt.	*I: In all what do you think about your labour in that hospital?* *R: As for me I was not happy about it. What made me a little happy was when the operation was over and they gave us the bill. Luckily for us the first nurse that I met….we didn't know her but they asked us to pay GHS 240 but we ended up paying GHS 20. The nurse asked them not to collect the money from us. That was what made me a little happy and also they didn't collect the soap and other items that I sent. They gave them back to me and then I came to the house with them. That was what made me happy but the delivery itself was not something that made me happy there.* *I: Why were you not happy?* *R: It was due to the way the nurses treated me that didn't make me happy. The treatment that they gave me didn't make me happy.* *I: And what else was the reason why you were not happy?* *R: When you go there and you are hungry they don't allow you to buy food to eat. They said that the infusion was food but we would still be feeling hungry but they said that it was food but we were still hungry.*
C.09	Deliver in same hospital again	Whether a woman would prefer to deliver or intends to deliver in the same hospital as her previous birth and why.	*I: Would you go there to deliver again?* *R: As for me I would prefer to give birth in the house.* *I: Why?* *R: Oh if I deliver in the house….I for instance…. my family members deliver pregnant women and so my family member will not beat me if she is assisting me to deliver. She will encourage me till I give birth.*
C.10	Recommend hospital to a friend	Whether a woman would recommend her friend/sister to deliver in the same hospital as her previous birth and why.	*I: Would you advise your friend to deliver at the government hospital?* *R: As for me I won't advise her to deliver at the government hospital but I will narrate my experience to her for her to decide what to do because even if I tell her she will be scared and so will want to deliver in the house.* *I: And so what you are saying is that you will never advise a friend to go there?* *R: Yes please.* *I: Why?* *R: Because of the way they beat me and kept saying "push, push" and I was not able to deliver too. And so I will tell my friend the same thing that when she goes they would say "push, push, push" but finally you will be operated. As for me that is what I will tell her.*
D.00	**Mistreatment experience**		
D.01	Unhappy/ uncomfortable experience	Any example of an unhappy or uncomfortable or mistreatment experience from a woman or health worker. Should include full context and code to any experience of mistreatment mentioned anywhere in transcript (e.g.: slapping, pinching, yelling at a woman during labor). Should also include feelings and reactions to the situation (from "witness, survivor or perpetrator" perspectives). This includes where and when the mistreatment happened.	*R: …And so when she came she said "that long time that you were brought you haven't delivered yet"? And then I said Maame nurse please one nurse came and attended to me and said that I will be operated. And then she said no I should not agree to any operation and that I should try and deliver by my self and then I said okay. And so I was there when she brought something and inserted it into my buttocks and then she examined it and said push. Then I said "Maame nurse I can't push". Then she slapped my thigh and said "I say push". Then she said "I say push". So anytime she would say push she would slap my thighs. It was there that the other nurse came and said ahh why are you worrying the girl like that? Look at her tommy. Can't you see that the baby has not descended? And they said that my baby was coming out with his buttocks. And so she insulted the other nurse and they carried me to the theatre for the operation.*
D.02	How common is this experience	Any general mention of frequency of occurrence of mistreatment. If not clearly mentioned in the text unit, memo what the experience is that they are referring to.	*I: okay, thank you ma. Yeah so as we were talking earlier on you know you talked about emm. care generally given to women and you said its' meeting your expectation but the're some exceptional few. So sometimes women are mistreated or poorly treated or managed during child birth. Have you ever seen or heard of this type of mis…mismanagement or mistreatment. Like those few people you explained maybe the woman stepped on the uniform and you know the nurse can now get a little bit temperamental.* *R: have once seen it but its' not in this hospital….* *I: But in your working exprience so far you've never heard of anything like that?* *R: Have not, (I: here?) to be honest here*
D.03	Factors influencing mistreatment	Any factors/drivers/reason for mistreatment occurring that is *NOT covered by D.04.1–D.04.4* (e.g.: miscellaneous factors for mistreatment)	
D.04	*Essential physical resources	When a lack of essential physical resources contributes to the occurrence of mistreatment (e.g.: not enough beds so women deliver on the floor)	*I: okay you don't think maybe because they don't have enough equipments or maybe like the chair is not enough, or maybe drugs could be a reason why they are acting like that* *R; well I don't, I can't really say it because anything we need to use we are the one buying it, because I don't really think they are using government equipment, because anything they want to use for you, they will ask you to go and buy it*
D.05	*Facility/ health system	When facility or health systems policies or practices contribute to the occurrence of mistreatment. Also includes staffing issues, such as provider/patient ratios and workload.	*I: Do you think that the reason why you were beaten was due to the fact that women that had come to deliver were many…* *[Respondent interjected].* *R: No it was not because of the work load.*
D.06	*Health workers attitudes/ practices	When poor health worker attitudes or practices contribute to the occurrence of mistreatment *(e.g.: "bad apple" or rude health workers, overtired health workers etc)*	*R: No it was not because of the work load. That is how they are. It was just because I couldn't push. If you couldn't push then they will be beating you. It is not because the clients were many that is why we were beating me.* *I: Can it also be because they didn't have enough supplies of medicines and equipment with which they would use to assist you to deliver?* *R: Oh even if the nurses have medicine they will be expecting you to give them money before they can help you. That is what they always do.* *I: And so it is not because they lack the supplies of medicine?* *R: No.*

Table A1 (*continued*)

#	Code	Definition	Example of proper use
			I: Or maybe the nurses are not many and so…. *R: Oh there are some grown up nurses that are mean*
D.07	*Patient behavior or characteristics	When patient behavior or characteristics is provided as a reason for mistreatment (e.g.: adolescents, disobedient or aggressive patients)	*I: Now I want to know what you think about the way women are taken care of when they go to deliver. You told me of how you were beaten to push. What do you think was the cause of this mistreatment?* *R: It was because I wasn't able to push.*
D.08	Suggestions for improving treatment	Any concrete suggestions for improving how women are treated during labor and delivery, including suggestions for improving the provision of supportive care (e.g.: providing better pay, sensitization training)	*I: Is there anything else that you would like to tell me about your work with women who are giving birth?* *R: I think we are not doing a very good job by educating the population and our competitors that is what I prefer to call them the herbal practitioners are actually drawing us back. They don't seem to have excuse the language ethics guiding their practice. Because they seems to be abusing the illiterate nature of our women. I think we could do with more education, and better training for our midwives and our district facilities should not try to do too much, not try to bit more than they can chew. We are not tired to work in this hospital if it means referring everybody so be it. They should refer any case that they cannot handle, they should do well to refer but not to do too much. We know the patient may refuse to come or insist to stay but you need to communicate it well to the patient and it will be sorted out. In all case we should be able to have a midwife who will be able to sell a deep freezer to an Eskimo… laughing … that is how convincing our midwives are supposed to be, so that we don't have women dying on them there.*
E.00	**Positive birth experience**		
E.01	Positive birth experience	Examples of positive or supportive care during labor/delivery	*R: When I went she said "oh Maame you have come to deliver"? And then I said yes. She asked me about my husband and then I said that I didn't have one and then she asked why and then she said that I shouldn't worry because God will do it and so I should follow her. And then I followed her and then she went and laid my bed for me to lie down. And so when I laid down one male nurse came and then called her. They said that she is the senior nurse at the government hospital. She was called to take care of the people at the eye clinic and so it was the one that came later that beat me.*
F.00	**Acceptability**		
F.01	Acceptable to pinch or slap during labor?	Any quotations of the respondent's reactions to this specific question of if it is acceptable to pinch/slap during labor, including any subsequent/related probes.	*I: thank you ma, so now I would like to ask your opinion on how you feel about the way women are treated during child birth, I'll just give you some statement and you tell me your own opinion (R: okay) and when you think it will be acceptable to do such. Okay. So if a woman was pinched or slapped by a health worker during child birth would this be acceptable?* *R: it's not acceptable* *I: why? why do you say that?* *R: Actually it's not acceptable because slapping her can make her angry, it can make her to.to have a problem but if you calm her down no matter how distressful she is; she's also a human being she will relax. But slapping her could make her misbehave and it could bother.further cause a lot of problem to her, to her own health.* *I: nmm.* *R: yes* *I: So bringing it to a more personal level how would you feel if this happened to you?* *R: Actually I would feel very bad! Very very bad because we are all human beings, no matter how you, you the care provider know that that woman is in distress is in pain, it's not a comfortable thing. The next thing you're supposed to do is to try and at least encourage her to make her feel strong but if you're slapping her or pinching her certainly it won't be good. So certainly if anything is done to me too I won't be happy, I will feel bad.*
F.02	Acceptable to yell or shout during labor?	Any quotations of the respondent's reactions to this specific question of if it is acceptable to yell/shout during labor, including any subsequent/related probes.	*I: if a woman was yelled or shouted at by a health worker during child birth would this be acceptable and if it is when is it acceptable?* *R: it's not acceptable at any point* *I: nmmm?* *R: there's no point in time that a woman should be shouted at.* *I: okay. How would you feel if this happened to you, if the nurse shouted at you? But I just want to ask again what if the nurse actually did the shouting for a particular reason? or its' not just.* *R: no matter the reason* *I: nmmm* *R: if you politely explain things to your patient (I: nmmm) it , makes it better, she feels relaxed too. So no matter the condition you have to try as much as you can to explain things in a low tune to a patient than shouting.* *I: nmmm. so when I was saying before I now brought in the other question, how would you feel if this happened to you?* *R: Actually i will feel bad, am also a human being, when am a patient too I will feel bad!*
F.03	Acceptable to refuse to help during labor?	Any quotations of the respondent's reactions to this specific question of if it is acceptable for a health worker to refuse to help during labor, including any subsequent/related probes.	*I: what of if a health worker refused to help a woman during her delivery would this be acceptable?* *R: then why is she there! She is employed to render services so why should she refuse? I don't think there's any reason for her to refuse because the position of her patient can even er be life threatening to her patient so if you have the loves of your patient you won't refuse. You will run to render the necessary assistance needed to save the life of the woman. You know quite well she can tear and bleed to death. But if you're there for her, guiding the perinum well she will deliver safely and have her baby, no problem she can go home. And its' also cost implicative on the patient because if she delivers on her own and bleeds if she did not die, she might need blood to be transfused (back ground noise calling Sandra). So its' saver if she delivers normally without any complications and go home.*

Table A1 (*continued*)

#	Code	Definition	Example of proper use
			I: thank you, how would you feel if this happened to you? *R: actually based on these explanation am giving you I will feel bad too.*
F.04	Acceptable to physically restrain woman during labor?	Any quotations of the respondent's reactions to this specific question of if it is acceptable to physically restrain a woman during labor, including any subsequent/related probes.	*I: okay. What of if a health worker physically held a woman down during her child birth will this be acceptable?* *R: It's not acceptable, it's not acceptable* *I: in any instance* *R: in any instances its' not acceptable.* *I: can you explain why you feel its' not acceptable?* *R: to hold her down?* *I: nmm* *R: to press her down?* *I: well physically hold her down* *R: ha han! when she's in labour?* *I: yeah, during her child birth, yeah giving birth.* *R: mmh. This question is not ….* *I: okay if a health worker physically held a woman down during her child birth…* *R: is it angrily or just normally…* *I: No! just physically held there is nothing explaining wether it is angrily or lovingly it's just that the woman was held down* *R: well do you feel…yo have held her freedom, ideally yo explain to her she will cooperate with you, even if its' I know it's' painful just go down do it this way, she will do. And if she's not cooperating there are ways you can encourage your patient jokingly: ha ha my dear you've been cooperating and I know definitely this is the time we need more of your cooperation, do it… it depends on approach, once you approach her very well she will relax. (I: nmm) she will there's no need to do it yourself. Okay.*
G.00	**Staffing**		
G.01	Motivation for being a health worker	Any mention of a health worker's motivation for becoming or continuing to be a health worker.	*I: Okay, any other additional thing you want us to know about you?* *R: well, what I would want you to know about me, I joined the nursing profession because of the love I have for patients, to help the needy and that is what thrills me; because, first of alll went to teachers' college, but emm. because I love taking care of the sick, that is what made me to join the profession.*
G.02	Rewarding part of work	Description of the most rewarding part of working as a health worker.	*I: okay, so the next set of questions i want to ask, again I just want to reassure you, and remind you your responses are confidential, whatever you tell is solely for the purpose of the study. So the next set of questions will be in relations to how your work environment is, and how staff are treated and stuffs like that. So i would want to ask what is the most rewarding part of your work and why is it the most rewarding part?* *R: well the most rewarding part of our work is the sacrifice we give to our patients, sometimes even when we close from our work we don't leave home to see the success of our patient delivering so I know it's' rewarding God will reward that effort because we are going extra miles, not only me, all of us that are in this unit. In one way or the other we've been straining ourselves going beyond our time to see to our patients' success, that is what I feel is the most rewarding.*
G.03	Challenging part of work	Description of the most challenging part of working as a health worker.	*I: Okay, what is the most challenging part of your work and why?* *R: the most challenging, sometimes women come with eclamp…eclamptic fits and em… you don't have the necessary things like the magnesium sulphate like the.things you need to attend to them promptly (I: mmm) that is the most challenging. It might be in the hospital store but the money is not there to purchase it but I think this time around that as been taken care of by another researchers, they provided those things we needed and its' to be given to the patients free. So those patients that are in need for now I don't think that problem is there, (I: okay), another one is the blood the women need, some may not have the money to run the test so its' another part that's challenging problem here. Because they actually need blood especially those that have exceeded their months of delivery they need it for induction, some they need it for CS and the money is not there. That one keeps us off…it makes us …feel bad because we want to see that this patients are being taken care at the appropiate time, so that the baby and the mother comes out in good health, but if those things are not there; its' delaying to the…woman…it's also detrimental to her, the baby too could be having breat…difficulty because of delay and that may even lead to admission or losing the baby so it's' very painful.*
G.04	Valued in work	Description of if they feel valued in their work as a health worker.	*I: Do you feel valued in your work?* *R: Actually I feel highly valued because it's a work that you feel happy, its' a work that you know you are helping, its' a work that when the outcome is good you are happy. So I actually feel valued.*
H.00	Miscellaneous	Anything not captured by the codes above	*n/a*

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