

## ORIGINAL RESEARCH

# Women's experiences of seeking reproductive health care in rural Ghana: challenges for maternal health service utilization

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Accepted for publication 22 May 2010

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YAKONG V.N., RUSH K.L., BASSETT-SMITH J., BOTTORFF J.L. & ROBINSON C. (2010) Women's experiences of seeking reproductive health care in rural Ghana: challenges for maternal health service utilization. *Journal of Advanced Nursing* 66(11), 2431–2441. doi: 10.1111/j.1365-2648.2010.05404.x

## Abstract

**Aim.** This paper is a report of part of a larger study exploring rural Ghanaian women's experiences of seeking reproductive health care. The aim of this part of the study was to describe rural women's perspectives on their experiences in seeking reproductive care from professional nurses.

**Background.** Nurses' relationships with childbearing women have been linked to women's reproductive healthcare-seeking behaviour and service utilization. However, few researchers have studied women's perspectives on their relationships with nurses when seeking health care. In Ghana, the high rates of maternal mortality raise concerns about a number of factors, including nurses' relational practices.

**Methods.** Data were collected in 2007 with a convenience sample of 27 Ghanaian women via in-depth interviews, focus groups and participant observation. Women's ages ranged from 15 to 49 years. The translated and transcribed data were thematically analyzed.

**Findings.** Healthcare providers' relational practice influenced women's healthcare-seeking behaviours. Major themes from women's stories were: (a) experiences of intimidation and being scolded, (b) experiences of limited choices, (c) receiving silent treatment, and experiences of lack of privacy. Women emphasized the importance of their relationships with nurses and the impact of these relationships on their healthcare-seeking.

**Conclusion.** Nursing education in Ghana must place emphasis on basic relational practices. Structural changes to health clinics and routine nursing practices are necessary to create conditions for privacy to address women's health concerns. Women's perspectives must be considered for service improvement. Further research is needed to examine nurses' perspectives on relational care.

**Keywords:** focused ethnography, Ghana, health service utilization, relational practice, reproductive health care, rural nursing, women's health

## Introduction

In developing countries there are frequent reports of high maternal morbidity/mortality [Global health council (GHC) 2008]. Maternal deaths are particularly problematic in rural areas of these countries. One contributing factor is poor provider-patient relationships, characterized by power imbalances and social hierarchy (Mayhew 2000, Anderson 2004, Oudshoort 2005). Recently in sub-Saharan Africa, there have been reports of deteriorating healthcare provider-patient relationships, irrespective of the social positions of those involved [Jewkes *et al.* 1998, Ghana News Agency (GNA) 2009a]. These reports, coupled with advocacy efforts by developing countries to reduce maternal morbidity/mortality rates by 2015 (UN 2000), have yet to have an impact on women's reproductive health-seeking. There has been no systematic study of women's perspectives on their relationships with healthcare providers. In the study reported here, we addressed this gap with the aim of informing improved quality of care and service utilization.

## Background

Despite global efforts to improve women's access to maternal health services, recent statistics indicate that maternal mortality rates (MMR) continue to escalate (UNDP 1999, Pettersson *et al.* 2004, GHC 2008), with developing countries accounting for approximately 99% of all deaths (GHC 2008). In sub-Saharan Africa, one woman in 12 will die of maternal-related causes (Donnay 2000, GHC 2008). Between 2003 and 2009, the MMR in Ghana increased on a daily basis (GNA 2007, 2009a,b), despite the relative availability of maternal health services. In rural settings, MMRs have raised alarms (GNA 2009a,c). Deaths related to reproduction are preventable because the causes of such deaths are well known (D'Ambruoso *et al.* 2005). Not only do rural women underutilize maternal health services, but also the gap between rural and urban women's general and reproductive health continues to widen [Ghana Demographic and Health Survey (GDHS) 2003, Heyen-Perschon 2005].

In northern Ghana, the use of maternal health services is considerably lower than in other parts of the country, despite continuing increases in total fertility rates – close to six children per woman [GDHS 2003, Talensi-Nabdam District Health Administration (TNDHA) 2007], thus placing a burden on women's health status. Despite efforts to prioritize the provision of safe reproductive health care through community education, the promotion of male involvement, and encouragement of home deliveries by nurse-midwives, supervised deliveries by skilled healthcare professionals and

contraceptive acceptance rates have declined and remain very low (TNDHA 2007).

In northern Ghana, few births are supervised by skilled personnel (GDHS 2003). The low numbers of supervised deliveries suggest that achievement of the UN Millennium Development Goals on maternal health by the year 2015 (UN 2000) remains a mirage in Ghana in particular and in Africa in general (Pettersson *et al.* 2004). Healthcare systems that fail to ensure equitable provision and access to health care, especially for women, contribute to deepening health disparities and hinder national and international development.

Studies have revealed that factors influencing health-seeking behaviour, such as socioeconomic status, culture, gender, environmental conditions, self-esteem, family influences and providers' attitudes, all play a major role in determining maternal health service uptake and utilization (Nazzari *et al.* 1995, d'Oliveira *et al.* 2002, Pettersson *et al.* 2004, Grewal *et al.* 2005, Shaikh & Hatcher 2005, Sauls 2007, Storeng *et al.* 2008, Schooley *et al.* 2009, Wong & Regan 2009). However, the majority of these studies have been urban-focused, and consequently rural women's perspectives have been neglected in the reproductive health discourse. In addition, most of the studies have focused on a single maternal service, thus limiting broader understanding of women's experiences.

## The study

### Aim

The aim of the part of the study reported here was to describe rural women's perspectives of their relationships with professional nurses when seeking reproductive health care from professional nurses. In this context, nurses' relational practices refer to those practices that influence relationships between nurses and patients and have the potential to promote health and healing (Doane & Varcoe 2007, Williams *et al.* 2009).

### Design

The study was based on a constructivist paradigm (Creswell 2007). This paradigm pays attention to subjective meanings and experiences of individuals and groups, and recognizes how these meanings and experiences influence people's behaviours and life choices. It encourages researchers to work with participants rather than simply studying them. Guided by this paradigm, women's perspectives during care-seeking are best described and interpreted by themselves. Focused ethnographic research methods (Knoblauch 2005)

were employed to generate data. Unlike traditional ethnography, focused ethnography defines a specific topic for study, and focuses on a small section of a society rather than the entire society. Researchers are often natives to the study setting, and their familiarity with the culture allows for use of a compressed timeframe for fieldwork (Knoblauch 2005).

### Setting

The research was conducted in two remote communities in the Talensi-Nabdam district of Northern Ghana. The communities are homogeneous in terms of cultural traditions and language. The nearest health centre serving these communities is about 15 km away (Talensi-Nabdam District Assembly 2007). This health centre provides a broad range of maternal and child health services, including antepartum, intrapartum and postpartum care, immunizations, child welfare, and curative health services. Despite the relative availability of healthcare services in this region, very few women access maternal health services (GDHS 2003, TNDHA 2007) and very little is known about the health of women in this area.

The communities are among the poorest in the country and the only source of income is subsistence farming. A few women engage in petty trading. There is a very high illiteracy rate among community members (see Table 1).

### Participants

A convenience sample of 27 participants between 15 and 49 years of age and who had received care from two rural clinics was recruited. Twelve women participated in individual interviews and 15 women participated in two focus groups (FG), composed of groups of seven and eight. Clinic nurses and community-based surveillance volunteers (CBSVs) assisted with recruitment after receiving orientation to the study. Using a researcher-prepared script, nurses invited every woman to participate in the study during clinic visits, while CBSVs invited participation during daily community activities such as fetching water at the riverside, farming and at the market. Nurses and CBSVs communicated the names of interested women to the researcher (VY), who arranged and met with women at their convenience to do interviews. Since the majority of women were illiterate, participants received an oral explanation about the purpose of the study and gave oral consent to participate. The oral method of consent is culturally-acceptable in this study setting. Two women could not participate due to their farm work. The researcher's visits to the clinic lasted for 2 weeks. Table 1 shows the participant sociodemographics.

**Table 1** Participant demographics ( $n = 27$ )

Variable	#	%
Estimated age (years)		
≥20	1	4
21–25	6	22
26–30	12	44
31–35	4	15
41–45	3	11
46–49	1	4
Marital status		
Married	24	89
Widow	1	4
Single	2	7
Educational background		
No education	19	70
Non-formal education	2	7
Primary school	4	15
Junior secondary school	1	4
Senior secondary school	1	4
Women's work		
Farming	15	56
Petty trading	7	26
Housewife	5	19
Type of marriage		
Monogamous	17	63
Polygamous	8	30
Age at first pregnancy (years)		
15–20	17	56
21–30	2	7
Don't know	8	30
Number of pregnancies		
1–5	15	56
6–10	4	15
Don't know	8	30

### Ethical considerations

Formal ethics approval was received from a university research ethics board and informal approval from community leadership of the study setting. Consent for participation was audio-recorded prior to each interview.

### Data collection

Data were collected in August 2007 via in-depth audio-taped interviews with individuals and focus groups lasting approximately 45–90 minutes. Focus groups (Litosseliti 2005) were not planned at the outset of the study, but were incorporated because of the enthusiastic response and interest of the village women in sharing their experiences. Consistent with Ghanaian culture, the oldest women were asked to respond to questions first, and then the conversation was opened to younger participants. While different perspectives were shared, there was overall group consensus on various issues.

**Table 2** Semi-structured interview guide

Questions
1. Tell me a story about what it has been like to ask for help for a women's health issue you have had?
<i>Probes:</i>
From whom do you normally seek health care?
What healthcare provider(s) are available to you?
Whom do you prefer?
Why do you prefer that particular provider?
How did you decide to choose this particular healthcare provider?
What encourages you to ask for help (e.g. my personal need, husband, friends)?
Apart from asking for help from someone, what else do you do on your own?
If the woman has not asked for help probe: what has made it difficult to ask for help when you have had a woman's health issue?
2. Tell me what happened when you sought help/health care?
<i>Probes:</i>
What were the nurses like?
How was your interaction with the nurses (friendly, not friendly, she appeared approachable/not)?
What kind of information did you receive?
What did you think of the information given to you?
How did you understand the information you received?
What was it like for you?
How did you feel about it?
Best/worst experience?

A semi-structured interview guide with open-ended questions was used, with prompts and probes to encourage further conversation and detailed descriptions of women's experiences (see Table 2).

Participant observation data were collected during times spent at the clinic and at other times when conducting interviews. Observations concerned participants, the physical setting, who was present, what was said, how it was said, non-verbal communication (gestures), and women's interactions with one another and with clinic staff (Morse & Field 1995, Speziale 2003, Richards 2006). An observation guide was used to generate data (see Table 3). Using principles of ethnographic fieldwork (Hammersley & Atkinson 2007), extensive fieldnotes were kept to record observations.

### Data analysis

Data were translated, transcribed verbatim, manually coded and analyzed thematically. Data analysis was guided by Morse and Richards (2002) framework for thematic analysis and included the following processes: (a) topic coding, (b) creating categories, and (c) abstracting. Fieldnotes from observations were reflected upon, coded and analyzed.

**Table 3** Observation guide

1. Clinic setting
How is the clinic set up?
Where is the reception area?
Where is the waiting area?
Is it welcoming?
What is the order of seeing patients?
2. What kind of women come to the clinic (e.g. younger, older, educated, uneducated)?
3. What time of the day do women come to the clinic (e.g. early morning, afternoon, evening, night)?
4. Why do they come at one particular time of the day?
5. Who accompanies the women (relatives, significant others, children, etc.)?
6. How are women received/treated at the clinic by nurses when seeking help?
How do the nurses interact with or relate to the women?
How is information delivered to women at the clinic by healthcare providers?
How do women interact among themselves at the clinic?
Are there any language barriers?
Are the women given any privacy?
Are services available to clients (e.g. drugs, contraceptives, vaccines)?
7. How are the routines of the clinic organized? For example, how much time does a client have to spend with a nurse (rushing, enough time to talk about problems)?
8. How are those who accompany the woman treated/received?

Coding for all data was completed by the first author and reviewed by the research team. The first author led a detailed analysis of the data retrieved for each category, and the team participated in refining themes. To enhance rigor, all transcripts were revisited frequently to ensure accuracy in the translation of context and spoken words from local dialect into English. Direct quotes and narratives from women's interviews are used to illustrate and support interpretations of the data.

### Trustworthiness

Trustworthiness of the data was supported by meeting the criteria for transferability, dependability, confirmability, and credibility (Lincoln & Guba 1985, Sharts-Hopko 2002, Golafshani 2003). A Ghanaian person, well-grounded in the local dialect (Nabit) and English, reviewed a randomly-chosen translated transcript for accuracy in translation. Transcripts, data coding, categorization and themes were regularly shared with the research team for cross-checking and questioning. Detailed fieldnotes and reflective notes were kept and reviewed frequently for emerging ideas. Data triangulation (Richards & Morse 2007) was employed by gathering multiple perspectives on women's experiences and by carrying out observations.

## Findings

Women experienced major challenges in accessing reproductive health care, and their relationships with healthcare providers more often than not influenced their healthcare-seeking behaviours. Although they described relationships characterized by positive interactions with nurses, negative experiences appeared to be more common. Because of the ramifications of these experiences, we focus here on the aspects that negatively influenced healthcare-seeking. Women's accounts of these negative experiences are discussed in relation to four themes: (a) experiences of intimidation and being scolded, (b) experiences of limited choices, (c) experiences of receiving silent treatment, and (d) experiences of a lack of privacy.

### Women's experiences of intimidation and being scolded

Based on women's narratives and clinic observations, it was evident that dominant discourses and practices in Ghanaian society devalued women and reinforced power relations (Amoakohene 2004, Ampofo *et al.* 2004) and also played out in women's interactions with nurses as they sought health care. For example, at clinics women, including those who were pregnant, routinely stood up when speaking to nurses. Nurses were observed to spend very little time with women and disregarded their questions during times that they provided care. Many women recalled experiences in which they were scolded for not seeking care earlier, for not practising birth control, or for asking questions. They were also threatened with treatment withdrawal or denial if they did not comply with instructions from nurses, and were treated 'like children', ignored, and disrespected. A focus group participant described her experience when seeking antepartum care:

I went to the clinic when I was pregnant and the nurse insulted me. I was angry and decided to go to another clinic. She said why is it that I did not come to the clinic till six months to tell her that I am pregnant. Was she the one who impregnated me?

Women believed that they needed to accept the disrespect, intimidation and scolding they received from nurses in order to obtain the care needed. Therefore they sought to avoid conflict with nurses by not expressing their feelings:

Well, the nurses are supposed to tell you what is wrong with you but when you go to them, they start saying nonsense to you. But because you are also looking for help from them, you cannot say anything so you just keep quiet.

Women's experiences with providers were not limited to seeking reproductive health care for themselves, but often

included seeking care for ill children. Sometimes they reported that their relationships with some nurses, particularly male nurses, deteriorated to such an extent that they did not want to seek care for themselves or their children from particular clinics and nurses, regardless of the seriousness of the condition. The scolding appeared to be worse at public clinics compared to private clinics. One woman who sought care for her sick child regretted her visit to the main public clinic:

The only problem is if that male nurse is there. When a child is sick and you run there in the middle of the night, he will shout at you and ask you where you were and why you are now coming? He will say he has no drugs for you. Because of that, women hate to go to the public clinic whenever he is there. Unless we have not enough money, otherwise we go to the private clinic.

Although private clinic staff were perceived as considerably friendlier, when women chose private over public clinics because of negative relationships with nurses, this had financial implications. The private clinic required additional payment, which created an increased financial burden and was something that the majority of women could not afford. One participant stated:

The public clinic nurses yell at you. As for the private clinic, the nurse will speak respectfully to you, even though he (nurse) will not give you medicine on credit, but you will be happy.

Poor relationships between nurses and women, as well as financial barriers, often led to inability to seek care or discontinuation of care-seeking started by women.

### Women's experiences of limited choices

Women thought that their choices in seeking reproductive health care were limited. In particular, they thought that nurses limited their choices related to labour and birthing. Women's preferences to give birth at home with support from trained traditional birth attendants (TBAs), their mothers-in-law or a peer, were not supported by nurses. Nurses would not come to women's homes to assist them, even when they were called. Instead they required women to walk the distance to the clinics, regardless of the stage of labour or the time when labour began. According to participants, TBAs were only allowed to report labour cases from their communities to nurses and/or accompany women in labour to the clinics. Thus, there was a strong attempt by nurses to turn TBAs into messengers, even with their training by the health ministry and the skills gained over the years in practice.

Women's strong preferences for obtaining birthing support from TBAs rather than nurses emerged from nurses' poor

relationships with women when seeking health care. A participant described her experience of giving birth in a clinic and her reason for preferring the TBA over clinic staff:

As for the nurses, when you are in labour and get there (clinic), they start to shout at you as if you are a small child...But you know, as for the TBA, whether she knows you or not, she respects you.

Despite the health ministry's advocacy of domiciliary deliveries by nurse- midwives to address woman's specific medical needs, women received no individualized accommodation of their care needs. Some families were disappointed by nurses' insensitive responses to helping women in labour in their homes, even when they were available to do so. For example, one participant recalled her experience when she was in labour at a time when nurses were on an outreach programme in the community and were called in to help:

When I was going to deliver it was an outreach clinic day at our village, so my family called the nurses. But they said they would not come to the house unless they bring me to the clinic. So my mother-in-law was sending me to the clinic, but I could not walk.

Not only did providers ignore women's preferences, but they also ignored their individual medical needs. A participant described her experience when she sought advice from nurses about repair of her fistula: 'The nurse looked at it [fistula] and said they can only repair it when I get pregnant and come to deliver at the clinic'. (FG7). For this woman, the choice of giving birth at the clinic was based on the expectation that the fistula would also be repaired.

### **Receiving silent treatment: women's experiences of nurses withholding information**

When women sought healthcare services at clinics, their expectation was that nurses would not only provide necessary treatments but would also help them understand their health problems, answer their questions, provide the guidance they needed to make informed decisions about reproductive matters (e.g., birth control), and take care of their health. However, their expectations remained unmet. Although it was observed that clinic walls were decorated with posters and pictures containing information about contraceptives and immunizations, these forms of information dissemination had little impact because the majority of women were not educated and had limited literacy (see Table 1). Even if a woman could read, the information displayed was in English and the majority did not speak or read this. Accordingly, there was a strong dependence on, and expectation of, oral advice and information from healthcare providers.

Women, however, repeatedly described receiving services from nurses without any accompanying explanation. A woman who was given contraceptives by nurses reported that 'they said nothing' to help her understand how to use the contraceptives or any side effects she might expect. This lack of information made it more difficult for women to make informed decisions, especially about contraceptives. A 17-year-old single woman with two children explained her information needs:

If I get it (contraceptive), I will like to do it. If someone is able to teach me how it works, I will like to do it - but I have not had someone that will really tell me what it is all about.

Women's ability to meet their reproductive healthcare needs was often severely compromised, and nurses' failure to provide information cut across all reproductive health issues. A woman who made efforts to seek antepartum care reported: 'I went to the clinic and all they did was weigh and check blood, and palpate my stomach, and that is it. After that, they did not tell me anything'. Unmet information needs led some women to seek information from peers who were equally uninformed and then to make decisions that were not always in their best interests. A participant who experienced contraceptive side effects reported:

I asked one of my friends why is it happening like that to me, and she said it means that it is not good for me because she is doing the same thing, but she does not have her menses twice... So I just stopped.

Field observations confirmed women's stories. Frequently, both women and their babies were observed receiving immunizations without any accompanying explanation about type of immunization, function and its possible side effects. These observations also revealed that nurses called women 'ignorant, uneducated, rural, and local people who lacked simple understanding'. This resulted in them offering the women little information about the care provided.

### **The influence of infrastructure: women's experiences with lack of privacy**

Clinic structures and practices also made it difficult for women to discuss their healthcare concerns with nursing staff. There was little privacy in clinics conducted in open rooms. One clinic was located close to the main highway and every passer-by, both on foot and on a bicycle, could see and identify every woman visiting the clinic. The clinic floor plan and traffic flow from the entrance to the reception area was not unlike a grocery store. There were no dividers to provide privacy. Case histories were taken in the midst of other clients waiting in the reception area. This lack of privacy was further

compounded by the tendency of nurses to interview women in loud voices, making it easy for those who were waiting to hear their concerns. The physical clinic structure also compromised privacy during physical examinations. On observation at the clinic, sometimes pregnant women were palpated with curtains opened so others saw their abdomens. This lack of privacy was a prominent theme in women's stories and had a profound effect on their health-seeking patterns. As a result, some felt constrained in what they could share with nurses:

As for that place (reception area), everybody is sitting there and looking at each other. You cannot talk about all your concerns. The kind of sickness that brought you there, you cannot say it before other people. If you want to talk about how your sickness started, it is not easy to say everything in front of others. You feel that they are listening.

Other women feared being seen by peers and community members, and the resulting gossip that could reach their family members. This was a concern especially if they were coming to the clinic for contraceptives, a practice that was generally not supported by their families:

They (peers) will say, 'Oh, I saw this woman at the clinic. She pretended that she was going to the grinding mill, only to be seen at the clinic' (laughs). They may even let this enter your mother-in-law's ears, and she will in turn feed the son's ears (husband) with the news.

From women's perspectives, the lack of privacy at the clinic and manner in which nurses neglected this aspect of care acted as barriers to reproductive healthcare-seeking. It was also evident throughout women's stories that although they were concerned about general and reproductive health issues, other factors such as family, culture, cost of care and, most especially, the attitudes of nurses and poor infrastructure served as major constraints to healthcare-seeking.

## Discussion

### Study limitations

Although the findings were based on a convenience sample from a homogeneous cultural sub-group and reflect the perspectives of women in rural settings only, the majority of populations in Ghana and in developing countries in general live in predominantly rural settings with similar situations. The data were collected by the lead author, who has lived and worked in Ghana as a nurse. Her familiarity with the culture and leaders in the community facilitated data collection and interpretation of the data. However, it is possible that the experiences of all women in this region are

not represented, such as those who may have perceived that participation in the research could lead to risks to their personal safety or future access to health care. The use of focus groups to gather data on intimate issues such as reproductive health may have also influenced what women felt comfortable sharing about their experiences. Despite these limitations, the findings add to the literature a broader understanding about rural women's experiences in seeking reproductive health care.

### Experiences of seeking health care

Our findings are unique in capturing the experiences of rural Ghanaian women's reproductive healthcare-seeking. Within the larger sociocultural and economic context, they indicate that nurses' practices in relating to women during healthcare encounters were a barrier to reproductive healthcare-seeking. Although nurses' perspectives were not included, the interviews and clinic observations pointed to ways that nursing practices and the clinical environments they created discouraged rural women from healthcare-seeking. They also corroborate previous findings on nurses' relational practices in Canada, urban Ghana, Papua New Guinea, and South Africa (McPherson 1994, Jewkes *et al.* 1998, Sutberns 2004, D'Ambruso *et al.* 2005), and suggest that the negative impact of these relational practices on women's reproductive healthcare-seeking is a global issue with important implications for women's health.

The challenges that rural women experienced in accessing reproductive health care were not unlike those of women in other developing nations. Other researchers have drawn attention to the recurrent concern about poor quality health services for women in developing countries and to the attitudes and relational practices of healthcare providers, including nurses (Jewkes *et al.* 1998, d'Oliveira *et al.* 2002, Anim-Appiah 2009) as major contributors. Our findings parallel reports from a study of the maternity care experiences of South African women of severe neglect, verbal and emotional abuse, treatment refusal and physical assault, such as (delete 'and') slaps on their faces and thighs (d'Oliveira *et al.* 2002). This poor treatment occurred when women did not comply with nurses' demands before and during labour, when they questioned midwives about their behaviour, and when they demanded to be treated better.

Our women's accounts of being scolded and intimidated, particularly by male nurses, reflected the general patriarchal African culture characterized by power imbalance and control and the social construction of gender (Amoakohene 2004, Ampofo *et al.* 2004). Similar to observations in South Africa, nursing practice in Ghana is structured around power

### What is already known about this topic

- Reproductive health issues account for high maternal mortality rates in developing countries.
- Socioeconomic and cultural factors can have negative impact on women's reproductive healthcare-seeking behaviour.
- Nurses' attitudes can have either positive or negative influences on women's reproductive healthcare-seeking.

### What this paper adds

- How nurses interact with women at clinics during healthcare provision adds a new perspective to the importance of relational care and its link to underutilization of maternal health services in rural settings.
- The manner in which nurses' interactions with women at the clinic played out demonstrates that relationships remain one of the most important challenges to the achievement of Millennium Development Goals on maternal health in developing countries.
- Nurses remain unaware of the impact of their relationships on women's healthcare-seeking and their lack of sensitivity in the context of women's daily realities.

### Implications for practice/or policy

- More emphasis should be placed on raising awareness among nurses about women's accounts of care-seeking, ethical practices and professional codes of conduct.
- Nursing regulatory boards and health ministries must play a major role in ensuring that nurses provide accessible, acceptable and culturally-appropriate care to all users, irrespective of their social conditions.
- Good role modelling is required for new nurses entering practice.

and control, and patients are often expected to comply with instructions while their personal needs are ignored (Akiwumi 1994, Jewkes *et al.* 1998). Embedded within the hierarchical healthcare system of this cultural context, nurses reinforced power and control in clinical encounters (Akiwumi 1994, Lee & Saeed 2001, d'Oliveira *et al.* 2002), scolding women for almost everything they did, whether this was delaying seeking health care or asking questions. Nurses failed to consider the realities of women's lives, such as geographical location, family influences, financial barriers, and the fact that the

majority were not formally educated, thus limiting their access to and interpretation of information that could benefit them.

Control of health information, how it is shared and with whom, has been identified as a problem related to power in healthcare practices in Ghana (Anderson 2004). Unique in our study were findings related to the manner in which nurses used 'silent treatment' and withholding information when providing care to rural women, and also how women's increased desire for information from nurses played out. However, based on our findings, a wide range of factors influencing information-sharing among nurses and women need to be acknowledged. The context that shapes nurses' work in developing countries, particularly in Ghana, cannot be ignored. Important contextual factors that influence information-sharing include general societal attitudes toward women, especially rural women who are uneducated, nurses' social status and work demands, the physical structures of clinics, the resources provided, and deficiencies in nursing education programmes, along with lack of effective role models. Anderson (2004) found that nurses and physicians provide differential treatment to hospital patients based on their social status. Other researchers have associated nurses' practice patterns in providing health care to women in rural settings with their own privileged social status (Mayhew 2000), which they use to bring about power imbalances. In our study, the manner in which nurses interacted with women during care-seeking, their insensitivity towards women's needs for privacy, and the limited information they provided may have reflected their perceptions of rural women's lower social status. Further, women's accounts of care-seeking suggest an apparent lack of insight among nurses about their poor relationships with patients and their impact (D'Ambruoso *et al.* 2005); thus this area needs further investigation. In addition, d'Oliveira *et al.* (2002) and D'Ambruoso *et al.* (2005) have associated nurses' poor relational practices with general conditions of service, inadequate personnel and the nature of education and professional socialization.

Consistent with other studies in resource-poor nations (Davis-Floyd 2001, Schooley *et al.* 2009), women in our study expressed a preference for TBA services because of the respectful and humanistic care they received from them. This may explain the higher number of deliveries supervised by TBAs in most developing countries including Ghana (Smith *et al.* 2000, Amoako *et al.* 2009). However, the healthcare system discourages the use of TBAs, even though the majority have received training from the health ministry. The apparent tension between professional midwives and

TBAs may indicate that professional midwives feel threatened by TBAs because of women's preferences (Davis-Floyd 2001). Fostering collaboration between nurses and TBAs has the potential to enhance opportunities for nurses to provide training to increase TBAs' skills to offer competent and safe services.

Improvements in reproductive healthcare-seeking behaviour and maternal health service delivery and utilization in rural Ghana and in developing countries could, in part, be realized through changes to nursing education to reflect the needs of service users (Akiwumi 1994). In addition to reinforcing basic relational nursing practices in curricula, developing nurses' understanding of medical anthropology (Hahn & Inhorn 2009) and social determinants of health might help to improve the knowledge and skills needed to deliver respectful and culturally-appropriate health care. In an era when Millennium Developmental Goals (MDGs) on improving maternal and reproductive health are gaining ground worldwide, there is a need for nursing regulatory boards and health ministries to develop mechanisms that will encourage changes in practice. Sanctioning nurses whose practices are contrary to policies on standards of care and that can impede women's healthcare-seeking could pave the way for equitable and universal access to health care by all and help to regain the confidence of service users. Clinic environments need to be designed to provide private spaces for nurses and patients to address reproductive and other health concerns.

## Conclusion

The study adds new knowledge and a broader understanding of barriers to rural women's access to and utilization of maternal health services and has implications for nursing practice, nursing education, health policy and future research. There is an overwhelming need for changes in nurses' relationships with women in clinical practice. This must start from nursing leaders and regulatory boards, who can create awareness of the importance of positive relational practices and service utilization, and also by responding to the need for adequate clinic facilities to support improvements in the provision of nursing care. Coordinated plans of action regarding current practice are urgently needed.

Addressing deficiencies in nursing education, especially related to the development of nurse-patient relationships, would help to improve practice. There is need for healthcare policy reform to place emphasis on patients' rights to quality care and universal access. Future research should be directed at describing nurses' and other healthcare providers' perspectives to assist in making changes.

## Funding

We would like to thank the University of British Columbia Okanagan School of Nursing for a Research Grant to support this work.

## Conflict of interest

No conflict of interest has been declared by the authors.

## Author contributions

KR & VY were responsible for the study conception and design. VY performed the data collection. KR, VY & JBS performed the data analysis. VY was responsible for the drafting of the manuscript. KR, JBS, JB & CR made critical revisions to the paper for important intellectual content. VY & JBS obtained funding. KR supervised the study.

## References

- Akiwumi A. (1994) In search of the 21st century nurse for Ghana. *International Nursing Review* 41(4), 118–122.
- Amoako F.J., Padmadas S.S. & Brown J.J. (2009) On the spatial inequalities of institutional versus home births in Ghana: a multi-level analysis. *Journal of Community Health* 34, 64–72.
- Amoakohene M.I. (2004) Violence against women in Ghana: a look at women's perceptions and review of policy and social responses. *Social Science & Medicine* 59(11), 2373–2385.
- Ampofo A.A., Beoku-Betts J., Njambi W.N. & Osirim M. (2004) Women's and gender studies in English-Speaking sub-Saharan Africa: a review of research in the social sciences. *Gender and Society* 18(6), 685–714.
- Anderson H.M. (2004) 'Villagers': differential treatment in a Ghanaian hospital. *Social Science and Medicine* 59, 2003–2012.
- Anim-Appiah M. (2009) *Maternal Death – Female Nurses Must Take Part of the Blame*. Retrieved from <http://allafrica.com/stories/200908120737.html> on 27 October 2009.
- Creswell J.W. ed. (2007) *Qualitative Inquiry & Research Design. Choosing Among Five Approaches*, 2nd edn. Sage, Thousand Oaks, CA.
- D'Ambruoso L., Abbey M. & Hussein J. (2005) Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health* 5, 140. Retrieved from <http://www.biomedcentral.com/1471-2458/5/140> on 20 February 2007.
- Davis-Floyd R. (2001) The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology and Obstetrics* 75(1), S5–S23. Retrieved from [http://www.davis-floyd.com/art\\_index.html](http://www.davis-floyd.com/art_index.html) on 20 October 2008.
- Doane G.H. & Varcoe C. (2007) Relational practice and nursing obligations. *Advances in Nursing Science* 30(3), 192–205.
- Donnay F. (2000) Maternal survival in developing countries: what has been done, what can be achieved in the next decade. *International Journal of Gynecology & Obstetrics* 70, 89–97.

- Ghana News Agency (2007, February 10) *Oda Government Hospital Records 20 Maternal Deaths Last Year*. Times online [internet] 10 February. Retrieved from <http://www.ghanaweb.com> on 14 February 2007.
- Ghana News Agency (2009a) *Health Workers Cautioned Against Poor Attitude to Patients*. Times online, [internet] 9 June. Retrieved from <http://www.ghanaweb.com/GhanaHomePage/health/artikel.php?ID=163383> on 14 August 2009.
- Ghana News Agency (2009b) *Maternal Mortality Costs the Lives of 169 Women in Brong Ahafo*. Times online [internet] 20 June. Retrieved from <http://www.ghanaweb.com/GhanaHomePage/health/artikel.php?ID=164005> on 20 August 2009.
- Ghana News Agency (2009c) *350 Women Die Out of Child Birth in Zabzugu/Tatale District*. Times online [internet] 20 July. Retrieved from <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID=165661> on 21 February 2009.
- Ghana Statistical Service & Noguchi Memorial Institute for Medical Research and ORC Macro (2004) *Ghana Demographic and Health Survey 2003*. GSS, NMIMR, and ORC Macro, Calverton, Maryland. Retrieved from <http://www.measuredhs.com/pubs/pdf/FR152/FR152.pdf> on 20 August 2009.
- Global Health Council (2008) *Global Health Opportunities. Understanding Reproductive Health*. Retrieved from [http://www.globalhealth.org/images/pdf/gho/2008\\_rh\\_understanding.pdf](http://www.globalhealth.org/images/pdf/gho/2008_rh_understanding.pdf) on 1 December 2008.
- Golafshani N. (2003) Understanding reliability and validity in qualitative research. *The Qualitative Report* 8(4), 597–606.
- Grewal S., Bottorff J.L. & Hilton A. (2005) The influence of family on immigrant South Asian women's health. *Journal of Family Nursing* 11(3), 242–263.
- Hahn R.A. & Inhorn M.C. (2009) *Anthropology and Public Health: Bringing Difference in Culture and Society*, 2nd edn. Oxford University Press, Oxford, New York.
- Hammersley M. & Atkinson P. (2007) *Ethnography: Principles in Practice*, 3rd edn. London, Routledge.
- Heyen-Perschon J. (2005) Report on Current Situation in the Health Sector of Ghana and Possible Roles for Appropriate Transport Technology and Transport Related Communication Interventions. Retrieved from [http://siteresources.worldbank.org/INTTSR/Resources/ITDP\\_20Transport\\_20and\\_20Health0Care\\_20\\_20Ghana.pdf](http://siteresources.worldbank.org/INTTSR/Resources/ITDP_20Transport_20and_20Health0Care_20_20Ghana.pdf) on 30 March 2009.
- Jewkes R., Abrahams N. & Mvowhy Z. (1998) Do nurses abuse patients? Reflections from south African obstetric services. *Social Science & Medicine* 47(11), 1781–1795.
- Knoblauch H. (2005) Focused ethnography. *Forum Qualitative Sozialforschung/Forum:Qualitative Social Research* 6(3), Art. 44. Retrieved from <http://www.Qualitative-Research.net/fqs-texte/3-05/05-3-44-e> on 6 February 2007.
- Lee M.B. & Saeed I. (2001) Oppression and horizontal violence: the case of nurses in Pakistan. *Nursing Forum* 36(1), 15–24.
- Lincoln Y.S. & Guba E. (1985) *Naturalistic Inquiry*. Sage, Beverly Hills, CA.
- Litosseliti L. (2005) *Using Focus Groups in Research*. Continuum, New York.
- Mayhew S.H. (2000) Integration of STI services into FP/MCH services: health service and social contexts in rural Ghana. *Reproductive Health Matters* 8(16), 112–124.
- McPherson N. (1994) Modern obstetrics in a rural setting: women and reproduction in Northwest New Britain. *Urban anthropology and Studies in Cultural Systems and World Economic Development* 23(1), 39–72.
- Morse J.M. & Field P.A. (1995) *Qualitative Research Methods for Health Professionals*, 2nd edn. Sage, Thousand Oaks, CA.
- Morse J.M. & Richards L. (2002) *README FIRST for a User's Guide to Qualitative Methods*. Sage, Thousand Oaks, CA.
- Nazzar A., Adongo P.B., Binka F.N., Philips J.F. & Debpuur C. (1995) Developing culturally appropriate family planning program for the Navrongo experiment. *Studies in Family Planning* 26(6), 307–324.
- d'Oliveira A.F.P.L., Diniz S.G. & Schraiber L.B. (2002) Violence against women in health-care institutions: an emerging Problem. *The Lancet* 359(9318), 1681–1685.
- Oudshoort A. (2005) Power and empowerment: critical concepts in the nurse-client relationships. *Contemporary Nurse* 20, 57–66.
- Pettersson K.O., Christensson K., de Freitas E.d.G. & Johansson E. (2004) Adaptation of health care-seeking behavior during childbirth: focus group discussions with women living in the suburban areas of Luanda, Angola. *Health Care for Women International* 25, 255–280.
- Richards L. (2006) *Handling Qualitative Data: A Practical Guide*. Sage, Thousand Oaks, CA.
- Richards L. & Morse J.M. (2007) *README FIRST for a User's Guide to Qualitative Methods*. Sage, Thousand Oaks, CA.
- Sauls D.J. (2007) Nurses' attitudes toward provision of care and related health outcomes. *Nursing Research* 56(2), 117–123.
- Schooley J., Mundt C., Wagner P., Fullerton J. & Donnell O.M. (2009) Factors influencing health care-seeking behaviors among Mayan women in Guatemala. *Midwifery* 25, 411–421.
- Shaikh B.T. & Hatcher J. (2005) Health-seeking behavior and health service utilization in Pakistan: challenging the policy makers. *Journal of Public Health* 27(1), 49–54.
- Sharts-Hopko N.C. (2002) Assessing rigor in qualitative research. *Journal of the Association of Nurses in AIDS Care* 13(4), 84–86.
- Smith J.B., Coleman N.A., Fortney J.A., Johnson D.J., Blumhagen D.W. & Grey T.W. (2000) The impact of Traditional Birth Attendant training on delivery complications in Ghana. *Health Policy & Planning* 15(3), 326–331.
- Speziale H.J.S. (2003) Designing data generation and management strategies. In *Qualitative Research in Nursing: Advancing the Humanistic Imperative*, 3rd edn. (Speziale H.J.S. & Carpenter D.R., eds), Lippincott Williams & Wilkins, New York, pp. 27–42.
- Storeng K.T., Baggaley R.F., Ganaba R., Ouattara F., Akoum M.S. & Filippi V. (2008) Paying the price: the cost and consequences of emergency obstetric care in Burkina Faso. *Social Science & Medicine* 66, 545–557.
- Sutberns R. (2004) Adding women's voices to the call for sustainable rural maternity care. *Canadian Journal of Rural Medicine* 9(4), 239–244.
- Talensi-Nabdum District Assembly (2007) *Talensi-Nabdum District Assembly Annual Action Plan*. Tongo, Ghana.
- Talensi-Nabdum District Health Administration (2007) *Talensi-Nabdum District half year reproductive health report*. Tongo, Ghana.

United Nations (2000) *United Nations Millennium Declaration*. Retrieved from <http://www.unmillenniumproject.org/goals/gti.htm#goal5> on 5 February 2007.

United Nations Development Programme (1999) *Human development report: Globalization with human face*. Oxford University Press, New York.

Williams S., Nolan M. & Keady J. (2009) Relational practice as the key to ensuring quality care for frail older people: discharge planning as a case example. *Quality in Ageing* 10(3), 44–55.

Wong S. & Regan S. (2009) Patient perspectives on primary health care in rural communities: effects of geography on access, continuity and efficiency. *Rural and Remote Health* 9, 11–42.

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