UNIVERSITY OF EDUCATION, WINNEBA

WOMEN'S PERSPECTIVE ON HUMAN RIGHTS ABERRATION RESULTING FROM THE NEGATIVE ATTITUDES OF MATERNAL HEALTH PROVIDERS: THE CASE OF NANUMBA NORTH MUNICIPALITY

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DECLARATION

I, SANUSA ADAMS BOL-NABA declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

....

Signature ***Date***

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis as laid down by the University of Education, Winneba.

SUPERVISOR: DR. GEORGE HIKAH BENSON

....

Signature ***Date***

DEDICATION

I dedicate this piece of work to my late parents, Alhaji Adam Salifu and Fati Adam, who stood by me and motivated me all my life.

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This research work is made possible by the grand mercies of the almighty Allah for giving me life, good health, and the abundance of grace bestowed on me to undertake this study. This would not have been possible without my supervisor, Dr. George Hikah Benson's encouragement, critique, and guidance.

It may not be possible to capture in print all those who have contributed to the success of this study. I am therefore most grateful to all who diversely supported me during this research work. I say, may Allah bless you all.

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
CSO	Civil Society Organization
CERD	*Committee* on the Elimination of Racial Discrimination
CEDAW	Convention on eliminate discrimination against women
CRC	Convention on the Rights of the Child
D &A	Disrespect and Abuse
FGD	Focus Group Discussion
GDHS	Ghana Demographic and Health Survey
GMHS	Ghana Maternal Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICEFRD	International Convention on the Elimination of All Forms of Racial Discrimination
ILC	International Law Committee
LMIC	Low-and-Middle income country
MDG	Millennium Development Goals
MHC	Maternal Healthcare
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
NGO	Non-Governmental Organization
PAHO	Pan American Health Organization
SDG	Sustainable Development Goals

UNICEF	United Nations Children and Education Fund
UNFPA	United Nation Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
YARO	Youth Advocacy on Rights and Opportunities
UDHR	Universal Declaration of Human Rights

ABSTRACT

The purpose of this study was to review the attitudes of maternal care providers and its risks towards maternal care seekers from human rights perspective in Nanumba North Municipality. This study was informed by the litany of reports of mistreatment of women during childbirth at health facilities. It was also to assist in unravelling the widely reported gaps in maternity care despite significant government and stakeholder investments in maternal healthcare as identified by the World Health Organization (WHO) and Ghana Health Service. Exploratory design was used to explore the experiences of women regarding maternity care services based on four human rights principles: dignity, autonomy, equality, and safety, which also reflected the prominent themes. The experiences of women reflect violations of multiple human rights principles with most respondents harbouring the perception that, most medical officers are inconsiderate and tend to be unfriendly and abusive. While some respondents see no alternative to skilled-based maternal health care delivery, a good number of women would also prefer to seek the services of traditional birth attendants. In general, respondents knew about their basic entitlements as health seekers. However, making the claims for those entitlements seem to be the main challenge. The study recommended among others that human rights be included in the curriculum of health professionals training, the need to partner other stakeholders to embark on rigorous sensitization on human rights in maternal health as well as undertake regular supervision of maternal care officers' operations. In conclusion, the findings are important for new health care policy, standard practice, and subsequent research.

CHAPTER ONE

INTRODUCTION

This chapter presents the background to the study, statement of the research problem, research objectives and research questions. The chapter further discusses the significance, the scope, as well as the chapter organization of the study.

1.1 Background

Disrespectful and abusive behaviors during childbirth have been documented in both developed and developing countries all over the world, making this a truly global issue. While the importance of the subject is not in dispute, Bowser et al (2010), cast doubts on the existences of any accurate estimate of the prevalence of disrespect and abuse. Further, Bowser et al have provoked thoughts and maintained that the term "respectful maternity care" have no existing operational definition and that its definition is only identified in the absence of the concept, "disrespect". According to WHO (2017) "The right to the highest attainable standard of health" employs legal obligations on member states to ensure appropriate conditions for the enjoyment of health for every person without discrimination. Article 25(1) of the UN Declaration of Human Rights identifies that, 'Everyone has the right to an adequate standard of living for health and well-being of himself and his family, including food, clothing, housing, medical care, and necessary social services…' (Phil, 2013).

The promotion of respectful maternity care is identified by Hannah (2013) as a complex issue that goes beyond relatively straightforward clinical quality improvement efforts, to issues of health system governance, social justice, human rights, social norms, and empowering female decision making. According to Cohen (2013), the concept of "human rights in patient care" refers to the application of

human rights principles to the context of patient care. The global drive to improve maternal and newborn health has made striking progress in recent decades, vastly expanding women's access to skilled providers during childbirth in most countries (WHO, 2014). Hannah (2013), and WHO (2014) asserts that 99 percent of preventable maternal deaths occur in the developing world and further noted that, maternal mortality is particularly a tragic issue because it occurs almost entirely among poor and disenfranchised women.

According to Ronsmans and Graham (2006), the top causes of maternal death are hemorrhage, hypertensive disorders (eclampsia), sepsis, obstructed labor, and unsafe abortion. Ronsmans and Graham further identified evidence from developed countries to prove that these medical conditions and others that affect maternal health are manageable or preventable if women received timely access to adequate health infrastructure and medical supplies. For example, the vast majority of obstetric complications leading to maternal death cannot be easily predicted and require urgent medical attention (diagnosis) when they occur (Kruk et.al, 2009). The majority of the global health community has adopted universal coverage of facility-based births as an intermediate goal for reducing maternal mortality. Hannah et al (2013) revealed that, Sub-Saharan Africa remain below 50 percent universal coverage despite the global push for facility-based deliveries with skilled attendants and facility delivery rates.

However, the anticipated gains with improved facility access have not produced the decrease of maternal and newborn deaths and disability that was expected. This situation has led to the need for a broader search within the health facilities. The global focus has, therefore shifted to improving quality of care in facilities and ensuring that basic human rights standards for women and their babies are met.

Quality health care according to Broek et al (2009) is a multidimensional concept with no universally accepted definition. Quality health care draws a fine link with Human rights in Patients Care and this seem to have been emphasized by Cohen et al (2013) who maintained the need for principled discourse of "patients' rights" that has evolved in response to widespread and severe human rights violations in health settings. Graham and colleagues as captured in Aradhana et al (2014) argue that quality care encompasses “clinical effectiveness, safety, and a good experience for the patient”.

Human rights in health delivery is a specialized area used by civil society groups, international organizations, governments, nongovernmental organizations, and individuals in their work especially with respect to maternal health care. As noted by Gruskin et al. (2008), it is broadly categorized into: advocacy, application of legal standards, and programming, including service delivery. In the case of family planning and reproductive health services, Bruce’ (1990) defined quality care by using six elements: choice of methods, information given to clients, technical competence, follow-up and continuity mechanisms, interpersonal relations, and an appropriate constellation of services.

Hulton et al., (2005), in relation to facility-based maternal health services, suggest quality of care is defined by effectiveness, timeliness, as well as the upholding of basic reproductive rights. This is confirmed by Broek and Graham (2009) and Hulton et al., (2000). However, every day nearly 800 maternal deaths occur around the world. In 2010 alone, the World Health Organization estimated about 287,000 maternal deaths (WHO, 2014).

The Committee on the Elimination of Racial Discrimination (CERD), emphasized that, international human rights framework identifies fundamental rights that belong to all people and holds governments accountable for ensuring that those rights can be realized. Human rights include sexual and reproductive rights, which are essential to an individual's self-determination and autonomy. Moreover, human rights bodies have recognized that enabling safe pregnancy and childbirth is essential to women's dignity and the exercise of their human rights and this was captured in the CERD Committee's Concluding Observations in 2014. As a result, ensuring adequate reproductive and maternal health care is considered a core government obligation.

In Ghana, the implementation of free maternal health services under the National Health Insurance Scheme and the government's efforts in expanding health infrastructure, providing equipment, training, and deploying more health personnel were key strategies for the achievement of the Millennium Development Goals (MDGs) as highlighted by (Darlingjong et al., 2018). Though maternal health care has improved over the past 20 years, the pace has been slow, Apanga (2018). Results from Ghana's recent Demographic and Health Survey (GDHS) indicated that national Antenatal Care (ANC) coverage was 97% compared to supervise delivery of 74% according to GSS, GHS and ICF international (2015). Women's decisions about the choice of place of birth are influenced by many factors, ranging from demographic, socio-economic circumstances, cultural to health system factors as estimated by WHO, UNICEF, UNFPA and the World Bank. The notion that, the attitudes and behavior of health care workers can affect patient care has long been recognized and there are urgent calls for more attention to be given to the assessment and improvement of interpersonal skills, as part of addressing the quality of care. Thus, the purpose of this study is to explore some of the negative attitudes exhibited by

maternal healthcare providers towards maternal health seekers in the facility. The study further aims at describing some of the human rights implication of these attitudes by healthcare providers to the care seekers (women) and the general public that could undermine accessibility of health. Finally, the study seeks to understand how the negative attitude may affect healthcare delivery to clients.

1.2 Problem Statement

Human rights have been gradually accepted as a guiding universal moral norm that transcends cultural differences. This universal norm has culminated in the worldwide abolition of slavery in the 19th century, the proscriptions of cannibalism and infanticide, and other goals (Lautensach & Lautensach, 2011b). Mendez (2013) reported a particular vulnerability of marginalized groups to torture and ill treatment in health settings, citing "structural inequalities, such as the power imbalance between doctors and patients, exacerbated by stigma and discrimination" (Cohen 2013). According to the WHO (2014), approximately 800 women die every day from preventable causes related to pregnancy and childbirth.

The WHO factsheet further outlined that in 2010, about 287, 000 women died during pregnancy and childbirth, where most of these deaths occurred in low-resource settings (WHO, 2014). Despite the convincing evidence of various interventions by states, maternal mortality rates are still high in many countries, suggesting a violation of women´s right to life (Mpembeni et al, 2019). Hannah (2013) observed that, most interventions aimed at increasing rates of facility-based deliveries have over the years targeted barriers such as inadequate transportation, infrastructure, high service costs, and a lack of information about the benefits of facility-based deliveries. In Ghana, Apanga (2018) asserts that the country's efforts have seen a curiously slow result.

Rosen et al. (2015) in a study of some sub-Saharan African countries asserted that women would prefer to deliver in medical facilities, but their previous experiences of poor-quality service, disrespectful conduct as well as maltreatment during childbirth by service providers have sometimes discouraged them. The situation is even worse in rural areas, where supervised delivery is said to be lower compared to that in urban areas in Ghana (GHS, 2015). Meanwhile, where health care services are deemed poor by their users, demand for the service is likely to be negatively impacted (Latunji, 2018).

Similarly, Nakua et al. (2015) revealed that about 42.3 % of mothers who attended an antenatal care clinic at least once for their most recent births, had their deliveries through unskilful personnel. Reasons attributed to this practice within such health facilities have been mentioned to include insults from health workers (23.5%), unavailability of transport (21.9%), and trust in traditional birth attendants (17.9%). These statistics raises series of questions regarding maternal healthcare seekers and providers as this study explores to finding answers. Are maternal healthcare seekers aware of their rights regarding the maltreatment received on the part of healthcare providers in the facility? Are healthcare providers aware of the implications of their actions in the violation of the rights of their clients? What steps can be taking to avert such practices among healthcare providers? These and many other nagging questions require detailed academic research to find answers, hence, the interest of the researcher in undertaking this study, especially in assessing the human rights perspective of the attitude of maternal health service providers. Although fundamental human rights principles are incorporated into legal and medical frameworks, human rights must be translated into measurable actions and outcomes (Miltenburg, 2016). Even though there are various efforts by researchers to study the

attitudes of health professionals from diverse angles, not much has been done to explore the human rights perspective through the practice of health professionals. The few studies that have been done (Dickson 2017, Esena et al. 2013) have attempted to identify and explain the challenges associated with patronage of maternal healthcare. Also, Asamanu (2018), Agbenor, (2017), Dapaah, (2016) and Ocran, (2014), have extensively studied the attitudes of Ghanaian nurses, the practices of healthcare professionals, and the knowledge and practices of Ghanaian midwives, among others. Yet Sumankuuro et al. (2018) also studied the "perceived barriers to maternal and new-born health services delivery", but their emphasis was on community members in low and middle-income settings within the study areas.

Thus, the insufficient academic literature to unravel the human rights implications of the maternal health care providers' attitude towards care seekers by academics calls for further studies. This study, thus, intends to fill the gap in the literature on the human rights dimension of attitudes of service providers towards maternal health care seekers in the Nanumba North Municipality.

1.3 Significance of the Study

This study updates the whole literature on both human rights and maternal healthcare in Ghana and any other part of the world. It adds up to the body of literature on the relationship between access to maternal healthcare and human rights as well. The study is also critical for policy developers and implementers to consider in improving the quality of maternal healthcare delivery in facilities. More importantly, the study serves as a source of knowledge or information to stakeholders to consider in the elimination of the barriers to accessing healthcare by pregnant women in health facilities. Locally, stakeholders within the facility in the study area could rely on this

document to addressing the challenges faced by pregnant women and other women in relation to healthcare providers during access to maternal care.

The study would further inform the public to appreciate the challenges and plight of women seeking maternity health services in the municipality and other related facilities to find local solutions to addressing such challenges.

1.4 Objectives of the Study

This study seeks to achieve the following specific objectives:

1. To identify the human rights issues in respect of maternal health care delivery in health facilities within the Nanumba North Municipality.
2. To assess how the attitudes of care providers infringes on the rights of maternal healthcare seekers.
3. To examine the risks regarding the attitudes of health care providers on the rights of maternal health care seekers in Nanumba North Municipal.

1.5 Research Questions

The study was guided by the following questions:

1. What are some of the human rights breaches by healthcare providers in respect of maternal healthcare delivery in the Nanumba North Municipal hospital?
2. What are some of the negative attitudes of healthcare providers that infringes on the rights of maternal care seekers?
3. What are the negative consequences regarding the attitude of maternal healthcare providers on the rights of maternal health seekers in Nanumba North Municipal?

1.6 Justification of the Study

The maternal mortality rate in Ghana is identified as rising at an unacceptable rate according to the Maternal and Neonatal program effort index (2002). While maternal mortality figures vary widely by source, estimated figures for Ghana suggest that roughly between 1,400 and 3,900 women and girls die each year due to pregnancy-related complications (Maternal and Neonatal Programme Effort Index 2002). Of the estimated total of 536,000 maternal deaths worldwide in 2005, the WHO (2005) revealed that, developing countries accounted for 99% of these deaths. Moreover, Sub-Saharan Africa recorded more than half of the maternal deaths, and that is translated into 270,000, followed by South Asia, which accounts for 188,000 (WHO 2005).

WHO (2017) estimated that there are 170 million pregnancies yearly across the globe, and 40% of these pregnant women risk unpredictable complications that could result in their death or injury, either to the mother or their infant. The authors also stated that 15% of the complications are potentially life-threatening and will necessitate immediate obstetric care WHO (2017). Reducing maternal mortality and disability will depend on identifying and improving those services that are critical to the health of women and girls in Ghana. Ghana's maternal and perinatal mortality rate is 205 per 100,000 live births. Maternal health services are said to play a vital role in achieving improved reproductive outcomes in various societies.

The Study's Scope

The scope of the study in terms of concept and location was limited to the main and relevant areas of this study. The concept was broadly framed around the predisposing factors, enabling factors, and need for care influences. The specific limitation

involved how factors such as knowledge, perception, and utilization influenced the concept of health seeking behaviour. The location was limited to the Nanumba Municipality alone and women at their reproductive ages.

1.7 Organization of the Study

Chapter one introduces the entire study, starting with an introduction providing background to the study, the quality of maternal health services from a human rights perspective. It covers the problem statement, objectives, and research questions. This chapter also discusses the significance of studies, among others.

The second chapter focuses on the discussion of literature and theories relevant to human rights and maternity healthcare services. The literature review was conducted based on the objectives of the study. This was done with the view of enabling the researcher to relate findings of the study to other existing scholarly works to see the area of commonality and difference and to draw the appropriate conclusion.

In Chapter three, the study discusses the research methodology. This chapter justifies the research paradigm under which the methods for the study were selected. It also covers the sources of data, sampling techniques and instrumentation, the study population, and the scope of the study, in addition to the data gathering procedure and ethical considerations. This chapter indicates the appropriateness of the methods for the systematic approach that a scientific study of this nature requires.

Chapter four provides the findings of the study together with the discussions to enable readers to follow the connection between the objectives of the study and research questions, the literature review, the theoretical framework, and the responses from respondents.

Chapter five of the study summarizes and concludes the entire study. The necessary recommendations are made to inform policy action and directives to ensure quality healthcare in line with human rights in Ghana.

1.8 Summary

From this chapter, it is evident that, countries may have made efforts to improve maternal and newborn health needs, however, it is evident that, certain barriers might nonetheless exist both within and without the health sector. Overcoming such barriers requires their identification, careful analysis, and their subsequent modification – through laws, policies and regulations that are consonant with human rights. This should be done with the ultimate aim of improving women's access to needed maternal services through the promotion and protection of their human rights.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section reviews relevant literature on the subject matter under discussion, that is, the perceived human rights issues on accessing maternal healthcare service in health facilities by women. The review was done under the backdrop of the study objectives.

2.1 Concept of Rights to Health

The International Covenant on Economic, Social, and Cultural Rights serves as a central provision where the right to health is tapped in international human rights law. As highlighted in Article 12, "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Hunt (2004) identified that, for more than fifty years, the constitution of the World Health Organization recognizes the enjoyment of the highest attainable standard of health as a fundamental human right. Similarly, international treaties also recognize a range of other human rights that are also of central relevance to health and include the rights to adequate education, shelter, privacy, food, non-discrimination, and prohibition against torture. There are a variety of links between health and human rights:

Human rights violations can have serious health consequences on the individual. Also, health policies and programs drawn and implemented can either promote or violate human rights in the way that they are designed, and finally, vulnerability and the impact of ill-health can be reduced by taking steps to respect, protect, and fulfill human rights (Marks, 2001).

Human rights are relevant to a larger number of health issues, including but not limited to prevention and treatment of diseases such as HIV/AIDS; sexual and reproductive health among others (Phil, 2013). It is also link with access to clean water and adequate sanitation; medical confidentiality; access to education and information on health; access to drugs; and the health of marginalized and vulnerable groups such as women (Marmot and Wilkinson, 1999). Human rights are also relevant to promoting health in broader contexts, such as in armed conflict, poverty reduction strategies, and international trade (Lautensach and Lautensach, 2011b). This study thus, consider the link between human rights & human welfare by scholars as critical for further analysis of the relationship between health and human rights. It will serve as a very useful source of information for research on many issues that are central to the promotion and protection of human rights as this study seeks to explore.

2.2 Maternal Health as a Global Development Priority

In the year 2000, the international community reached an historic agreement to work together to improve maternal health. Captured as one of the eight Millennium Development Goals (MDGs), all countries agreed to pursue and improve maternal health and ensure that survival became a shared global priority. Ronsmans and Graham (2006) reiterated how over one and half decades of the MDGs guiding the international development agenda has contributed to a nearly 50% reduction in the global maternal mortality ratio (MMR) between 1990 and 2015.

The World Bank (2012) estimated a maternal mortality rate of 210 maternal deaths per 100,000 live births across the world. This study confirmed an earlier study by the WHO, UNICEF, and UNFPA, which estimated 287,000 maternal deaths worldwide in 2010. Similarly, the global maternal mortality rate plausibly ranges from 170 to 300

maternal deaths per 100 000 live births (Hunter, 2002). The global adult lifetime risk of maternal mortality (that is, the probability that a 15-year-old woman will die eventually from a maternal cause) is one (1) in one hundred and eighty (180). According to WHO et al (2012) reports, developing countries account for 99% (284 000) of the global maternal deaths, the majority of which are in sub-Saharan Africa (162 000) and Southern Asia (83 000). These two regions accounted for 85% of the global burden, with sub-Saharan Africa alone accounting for 56%.

2.3 International Conventions

According to Haigh (2002), there is a seeming unanimous agreement among scholars that the use of human rights terminology and the notion of "universal rights" emerged during the period for the preparations and establishment of the United Nations. While the Universal Declaration of Human Rights (UDHR) is considered a nonbinding agreement, it is regarded as part of international customary law. When it comes to international human rights law, special attention is given to the international conventions.

According to Tim (1998), the first category in a law-making treaty, which can establish or legislate general international rules that can bind state parties, and sometimes non-state parties, is by treating them originally as customary law. However, there is a general rule of international law that implies that, treaties cannot bind third parties without their consent, and this is corroborated by article 34 of the Vienna Convention on the Law of Treaties, 1969. This may explain why Tim (1998), believe that the enforcement of treaties on third parties does not accrue from the treaties themselves but rather from authority derived from customary international law. The second category is contract treaties, which usually organize the relationship

between two parties, and do not produce legal obligations. The language and concepts used in these treaties, as espoused by Dixon (2013), have already been argued to be insufficiently precise. This is because each of them contains some elements of what has been described as a right to health care, and they remain relevant to this discussion. Most importantly, the author asserts that, the articulation of the right to health care in a law-making treaty could and should formulate general principles of law and customary rules which compels all states, especially those who have not signed or ratified any international agreement on this subject (Dixon, 2013).

According to Bownlie (1995), it is generally believed that customary international law can be generated by all actions of states, including a bilateral treaty. Yet, the International Law Committee, suggested that customary international law might be instituted by different states on international activities (Tim, 2012). Health is an essential social good for all nations. Hence, international treaties have played a fundamental role in raising awareness by focusing on the right to health care and rights in health.

This significant role of the treaty in human rights is recognized for several reasons: First, human rights are a novel and universal issue, which began to develop systematically following the Second World War and became one of the major projects of the United Nations' Charter (Henkin, 1979). Secondly, treaties are often written documents, which makes them clearer and explicit than other sources. Because of this clarity, treaties are used more by states to systematize international affairs. However, Article 31 of the Vienna Convention provides a guide for interpretation which is designed to minimize this anticipated difficulty. In this respect, Gardiner (1997),

explained that the preparatory work and diplomatic documents of the treaty could be used as a reference to interpret this treaty.

According to Brems (2007), a treaty can also establish a mechanism for monitoring its application. Most importantly, this mechanism usually issues decisions or announcements regarding the implementation of the treaty by state parties. In such cases, this body is also considered the only authorized organization that can deal with the interpretation of the treaty. Linking this with human rights matters, there is an important point that arises from the establishment of special bodies by treaties. These specialized organizations often focus on related human rights matters that are subject to the convention that instituted the body. It is worth noting, according to Dutton (2012), that it is not enough for states parties to sign or ratify treaties involving human rights issues; they must also act to demonstrate a genuine intent to treat them as law. Moreover, state parties are required to take all necessary steps to ensure the application of human rights in the same way as other legal obligations (Rutherford, 2018). Because of their international obligations under conventions that are concerned with health care, states are required to take positive action, such as enacting new laws or at least notifying other states in the event of the spread of disease. Even though there is still uncertainty about the status of the right to health care as a human right, it can be seen as more derivative from international conventions than any other source of law.

In accordance with article 18 of the Vienna Convention, signatory parties are required to show their good faith in relation to the subject of the international agreement. Although the Universal Declaration of Human Rights (UDHR) is a non-binding

convention, it has played a significant role in generating serious legal discussion of the right to health care internationally. In article (25), the Declaration states that:

> Everyone has the right to a standard of living adequate for the health and wellbeing of themselves and their families, including food, clothing, housing, medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond their control.

It further states that:

Motherhood and childhood are entitled to special care and assistance and that all children, whether born in or out of wedlock, shall enjoy the same social protection.

In summary, despite the different language adopted in accordance with the various relevant treaties, the right to health care proposed here, which encompasses these commitments, has the practical status of an international obligation requiring the international community to work together to ensure the provision of appropriate healthcare (including preventive programs) for all.

2.4 Explication of the concept of Right to Health

Writers such as Toebes (2001) prefer to use the phrase "the right to health" as the appropriate expression in terms of legal discourse. The WHO describes health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity". Despite its ostensible value, the above definition has come under wide criticisms. The subject matter over the period has continuously divided opinions and still does the same today. However, what stands out is the admission of how broad and seemingly complicated the topic is presented. This assertion is corroborated by Ruger (2006), who explained that the fundamental problem of

referring to the "right to health' is that the breadth of the concept causes difficulty in its implementation. The editors of The Right to Health in the Americas, Fuenzalida and Scholle-Connor (1997), argued that the right to health is too broad, hence it is impossible to achieve it. This, the authors emphasized that, several scholars agrees that the right to health is unachievable since no right can guarantee everyone's health. To ensure the effectiveness of the right to health concept, Buchanan (1984) argues that it needs to be refined and limited. This limitation, however, does not imply that such rights in the context of health must be reduced to the point where they fail to meet the expectations of patients.

In other words, neither the broader concept of the right to health, as in the international trend, nor the narrower concept that limits it to only medical care or emergency care, is acceptable. In fact, a definition that meets the needs of the people and which it is possible to achieve is required. Sprumont (1998) also noted the importance of recognizing a minimum content for the right to health, arguing that if the content of such right is unlimited, the government's health obligations will be more political than legal. Therefore, the right must be restricted to some degree, allowing us to ensure that it becomes possible to achieve.

Asher et al. (2004) points out that, human rights are claimed rights, and this implies that the rights of one party imposes a corresponding duty on the other to implement them. Bok (2004) has stressed that the WHO definition of health must be seen as no more than a historical document and that it should be respected as such. However, in operational terms, the author believes that the WHO definition of health is impractical.

Meanwhile, there are other essential elements of the Right to Health as contained in the General Comments 14, of the UN Committee on Economic, Social, and Cultural Rights (CESCR). These elements provide detailed guidance to States on their obligations to respect, protect, and fulfill the right to health. These are found within the broader concepts of availability, accessibility, and acceptability. States are required to make available and accessible, health facilities and other essential goods necessary for the fulfilment of the general rights to health by the people (UN, 2016).

2.5 Right to Health Under International Law

The idea of a right to health under international law is found in the 1948 Universal Declaration of Human Rights. The notion was unanimously proclaimed by the UN General Assembly as a common standard for all humanity. Referring to article 25, the Declaration provides a road map for the right to a "standard of living adequate for the health and wellbeing" of "self" and "family," which includes the right to medical care and to security in the event of sickness, disability, or other lack of livelihood in circumstances beyond control. A close look at international laws suggests that there is a right not merely to health care but to a much broader concept of health. This is because rights are realized inherently and within a social context. The framers of these values and norms obviously anticipated that, determinants of health and ill health are not purely "natural" but are also factors of societal relations; hence, the incorporation of the phrase "Right to the Highest Attainable Standard of Health". And this is further highlighted by the UN Committee on Economic, Social, and Cultural Rights in General Comment 14. The Universal Declaration of Human Rights is widely acclaimed as the first international declaration of fundamental human rights, both freedoms and entitlements alike. United Nations High Commissioner for Human Rights Pillay (2008) noted that the Universal Declaration of Human Rights "enshrines

a vision that requires taking all human rights—civil, political, economic, social, or cultural—as an indivisible and organic whole, inseparable and interdependent".

Similarly, Gruskin et al (2007) argued that the Universal Declaration of Human Rights expresses a "responsibility that extends beyond the provision of essential health services to addressing the determinants of health such as provision of adequate education, housing, food, and favourable working conditions," and that these provisions "are human rights themselves and are necessary for health." In 1966, the covenants on civil and political rights and economic, social, and cultural rights were promulgated which Craven (1995), refers to as twin covenants.

Article 12 of the ICESCR explicitly sets out a right to health and defines steps that states should take to "realize progressively" ("to the maximum available resources") the "highest attainable standard of health," including "the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child"; "the improvement of all aspects of environmental and industrial hygiene"; "the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases"; and "the creation of conditions which would assure all medical service and medical attention in the event of sickness." Yet, Article 2 of the ICESCR states that the right to health demands, just like all other human rights, "international assistance and cooperation." The idea of referencing the "highest attainable standard" of health, taken from the preamble of the 1946 constitution of the World Health Organization, buttresses the dictate of ICESCR and implies that the state has a role to play in levelling the social playing field with specific regard to health (Toebes, 1999; Kinney, 2001).

A review of the international instruments and interpretive documents by Kinney (2001), Chapman (2002), and other scholars makes it clear that the right to health as it is enshrined in international law extends well beyond health care to include basic preconditions for health, such as potable water and adequate sanitation and nutrition.

2.6 **Assertion of the Universal Rights of Childbearing Women**

Human rights are fundamental entitlements for all individuals, recognized by societies and governments and enshrined in international declarations and conventions (UN charter, 2010). Till date, no universal charter or instrument specifically delineates how human rights are implicated in the childbearing process or affirms their application to childbearing women as basic, inalienable human rights (Global Health Policy, 2017). However, the UN Charter aims at addressing issues related to disrespect and abuse among women seeking maternity care and provide a platform for improvement. This, seeks among other things, to:

- Raising awareness of childbearing women's inclusion in the guarantees of human rights recognized in internationally adopted United Nations and other multinational declarations, conventions, and covenants.
- Highlighting the connection between human rights language and key program issues relevant to maternity care.
- Increasing the capacity of maternal health advocates to participate in human rights processes.
- Aligning childbearing women's sense of entitlement to high-quality maternity care with international human rights community standards; and
- Providing a basis for holding the maternal care system and communities accountable to these rights.

By drawing on relevant extracts from established human rights instruments, the Charter demonstrates the legitimate place of maternal health rights within the broader context of human rights. Meanwhile, Bowser and Hill (2010) identified seven rights from the categories of disrespect and abuse (see table).

Tackling Disrespect and Abuse: Seven Rights of Childbearing Women

	Category of Disrespect and Abuse	Corresponding Right
1.	Physical abuse	Freedom from harm and ill treatment
2.	Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
3.	Non-confidential care	Confidentiality, privacy
4.	Non-dignified care (including verbal abuse)	Dignity, respect
5.	Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
6.	Abandonment or denial of care	Right to timely healthcare and to the highest attainable level of health
7.	Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

Source: Bowser and Hill (2010)

All these rights are grounded in international or multinational human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on

Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women. Each right is sourced to the relevant instruments.

2.7 Human-rights criticism

Over the last few decades, prominence has been placed on human rights to attain common moral values based on the mutual acceptance that the humanity of individuals is conveyed through personal interactions with others in a specific community. Even though this ideology is receiving global recognition, several scholars have vehemently criticized the whole idea, focusing on the need for it to be adopted as a complement to existing values rather than human rights being stand-alone. For example, Gusman (2015) contends that for human rights to have universal status, they must be justifiable by different moral cultures and acceptable by the majority, though not necessarily all cultures around the globe. Staekle et al. (1998), Mswela (2017), and Posner (2018), contrarily, believe that international human rights law is not universal in the sense that it cannot substitute national laws but only complement them.

Posner (2018) insists that there is little evidence of it improving the general well-being of humankind. Yet, Mkabela (2014), asserts that, Ubuntu which is a traditional African value system, incorporates moral values such as humility, modesty,

conformity, and empathy, forming the foundation upon which individuals are viewed through a lens that places more emphasis on individual duties and responsibilities than individual human rights.

2.8 Disrespect, abuse, and patients' perception of quality of care and satisfaction

Bowser and Hill (2010) in exploring the evidence for disrespect and abuse in facility described seven major categories of disrespect and abuse that childbearing women encounter during maternity care. These categories overlap and occur along a continuum from subtle disrespect and humiliation to overt violence, which includes physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities. Interpersonal care that is disrespectful and abusive in nature to women before, during, and after birth is reported to be appalling, according to Bowser and Hill because of the high value societies attach to motherhood and the intense vulnerability of women during the time of birth. However, all childbearing women needs and deserve respectful care and protection of their autonomy and right to self-determination. Furthermore, disrespect and abuse during maternity care are violations of women's basic human rights.

Studies by Bruster et al., (1994) suggests that patient satisfaction scores present a limited and optimistic picture, since questions about specific aspects of patients' experiences showed that inpatients who rated their satisfaction as "excellent" at the same time reported several problems. This was supported by Jenkinson et al. (2002). Riiskjr, Ammentorp, & Kofoed (2011) suggests that there is a question of whether it may be difficult for patients to criticize healthcare quality when answering questions with fixed responses and where there is no space for actual care situations to rate.

Other examples of this discrepancy are the coexistence of high levels of patient satisfaction with pain management and high levels of pain (Sauaia, Min, Leber, Erbacher, Abrams, & Fink, 2005; Beck, Towsley, Berry, Lindau, Fields, & Jensen, 2010). The results from an interview study examining this discrepancy between high satisfaction ratings and high levels of pain intensity indicated that patients expected to have some unrelieved pain after surgery, the healthcare personnel did their best, and the patients did not want to be troublesome to busy personnel (Idvall, 2002). The discrepancy between high scores on patient satisfaction and poor healthcare episodes is a problem when the purpose of healthcare quality research is to improve the quality of care.

2.9 Attitude and Behaviours of Maternal Health Care Providers (MHCPs)

Maternal health care providers' (MHCPs') attitudes and behaviours are important quality indicators because they influence how women, their partners, and families perceive and experience maternal health care, both positively and negatively. Lack of respectful care from providers such as doctors and midwives, may lead to dissatisfaction with the health system, diminishing the likelihood of seeking antenatal (ANC), delivery, and postnatal services (Ratsma and Malongo, 2009).

In addition, MHCPs' attitudes and behaviours might directly affect the wellbeing of parents and clients and the relationship between patients and providers. Negative behaviours can, moreover, undermine the quality of care and the effectiveness of maternal health and infant health promotion efforts. This situation compromises women's rights to dignified and respectful maternal healthcare. Taken together, the attitudes and behaviours of MHCPs are an important determinant of maternal and infant health outcomes. A statement by the World Health Organization (WHO) (2012) and the Human Reproduction Programme calls for greater attention, research, and

advocacy around the maltreatment of women at the time of childbirth in facilities. Though several individual studies have explored the providers' attitudes and behaviour, few have reviewed and synthesized these findings. To date, reviews have either focused on specific attitudes and behaviours, such as disrespect and verbal and physical abuse. A more comprehensive review of the attitudes of Maternal Health Care Providers (MHCP) that spans the continuum of the maternity period will add important information and evidence that could influence and inform policies and strategy on the subject matter.

2.10 Case presentation

2.10.1 Maternal mortality and human rights: landmark decision by United Nations human rights body

The idea of reducing maternal mortality by three quarters between 1990 and 2015 was one of the important objectives of Millennium Development Goal 5. However, progress towards this objective, according to a MDG report (2011) proved slower than expected, despite global commitment and the fact that the majority of maternal deaths, 99% of which occur in developing countries as identified by the WHO. This situation can only be prevented through well-known interventions. The United Nations (UN) Human Rights Council has marked maternal mortality as not just a development issue, but also one that bothers human rights.

A 2010 report for the United Nations High Commissioner for Human Rights, points out that, human rights can enhance accountability for preventable maternal mortality. The UN Secretary-General's Global Strategy on Women's and Children's Health and the ensuing Commission on Information and Accountability for Women's and Children's Health have highlighted that strengthening accountability is an

essential but neglected strategy for improving women's and children's health and reducing maternal mortality. In linking accountability with human rights, the Commission built its accountability framework on the right to health, equity in health and gender equality. The Committee on the Elimination of Discrimination against Women, which is charged with overseeing States parties' implementation of their obligations, became the first UN human rights body to issue a decision on maternal mortality. This case among other subsequent cases concerned a woman called, Alyne da Silva Pimentel, a Brazilian of African descent who died from pregnancy-related causes after her local health centre wrongfully diagnosed her symptoms and delayed providing her with emergency obstetric care.

According to the facts of the case, she began haemorrhaging and suffering from other complications of the stillbirth, prompting clinic doctors to recommend transfer to a better equipped public hospital. However, the public hospital did appreciate the idea of using its only ambulance to transport her. Meanwhile, the family of Alyne was also unable to obtain a private ambulance to convey her after long hours of waiting. She finally reached the hospital in a very critical condition where the facts state she was left again, largely unattended in the hospital hallway for 21 hours till she died. The mother of the deceased took the case to the CEDAW Committee. There, her argument was that, national authorities never made any effort to establish professional responsibility and that she had been unable to obtain justice for her daughter in Brazil. Alyne's death exemplifies circumstances that are all too common everywhere and that, preventable maternal deaths seem to be concentrated among marginalized groups of women, and they are marked by a lack of accountability.

In *Alyne da Silva Pimentel v. Brazil*, it was established that states are bestowed with the obligation to guarantee the human rights of women irrespective of their racial and economic backgrounds, and to do so in a timely manner whilst ensuring non-discriminatory access to appropriate maternal health services. The Committee also established that even if the government outsources services to private health-care institutions, those institutions must remain directly responsible to the government. Hence, the government must regulate and monitor the actions of these institutions. The Committee found violations of the right to access health care and emphasized the importance of effective judicial protection in the context of non-discrimination. The CEDAW came to the conclusion that Alyne was abandoned to die of entirely preventable causes because of her race, gender, and economic status. It was emphasized that Alyne had experienced what is termed "intersectional discrimination" as she was "discriminated against, not only on the basis of her sex, but also on the basis of her status as a woman of African descent and her socioeconomic background." The CEDAW Committee found that Alyne's death constituted gender discrimination under CEDAW and a violation of the right to life under the ICCPR.

These rights are guaranteed by the CEDAW in the 187 countries that are party to it and legally bound by its provisions, as well as by most countries' constitutions and laws. Cases of this kind provide opportunities to advance international and domestic accountability. The Committee, in its authoritative interpretation of states' obligations under the CEDAW, made several general recommendations that are intended to reduce preventable maternal deaths. These were included in the forty-ninth session:

(i) to ensure women's right to safe motherhood and affordable access to emergency obstetric care.

(ii) to provide adequate professional training for health workers.

(iii) to ensure that private health-care facilities comply with national and international reproductive healthcare standards.

(iv) to implement Brazil's National Pact for the Reduction of Maternal and Neonatal Mortality, which includes the establishment of more maternal mortality committees to monitor maternal deaths; and

(v) to ensure women's access to effective remedies when their reproductive rights have been violated. The Committee also recommended that Brazil provide reparation, including monetary compensation, to Alyne's family.

The case of Alyne da Silva Pimentel presents a global significance which includes global repercussions. Nationally, its impact will be felt in the extent to which Brazil complies with the CEDAW Committee's recommendations. The Committee's recommendations regarding maternal mortality committees and access to effective remedies demonstrate how a human rights approach can strengthen accountability for maternal deaths at the national level. Shortly, Brazil set up an inter-ministerial working group which included the Ministry of Foreign Affairs, the Ministry of Health, the Secretariat for Women's Policies, the Secretariat for Human Rights, and the Secretariat for the Promotion of Racial Equality to implement the recommendations from the decision. After the 2-year period of the CEDAW decision on Alyne's death, leading to her family's compensation, there was no meaningful address to the health system failures and this led to, international and regional CSOs making demands on Brazil to act. Furthermore, CSOs who had in their possession the CEDAW decision, presented documentation and testimony and called on the government to compensate Alyne's family and address the pervasive discrimination in Brazil's health system and the persistence of poor health facility conditions, according to the Center for Reproductive Rights. The CEDAW Committee requested that Brazil

submit within six months, i.e., by February 2012, a written response detailing any action taken in response to its views and recommendations. The report further confirmed that in 2014, Brazil finally paid reparations to Alyne's mother. Brazil acknowledged responsibility for Alyne's death and made some progress towards implementing a new maternal and reproductive health program. International mechanisms are intended to ensure accountability in particular situations where national mechanisms are infected, inaccessible, or even non-existent. For example, UN treaty monitoring bodies, which independently oversee the implementation of international human rights treaties, review national reports submitted by states parties on a regular basis and make recommendations. Some of them, like the CEDAW Committee, also oversee complaints procedures such as the one described herein.

2.10.2: Addressing challenges in accessing legal abortion in Peru through the ICCPR and CEDAW

Peru has also had to deal with two major issues regarding the right to access legal abortion brought before international treaty monitoring bodies. Karen Noelia Llantoy Huamán decided to terminate her pregnancy when she discovered that the fetus she was carrying was anencephalic. This posed a serious health risk to the 17-year-old Peruvian. *Karen Noelia Llantoy Huaman v. Peru* ("*K.L. v. Peru*") was issued in 2005 by the UN Human Rights Committee. At Archbishop Loayza National Hospital in Lima, the hospital director refused to allow an abortion procedure. His grounds for refusal were article 119 of the Criminal Code, which only permitted therapeutic abortions where termination was the only way of saving the mother's life or avoiding permanent damage to her. Huamán's anencephalic daughter died four days after she was born, causing her to fall into a deep depression. In a complaint to the committee, Huamán asserted that the hospital caused her both physical pain and

mental suffering by forcing her to continue her pregnancy. In her estimation, the law that prevented her from terminating the pregnancy is a violation of article 7 of the Covenant on Civil and Political Rights, which prohibits cruel and inhuman treatment, and of article 17, which protects women from interference in decisions that affect their reproductive rights. Karen Noelia Llantoy Huamán further asserted that Peru's failure to adopt economic, social, and cultural measures to safeguard her rights under article 17 was tantamount to a violation of article 24 of the Covenant. On the other hand, Peru never challenged or contended Huamán's claim, and therefore, the Human Rights Committee found that the facts presented reveal a violation of article 24, which guarantees state protection to minors. It concluded that the cause of the physical pain and mental suffering she experienced was directly linked to the state's refusal to allow Huamán to obtain a therapeutic abortion. The Committee found that Huamán's case presented fertile grounds for Peru to rectify the existing abortion law.

The year 2011 saw Peru handed another ground-breaking decision for the second time by an international treaty monitoring body specifically addressing abortion as a maternal health issue. This case, recorded as *L.C. v. Peru*, occurred in a poor suburb which is very close to Peru's capital city of Lima. A 13-year-old girl by L.C who got pregnant after being raped repeatedly for several months by a 34-year old man. After L.C got to know she was pregnant, she desperately jumped off a building in a suicide attempt, severely injuring her spine in the process. Despite a recommendation from her physician, health providers denied the 13-year-old girl access to back surgery to correct her spine, claiming that back surgery would interfere with her pregnancy. Medical authorities also rejected a request for an abortion to be carried out on L.C by her mother for fear of prosecution under Peru's criminal abortion law. Subsequently, L.C. suffered a miscarriage, and the hospital authorized the spinal surgery. At this

time, it was too late and L.C suffered permanent damage to her spine, which left her permanently paralyzed.

On June 18, 2009, the Centre for Reproductive Rights and the Centre for the Promotion and Defence of Sexual and Reproductive Rights filed a human rights petition on behalf of L.C. against Peru before the United Nations Committee on the Elimination of Discrimination against Women. The human rights lawyers argued that L.C.'s abortion was legally authorized and should have been provided under the maternal health exception to Peru's criminal abortion law. Peru's failure to ensure access to therapeutic abortion and essential health care services as required under CEDAW, the Committee held that the provisions requiring governments to protect women's human rights and eliminate gender-based discrimination in health care services have been violated by Peru. Irrespective of the rulings against Peru in K.L and L.C's cases, the country was reluctant to act on implementing the recommendations by CEDAW. This provoked CSO's in public health, legal and medical experts to put unrelenting pressure on the government of Peru to implement both recommendations by the Human Rights Committee and the CEDAW Committee.

The pressure finally yielded results in 2014, when Peru developed and published hospital guidelines for accessing legal abortion based on maternal health indicators. K.L. got her compensation in 2015, whereas in March 2016, Peru finally acknowledged that the government and public health system had failed L.C. and issued an apology for their actions and inactions. The vagueness of the criminal abortion statute had a chilling effect on physicians, who feared arrest and prosecution. For years, Peru's Health Ministry has resisted appeals to provide guidelines for

physicians or hospitals on when they can provide legally acceptable abortions. These two cases stimulated a historic change and set a standard in addressing the connection between access to safe abortion and the government's responsibility for ensuring women's health in Peru. As in the case demonstrated above, it is worthwhile to note that securing a favourable decision alone will not always bring about an immediate transformation. As a catalyst for additional advocacy and precedents for holding governments accountable for the failure to provide necessary reproductive health care services.

2.10.3 Using National constitutions to address the right to health.

According to the study by Kinney and Clark in 2005, it is estimated globally that every two out of three national constitutions have made provisions to promote health and also show express intent to facilitate health care services for the entire population. These legal provisions have provided a tool for its citizens and interested parties, including CSOs, to advocate, as per the opinion of Kinney and Clark, "for better health and health care as well as for the implementation of the international human right to health." Examples of cases of the right to health handled by the national legal system (Court), especially for maternal health.

2.10.4 India's Domestic litigation on rights to maternal Health care and reproductive rights

In two cases filed in the Delhi High Court as *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others and Jaitun v. Maternal Home MCD, Jangpura & Others,* concerning the right to maternal health for two urban-poor pregnant women, who were denied health care and other services to which they were entitled under India's existing health care and social services programs. The first case where

national courts in India were used in determining rights to health included that of Shanti Devi, an Indian woman. Shanti was a poor woman who lived below the poverty line, and by virtue of her financial status, she qualified for a free public maternity health benefit as rolled out by the Indian government. Shanti Devihas a history of pregnancy-related complications. However, for some strange reason, when she got pregnant with her fifth child in 2008, she was unable to access and obtain the care she needed despite being qualified for the state's health intervention. In the space of two weeks, she was denied admission by four separate public hospitals because she did not have a ration card and could not therefore demonstrate her eligibility for free health services. In Delhi, Shanti Devi was finally admitted to a public hospital where it was realized she had a stillbirth and the stillborn foetus was finally removed. Even though she needed further medical attention, the hospital quickly discharged her. According to Kaur (2012), it took the intervention of the Human Rights Law Network (HRLN) to get Shanti readmitted to the hospital for 18 days more. At no point in time was she given any follow-up care as required under government health programs. Shanti Deva was also not given any counselling on family planning, and she never had access to contraceptives. Shanti Devi became pregnant again for the sixth time, but this time she refused to seek professional maternal care for fear she would face rejection and maltreatment like before. She died shortly after the premature birth of her sixth child after she went into premature labour at home.

In the second case, Fatema, made several visits to public-owned health facilities and was similarly denied access to medical care and other assistance guaranteed under existing government programs. Apart from being pregnant, Fatema was also a homeless woman. She also suffered from other health conditions such as epilepsy, anemia, and others, which left her in a dangerously risky situation with the pregnancy.

Fatema gave birth to her baby (Alisha) under a tree, in full public view. The Delhi High Court, where the two cases were consolidated and heard, ruled that Shanti Devi and Fatema were entitled to access the public health system, which it termed "public benefits." Basing its decision on the right to health as determined by the Indian Supreme Court in *Paschim Banga KhetMazdoor Samity & Ors v. State of West Bengal & Anor*, the ruling further stated that the public health system violated the right to life and health under the Constitution of India. In Kaur's (2012) estimation, this ruling paved the way for substantial reviews by exposing the severe shortfalls in India's health programs. The decision sets a national and international precedent for using constitutions to support maternal health rights. According to Dhital and Satpute (2015) in their work, claiming the rights to safe motherhood through litigation, it is safe to acknowledge that the Laxmi Mendal case has influenced subsequent judicial decisions in India and beyond, as in Millicent Awuor M, Margaret Anyoso Oliele v Attorney General and others in a constitutional petition in Kenya. It further empowered a domestic campaign for access to safe maternal health care services with an additional tool for holding governments accountable.

The HRLN further filed 25 additional cases that address other aspects of maternal health in the country, as cited by Dhital and Satpute. The Human Rights Law Network demanded implementation of the court orders in the Shanti Devi and Fatema decisions. In response to subsequent accounts of women's failures to access varied family planning and maternal health care schemes, the Indian courts intervened *suasponte* to enforce the directives associated with its decisions in the case of Court on its own Motion v Union of India, Delhi High Court (2011). The *Laxmi Mandal* case has exposed real difficulties in reaching the most vulnerable populations despite all the multiple ground-breaking maternal health programs and policies that

are targeted at the poor. However, the concerted efforts of the various stakeholders can always bring the broader systemic change that is needed desperately.

2.11 Mobilizing for Broader Health System Change in Addressing Preventable Maternal Death and the Role of a Negative Ugandan Court Decision

Significant gender inequality and poor maternal health persist in Uganda despite the inclusion of protections for women's rights and health in the nation's foundational documents. Singh, Bloom et al. (2015) believes that access to maternal care services for Ugandan women can be restricted by a lack of control of resources and limited decision-making power in their families. The right to health is not explicitly guaranteed in the Ugandan Constitution. However, the importance of the health of Ugandans is demonstrated in several provisions outlining national objectives, as well as many of Uganda's policies.

In 2011, two cases involving two women, namely Nalubowa Sylvia and Jennifer Angukon, were filed to demand the government provide essential and quality maternal health services. Sylvia, for example, required emergency obstetric care in 2009, which didn't exist in the local health center after the midwife realized that Sylvia was having twins and had already delivered one of the two. This was also contained in the Center for Health, Human Rights and Development (CEHURD, 2011) study on "advocating on the right to reproductive healthcare in Uganda: the import of constitutional petition No.16 of 2011". At the district hospital where she was referred to deliver the second baby, CEHURD noted that Sylvia Nalubowa was asked to pay for maternity services and other related commodities before she could be given health care. Sylvia Nalubowa, who was battling for her life in the mist of bleeding and pain, offered her land in exchange for medical care. According to

CEHURD (2011), Nalubowa never got the care she needed and died with one of the twin babies in her womb.

Another case recorded in 2010 and presented by CEHURD cited a pregnant woman called Jennifer Anguko. Jennifer experienced a health emergency but was never given any care for more than ten (10) hours when she was rushed to a public hospital. After she finally caught the attention of medical officers, the patient's uterus had ruptured, and there was nothing that could be done to save Jennifer and her baby. She died with her baby in her womb. Over the years, Uganda has been saddled with deteriorating health systems.

According to the WHO, UNICEF et al. and corroborated by the Uganda Demographic and Health Survey (2011, 2012), the maternal mortality ratio ranged between 343–435 deaths per 100,000 live births. These frightening statistics put Uganda among the top 60% of countries with high global maternal deaths and maternal mortality ratios. Despite efforts to make health care services accessible to Ugandans by abolishing user fees in 2001, several other key health related factors still remain a hindrance to access to health care.

Some of the challenges identified by the ministry of health, health systems 20/20, and the School of Public Health of Makerere University include insufficient resources like scarce pharmaceuticals, absenteeism of health care workers, and "informal fees" payments demanded of patients before they can receive health services and emphasized by Zikusooka, Kwesiga, Lagony, and Abewe (2014). The authors further suggested that the dis-empowerment of women and girls as well as the limited health care resources are said to have a significant impact on the quality, affordability, and accessibility of health services for women in Uganda and directly influence maternal

mortality. These health system challenges are exacerbated by "discriminatory social practices," "negative attitudes towards women and girls," and the "limited power women and girls have over their reproductive lives," according to CEHURD.

In 2011, lawyers at the Centre for Health, Human Rights and Development (CEHURD) filed Petition No. 16 in the Constitutional Court of Uganda against the Ugandan government based on its failure to prevent the pregnancy-related deaths of Sylvia Nalubowa and Jennifer Anguko. CEHURD argued that Uganda violated international and constitutional law by not providing this "basic maternal health care package" to Nalubowa and Anguko, as well as hundreds of Ugandan women in similar circumstances (CEHURD & Others v. Attorney General, 2011).

The Attorney General of Uganda argued that the complaint's allegations required the court to make a judicial decision on a "political question" involving state priorities and budget allocation best left to the legislative or executive branches of government. The Constitutional Court agreed and dismissed the case based on the political question doctrine, stating that the court has "no power to determine or enforce its jurisdiction on matters that require analysis of health sector government policies."

Plaintiffs appealed the decision to the Supreme Court of Uganda in 2013 and the constitutional court decision was reversed in 2015. The Supreme Court further held that the Ugandan Constitution provided direct access to the Constitutional Court for constitutional interpretation and that the question of "political doctrine" did not apply to the constitutional claims asserted in the case as noted in the CEHURD & Others v. Attorney General 2015 Supreme Court decision. The Supreme Court directed the Constitutional Court to consider the facts of the case, supported by evidence, and determine whether the failure to deliver maternal health care services violated the

right to access medical services under the constitution. The case was reopened by the Constitutional Court of Uganda on September 1, 2016.

Despite the setback, the case brought public attention and advocacy to the issue of maternal mortality in Uganda. According to Larson (2015), a coalition was formed by various independent CSOs working on maternal health issues with the goal of pooling resources to advocate for maternal mortality reduction. The writer, Larson (2015), also noted that the Coalition and others in the public health community advocated for an increase in the budget in order to facilitate recruitment, motivation, and retention of health workers. Their efforts were rewarded as members of Parliament blocked a budget that failed to address the Coalition's demands. According to the daily monitor (2012), this situation compelled the government to allocate 15 million dollars to address the health care workforce shortage.

The sad stories of Sylvia Nalubowa and Jennifer Anguko sparked extensive media coverage and focused public attention on the prevalence of maternal deaths in Uganda and the need to address a government health system that is rife with social and cultural hierarchies that discriminate against, devalue, and disempower women. The dismissal of the case by the Constitutional Court brought support and resources into Uganda to help local CSOs pursue the appeal and obtain the subsequent successful ruling by the Supreme Court of Uganda. The combined efforts of human rights lawyers and other actors resulted in strategic, targeted efforts that amplified the potential impact any single actor or advocacy group could have had alone. The above cases present a clear signal that human rights litigation can improve maternal health and increase access to reproductive health care. The governments of Brazil, Peru, Uganda, and India were found to have violated human rights law by international

treaty bodies and domestic courts. Various CSOs and the public health community who were armed with these decisions demanded both individual compensation and systemic changes to address access to reproductive health care and achieve reductions in maternal mortality. From all indications, the cases studied demonstrate the importance of partnership between stakeholders in the field, including CSOs, the public health community, the political class, and even lawyers, in working toward recognizing, implementing, and realizing the right to reproductive and maternal health.

Finally, by highlighting the tragic stories of Alyne da Silva Pimentel Teixeira, Karen Noelia Llantoy Huaman, L.C., Shanti Devi, Fatema, Sylvia Nalubowa, and Jennifer Anguko, human rights lawyers claimed the attention of the government and broader society. The resulting international and domestic decisions demand the government address the systemic discrimination that resulted in irreparable harm and preventable maternal death. The individual stories of these women, mothers, sisters, and wives call out for a health system and a broader social and political structure where women's health is important and women's lives are valued.

2.12 Patients' Satisfaction and Quality Healthcare in the Context of Ghana

Ghanaians perceive the quality of health services as sub-standard and therefore choose alternative sources of treatment (Turkson, 2009). Trust and confidence are undermined by frequent shortages of drugs and medical supplies, long queues, the absence of emergency services and poor staff behaviour. This has resulted in low utilization of health services despite the substantial investment aimed at improving access to health services in Ghana (Shield Workpackage Report, 2007; Gyapong et al., 2007). However, others perceive the quality of healthcare in Ghana to be high.

Turkson (2009) looked at the quality of healthcare delivery in a rural district of Ghana and found that generally the quality of healthcare delivery was perceived to be high for most of the indicators used. That is, ninety percent of the respondents were satisfied or very satisfied with the care given during their visit to the health facility. The participants, however, perceived the poor attitude of some health workers, long waiting times, high cost of services, inadequate staff, payment policies for health services, frequent referrals to hospitals, and lack of ambulances at facilities as being detrimental to the effective delivery of quality healthcare.

Furthermore, another study by Atinga et al. (2011) examined how communication, provider courtesy, support/care, environment of the facility, and waiting time significantly predict patients‟ satisfaction with the quality of healthcare in two hospitals located in northern Ghana. They observed that the five-factor model, support/care, environment of the facility, and waiting time determine patients' satisfaction with the quality of healthcare delivery. The dependent variable's explanatory power was explained by 51 percent in the regression model. Peprah (2014) conducted a study at Sunyani Regional Hospital in Ghana to assess patients' satisfaction using the SERVQUAL model by Parasuraman et al. (1998). The SERVQUAL instrument was adapted and modified to capture the relevant data. A total of 214 patients were sampled for the study. The study's analysis was for descriptive statistics, and patients' satisfaction was determined by the service quality gap. The study results indicated that the overall satisfaction of the patients concerning the service quality of the hospital was good. Again, the study recommends policy action to improve service delivery in the communication/interpersonal relationship, assurance, and responsiveness dimensions.

2.13 Code of Ethics of Ghana Health Service

The Code of Ethics for the Ghana Health Service (GHS, 2008) defines the general moral principles and rules of behavior for all service personnel in the Ghana Health Service. The Service shall be manned by persons of integrity, trained to a high standard to deliver a comprehensive equitable service for the benefit of patients/clients and society as a whole.

- All Service personnel shall be competent, dedicated, honest, client-focused and operate within the law of the land.
- All Health Professionals shall be registered and remain registered with their Professional Regulatory Bodies.
- All Service personnel shall respect the Rights of patients/clients, colleagues and other persons and shall safeguard patients'/client' confidence.
- All Service personnel shall work together as a team to best serve patients'/clients' interest, recognizing, and respecting the contributions of others within the team.
- All Service personnel shall co-operate with the patients/clients and their families at all times.
- No service personnel shall discriminate against patients/clients on the grounds of the nature of illness, political affiliation, occupation, disability, culture, ethnicity, language, race, age, gender religion, etc. in the course of performing their duties.
- All Service personnel shall respect confidential information obtained in the course of their duties. They shall not disclose such information without the consent of the patient/client, or person(s) entitled to act on their behalf except where such disclosure is under the law or is necessary in the public interest.

- All Service personnel shall treat official discussions, correspondence, or reports obtained during official duties as confidential. In situation where such disclosure is necessary, it is legally.
- All information obtain from patients/clients is used for the prime purpose of their management. Any other use of such information is by the consent of the patient or person(s) entitled to act on his/her behalf.
- All Service personnel shall provide information regarding patient's condition and management to patients or their accredited representatives humanely and in the manner, they can understand.
- All Service personnel shall protect the properties of the Service including properties entrusted in their care.
- All Service personnel shall respect the rights and abilities of disabled persons and the aged and work together to serve or safeguard their interest
- All Service personnel shall keep their professional knowledge and skills up to date. • No Service personnel shall demand unauthorized fees from patients/clients.
- No Service personnel shall accept any gift, favour, or hospitality from the patient/public, meant to exert undue influence to obtain preferential consideration in the course of their duty.
- All Service personnel shall refrain from all acts of indiscipline including drunkenness, smoking, immorality, abuse of drugs and pilfering in the course of performing their duties.
- All Service personnel shall avoid the use of their professional qualifications in the promotion of commercial products.

- All Service personnel shall act in collusion with any other person for financial gain.
- No Service facilities and resources are used for unauthorized private practice.

2.14.1 The Patients Charter in Ghana (2008)

The Ghana Health Service is for all people living in Ghana irrespective of age, sex, ethnic background, and religion. The service requires collaboration between health workers, patients/clients, and society. Thus, the attainment of optimal health care is dependent on teamwork. Health facilities must therefore provide for and respect the rights and responsibilities of patients/clients, families, health workers and other health care providers. They must be sensitive to patient's socio-cultural and religious backgrounds, age, gender and other differences as well as the needs of patients with disabilities. The Ghana Health Service expects health care institutions to adopt the patient's charter to ensure that service personnel as well as patients/clients and their families understand their rights and responsibilities. This Charter is to protect the rights of the patient in the Ghana Health Service. It addresses:

- The Right of the individual to an accessible, equitable, and comprehensive health care of the highest quality within the resources of the country.
- Respect for the patient as an individual with a right of choice in the decision of his/her health care plans.
- The Right to protection from discrimination based on culture, ethnicity, language, religion, gender, age, and type of illness or disability.

2.14.2 The Patients' Rights

The rights of patients as contained in the patient's charter in Ghana are

- The patient has the right to quality basic health care irrespective of his/her geographical location.
- The patient is entitled to full information on his/her condition and management and the possible risks involved except in emergencies when the patient is unable to make a decision and the need for treatment is urgent.
- The patient is entitled to know of alternative treatment(s) and other health care providers within the Service if these may contribute to improved outcomes.
- The patient has the right to know the identity of all his/her caregivers and other persons who may handle him/her including students, trainees, and ancillary workers.
- The patient has the right to consent or decline to participate in a proposed research study on him or her. The patient may withdraw at any stage of the research project.
- A patient who declines to participate in or withdraws from a research project is entitled to the most effective care available.
- The patient has the right to privacy during consultation, examination, and treatment. In cases where it is necessary, to use the patient or his/her case notes for teaching and a conference, the consent of the patient is paramount.
- The patient is entitled to confidentiality of information obtained about him or her and such information shall not be disclosed to a third party without his/her consent or the person entitled to act on his/her behalf except where such information is by law or is in the public interest.

- The patient is entitled to all relevant information regarding policies and regulation of the health facilities that he/she attends.
- The patients or their accredited representatives know procedures for complaints, disputes, and conflict resolution, in medical situations.
- Patients should know of all hospital charges, mode of payments and all forms of anticipated expenditure prior to treatment.
- Patients should know of all exemption facilities if any.
- The patient is entitled to personal safety and reasonable security of property within the confines of the institution.
- The patient has the right to a second medical opinion if he/she so desires.

2.14.3 The Patient Responsibilities

The patient should understand that he/she is responsible for his/her own health and should therefore co-operate fully with healthcare providers.

- Patients are responsible for providing full and accurate medical history for his/her diagnosis, treatment, counseling, and rehabilitation purposes.
- Patients are responsible for requesting additional information and or clarification regarding his/her health or treatment.
- Patients are responsible for complying with prescribed treatment, reporting adverse effects, and adhering, to follow up requests.
- Patients are responsible for informing his/her healthcare providers of any anticipated problems in following prescribed treatment or advice.
- Patients are responsible for obtaining all necessary information, which have a bearing on his/her management and treatment including all financial implications?
- Acquiring knowledge, on preventive, promotive, and simple curative practices and where necessary to seeking early professional help.
- Patients are responsible for maintaining safe and hygienic environment in order to promote good health.
- Patients are responsible for respecting the rights of other patients/clients and health service personnel.
- Patients are responsible for protecting the property of the health facility.

The analysis of various legal provisions reveals the rights and responsibilities of patients, which are of paramount consideration during the course of treatment. The medical facility should provide the best quality service possible, taking into consideration the best interests of the patients. With the requisite laws in place, the

availability of qualified health workers with the right tools and the willingness to work according to the laws, and patients ready and willing to take up their responsibilities, the health system should be able to provide a satisfactory service to the consumers/patients. What are consumers or customers expecting from the service? It is the soft and non-technical aspects of health care delivery and treatment, which are communication with nurses, communication about medication, waiting time in accessing health care, responsiveness of hospital staff, pain management, cleanliness of hospital environment, patients' protection of their rights, and general perception of services, that are the issues of concern to consumers of health care services. This study therefore assessed the human rights perspective of maternal healthcare providers in the Nanumba North Municipality of the Northern Region purely on the opinions of maternal health-seekers. The issues raised under the literature review revealed a relatively paucity of information on outpatient satisfaction with health care delivery. Since the majority of the customers of any health facility are outpatients, the research will target satisfaction with the quality of health care services provided at health facilities in the Nanumba North Municipality.

2.15 Theoretical Framework for the Study

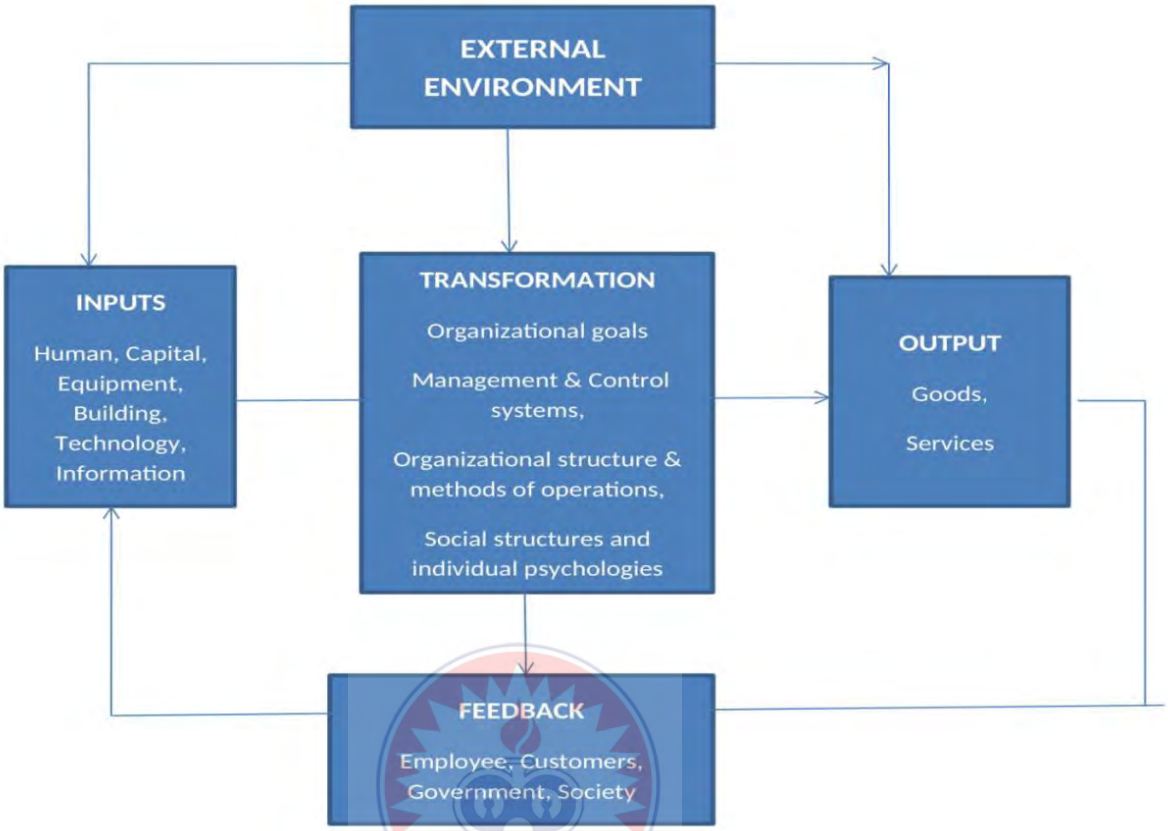
The main theory underlying this study is the system theory of management. This theory is regarded as one of the total quality management approaches espoused by Dobbins and Crawford-Mason, (1998). System theory views organizations as a unified and purposeful system of interrelated parts. This approach expects management to look at the organization as a whole and as part of a larger, external environment. As Ludwig von Bertalantly et al (1956) pointed out; the system theory tells us that the activity of any part or segment of the organization affects, to varying degrees, the activity of every other segment. This presupposes that every part of the

system, including the work force, must work to support each other. When the sub-systems of an organization do not support each other, then the organization cannot focus on quality management. The theory therefore emphasized that every organization interacts with the internal and external systems by taking resources from the environment and providing output. According to system theory, every organization has two major inputs:

1) Human Resources – come from people who worked in the organization by contributing their time, energy, value systems to the organization in exchange for wages and other tangible and intangible resources.
2) Non-human Resources- consist of raw materials and information, technology, physical infrastructure.

Human and material resources are inputs into the system and are transformed into final products and services to satisfy consumers. For instance, the hospital's inputs are its staff, supplies, and patients. The patients go through the application of medical knowledge and treatment, and the inherent organizational culture and value system. The output is patients restored to a level of psychological and physical health consistent with the severity of their diseases. The system receives feedback from the external environment for assessment in terms of quality of service. How do organizations assess feedback on services provided? It is through customer surveys and the organizational systems that improve through the results of such surveys. Management must therefore coordinate the activities of the entire organization and recognize that the organization is an element of the larger system, consisting of individuals, organizations, and institutions that make demands on the organization because of their dependency on it for some valued services.

Below in is a graph of the theory.



If one applies the system theory to assess customer satisfaction in service industry like the hospital, one should know that you could not separate the product or services from the provider. This justifies the need for continuous quality assessment of the system to ensure that quality services delivery. The question of satisfaction is therefore paramount for customers who regularly visit health facility and pay their hard-earned money in exchange for quality services from medical professionals. The ability of health care management to establish systems to improve service delivery will determine a repeat visit to the same facility next time. This is more so in the presence of increasingly availability of equally competitive services at their disposal.

2.16 Summary

This chapter of the study explored complex patterns of maternal health outcomes. This opened the way for personal level causes of maternal health outcomes to be instigated within the maternal healthcare setting. This is important insofar as the predispositions of individuals are shaped by the social and physical environment within which they live and/or work. Growing research in the last few decades has seen researchers and policymakers placing more emphasis on the socioeconomic dynamics of society as opposed to traditional biomedical factors or dispositions of individuals to explain differentials in population pattern in demand for health. This chapter is motivated by the need to understand health outcomes from existing empirical findings by other researchers, which stress the importance of explaining the neighborhood within which people live and how it influences demand for health, especially in maternal health.

CHAPTER THREE

PROFILE OF STUDY AREA AND RESEARCH METHODOLOGY

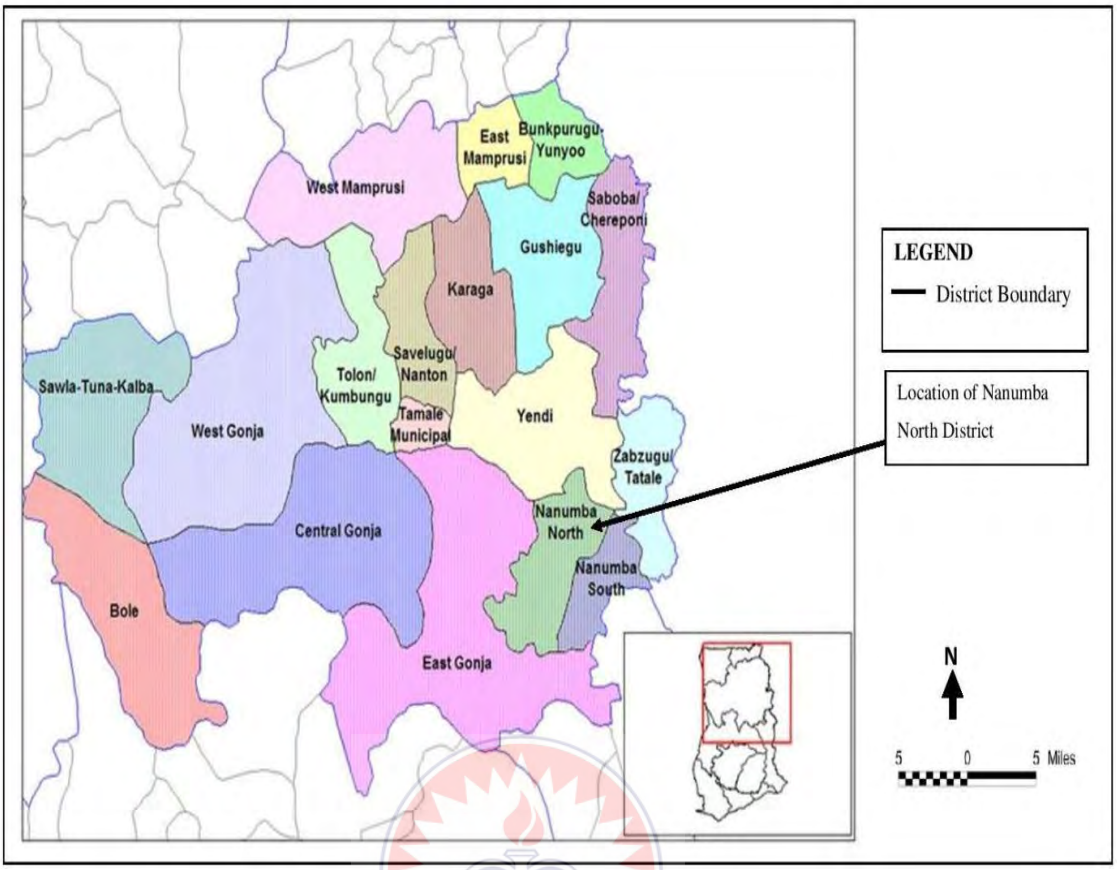
3.0 Introduction

This chapter provides the profile of the Nanumba North Municipal as a study area. The chapter looks at the location, size, demography, economy, and health situations of the municipality. In addition, the chapter discusses the methodology employed to undertake the study. This includes the research design, data types, sources, and data collection methods, as well as the sampling techniques used in carrying out the study. Both primary and secondary source of data were used for the study. Data collection tools such as interview guides, observation and focus group discussion were used to obtain the needed data on human rights issues in maternal healthcare programmes from participants.

3.1 Profile of the Nanumba North Municipal

3.1.1 Location and size

The Nanumba North Municipality is situated in the eastern part of the Northern Region and lies between latitudes 8.5 N and 9.25 N and longitudes 0.57 E and 0.5 E. It covers an estimated total landmass of 1986 square kilometers. The Municipality is bounded to the west and south-west by East Gonja District and Yendi Municipal to the north. It also shares boundaries to the east with Zabzugu District, to the south with Kpandai District, and to the south-east with Nanumba South. The capital of the municipality is Bimbilla (GSS, 2012) (see figure 2).



3.1.2 Physical Characteristics (Climate and vegetation)

The Municipality is found in the Tropical Continental Climatic Zone, which is typified by high temperatures throughout the year. Temperatures range from 29 to 41 degrees Celsius. Like certain parts of other West African countries, the influence of the wet South-West monsoon and the dry North-East trade winds is significant in the district (GSS, 2012). During the Harmattan season, temperatures can fall as low as 16°C during the night and morning. Annual rainfall averages 1,268mm, with most of it falling within six months – April to September. During this period, streams overflow their banks, causing wide-spread flooding that affects a lot of settlements and farmlands. The rest of the year remains virtually dry and serves as a fallow period for a lot of the farmers. During the dry season, there are rampant wild bushfires, sometimes set by youths to flush out animals from their habitat. The predominant

vegetation type in the district is the Guinea Savannah, with tall grass interspersed with drought and fire-resistant trees. Tree species found are the dawadawa, sheanuts, baobab and other fire- resistant trees (Nanumba North District Assembly, 2009).

3.1.3 Demographic Characteristics

The Municipality is largely rural in nature, with a population of between two hundred (200) and five hundred (500) people in small settlements dispersed all over the area. The total population of the district is 141,584, comprising 69,997 males and 71,587 females (Ghana Statistical Service, 2012). The population of Nanumba North Municipal forms 5.7 percent of the entire population of the Northern region with an annual growth rate of 2.7, which is slightly lower compared to its region's 2.9 percent but higher than the national growth rate of 2.5 percent (GSS, 2012).

3.1.4 Migration and implications for development

The Nanumba North Municipality has fertile soil that is pulling a lot of people into the area, especially in the Konkomba area. Many people come into the municipality to embark on yam farming during the rainy season. Usually, a lot of the settlements in the municipality develop indiscriminately without recourse to any laid-down plan. The issue of internal migration is also very common because of the predominant practice of shifting cultivation farming systems, which makes many people move from one place to the other. This trend of people's movement tends to put a lot of pressure on facilities provided in communities that receive people, whilst some facilities are abandoned when people move away from that community (Nanumba North District Assembly, 2009).

3.1.5 Social Characteristics

The municipality has one hundred and ninety (190) communities, with Bimbilla as the municipal capital. Bimbilla serves as the seat of the Paramountcy of the Nanumba Traditional Council with a population of 24,013. The main language spoken is Nanungli and most of the people are farmers, with some few government workers, self-employed and traders. Bimbilla also provides administrative, banking, educational, marketing, and health services to the periphery. Chamba is the second largest in the municipality, which is about 28.8km west of the capital. It has a population of 4,826 who mostly speak Likpalkpa and Nanungli. The area also provides health, marketing, and educational services to its surrounding communities. Other notable settlements also include Taali, Sabonjida, Dakpam, Pusuga, Bakpaba, Lepusi, Nakpa, and Markayili. The settlements are quite scattered in their distribution (Nanumba North District Assembly, 2009).

3.1.6 Infrastructure for Socio-Economic Development

The municipality has one municipal hospital, which is in Bimbilla, the capital, four clinics, and one Community Health Planning and services (CHPS) zone. Besides, there are several private pharmacies, drug stores, and licensed chemical operators that are patronized by many patients in the district (Nanumba North District Assembly, 2009).

3.2 Research Methodology

The research design, Data collection and sources, sampling procedure and method of data analysis are all covered under the research methodology.

3.2.1 Research Design

Qualitative study, according to Pope, Van Royen et al. (2002), is seen as holistic and requires exploratory understanding of the larger concept through words; making it favorable for eliciting attitudes that cannot be revealed through quantitative methods. The choice of a method to apply in particular research is dependent upon the nature of the research problem. The bulk of the existing research in the study area has mostly taken a quantitative approach, and therefore there is a lack of rich insight and texture that a qualitative study could provide. According to Babbie et al. (2007), exploratory research takes place when problems are in a preliminary stage, new and when data is difficult to collect. This study will use a qualitative approach to investigate women's perspectives and experiences with maternity services. Exploratory research is flexible and can address research questions of all types (what, why, how). The study, as explained by Yin (1994), provides a systematic way of looking at events, collecting data, analyzing information, and reporting the results. Exploratory research helps to learn the essence of the problem; to make sure that there is a problem, and to find out the character of this problem. In such a situation, it is necessary to understand the general nature of the problem, identify possible alternatives to the solution, as well as relevant variables that need to be considered.

3.2.2 Data Sources and Collection

The study relied on both primary and secondary data sources. Primary data were obtained through interview guides, focus group discussions, and observation. The data collection using the interview guides helped the researcher to ask probing questions in order to further enhance the researcher’s understanding of the phenomenon. Direct observation was considered in an attempt to validate the responses that the study received from respondents. The data were collected from women who have gone

through maternal care services from government and private health facilities, including traditional birth attendants (TBA), to ascertain and understand the reason behind their choice of place of delivery. It has everything to do with factors relating to human rights that might have risen due to the attitude of maternal health providers.

On the other hand, the secondary data was obtained from journals, institutional reports, government documents, the internet, publications, and magazines, among other materials relevant to the study. Special care was taken to avoid overburdening the respondents. The focus group discussions were conducted for the women at the Bimbilla community center and market square. A focus group discussion is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs, and attitudes for soliciting information for the study. The interviews were conducted using the two main languages spoken by the people within the Nanumba North Municipality, which are Nanumli and Konkonba, and were translated back into English. Data collection was, however, completed between September and October 2020.

3.2.3 Sampling Procedure

The target population of the study were women within the age bracket of 20–49 who had given birth within the last five years. The study sample was drawn from the Nanumba North Municipality, which had a population of 49,748 as at 2010 (GSS, 2012). Reducing the number of individuals in a study, according to Ben-Shlomo et al. (2013), reduces the cost and workload, and may make it easier to obtain high quality information, but this has to be balanced against having a large enough sample size with enough power to detect a true association. Typically, in big data situations when cases are reported in large numbers, a small number is used, such as 4 to 10. The number relates to the question or to the type of qualitative approach used, such as

narrative, phenomenology, grounded theory, ethnography, or case study research (Creswell, 1998). The research employed purposive sampling techniques in selecting the respondents. In purposive sampling, the units of the sample are selected not by random procedure but are intentionally picked for study because of their social characteristics (Kumekpor, 2002).

The range rule of thumb, according to Ramirez et al. (2018), works best for data from a normal distribution where the sample size is close to thirty. Considering time, cost, and respect for accuracy, the Range Rule of Thumb was adopted for the study. A sample size of 31 respondents was drawn from the population using the purposive sampling method from Nanumba North Municipality. Participants included women who have given birth and live within the towns of Bimbilla, Pusuga, Chamba, and Nakpa. These towns were selected because; they are the most populous in the Nanumba North municipality according to Population and Housing Census (GSS, 2010) with easier access to health facilities and were likely to be more informed on maternal healthcare issues. Health services providers were not included in the interviews because the study was more interested in the users' perspectives.

Table 3.2: Distribution of Sample Sizes [Communities and number of questionnaires administered]

Study area	Sample size distribution among selected communities	Total no. of women/ questionnaires administered
Nanumba	Bimbilla	10
North	Pusuga	7
Municipal	Chamba	7
	Nakpa	7
TOTAL		31

3.2.4 Data Analysis

Bowley (2014) observes that it is never safe to take published statistics at their face value without knowing their meaning and limitations, and that it is always necessary to criticize arguments that can be based on them. Processing of data was done through the categorization of verbal and/or behavioral data. The data was classified and summarized into a consumable data. Field data was transcribed according to themes for the qualitative information. Transcripts were edited for grammatical errors without making any changes to the content. The study implemented a coding scheme developed based on four human rights principles: dignity, autonomy, equality, and safety, which involved placing extracts from the data in various categories and labeling them by theme. These themes were derived from the literature review, observations made from interview content and included policy design. This was subsequently split into relationships between sub-themes and a thematic map which allowed for analysis of patterns, including evidence of consensus and disagreement between participants. The data was edited to ensure consistency in responses, notes taken and completeness of interview. Data generated from the interview was analyzed

using key research questions and the study objectives as broad themes for easy interpretation.

3.2.5 Ethical Considerations

Research ethics is one important consideration that a study must not underestimate. There is a need for a researcher to take the necessary steps in accordance with this laid down principle to gain the trust and ultimately the consent of the targeted respondents. Participation was considered voluntary, and participants were made aware of the fact that, they could withdraw from the study at any point in time if they so wished. Participants were also assured of their confidentiality and anonymity so that their information and identities would not be revealed to any third party. First, the researcher sought permission from the respondents and explained the aims and objectives of the study to them before soliciting the needed research data. The respondents were assured that the data they provided would be treated with confidentiality as the study was used for academic purposes only.

3.2.6 Summary

The chapter examined the study location and its demographic influences on maternal care. The study employed and discussed the choice of an exploratory design to undertake the study. Exploratory research helps to learn the essence of the problem; to make sure that there is a problem, and to find out the character of this problem. Since the larger amount of data was obtained from existing sources (secondary), it served as a preliminary basis for analysis before the primary source of data. The research also considered snowballing sampling techniques in selecting the respondents, since the researcher anticipated difficulty in locating respondents on his own and expected referrals. The data were collected from women who have gone through maternal care

services from government and private health facilities, including traditional birth attendants (TBA), to ascertain and understand the reason behind their choice of place of delivery. Data collection tools such as interview guides, observation and focus group discussion were employed to obtain the needed data on human rights issues in maternal health care.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION

4.0 Introduction

This chapter presents the results of data collected extensively across four towns namely Bimbilla, Pusuga, Chamba and Nakpa in the Nanumba North Municipality, of the Northern region, Ghana. These communities represent the most educated and enlightened populace and also hosts the most health facilities and as such, the researcher tapped into valuable insights provided by respondents in satisfying research questions. The study adopted qualitative approach in presenting data gathered hence, the findings necessitated a descriptive presentation of responses gathered from interviews and focused group discussions. The interviews and focus group discussion were held to gather the experiences of women on human rights in maternal health delivery in relation to the attitude of service delivery staff therein. The results also include relevant transcripts from personal interview sessions as they relate to the objectives of the study. The results are presented in line with the overarching research objectives.

For easy interpretation and understanding by the reader, the findings were divided into three (3) parts. It begins with the presentation of the demographic characteristics of focus group participants (women groups) from the 31 sampled respondents across the three communities that constituted key informants of the study. In the second section, the researcher presents findings on the roles of perceived attitude of health service providers played in human rights. This study relied on the opinion of selected women who are experienced in the area in order to satisfy the above research objective. This is followed by a discussion and presentation of results based on established research questions. In the third section, the study provides valuable

insights on the human right implications of the attitude of health care providers, as well as the opportunities that exist towards building resilience in the maternal health care in Nanumba North Municipality. The study made some findings from the interviews and 2 focus groups with 5 participants each, and the discussion is centered around women of productive ages from 20-49.

The Nanumba North Municipal health directorate is supposed to provide varied maternal services including health education to serve the needs and demands of women. Just like Al-Taiar, Clark et al. (2010), many scholars have widely acknowledged that the kind of services provided at maternal care centers can influence the rate of women accessing antenatal care during pregnancy. In the final section, the researcher presents the views of respondents with regard to the attitude of maternal health care provider towards their service seekers (women). The concept is defined in relation to women's health, as well as participation in decision-making processes in health delivery.

4.1 Demographic Characteristics of Respondents

This section of the study covers the socio-demographic characteristics (age, marital status, religious background, and educational level) of women groups sampled from the Bimbilla, Pusuga, Chamba and Nakpa towns in the Nanumba North Municipality, constituted research participants. It was necessary to investigate the demographic features of respondents since they do not only influence individual and group perceptions and actions but equally informs the reader of the sort of people from whom primary data was collected.

4.1.1 Age distribution

The researcher begun by exploring the age distribution of respondents. The study estimated that, the age distribution of a population could possibly influence the perception of what constituted human rights and whoever is likely to able form a well-informed opinion about the subject matter. How the attitude of maternal health care provider may affect different age groups and the response mechanisms adopted with regards to health care support. In this regard, the age groupings were put into four categories, in the intervals 20-29 years, 30-39 years, 40-49 years, and above 50 years.

Table 1: Age distribution of respondents

Age	Frequency	Valid percentage
20-29	10	32.3%
30-39	15	48.4%
40-49	6	19.4%
Total	**31**	**100%**

(Source: Fieldwork, 2020)

From the table above, the results show that 10 of the respondents sampled for the study were within the ages of 20–29, 15 of the respondents came under the age bracket of 30-39 years, and the remaining 6 of the respondents were between 40–49 years old. From the above analogy, it can therefore be derived that Nanumba North has a 'youthful' female population from the population distribution of women, since cumulatively 80.65% of total respondents fell under the age category of 20–39 years. As a point of departure, according to the United Nations, youthfulness is classified as having a range of 15–24 years (United Nations, 2001). As the UN's definition of "youth" appears to be universally accepted, it is important to clarify what constitutes

the definition of a youthful population as a point of departure. The UN, in its definition, does not consider differences in national policies regarding age classifications. Furthermore, the categorization fails to acknowledge variations in context or societies, regarding the interplay of sociocultural, economic, and political factors that remain critical in defining the concept of youth. For this study, taking into consideration the inherent pitfalls of the United Nation's definition, the concept of "youth" is adapted from the National Youth Policy of Ghana, for this study. According to the policy framework of the Ghana National Youth Policy, all persons between the ages of 15 and 35 constitute the country's youth (National Youth Policy, 2010). Hence, the youthful nature of the study population reflects national population dynamics, with data obtained from Ghana's 2010 population and housing census. These further points out that people aged between 20 and 35 years constitute about a third of the population of Ghana (Ghana Statistical Service, 2013). The youthful nature of the population could thus represent both positive and negative outcomes in terms of public policy, specifically public health, including maternal health care, women's empowerment, and development in the study area.

4.1.2 Educational Background

Education performs a rather conservative function within the society. Through schooling, each generation of young people is exposed the existing norms, beliefs, and values of our culture. Thus, in this study it is necessary to ascertain the level of education of the respondents. This is due to the possibility that education can act as an empowerment/enlightenment tool for decision-making in seeking maternal health care, as well as identifying and reducing the risk of human rights abuses in the maternal health environment in the Nanumba North Municipality. This expectation is

backed by Kabeer (2005), who conceptualized empowerment in the light of education as critical in furthering people's ability to make and act on their own life choices.

The findings show that out of a total of 31 respondents sampled, 4 of them had no formal education, with 15 respondents indicating that they had basic level education (primary and junior high school). Furthermore, 7 respondents had graduated from high school, while the remaining five respondents had tertiary education (university, polytechnic, nursing, and teacher training). The table below summarizes the educational level of respondents.

Table 2: Educational distribution of respondents

Level of Education	Frequency	Percentage
No formal education	4	12.9%
Basic education	15	48.39%
Secondary education	7	22.58%
Tertiary education	5	16.12%
Total	**31**	**100%**

(Field work, 2020).

The low level of education among respondents sampled for the study generally reflects the broader picture in the Nanumba North Municipality in terms of education with reference to data from the Ghana Statistical Service, (2014). In this regard, a low level of education could represent a negative return in terms of agency, as women's ability to make strategic life choices may be curtailed. Relating to Collier's (2000) observation, uneducated women have lower self-esteem and lower income earning opportunities than educated women.

Low levels of educational attainment among women could have negative implications for empowerment in the study area. Goldstone (2001) and Lia (2005) particularly observed that there is existing evidence indicating that expanding higher education without opportunities could equally spur discontent, particularly in contexts of high unemployment. It is therefore a key factor to understand that, expanding opportunities for education and skill training must go hand in hand with increasing the absorptive capacity of labour markets.

4.1.3 Occupation of respondents

Predominantly, majority of the study respondents were farmers. This was followed by teachers who works in the formal sector, as well as traders in the informal sector. Other activities engaged by respondents are hairdressing, tailoring, among others. The table below gives a detailed composition of the occupation of the study participants. See table 3.

Table 3: Occupational background of respondents

Occupation	Frequency	Percentage
Hairdressing	3	9.7%
Farming	9	29%
Tailoring	2	6.5%
Nursing	3	9.7%
Teaching	5	16.1%
Trading	5	16.1%
Unemployed	4	12.9%
Total	**31**	**100%**

(Field work, 2020)

From the above table, it can be concluded that most women sampled for this study were engaged in the informal sector of the local economy for livelihood. These findings corroborate earlier studies related to women's involvement in the active labour force. Allden (2008) relates the lack of formal sector skills to low levels of education and training, and this could possibly lead to the surge in low self-esteem in women. One unemployed mother (respondent) said:

> *Even though I have health insurance, I wish I had enough money* on *me before visiting the health centre. At that place, money matters can come up*". *(Respondent, FGD)*.

It must be emphasized that the proportionately high involvement of women in the informal sector is a general trend in developing countries as suggested by Justino et al. (2012).

4.1.4. Marital status

Ringbäck et al., (1991–95) present compelling evidence of a higher premature risk of death among lone mothers in Sweden, compared with mothers with partners. Their work raises interesting questions as to how the mortality disadvantage of lone mothers developed over time, and to what extent biomedicine can contribute to narrowing the mortality gap. Between 1980 and 1997, a total of 11.93 million live infants were born in West Germany; the proportion born to unmarried mothers increased from 7.6% in 1980 to 14.3% in 1997. Against this backdrop, the study sought to determine the marital status of respondents, as well as how it determines the attitude of maternal care providers towards maternal care seekers. The rational of marital status is to determine the behaviour of health care workers towards the married and unmarried. The findings are summarized in the table below.

Table 4: Marital status of respondents

Marital status	Frequency	Percentage
Never married	6	19.35%
Married	17	54.84%
Cohabiting	2	6.45%
Separated	1	3.23%
Divorced	2	6.45%
Widowed	3	9.68%
Total	**31**	**100%**

(Field work, 2020).

From the table above, it can be deduced that marriage represented an avenue for women to secure some level of prestige and respect from maternal care providers at maternal health centers. Of the majority of women sampled, 17 women, representing 54.84%, were married. As highlighted in the table above, out of a total of 31 respondents sampled, 6 were never married, and 3 women, which represented 9.68%, were widowed. Two (2) women each were recorded to be either divorced or cohabiting at 6.45%, and finally, one woman, who represented 3.23%, was recorded to have separated from the husband.

According to the findings of the study, some women appear to agree that marital status has an impact on how health professionals interact with their patients. But the majority believe that it is often better to go to the maternal care center with a matured and respectable partner. A respondent in the FGD said:

I have visited the hospital four times for childbirth. On two occasions, I went with my husband. On the other two, I went alone and with my husband's younger brother. It was often better with my husband.

4.1.5 Length of stay in study community

The study also sought to find out how long respondents had resided in Nanumba North. This category is intended to determine the perception of the attitude of health professionals towards residents and their period of stay. Information obtained from the fieldwork indicates that out of a total of 31 respondents, 20 of them had since birth resided in the Bimbilla, Pusuga, Chamba, and Nakpa communities of Nanumba North. Furthermore, three (3) respondents had resided in the study area for less than a year; six (6) respondents were residents for between 6 and 10 years, with the remaining two (2) respondents having resided in the Nanumba North municipal for between 1 and 5 years. The findings are summarized in table 5 below.

Table 5: Length of stay in Nanumba North

Duration	Frequency	Percentage
Since birth	20	64.52%
Less than a year	3	9.68%
1-5 years	2	6.45%
6-10	6	19.35%
Total	**31**	**100%**

(Field work, 2020)

From the above data, the majority of women sampled for the study have resided in Nanumba North municipal for a long time, as they have lived there since birth, with a relatively low number of respondents having resided in Bimbilla, Pusuga, Chamba,

and Nakpa for less than five (5) years. These findings were particularly helpful to the researcher since it was possible for most women sampled for the study to relate their experiences over time, regarding the varied experiences of the maternal health services with regard to the attitude of health workers and how this affected their human rights as well as women's empowerment in Nanumba North.

4.1.6 Acts of care seekers that impact the MHCPs behaviour

The primary questions that the study sought to answer relates to women's perceptions about how maternal care providers' attitudes impacted them in terms of their human rights, from pregnancy to childbirth and their level of participation therein. Using an open-ended question approach, the study first asked respondents if they perceived and/or bore witness to health professionals perpetuating ill-behaviours in Bimbilla, Pusuga, Chamba, and Nakpa health centres and hospital. Thus, during a FGD, a trained nurse who also double as a respondent acknowledged that some of his colleagues sometimes act unprofessionally towards their clients, but that, was quick to add that such attitudes were often born out of provocative conduct by the clients. He said:

> *It is true, I have witnessed the negative conduct of some of our colleagues, but we should admit that we are also human beings, and, beyond our career, we have personal issues too* (Participant FGD Nurse).

This response raises concerns about situations where an individual's personal life frustrations can be visited on an innocent health seeker. From grievance theory, conflict is a product of frustration and the cumulative effect of such feelings across a particular group in society (Humphreys and Weinstein, 2008: 440). A respondent

confirmed the view that some women contributed in diverse ways to triggering the negative attitude of care providers. A pregnant woman had this to say:

> *...sometimes we (clients) are also to be blamed. We have time to prepare for our baby's delivery from the time we are pregnant, but we normally think it is too early until that day when we realize we don't have the recommended items. For me, it was the time I went to deliver that I realized that I had nothing. At the hospital, I called my husband to buy some items. But by the time he brought them, it was a bit late after I had delivered already in the hospital. There, I had to borrow some materials and the midwife kept talking angrily and shouting over me, but I understood her point of view, because I should have done the needful.'* (Participant FGD Teacher).

From the above narrations, it can be deduced that the negative attitudes of health care providers towards pregnant women at the healthcare centre is a double edge sword as it is caused by both the providers and the clients themselves. In so doing, many insights are borrowed from the theory of grievance. In relating this situation to Sutton (2009), there is a potential equal trigger of opposing views driven by the same motives as the person in conflict. From the narratives presented above, it can be deduced that the challenges with the attitude of maternal care providers in Nanumba North municipal may go beyond socially constructed perception, but there may be other trigger factors that cause a professional to display a bad attitude and how health seekers and providers see each other. As indicated by Cunningham (2003: 172), women can use their gender stereotypes to avoid detection, as their non-threatening nature may prevent in-depth scrutiny.

4.2 Maternal Health Care Seekers understanding of Human Rights

The researcher spoke to women who have experienced maternal health care delivery in the four identified towns in the Nanumba North Municipality. This was to ascertain their perception of the attitude of the maternal care providers to help the study identify

the human rights issues within the study area based on identified human rights benchmarks. The human rights concept is something that binds all humanity, no matter where we come from or our background. But it is a complex idea that can easily be infringed upon. We look at how women in the childbirth stage own conception of human rights, as this may lead us to how they feel about their importance and whether it is something they can stand up for. The study revealed that about two thirds of the women who responded to the interviews believed that human rights entails treating everyone, especially in the health facility with respect. This was articulated by a 26-year-old respondent, who said:

> *What I know is that human rights are about treating people right. I also know that human rights are for everyone to be treated with respect and equality.* (Nakpa participant, 26-year-old teacher).

The study further observed that participants individual conception of what constitute human rights is a challenging task. However, some women understood human rights as related to facility based maternity services. Some women mentioned personal care by healthcare providers and the availability of diverse medical and non-medical equipment as constituting human rights. A 35-year-old trader from Pusuga and a hairdresser in an interview explain that:

> *When the government builds things like this [health center], they expect that we will use it in our community's interest and there must be all the equipment to take care of us. If we are going there to care for ourselves, no one can stop us.* (Pusuga participant, 35-year-old trader).

Another participant sees human rights in the light of the provision of certain items in the facility in the following statement:

> *They must always make available medicine and beds for those who are asked to sleep overnight for the doctor to observe them. They are human beings, and they must be given decent treatment.* (Participant FGD hairdresser).

Furthermore, some women believed that timeliness is a right and that there should be some guarantee of a certain level of respect. This was expressed in relation to what they described as preferential treatment often undertaken by some healthcare provider to some clients without regard to others.

> *If I come first to the facility*, the *doctor must treat me first. That is the right thing to do. First come first served. If they want to attend to someone before me, I must be informed and given a reason, otherwise, I see this as an infringement on my right*. (Chamba participant, 48-year-old farmer).

Beyond the idea of preferential treatment as participant described as human right issue, they also narrowed the conception of human rights to being attended to appropriately in the consulting room by the doctor. General perceptions about "human rights" captured the notion of "being treated well" which was explained as "receiving the services that you need". A Bimbilla teacher of 28 years and an unemployed 34-year-old were both very particular about being treated well.

> *When you are talking about childbirth and health, I should be able to go to the hospital when I am not feeling well. But I must not come back worse than before. Pregnancy is an important part of the* family, *and the doctors know it'. The doctor should be able to give me the needed attention in terms of treatment* (Bimbilla Participant, 28-years old teacher).

Another participant added:

> *Human rights should make everyone go to the clinic for treatment without contemplating it because we must be treated right by the hospital workers without complaining* (Chamba participant, 34 unemployed).

From the above narratives on the understanding of the term "human rights" by participants, it was revealed that most of the participants had shown some appreciable level of knowledge of what constitute human rights. Most of the respondents

mentioned at least one of the cardinal areas of the study (dignity, safety, autonomy, and equality).

4.3 Human dignity and human rights

Basically, the human right concept relating to human dignity means that all people holds a special value that is tied to their humanity, and this particular value has nothing to do with their religion, race, gender, ability, or whatever other factors other than being human. Article 1 of Ghana's constitution states that "all human beings are born free and equal in dignity and rights." This statement was given further value in the preamble of the International Covenant on Civil and Political Rights, which reads:"... these rights derive from the inherent dignity of the human person." In this study, many women stated that "being treated well" needs to begin with "being received well." Conceptually, "being received well" embraced a number of procedures upon arrival at the facility, physical examination, and being informed about the process of labor. Thus, where a pregnant woman is ignored by healthcare providers upon arrival at the facility, that could constitute an infringement. One participant explained that patients feel accepted, cared for, and comforted when they are received politely by healthcare providers at the facility. That is, being "being treated well" by maternity health care service providers implies being given the needed care and attention during and after birth.

> *I think it is the way you receive people. The way they speak to us and the way they welcome us is essential. It's not about giving things to people. When you talk to patients calmly, it can be a relief to many of us. Just be polite. "(*Bimbilla Participant, 30 years trader).

While certain opinions see dignity as a personal trait that needs to be exhibited by individuals, others see it as unconditional.

> *For me, how I feel about people make me see how dignified and worthy they are." I believe it (dignity) is a matter of first impression". 'I can also say that it is bigger than we are looking at it. If we leave it like this... people's biases towards you will win. Everybody deserves humane treatment'* (participant, FGD, Bimbilla town).

Conceivably, "not being treated well" is seen by some respondents as a mark of humiliation and a disrespectful experience. The experience of humiliation was expressed as follows:

> *Naturally, as humans as we are, when you are designed to get something or benefit from something and somebody* deliberately frustrates (denied) you, you will not feel happy. In fact, it is a sign of disrespect to the patient when certain services are denied without recourse to one's condition at the time. Imagine being pregnant and ready to give birth, yet somebody negligently denied you attention, for instance! (Pusuga Participant, 40-year-old farmer).

Furthermore, some women reported discomfort at seeing "strangers" in and around the delivery ward who are not hospital staff as another form of human right abuse. These situations are usually encountered when caregivers of other patients come around the ward to visit their patients. In such condition, some women who are not known to such people feels discomfort on seeing them especially when they are in critical condition of labour. Similarly, the issue of whether having male staff working in maternity or labour wards is dignifying was also raised. A respondent said:

> *Allowing all manner of people (especially males) into and around the labour ward is not healthy. I always feel that people may deliberately peep through some openings and windows to see us deliver. That room (delivery ward) is only for women who want to have a baby(ies). I believe my dignity is protected if men are not allowed to enter. As for the male health workers, hmm…I wish the authority could do something about it to allow only female professionals into the delivery room, but it is difficult* (Pusuga participant, 29 years).

Women expect to 'receive comfort' and believe that health workers can treat them well by taking care of them. In explaining her understanding of dignity, one respondent stated that she expected healthcare providers to comfort a woman by using comforting words. One respondent indicated that she felt comforted by healthcare workers at a particular private facility, which motivated her to go back there another time. This the respondent indicates involves the soothing words of encouragement that the healthcare providers at such facility provided.

> They comforted me in a good way… and told me that: "let's pray to God, and you are going to deliver safely. In such situation, when in the end, you deliver safely, next time you will be motivated to go back there because the nurses were very nice towards you (Pusuga Participant).

Others' perceptions of their own worth are influenced by their sense of dignity. The way people feel, think of their worth, or value themselves and others is critical in defining dignity. A respondent notes that "to *treat someone with dignity is to treat them as being worthy"* (Bimbilla Participant, 28 years teacher).

4.3.1 Being informed and listened to—Autonomy

Autonomy has traditionally been thought to connote independence, and hence reflect assumptions of individualism in both moral thinking and designations of political status. Despite its severe criticism, individual autonomy is an idea that is generally understood to refer to the capacity to be one's own person, to live one's life according to reasons and motives that are taken as one's own and not the product of manipulative or distorting external forces. Several writers Christman (2009), Benson (1990), and Friedman (2000) have underscored the need to understand that procedural accounts of autonomy would wrongly attribute autonomy to those whose restricted socialization and stultifying life conditions pressure them into impulsively accepting

and normalizing oppressive values and norms. Reference is made women who normalizes and internalizes the belief in the social authority of husbands and/or accepts that only by having and raising children is her life truly complete. For such women who reflects on these values, they may well endorse them, even if doing so is free of any specific inhibition from any immediate influence or factor. A careful study of the discussion by Christman (2009), Benson (1990), and Friedman (2000) further claimed that such women surely lack autonomy, so only if autonomy includes a requirement that one be able to recognize basic value claims (such as the person's own equal moral standing) will that concept be useful in describing the oppressive conditions of a patriarchal society.

Although some women could not personalize the definition of what constitute autonomy, most of them seemed to have an idea about the concept but had limitations on how to express their understanding by situating it within the context of maternal health. One participant said: *"I know it, but I don't know how to put it together"* (participant, 23 years, Pusuga). Again, most women indicated how important it was for them to be informed by healthcare workers about what to expect during labour especially as first timers. This can also be interpreted as a matter of respecting rather than belittling a woman's experience of pain. As a participant from Nakpa narrates:

> *You must be informed when you go there, and you must be told everything about how things are going. So that you can know what is going on after this hour... And if they see you are somehow afraid, they must advise you in a good way to make sure that you relax because giving birth is not an easy thing*' (Nakpa Participant, 28-year-old tailor).

The core argument in these approaches is that autonomy requires the ability to act effectively on one's own values (either as an individual or member of a social group), but that oppressive social conditions of various kinds threaten those abilities by

removing one's sense of self-confidence required for effective agency. However, other participants are of the opinion that, autonomy is about one's decision-making process, especially during childbirth. A participant said:

> *When my decision is being heard and taken without questioning my intelligence, it makes you feel respected*". "*If you have a problem, you should be able to make your own decision on how to handle it on your own. Assuming I am ill and want to seek treatment, I can go for treatment from either a herbalist or hospital. I must decide whether to go to one or the other depending on my comfort and feelings. That is my understanding* (Pusuga participant, 38-years-old unemployed).

Fairness is achieved only when an overlapping consensus among people moved by deeply divergent but reasonable and comprehensive moral views can be attained. Relatedly, some women expressed the feeling that when it comes to interventions that may be necessary to ensure a safe birth process, they need to be actively involved.

> *When the healthcare givers get us involved, it does not necessarily mean that they don't know their work. They should know that they are the professionals, but it's our body and our problems. We can engage with each other.* " (Nakpa Participant, 33 years trader).

Another participant adds that:

> *Being* able to walk to the nearest health center for observation and treatment even if no one is at home or no one is offering support means that we know what we are looking for." I should be able to know on my own when to visit a health professional without waiting for someone to tell me (Nakpa Participant, 35 years nurse).

Some participants explained that although they believed they were 'heard' by maternal health care workers, this did not necessarily equate with being "listened to".

> About the autonomy issues: sometimes they [healthcare officers] act like they heard what you are saying, but it is different to be heard and another to act on

it. It doesn't mean that they are going to act on what you have asked them to do. At other times, they even pretend not to hear what you are saying. (Participant, Bimbilla Town).

4.3.2 Being treated equally—Equality

Article 1 of the UDHR states: "All human beings are born free and equal in dignity and rights." Freedom from discrimination, set out in Article 2, is what ensures this equality.

Equality implies that all individuals have the same rights and deserve the same level of respect. All people have the right to be treated equally. This means that laws, policies, and programs should not be discriminatory, and that public authorities should not apply or enforce laws, policies, and programs in a discriminatory or arbitrary manner.

The perception of equality, as it were, was 'to receive the same kind of services as anybody else' but from a quality perspective. However, it was easier for women to talk about situations in which this principle of equality was violated. Women viewed discrimination in relation to personal characteristics, age, experience, geographical location, as well as cleanliness, popularity, religious beliefs, and affordability (money). Most participants believe that equality should not just be professed, but must be seen to manifest in fairness, kindness, and respect.

> *"Equity," in my opinion, is when people are seen and treated on the same level" (FGD Bimbilla Town Participant).* No *matter how someone's individual circumstances are, they should be treated with respect and kindness* (Chamba Participant, 39-year-old farmer).

Another respondent said: *Hmmm…I think equality goes with fairness. The one who is fair will ensure equality.* (Nakpa participant: 31 years unemployed).

Many respondents made admissions and acknowledged their practical situational differences.

> *Every single one of us is different in our own unique way. From our physical appearance to the way we talk and do our things […] … people may not be nice to someone who is quite different from them. T*his can range from as simple as ignoring them, to as severe as discriminating against them. (Bimbilla Participant, FGD).

To others, the specific needs matter. These groups are of the view that, equality should be situated on a case-by-case basis. However, the general understanding is that quality treatment must be the key. Some respondents expressed their opinion at a FGD and said:

> *'When demands and requirements are similar, for example, all those who want maternal care… some should not be getting good relationships and others should be mistreated. Equality means being equal.'* (Nakpa Participant, 45-year-old Nurse). '

Another one said:

> *…it means treating people exactly the same depending on their individual needs'. …*For example, when my husband buys things for us [his wives], he shares them among us without cheating anyone. Even among his children, everyone is treated the same. I think that is equality (Nakpa Participant, 23-year-old hairdresser*).*

In other circumstances, the principle of equality can require a state to take affirmative action to eliminate conditions that cause or help to perpetuate discrimination. Some respondents decided to go religious in their definition of equality.

> ...just like Mallams teach us to see all human beings as the same, I see equality in that one. The two can fit inside each other. (Bimbilla participant, 40 years old and unemployed).

4.3.3 Personal safety and security as human rights

Feeling safe means being self-assured and ditching the self-doubt. Article 3 of the Universal Human Rights states that, everyone has the right to live, to be free, and to feel safe. The demand for establishing a right to safety emerges in a society where people feel the need for a norm on which to base an actionable claim for protection from physical, social, or emotional harm. This need is also strengthened when societal agreement and action take hold. Victims can experience significant social isolation and an unsafe feeling of bullying that leads to emotional and physical harm, loss of self-esteem, feelings of shame and anxiety.

One form of emotion that is often felt without consciously knowing it, is the feeling of safety. Thus, participants in this study were asked about their understanding of safety. Varied responses were given in respect of that by the participants. For instance, some of them expressed their understanding of the concept in the following statements: *"Feeling safe means, you do not anticipate either harm or hurt, emotionally or physically'* (Bimbilla participant, FGD). This feeling of being safe was often strongly associated with "the outcome of birth".

Another participant had this to say:

> *"Safety in my thinking means, trying to avoid danger... like when you see danger ahead and you manage to escape"* (Bimbilla Participant 41 years old, nurse).

Some participants linked safety to how they felt about specific events. *'I want to believe that safety bothers us in the way we feel about some situations.'* (Chamba participant, 26 years old, student).

While some care seekers saw safety as a personal responsibility of the individual, others also viewed it as a conscious initiative by others or institutions to guide clients. Although not all the respondents were able to define safety, a lot more respondents said they knew "safety" but could not define it. Although human rights and its principles remained abstract terms, women were able to express their opinion with respect to what constitute safety.

In relating this concept to human rights especially with respect to pregnant and maternal mothers experiencing it at the health facility, the study revealed that, most respondents had expressed their views that, the issue of safety is something they cannot really talked about as either coming from providers or other authority from the health facility. Indeed, maternal health seekers from all the study areas had indicated there was no instance of danger toward them at the facility anytime they visited it. However, few had raised concern about the nature the facility ceiling fans and sometimes leakages of the roofing sheet. One respondent said:

> *Errrh…I can't remember any form of danger that I have encountered at the facility during the period of my visit. The only thing I remember is that, during my last visit to the facility, I was not too comfortable with the ceiling fans of the maternity ward. It was too noisy and sometimes I feel like it was about to fall. Also, during the rainy season, some of the roof in the ward were leaking. Apart from this…well there is nothing I can talk about.*

Generally, exposure to safety concerns and health hazards are often unavoidable but taking steps to reduce to harm can help to keep everyone safe. **The WHO**

Constitution (1946) envisages and emphasized the right to the highest attainable standard of protection against all forms of hazards. This definition is supported by other economic, social and cultural rights agreed in international human rights instruments. Like other rights, the right to safety carries obligations – primarily on governments, but also on other stakeholders – to take steps to realise it. The understanding of the concept allows for the easy identification of the human rights issues in the subject of safety and information of the needed cause of action.

4.4 Awareness of pregnancy condition and the impression

Pregnancy is a crucial time to promote healthy behaviours and parenting skills. According to World Health Organization (WHO) estimates, approximately 295,000 women died in 2017 because of pregnancy-related complications. Every pregnant woman faces the risk of sudden, unpredictable complications that could end up with death or to the infant (WHO, 2014). Inadequate care during this time breaks a critical link in the continuum of care and affects both women and babies. Women's understanding of their condition through pregnancy to delivery cannot be under emphasized. Getting to know it when one is pregnant should often be as important as understanding the stages and the challenges that comes with pregnancy. This provides an opportunity for early detection of conditions and situations that may require medical attention. During an interview and a FGD, some female respondents drew the attention of the study to the "stages" of pregnancy. "*I read on the internet that it (pregnancy) is grouped into three stages (trimesters) and each has its own challenges"* (28-year-old teacher, FGD).

Another participant said:

> "*When I miss my period, I try to remember the time I met my husband and compare it to my ovulation time. Mostly, I suspect pregnancy when my cycle delays*'" (Chamba participant, 30 years old).

A 25-year-old nurse who participated in the FGD summarized the expected number of weeks that women are supposed to carry pregnancies. She said:

> '*Sir, you know, counting from the first day of your last normal period... [monthly flow], pregnancies are supposed to last about 40 weeks*'. (Participant: 25-year-old nurse FGD).

Another nurse from Nakpa also mentioned that women must expect some physical and emotional changes, but also added that not all pregnant women have the same changes during pregnancy. "*If you have been pregnant before, you might feel differently this time around. Just as each woman is different, so is each pregnancy.* " (Nakpa participant, 31-year-old nurse).

Obstetric danger signs (ODS) refer to the loss of consciousness; persistent vomiting; severe persistent abdominal pain; vaginal bleeding; swelling of the face, fingers, and feet; blurring of vision; fits of pregnancy; severe recurrent frontal headache; and high-grade fever. Although this is not to exactly say that every one of these symptoms above are obstetric danger signs, they may as well be conditions that should not be underestimated.

Most of the women who participated in the study had, at one stage or another, experienced some pain or ailment. In the responses, the study noticed a pattern with participants' responses that reflected the various stages of pregnancy, that is, the first, second, and third trimesters.

I was drowsy and weak almost all the time and a doctor suggested I get a blood tonic. My mother in-law suggested that I blend some herbs.' (Bimbilla participant: 35-years-old trader).

In my pregnancies, I feel headaches, heartburn, weight gain or loss. I usually feel uncomfortable' (Nakpa participant, 29 years trader).

'Initially, I had pains in my breast, and it looked thunder. This is always after I miss my monthly flow period in my pregnancy' (Participant FGD).
This is my third pregnancy…and at each time, I feel extreme tiredness. I have been told on several occasion by my colleagues that, it is normal'. (Bimbilla participant, 33-years-old nurse).

Even though some women acknowledged that, they have heard other women complain about the pain and minor sickness associated with pregnancies, they never experienced any of such issues during their pregnancies. One participant said:

'Maybe I am yet to experience my own issues, … I hear people talking about the struggles and pains during pregnancies. As for me, I don't have an issue with my pregnancy'. (Bimbilla participant, 27-years-old teacher).

Even though the majority do not know about their health status before their pregnancies, other women know about their conditions even before they conceive.

'I don't know about any conditions. But I know that from how I feel as a first timer, it is impossible to understand certain things during that period. Almost every stage felt uncomfortable… For example, I feel pain, weak and tired at all times.' (Nakpa participant, 20 years unemployed).

A farmer from Chamba had high blood pressure before she conceived. She knew about it long before now. She said:

It felt awkward throughout. I have high blood pressure--something I knew about before my pregnancy. There was this man who used to bring herbs for me to boil, drink and bathe with'. (Chamba participant, 34 years farmer).

According to the US Department of Health and Human services, childbirth is different for everyone. The study further identified that; most women find the second trimester of pregnancy easier than the first. Some participants had these to say:

> *"...The edge of vomiting (nausea) and tiredness (fatigue) will fade at some point during the pregnancy.*' (Nakpa participant, 27- year-old teacher).

> *'You will see that some changes to your body are now happening. You will notice that the abdomen will expand because the baby continues to grow'.* (Chamba Participant, 36 years nurse).

Another one said:

> *I have given birth twice already, and in both my experiences, I usually, have had swelling in my ankles, and face.* My fingers, ankles, and other parts of my body are suddenly and severely swollen. It felt like I was growing fat in a short time. It felt *strange* and I sought a herbal remedy (Chamba participant: a 29-year-old farmer).

Some medications are not safe to take during pregnancy. It is important that a woman take only those that have been approved by her doctor.

4.5 Health Condition Before visit to the facility

The World Health Organization (WHO, 2014) envisaged a world where every pregnant woman and newborn receives quality care throughout the period of pregnancy, childbirth, and the postnatal period. International human rights law is a fundamental commitment of states to enable women and adolescent girls to survive pregnancy and childbirth as part of their enjoyment of sexual and reproductive health and rights. And living a life of dignity according to the office of the United Nations High Commissioner for Human Rights (OHCHR). It is estimated that around 99% of maternal deaths occur in low-resource settings, and that most causes are preventable.

However, the study discovered that, within the study area, some pregnant women sometimes ignore reporting cases of complications to the hospital for urgent attention during the early stages of pregnancy. They often sometimes wait until they feel uncomfortable about their body and well-being, before reporting to the hospital. This practice has the potential of resulting to unwanted maternal death as the early sign are often ignored. Some of the participants highlighted this and said:

> *I noticed that my urine smells badly, reddish and looks cloudy'…initially, I thought it was normal, but the problem persisted and that was when I decided to look for solution from herbal treatment* (Bimbilla participant 31 years trader).

Another one said:

> *I went to the hospital when I realized that, anytime I used the bathroom, I felt a burning sensation and it continued for some time* (Bimbilla Participant 26years teacher).

Yet, this participant detailed this:

> At all times, I felt dizzy and lightheaded. It made me feel like I would fall, and the environment was getting dark*'*. 'People said I looked pale, and my skin was yellowish. I personally felt irregular heartbeats. *Sometimes too* I could urinate like 7 times at night and even more during the day. It got me scared. (Bimbilla participant, 36 years hairdresser).

Early and timely reporting of sign and symptoms by pregnant women to the hospital for ANC has the potential of preventing untimely deaths and thereby reducing maternal mortality. However, where such dangers are ignored either due to negligence or ignorance, the consequences are death. To this end, scholars Mathews et al., (2010), Marmot and Wilkinson (1999) have identified some early sign during pregnancy and classified them as "high risk pregnancy". These conditions are often associated with maternal age; existing medical condition before pregnancy and that which

occur during pregnancy e.g., High blood pressure, diabetes, depression, and obesity, among others.

Indeed, Alkema and Chou et al (2016) estimated that, an approximately 303,000 women and adolescent girls died out of pregnancy and childbirth-related complications in 2015.

Mathews et al., (2010), further indicates that, girls under the ages 17 or women over the age 35, stands the highest chance or greater risk of complications than those between their late teens and early 30s. High-risk pregnancies require management by a specialist to help ensure the best outcome for the mother and baby. Nevertheless, Campbell et al. (2006) reiterate the fact that effective interventions exist at reasonable cost for the prevention and treatment of virtually all life-threatening maternal complications. ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behaviours such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing.

4.5.1 First visit at the facility: The experience of Maternal care seekers

The attitudes of staff and their mode of interaction with clients at the facility are critical to the smooth delivery of healthcare for all. These attitudes and interaction are most likely to influence the experiences of clients who visits the facility. To this end, the experiences of care seekers from minority groups are more likely to be different from those of the majority groups in terms of communication and decision-making.

Unhelpful attitudes of health professionals may lead to clients being less willing to seek care or arriving late for antenatal care, especially pregnant women (Mamdani & Bangser, 2004). More importantly, the notion of impression can be a defining factor.

The study discovered that most pregnant women had their first visit to the health center within the first trimester of pregnancy. A participant who had visited a private facility for the first time in her second childbirth narrates her first experience which is reflective of several rural women who have at some point sought the service of a traditional birth attendant. The participants said:

> *My first time of visiting the health facility was not that easy for me. It was* a private clinic. On arriving there, I was clueless about how to go about things. Even knowing where to start from was a problem. That was my first time ever visiting a hospital.″ (Bimbilla Participant, 31 years trader).

Other participants said:

> *My first visit was to the municipal hospital. I was reluctant because I didn't want to feel vulnerable at the hands of those people (health professionals). I was told that they misbehave a lot* (Pusuga participant, 35 years hairdresser).

Indeed, the knowledge, understanding, and attitudes of maternity care healthcare providers are critical determinants of care delivery. It is contingent on maternity care providers to value diversity among service users and to offer individualised and culturally congruent care. The study further discovered that many participants had mixed reactions to their experiences at the maternal care centres upon visit. An example is a narration of a 32-year-old trader who sought maternal care services in Bimbilla, and said:

> *In my situation, I was in serious pain, so I couldn't even speak out loud, but they (healthcare providers) kept shouting on me to talk aloud for them to hear. I needed help, and that is why I went there. I was even feeling sorry for myself.'* (Bimbilla Participant, 32 years trader).

Individualized care with friendly, unhurried HCPs encouraged women to attend for maternity care and positively influenced their sense of well-being. However, in most

instances, respondents reported abuses and discrimination. Thus, most maternal healthcare seekers in the study were not enthused by their experiences, especially at the municipal hospital. Another participant said:

> *When we were going to the hospital, I knew my pregnancy was eight months old, so I told my sister not to take my things (delivery items). When we got to the hospital, the nurse we met said, "As for these villagers, they don't know anything, and they are very difficult people too". I insisted I was only a few days after 8 months, but she wouldn't take it* (Pusuga participant, 25 years teacher).

Staff of maternity care require a greater level of mandated education to have better cultural awareness of the needs of diverse client groups. However, where this cultural awareness appears to be lacking among care givers in the health facility, it undermines human rights and the quality-of-care delivery. A participant pathetically narrates her ordeal at the facility when health care providers tagged her as a villager and consequently abused her verbally. She said:

> *When we got there (hospital) the nurses were finding it difficult to welcome us, after alighting from the motor bike. I didn't talk because I was in pain. Then the nurse asked me to go and sit on a chair. But another nurse said I should go and lie down on the bed. There, I heard one of the nurses saying, "that villager sitting there, which bed is she going to lie on?" Thereafter, the nurse took a cloth and spread it on the bed for me to lie on.* After that, *I didn't know that, as a pregnant woman, when you lie down, you must lie on your right side. One nurse saw me turning myself around, and she pinched my hand and said I'm stubborn* (participant, 29 years' hairdresser*)*.

Language barrier between healthcare providers and maternal health seekers was noticed as part of the experiences at the health facility by clients. Some women faced significant language barriers in the health centre and felt that their language difficulties made them problematic patients.

> *When I met with the nurses, they had difficulty I. understanding my language. Likewise, I couldn't also understand them, but there was not any known person to do the translation for us. So, for sometimes, we couldn't understand each other.* I *spoke [my language] and the nurses also spoke English. So, I asked them to wait in a sign language so that*, *I could get an interpreter… I didn't understand them, and you didn't understand me. But they (nurses) kept on talking and talking* (Participant, 37 years farmer).

From the narrative above, it can be deduced that the experiences of maternal health seekers include the fear of a negative attitude of care providers at the facility. Such perceptions are said to contribute to low attendance by maternal mothers to the facility. Thus, the perceived negative attitude of healthcare providers by maternal healthcare seekers could be linked to the issue of human rights. Indeed, the provision and access to health care to all, are to be ensured without fear or favour. Where, healthcare seekers anticipate a negative attitude toward them by providers, then it turns to infringe on the rights of such people, and thus, a violation of the human rights protocols.

4.5.2 Experiences from the attitude of health personnel by care seekers

Many maternity health care seekers shared their experiences of what they observed about the attitudes of healthcare personnel. Patients identified timeliness as a challenge, as some noted:

> *...we are made to join a long queue for several hours, only for them to come and order us around*'. *Imagine the situation of a pregnant woman. Do they think if it were not for our condition, we would have anything to do with this place? They never come early.* (Participant Bimbilla, 40years trader).

A Nakpa participant lamented that, they reported to the health facilities very early to join the queue only for the health professionals to come around very late. Participants emphasized their frustrations.

> You go to the centre [maternal health] as early as 6:00 to join the line, only for the officer to arrive after 9 am. If you don't come early, you will be at the back of the very long queue, and even if you come early, the doctor will still be late. It is very frustrating and annoying (Nakpa participant, 38 years hairdresser).

Apart from the timeliness, some patients are not happy with absenteeism and the slow pace of work by the healthcare givers. This was recounted by a patient. She said:

> *For me, the place is very far, but I struggle to get there. This is my third delivery, and anytime I go to the health centre, I come home very late at night. The officers were slow, and I was told they reported late too. They know we are many and some come from different towns, but they don't seem to care*'. (Chamba participant, 29 years teacher).

Beyond the above experiences, some other participants shared their experiences about the attitude of healthcare providers toward maternal health seekers which some of them are consider a violation against their rights. One participant said:

> *I don't think they consider those who don't stay in this town. They spend more time chatting with each other, and you can't even tell them to hurry up either. At times, you are hungry and angry at the same time, but they officers don't care how you feel. This I am sure is against the law, for an officer to continuously engaged in a private chat with colleagues to the negligence of patients waiting in a queue (*Pusuga participant, 36 years hairdresser).

Beyond what is described as negligence on the part of health care providers, some participants noted that health care providers often shouted at them at the attempt to draw their attention to attend to them. Sometimes, they (providers) they take advantage of little mistakes by the care seekers to shout on them because they did not

arrive at the health facility with the required items for childbirth (e.g., soap, baby dresses, etc.). A participant lamented over this kind of attitude and said:

> *For the mere fact that I didn't take all the items required for delivery when* I *got there, one nurse asked me to sit on a chair, but another nurse asked her to allow me to lie down on one of the beds. In disagreement, the other nurse said that the one sitting there doesn't look like someone who* bathed *…which bed is she going to lie on? Before I could open my mouth, she shouted at me to shut up and called me a 'villager* (Bimbilla participant, 29 unemployed).

Another pregnant woman confirmed the observation but indicated that she is now discouraged from going to the health centre when pregnant. This is because the negative attitudes of the personnel on duty toward patients was uncalled for, and against their dignity.

> *Look, let me tell you sir. I walk a long distance to get to the facility. I was also made to wait unnecessarily. However, I when I begin to draw their attention about how long I have been waiting, they said I like talking too much. . .* and that I was too knowing. hmmm*, therefore I do not feel like going back to that facility again when the need arises (*Pregnant woman, FG1 Bimbilla).

Several scholars including Akowuah et al. (2018) and Choudhury et al. (2011), have documented that, the attitudes of health workers are strongly correlated with high health care seeking behavior among clients.

4.6 Situating the experiences: Being treated well (dignity)

Some women recounted their experiences over midwives shouting on them when they were ready to bear down during the second stage of labour. These derogatory remarks usually target the woman's inability to "push" as expected.

> *I remember one moment when a birth attendant (midwife) at the hospital shouted at me …Hey, madam, you are not the only one to give birth here. There are others waiting for us, and you shouldn't waste my time. We are*

workers, so if you want to be pampered, go to the one who got you pregnant'. (Bimbilla participant, 28 years unemployed).

A woman who was in labour away from home and was rushed to the hospital for child delivery was also not enthusiastic about the treatment she got from the midwife.

> I was in labour, but I thought it was just a normal pain, so before I could realize I was due, I wasn't at home and was quickly rushed to the hospital by a friend's husband, whilst my husband was called to bring my delivery items to the hospital. The nurse was angry that I came with nothing and didn't accept any explanation. Even after my husband came with the items about minutes later. She shouted at me and finally left me unattended until the baby began to come out. I had no option but to plead with her, and she finally helped." *(Pusuga respondent, a 28-year-old tailor).*

One respondent was, however, not satisfied with the logistics used and the general environment of the ward. She complained about the bed on which she gave birth and the mosquito net she used. She explained.

> I felt the condition of the bed looked very bad and didn't feel comfortable, especially on that mattress I was made to sleep on. The mosquito nets also needed to be changed because they were not good enough for people to sleep inside them (Chamba Respondent, 25 years teacher).

4.6.1 Autonomy, Privacy, and Human Right

The study also discovered how religion influences the health of patients, especially maternal mother. A mother who doubles as a teacher and has been attending postnatal care at a health centre expressed her opinion on how she was influenced to take up her antenatal care during pregnancy by her husband. According to her, her religious

doctrine encouraged them to obey their husband, and that during the period of her pregnancy she obeyed the husband's order.

> I am a Muslim, and my beliefs tell me that the husband should make all decisions for the family. So, I listened to him and respected him. He told me to choose this place [health post] for all my health care matters. It has helped me a lot, and I'm grateful to my husband. (Participant, 28 years old, teacher FG1).

Another participant expressed displeasure with nurses or midwives conducting interviews in a loud voice or undertaking examinations in open settings in which other patients could hear or see. To the patients it is a violation of one's rights to privacy, as remarked by a participant:

> Everybody is sitting there (reception) and waiting to be heard. You cannot talk about certain things, especially the kind of sickness that brought you there. Some things can simply not be said when other people are present. 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, which is clearly against my privacy (Participant, 33 years old and unemployed).

Some women noted that, although they had spoken to the healthcare workers, it didn't necessarily mean that they had listened to what they said.

> Sometimes as a client, you think that something is good for you and that it is your right to have it... [maybe this bed and not the *other].* But after saying it, they won't utter a word in response, and they won't also do what you are suggesting. I've had that experience, and a similar thing happened when I was accompanying my sister-in-law during her labor." *(Nakpa participant, 24-year-old tailor).*

A respondent who was also a newly trained nurse explained that even when they knew that the healthcare worker was wrong and that they were right, they still had to remain silent. Thus, the right to privacy and autonomy by the patient is critically violated anytime by the professionals, indicated:

> As a newly trained nurse, I have standard knowledge of the basic things at this stage. Experienced maternal care seekers know what exactly to expect from child delivery unless there is a major complication. However, when the health worker gets some procedure wrong, you cannot say anything because she will tell you that she is doing her work. *(Bimbilla participant, a 26-year-old).*

Relevant to this discussion is whether possible state differences about when a patient is impaired may bring up ethical issues for nurses who are in positions where they provide care to patients with impaired decision-making capabilities. Pregnant teenagers and some young adults under age 21 who participated in the FGD identified a lack of communication from ANC providers as worrying and distasteful.

> 'It's frustrating when the midwives just look at me in that weird manner but say nothing. Instead, one of them called my mother, who accompanied me to the centre (hospital), and talked to her without me. I struggled to understand why she did not talk to me and seek my consent before talking to my mother. Even though she is mother, I think I should be consulted in such decision process of my health. The pregnancy is mine and not for my mother, so I should have that autonomy to decide (Chamba participant, FGD 2).

From the narrative above, it is succinct to ask the question: Is it ethical to overrule your patients' preferences? According to Beauchamp and Childress (1994), weak paternalism infers that, the health care provider is protecting the patient when the

patient is unable to make decisions due to problems such as depression or the influence of medications. On the other hand, "strong paternalism...involves interactions intended to benefit a person despite the fact that the person's risky choices and actions are informed, voluntary, and autonomous". Thus, a situation where a patient is denied consultation over her condition by care providers when she is not on medication or underage, will appear to violate the rights to the privacy and autonomy of such patient.

4.6.2 Feeling Safe: security and human rights

Safety, security, and human rights are inextricably interwoven and intertwined. It is mostly difficulty in separating one from the other. Thus, this study attempted at discovering whether maternal mother who visit the health facility for check-up and delivery often feel safe and secured in the hand of healthcare providers and how that relates to their human rights. However, the study noticed that there was a great deal of mixed feeling from participants regarding their safety and security as they utilized the services of the health facility for delivery and other related purposes. Whereas some participants indicate the surety of their safety and security, other think otherwise. Varied reasons are given in respect of these opinion by the participants. For instance, some women were firm in their belief, as they indicated that they felt safer giving birth in a health facility. This opinion was strongly informed by the experiences of multiple maternal health seekers who associated their feelings of security with their delivery outcome. One such participant said:

> I have had my two babies delivered through operations, and in both situations, I came out feeling well and satisfied. Naturally, that process is painful, but I am always assured of its success *(*Nakpa participant, 31-year-old trader*)*.

Another participant said:

> You see *errn*, they [health professionals] may have their issues, but when it's time for them to deliver your baby, they work with seriousness. In fact, not just that alone... When you enter the office and they see that your condition needs serious attention, most of them will gladly help (participant, 27 years old, hairdresser).

Yet, another participant intimated that:

> I remember a time when I had an argument with an officer at the OPD. I had come alone when I felt I was almost due (labour), but my husband had not returned from the farm. This meant that I had to go through the process on my own. I went to the labour ward only to be greeted with a smile from the lady I argued with. She was so nice to me from that time till I put her to bed. Personally, I felt very calm. "(*Participant, FGD).*

However, not all the participants were satisfied with issues concerning their safety and security within the facility, especially in the hands of service providers. The latter included examples of women being left alone to give birth, being refused services or where a lack of available equipment resulted in unfavourable outcomes. A participant from Bimbilla had some reservations about how the situation was handled. She said:

> As for being received, you can go there and be received, but you see them just walking around as if nothing is at stake. Meanwhile, you are in labour. I have heard women complain that they saw women deliver without any nurse attending to them. In this situation, there is no motivation to go to the hospital. Just imagine you travelled a long distance to the hospital and delivered alone;

> isn't it better you stayed and delivered at home (Participant, 40 Years Teacher).

Other women expressed safety concerns about the risks, which included cracks on the walls of the hospital ward and a lack of walls around the building.

> One morning, we saw a giant black snake behind the door. The hospital security had to come in and get it killed. Anytime I think of it, I always don't feel like going there to give birth. The last time I went for ANC, I was afraid to pass where the grass was. Sir, you may think I am telling lies. Anytime you go to the hospitals, just try, and enter any of the wards and look around the walls. Some parts of the building look like they are about to fall apart. I don't feel comfortable at all (Participant, 29 years teacher).

4.7 Equality, Discrimination and Human Rights

The right to equal access to health is enshrined in the 1992 constitution of the Republic of Ghana. All people are equal before the law, and as such should be recognized and treated equally in terms of the allocation of state resources. It is also recognized that; all individuals are given equal opportunity to achieving their God's given talents in life. However, where distinctions and other artificial barriers are created to deny others from benefiting from what is due them, then it tends to infringe on the rights of such people. Thus, within the health system, especially maternal healthcare, all mothers are required to access free maternal healthcare during pregnancy. However, the study discovered among participants during interview that their rights to equality were threatened or violated. This was narrated along the lines of personal characteristics, age, geographical location, as well as cleanliness, and money. An example was narrated by a woman in Bimbilla. She said:

> If they realize that, you are from a village, they don't respect you at all. One time, I was in a queue to meet the doctor with other women from my village and several others. When they called for the next person and I was about to enter the room, a certain pregnant lady just came from nowhere and was asked to enter and meet the doctor while I was made to wait further. She and her husband are from the town where the doctor is and I know them very well. Oh sir, if you want, ask everyone who has been there [hospital] before. It's a normal thing to see there, and they call it "protocol (Bimbilla participant, a 30-year-old trader).

Another lady mentioned that she believes some care seekers win favour because of their educational background and marital status.

> My brother, if you are not married, or didn't come with a respectable matured man or husband, and you are not well educated like me, just accept your faith, and wait patiently for your time." (Participant, unemployed).

The feeling of being treated unfairly forced some to go to the traditional birth attendant and this was captured in a narrative by a participant who said: *They don't respect those of us who are from the villages. Hence, I always prefer to deliver at home with the help of a* TBA." (Participant, 40-year-old farmer).

Despite the above negative experience by maternal health care seekers, the study also discovered some other positive comments from some participants who had received some form of fair treatment, especially from the pharmacy and laboratory personnel. A participant said:

> Honestly, I can't say that they have not been fair to me. The truth is that most of the time, I don't take notice of some of these things, but a few days ago, I

> was at the laboratory and the pharmacy, and we were all given equal treatment. The man at the counter at the pharmacy was very nice to us. (Bimbilla Participant, 33-year-old teacher).

The respondent came to the health facility when she felt that she was in labour but ended up having an emergency Cesarean section. She said:

> I was in there for some days, but my husband was only allowed to come in for a few minutes at each visit. I needed someone, especially him, to help keep records of what was being said and to support me through. Some of the midwives and nurses were visibly reluctant anytime I sought their help. It was just hard when I couldn't get out of bed, and I had to call the midwives every time. Even for the bath, I had to wait until he came in so I could go shower. So, I asked myself, why not allow him to stay for longer hours with me? But the staff won't allow *(Bimbilla participant, 34 years teacher)*.

Another woman from Chamba narrated how she helplessly laid down while health staff stepped over her without remorse.

> Just imagine being stepped over by hospital staff while you are lying on the ground in front of the main doors. It was like a joke, but interestingly, none of them bothered to ask if I was OK. They didn't even try to help me up or get someone to help me up. I was there until my husband came around and helped me up. I was probably on the ground for about 10 minutes or so, but that felt like forever. After I was feeling better, I tried complaining to a lady behind one of the counters about what had happened, and she didn't show any expressions *(Chamba participant, 26 years unemployed)*.

4.8 Choice of Health centre by Maternal Health Seekers

Choices in care in the Nanumba North Municipality are an important factor which has an impact on the quality outcomes of maternity health care and for that matter, human rights related issue against maternal health seekers. This is as important as the timing and levels (stages) that enable health personnel to undertake various screening tests and diagnostic procedures, some of which are done routinely, and others are provided to women based on identified problems and risk factors. Pattinson (2005) highlighted that the first ANC visit by pregnant mothers should take place as early as possible. This according to the author should be before 12 weeks of gestation and preferably at the confirmation of pregnancy. Ideally, during the first ANC visit, all women are classified as basic ANC using the classifying form or first visit checklist provided. All women with risk factors should either be referred to an appropriate level of care or follow a specially prepared schedule based on the risk factors identified. However, where this identified risk factors are ignored by healthcare providers to mothers or pregnant women without an appropriate reason, it becomes a human rights issue, since it has the potential of leading to unwanted maternal death.

Pattinson (2005) guidelines highlighted the importance of preparing an individualized ANC and delivery plan for each woman at the first ANC visit and that plans should be reviewed during each subsequent visit and adjusted based on the identified needs. This plan, according to the author, should be prepared in consultation with the women concerned and advise women about nutrition and self-care, which ensures that the woman is involved in her own care.

The study discovered that, most women often choose to visit the public maternal care centres at one point or another during their pregnancy, as it is believed that the

personnel are well trained to handle their cases. Interview with some participants revealed the following viewpoint on the choice of health facility. She said:

> For me, I think the main hospital was the best place to go for my check-up. I honestly don't trust any other process especially the private facilities apart from the public facility. Most often, there are more trained and qualified personnel at the public facilities than the private ones. The only challenge I know about this public facility is with regard laziness on the part of some personnel during duty, which can't be the case at the private facility. So, the main hospital is the place where most of us go during the period (Participant teacher).

This was also confirmed another participant in the following statements:

> I know that public health officials can be mostly misguided, but I still like that place because, they are trained professionals and I assume that they have best practices in their work.' (Bimbilla participant, 28 years tailor).

Another participant had contrary view on the choice of health facility during pregnancy. Unlike those maternal care seekers who prefers the government hospital, compared with the private facilities, this participant thinks otherwise and said:

> I often visit the private health facility for my check-up. For instance, I visit one of the private centres to take a scan to determine the number of months of the pregnancy. One reason I prefer the private facility to the public one is that there is much attention for the patient there, compared to public one. In fact, sometimes we are pampered over issue, and they respect every aspect of our rights during the process. So, why would I ignore such an opportunity for anything less? (Participant, 27 years unemployed).

From the above narratives, it can be concluded that the choices maternal health care seekers make regarding the choice of facility during ANC are informed by varied reasons and preference. Whereas respect for human right is considered key to the preferences of choosing a facility especially for the private, the level of expertise by personnel also informs the choices maternal care seekers make. Indeed, it is a mixed reaction from participants as regard private or public facilities that promote human rights of care seekers during visit as discovered by the study.

Ordinarily, any maternal care seeker will want to select a facility where they will feel comfortable and having honest conversations with staff who have the needed expertise in the area that meets their health needs. No matter how long a maternal health seeker plans to see their primary care giver, their relationships or anticipated relationships are always the most important. Many women who experienced the private health care centre indicate their liked for it and hoped they would go there anytime they were pregnant or about to deliver.

> Personally, I prefer the private health centres for my pregnancy care and child delivery because, they are always nice, and they receive you well. Again, the place is not often crowded, and there is no time *wasting* there (Participant, 27 years teacher).

The women who sought the services of traditional healers and traditional birth attendants placed much emphasis on how patient, caring and attentive they were to details.

> It feels very comforting with traditional birth attendants (TBA). They have a lot of time and patience. When my husband decided to put me in her (TBA) care, she checked up on me anytime she was around. She visited me

> frequently and tried to know whether I had some pains so that she could help me. (Nakpa participant, 25 year old trader).

Meanwhile, most of the women who preferred public maternal care facilities were very particular about the professional training of the staff. The fact that, the public facilities have the full backing of the government gave women some level of confidence.

From the study, it was observed that, majority of women who would prefer government health facilities are mostly from the urban setting, but a good number of them also prefer private-owned health facilities. Yet, many of the women who participated in the study from the rural areas would prefer the traditional birth attendant at some point.

4.9 Describing the Surrounding of health facility

A "safe hospital environment" is defined as the environment that best provides the patient and healthcare professional with the comfort and safety conditions that effectively meet all their vital needs. However, where the environment appears to threaten the peace and security of individuals, their rights are equally at risk.

Participants from the study expressed their opinion on the state of the hospital environment they visited. Some respondents found the overgrown, grassy nature of the surroundings and the strong stench from the hospital drain to be of critical importance, and threat to their health conditions.

> I have visited the community CHPS compounds and the district government hospital and haven't been impressed at all by how they allow grass to overgrow. It can become a breeding ground for dangerous reptiles. In fact, it is

> more dangerous to our health conditions than the pregnancies we are carrying (Participant, 29 years teacher).

Another respondent agreed with the earlier statement and added that, there is a strong odour that comes from the drain in the maternal ward.

> There is a strong smell that comes into the ward anytime the wind blows toward the direction of the maternity ward. Sometimes it smells like rotten fish, and at other times, it smells like fresh fish. It gave me nausea and made me feel like vomiting (Participant, 20-year-old student).

Others also expressed worry about the lack of a fence wall to separate the hospital from external invasions. A participant summed it up as:

> The place is very open. Anybody at all can just pass through the hospital on a motorbike or bicycle, whilst patients and pregnant women also commute from one department to the other. It is difficult to know the hospital boundaries and be able to regulate who is a client, who is visiting a client, and who is just a passer-by *(Nakpa participant, 31 years Nurse).*

4.10 Whether or not patients got accompanied to the health centre

Getting someone to accompany a patient to a health centre especially during pregnancy and child delivery by women is largely dependent on several factors, including the stages of the pregnancy. Many respondents, including those who had someone to accompany them to the maternal health centres, associated that with the stage of the pregnancy.

> As for me, usually I don't think it is necessary for someone to come with me to the centre for ANC. I don't know whether he [husband] will agree or not

during that time [ANC], but I think I like it alone for now (*Participant, 31-year-old trader).*

This is to say that women in the study area would need someone to accompany them to the health centre depending on the stage of their pregnancy.

If it's delivery time and he is around, he will come with me. As for ANC, he won't come. At the stage [first trimester] ..., he would rather ask me to take herbals. But during the other periods [second and third trimester] of delivery, he will be the one pushing and following me to the hospital." *(Bimbilla participant, 23 years old, unemployed).*

Distance to the health facility and availability of a means of transportation, season, etc. were also cited as determinants for getting someone to follow a pregnant woman to the health centre for ANC. For instance, the longer the distance, the more difficult it is to get someone to accompany you, especially when there is no proper means of transport. In their study, "the inaccessibility and utilization of antenatal health care services in Balkh Province of Afghanistan," Hadi et al. (2007) related the utilization of antenatal care (ANC) services to the participation of women in activities.

They identified that the use of each of the ANC services was significantly lower among women who were involved in economic activities than among those not economically active. The reverse of Hadi et al. (2007) is also and exactly true with regards to finding someone to accompany a maternal health seeker to a health centre. This was observed by a respondent from Nakpa who said:

I always go alone to the hospital because the road is bad and far, and my husband doesn't have a motorcycle." Apart from the time we are due for

> delivery, it is difficult to get someone who is willing to give out their vehicle for ANC attendance (Nakpa participant, 29 years old and unemployed).

During the rainy season, many people will go to their farms and may be unavailable to help.

> We need food to survive first because, even if you have children without being able to take care of their nutritional needs, it is useless... But as for having babies, if you are destined to have children, they will always come. Everybody goes to the farm to work for a livelihood*." (Participant, 34-year-old trader).*

From the responses, many women visited the maternal health facility with family members only during the delivery stage. While some women visited the health centre with their husbands, the majority showed up with other family members (mothers, sisters, and cousins). Thus, analysis of the responses points to the fact that it is usually uncommon to have someone come along with a pregnant woman to the health centre for ANC and other check-ups during the first, second, and post-natal periods except for the third trimester (labour).

It must also be emphasized that, for hospitals and health care institutions to coexist, ensuring that patients receive proper care takes more than just performing normal procedures and making diagnoses. But rather, communication is a crucial component in all steps of human interaction, more importantly, under the health care process. Organizations with strong communication policies can enhance their patients' health, while those who do not have effective procedures in place can negatively impact patient well-being. Data for the study has shown a complete mixed of results from maternal care seekers' interactions with health professionals. While some health care seekers viewed their interactions with health care providers as poor, others felt

otherwise and that it was something that should happen in any human setting. For instance, a participant said:

> It feels like they (health workers) are not answerable to anyone but themselves. It's very bad!" Sometimes, they ask you questions about your condition, and after that, they prescribe medication without telling you exactly what the condition is." *(Participation, 32 years and unemployed).*

Some respondents believe that healthcare providers are human and will make mistakes from time to time; "*it is a human institution, and we cannot avoid mistakes. If the mistakes are few, we forgive and move on".*

4.11 Maternal Health Evaluation of the Attitudes and Practices of Health Care Providers.

Generally, the attitude and practice of health professionals have been questioned in relation to human rights of maternal health care delivery in the Nanumba North municipality.

From the interactions with participants, the number of maternal care seekers who are dissatisfied with the attitude of health care providers appears to be more, compare with those who were satisfied. During a conversation with one of the mothers, she said:

> I don't know why they behave in that manner, but they [hospital management] should try and do something about it. Their behavior is very bad, it is not helpful. We go there not because we enjoy it but because of our assurance of safety and the less expensive nature of public facilities'. to be honest, I don't like the behaviour of most of the health care providers at all. They have this

> lackadaisical attitude, and they act very bossy. Sometimes they shout at you as if they are better human being then you. (Bimbilla participant, FGD).

Some of the women see maternal health care providers as generally insensitive.

> ...they (health staff) do not care for us at all, when you go in the morning, they will say why are you coming so early? When you go in the afternoon, they will say why did not you come in the morning? When you go in the evening, they will say they have closed and that doctor is not around so, come the next day. In fact, they are insensitive, and they talk to us anyhow'. (Participant Pregnant woman, FG2).

From the samples of responses from both the FGD and the Interview sessions, it can be concluded that maternal health seeker from the study areas are generally dissatisfied with the attitudes and behaviour of care providers at the facility in the study area.

4.12 Summary

The chapter presented and analyzed data gathered in satisfying the study's research objectives. It is well documented that the attitudes and behaviors of maternal health care providers have a considerable influence on women's and their families' perceptions of quality of care, decisions to seek care, and the ability to access appropriate and adequate maternal health care. The findings of this study were observed to be shifting towards and in support of the perception that maternity health care providers attitudes need to be given special attention. During the utilization of MCH services, women's interactions with care providers may help them develop trust in the health care system. This idea of trust is to provide motivation to use multiple services and play a key role in improving the health status of women by establishing

healthy medical relations. In such situations, Musa, Schulz et al. (2009) identified the lack of patience and trust as more of a poor human relations issue, which was in support of O'Malley, Shepperd, et al. (2004). The various studies pointed out poor clinical interaction, less communication, a lack of continuity and ultimately reduced utilization of preventive health care (Pearson, Raeke 2000). The motivational factors for such attitudes or attitudinal concerns against health workers are not known as they were not a part of this study. Surprisingly, few studies have comprehensively sought to understand these issues of uncomplimentary attitudes of health providers in low- and middle-income countries like ours (LMIC). The lack of intervention research on this topic is especially curious, as no studies specifically aimed at altering MHCP attitudes or behaviors have been identified. The study mostly identified instances of non-dignifying care, physical abuse, non-confidentiality, discrimination based on specific patient attributes, abandonment of care, and detention of patients in facilities. Positive attitudes, on the other hand, were described in terms of being friendly, respectful, and caring. The rest were informative and sympathetic, but they were much less frequently reported. Providers were more likely to be caring and understanding when they had a pre-existing relationship with the patient, and this fed into the interception of discrimination and equal treatment.

In analysing the attitude of maternal health providers in Nanumba North municipality, the study completely agrees with Mannava et al.'s (2015; P.13) factors on behavioural issues that influence the pattern of health seekers' choices for maternal health delivery.

4.13 Suggestions to Improve the Service

Finally, participants were asked on their perspectives to improving maternal care services in public health and other related care centres. As a result, they suggested that health workers, particularly maternity care providers, be retrained in how to treat care seekers with respect and dignity. They also called for the availability of the needed drugs and equipment to be made available whenever pregnant women and new mothers are in need. Workers in public health institutions should be passionate about their work, and they should be exemplary for interns and entry-level staff. To respect the privacy of mothers, the number of students should be limited to two or three. Healthcare providers should be punctual. Participants also commented on facilities like the shortage of bed sheets, the neatness of the hospitals, and the shortage of ambulances. Further comments were also provided; healthcare providers give poor treatment to mothers. Therefore, the administration and the concerned bodies should take corrective measures because a little mistake may cost a life.

CHAPTER FIVE

SUMMARY, CONCLUSION AND POLICY IMPLICATIONS OF THE STUDY

5.0 Introduction

This chapter summarizes the research findings and discusses how they satisfy the study's objectives. It raises critical questions with the aim of drawing out the complexity of issues of human rights in relation to the attitude of maternal healthcare providers toward maternal health seekers. It also addresses whether or not the attitude of the maternal service provider infringes on human rights and the potential risk. These four towns, namely Bimbilla, Pusuga, Chamba, and Nakpa, in the Nanumba North Municipality in Ghana, were the focal point. This chapter is presented whilst considering the objectives of the study and reviewing literature related to the topic under investigation as pointed out in the theoretical framework. It further communicates the implications of key research findings within the laid-out human principles of dignity, safety, autonomy, and equality, which will be central in addressing the research objectives. The chapter concludes with recommendations and areas for further research on issues of maternal health care providers and human rights within the study area.

5.1 Summary of the Major Findings

The study elicited the opinions and experiences of maternal health seekers about the attitude of maternal health caregivers. As highlighted by UNICEF (2004), maternal health care is a potentially important way to link a woman with a well-functioning health system, which will be critical for saving her life if a complication, but this does not exclude antenatal and post-natal care. The study also established other factors that

are preventing women in developing countries such as Ghana from getting life-saving health care they need to include cost (e.g. direct fees, transportation, drugs and supplies); burdening demands on women's time; women's lack of decision-making power within the family, among others. This situation is compounded by the perceived behavioral traits and attitudes of maternity health care providers.

The research focused on identifying human rights issues in maternal health care delivery in Nanumba North Municipality of Ghana. It further dealt with, the principles of human rights, which are adopted in underlining the infringements of the rights of maternal health seekers. Finally, the study highlights the challenges to women's human rights in terms of their decision-making and participation, especially at the maternal health level. The findings of the study are summarized below.

Human rights are becoming central to daily ethical and political discourse, which indicates a weighty shift regarding how humans understand the foundations of morality. While there were varied opinions expressed by respondents of the study, its findings of seem to confirm the long-held perception of the manifestation of bad attitudes of maternal health care providers. The narrative points towards women as passive victims in contexts of the attitude and behaviour of service providers within the study area. Study participants did not hide their thoughts, as many of them confessed to ever seeking the services of traditional birth attendants (TBA) at a given stage of their pregnancy for delivery, advice, or herbal treatment, or both, for one condition or the other. Generally, all the participants who were sampled across four towns in the Nanumba North Municipality, namely Bimbilla, Pusuga, Chamba, and Nakpa, in the Nanumba North Municipality in Ghana have also at some point felt mistreated or unwelcome at the facilities they visited for maternal care.

Even though this particular opinion was dominant, the entire narrative was not all about picture of doom. From the narrative, there were many other consoling instances where participants were vocal and expressive of how well they were received by a health professional and were appreciative. Several studies in different settings within Ghana and beyond have demonstrated poor attitudes and behavior, or their perceptions of maternal care providers and this study goes to confirm. In Mannava (2015) for example, women reported experiencing scolding, shouting, physical abuse, and abandonment during childbirth. These issues have been captured in several of the narratives by the study participants. The rest includes health facilities' non-responsiveness to patients' needs, as well as their inability to provide the necessary emotional and physical support during childbirth. Failure to push, young age, and inability to bring all the items required for the birthing process were reported in our study as potential triggers for mistreatment. This phenomenon is also widely reported in a study by Moyer et al. (2014) and Rominsk et al. (2016), in previous studies in Ghana.

The human rights laws embed the right to maternal health care and emphasize the right of maternal health seekers to make their own choices and be involved in the decision-making process about their maternal care. This means that public organizations like hospitals must treat patients with dignity and respect. It is worthwhile to note that, under the same laws, the care that health professionals give in maternity must come with dignity and the freedom to make decisions about oneself (autonomy). Both Goer (2010) and Hodges (2009) agree that disrespectful and undignified care during facility-based childbirth also occurs in higher-income countries, but the pattern and forms of mistreatment may differ, especially with that of developing countries. Furthermore, there is a perceived power disparity between the

service provider and client relationship, as well as social exclusion, which causes some female abhorrence and fear of seeking maternal health care from skilled birth attendants and the formal setting. This resonated well with the study, as some women struggled to question certain health professional postures. In a Similar study, Nguyen, Gammeltoft, et al (2007), narrated a situation where Vietnamese doctor was quoted espousing how extreme he and his colleagues health professionals can go to prove their superiority before their clients. According to Jewkes (1998), rude and abusive attitudes towards patients seemed to enable maternal health care givers to feel superior and maintain their middle-class identity. The latter's study observed what appears to be an acceptance of a culture of abuse at health facilities based on the fact that health providers and seekers seem to see mistreatment as normal.

Such situations have led one of the participants to confess that she was already seven months pregnant but had never had any ANC since she got pregnant till date. She went on to say that she feared that, even at that stage, she still feared visiting the maternal health centre for their services for fear that they would use salty words on her. Even though philosophers measured human behaviour during pre-modern times against the will of God (adherence to natural moral obligations), modern considerations necessitate measuring human behaviour as being morally good or bad by measuring its degree of adherence to legally sound human rights (Muis 2014). Women would rather not attend antenatal care (ANC) because of poor communication and disrespectful treatment by providers. These narrations were very common among rural women during the FGD. These power differentials and social exclusion often related to perceived discrepancies in in terms of access and participation in decision-making processes at both the local and national levels.

However, some health professionals were acknowledged by patients for their care and sensitivity towards their plight despite the workload and burnout. International human rights law establishes states' obligations to act in certain ways or refrain from acting in certain ways to respect, protect, and fulfil individuals' and groups' human rights and fundamental freedoms. The charter articulates the rights of two entities, the woman, and the new-born, within the vision and provision of a framework for ethical, high-quality, respectful maternity care that supports and upholds the dignity of both. Both human beings, the new-born, and the woman, have rights that must be respected and guaranteed independently. Finally, the respondents suggest that perceived inequalities, lack of autonomy, safety, and non-dignifying treatment fuel questions being raised, which are attributed to the behaviour and attitudes of healthcare givers, which point to violations of the rights of maternal health seekers in the Nanumba North Municipality. This enforces the philosophical view that human rights are a product of a specific society and its prevailing legal system due to their interdependency on human behaviour, rather than belonging to humans merely based on their humanness.

Secondly, with regard to how attitude of maternal health care infringes on the rights, the study generally revealed the diverse challenges that are confronting maternal health care seekers in the Nanumba North Municipality. For the purposes of this study, health professionals' attitudes toward maternal health care were narrowed to four key human rights measures such as autonomy, dignity, security, and equality, as well as their effects on their clients' perceptions. Primarily, the respondents intimated their discomfort and disquiet with the attitude of maternal health care providers within the study area. Universal human rights are usually expressed with guarantees from legal instruments such as international treaties. The studies of Keith (2010) and

Kirchschlaeger (2015) draw specific attention to the plight of people in the minority group (vulnerability and marginalized). As emphasized by respondents earlier, this study reports on provider's neglect or abandonment of patients, limited to late attendance of maternal health service providers, availability or absenteeism, and refusal to deliver services even if they were available. Those discriminated against endure human rights violations because they do not possess sufficient knowledge or means to claim them with reports of favoritism and nepotism. International human rights law is the accepted standard for state actors; in other words, it determines states' obligations to act in a certain way or refrain from acting in certain ways to respect, protect, and fulfil individuals' and groups' human rights and fundamental freedoms. Since human rights are derived from human beings, it is instructive to know that, by nature, humans are egoistic, in that they selfishly seek individual satisfaction at the cost of others (Wilson 2013).

The story of abandonment for example, recurred frequently, and was widespread, primarily in government-run health facilities and centres. Several of these cases were notable during consultations or in critical situations when assistance was required. The study reports nurses and midwives sleeping, chatting, watching television, or did not inform doctors of the delivery. Lack of regard for privacy was another concern raised by women in all four towns of the study. Women felt that their personal privacy right to autonomy were not respected during examinations prior to or following childbirth or abortion. The fact that other individuals including facility staff were allowed to enter and leave the maternity ward from different department uninvited was a matter of concern. Similar concerns were also shared by those who were scheduled for counselling or who had been through the process of counselling in the past. The study also observed differences between women admitted to urban and

rural sub-district obstetric facilities and found that a higher proportion of participants reported respect for privacy in urban facilities than in the rural setting. The Human rights charter is based on widely accepted human rights instruments, including the Convention on the Rights of the Child, the Convention on the Elimination of all forms of Discrimination against Women, the International Covenants on Civil and Political Rights, and Economic, Social, and Cultural Rights. It is also supported by regional human rights instruments, including the African Charter on Human and People's Rights, the African Charter on the Rights and Welfare of the Child, and the European Convention on Human Rights and Biomedicine, among others.

Although international human rights exist beyond the determination of specific societies, they essentially serve as individual legal entitlements, primarily against all states and state entities. Such entitlements allow humans to legitimately claim equal protection for their basic human needs, dignity, and fulfillment of their ideal of living a life worth living, regardless of where they live (Keith 2010; Ajey 2015). The fact that, some care seekers have contemplated going to a traditional birth attendant (TBA) due to fear of being mishandled at hospitals is a clear indication of a situation that requires special attention. With regards to being treated humanely by maternal service providers in the Nanumba North Municipality, the study revealed that, in principle, women felt their human rights were threatened or violated by virtue of the posturing of service providers towards them.

Observations are that most of the respondents from rural towns (Chamba, Nakpa, and Pusuga), are more likely to report violations of their right to dignity and equity than their counterpart from the urban towns. This is evident in the responses, of the women being scolded by maternal health professionals for not bringing child delivery items

whilst in labour, for not being well dressed, for not having enough money to pay for toiletries, or for no known reason. Furthermore, others get embarrassed for holding expired health insurance or not having any at all. In addition to verbal assaults, women also experienced physical abuse during labor when they did not follow the instructions. Many respondents reported being unaware of their "rights" as health seekers, but from the responses they could perceive wrongdoing with the feeling of mistreatment. Women, however, describe their experiences or what they heard about several unsafe situations that can occur during labor. These situations were related to labor complications, such as severe loss of blood, cord or placenta problems, convulsions, other pre-pregnancy conditions, or even mal presentation of the baby. Human rights law sets out the way we can expect to be treated by the government and all public bodies, such as the National Health Authorities. This also put an obligation on caregivers in public and private institutions to be weary of human rights as they go about their work. In the UK for example, Human rights are also protected by clinical negligence law, which is part of common law. Since the practical realization of human rights depends upon the conscious willingness of humans themselves (Cruft R et al. 2015), human rights will continue to have a strong moral foundation regardless of their legal status.

Finally, just like some thoughts being expressed by respondents to this study, mistreatment of health care seekers is commonly seen as harmful acts that are targeted towards a person, or a group based on actual or perceived group membership. Attitude is crucial and cannot be underestimated in nursing. The role of maternal care providers cannot be isolated from how their clients perceive and respond to situations or cases before them. The attitude of critical service providers like maternal health care givers can be measured in verbal or nonverbal expressions and can take the form

of discrimination. For instance, hate speech comprises the verbal or written expression of prejudice aimed at harming another group. Even though there are other factors that may influence or trigger the bad or good attitudes of nursing care providers, this aspect of the study in Nanumba North Municipal sought to understand how such behaviours can impact maternal care and how they impact on human issues. Participants from the IDI and FGD had a negative perception of public health institutions, particularly the maternity service. They do not even want to go there, especially to the hospitals, because of the poor conditions and services they receive. It is due to the provider's attitudes, deficit of facilities, use of unqualified staff (students), and other situations that repels interest in public health institutions. Given this, human rights law requires the support of a comparable moral awareness and ethos in order to be effective and regarded as just.

According to Kirchschlaeger (2015), human beings do not follow legal principles solely out of fear of the consequences, but rather because they believe in and share the ethical principles emphasized by legal imperatives. Acts of hate are thought to be effortful or intentional. The negative health consequences for victims are numerous, with much of the literature focusing on the victimization of people based on race, sexual orientation, and gender minority status. Experiences of mistreatment are associated with poor emotional well-being, such as feelings of anger, shame, and fear. As many participants in this study expressed dissatisfaction and reluctance to visit maternal health posts for nursing care, victims tend to experience poor mental health, including depression, anxiety, post-traumatic stress, and suicidal behaviour. As many factors may be associated with the bad attitude of health professionals, some of the medical impacts may include stress, physical injuries, difficulty accessing medical services, and poor overall physical health. The experience of hate-motivated

behaviour can result in the blaming of victims and lower empathy toward fellow victims.

The numerous responses from this study that further suggested neglected, verbally and physically abused by maternal health care providers, among others, are not just human rights abuses; instead, they serve as a deterrent to seeking facility-based ANC and delivery. An entire community can feel the impact of victimization even though not all have experienced mistreatment. Members of the targeted community may experience vicarious trauma symptoms resulting from witnessing others being victimized. In addition, a review of structural discrimination shows that for a targeted vulnerable group, long-standing and systemic inequalities can be seen in economic, housing, and educational disparities.

Mistreatment during facility-based childbirth is increasingly recognised as a widespread problem. Complementary findings by De Graft-Johnson et al. (2006) and McMahon et al. (2014) identified that comparable finding of mistreatment of women, in varied forms, during childbirth in health facilities in several African countries, including Tanzania, Kenya, and Nigeria. There are many rumours and real stories that participants know. Rumours harm the institutions. As they reported, they are afraid to go to public health institutions after hearing different rumours and real stories. Despite some complaints, many still described public health facilities as useful settings for maternity services. They were considered affordable, accessible, staffed by qualified personnel, and usually stocked with quality medications and equipment. They prefer public health institutions because they have well-equipped materials, the provisions of free maternity services, the availability of organized professionals, and the provisions of a guarantee for their lives. Apart from the attitude of health

professionals in Nanumba North Municipality, factors like economic and educational backgrounds, marital status, distances etc., also formed the basis for women to seek maternal health care services or otherwise. Mistreatment is generally a human right abuse and has the serious potential that can make facility-based childbirth in the future a major disincentive.

Because of experience from health centres, it is more likely for women to resist any idea of visiting a skilled birth attendant, which increases the risk of undetected complications during pregnancy or childbearing periods. As such, during the maternal/childbearing phase, the behaviours of health professionals in Nanumba North Municipality are put under strict scrutiny as the expectations are very high and it is more convenient for women to take notice. According to Marks (2009), legal systems in this regard are aimed at limiting and guiding human behaviour by combining human rights with corresponding responsibilities.

5.3 Conclusion

The interplay between the egoistic nature of humans and the need for humans to harmoniously co-exist in society amongst other humans depicted the effect of society-specific conditions on human behaviour. In general terms, the study's findings are relevant to the Nanumba North Municipal, Northern Regional, and National discourses on the attitude of maternal care providers and how they impact the human rights of maternal care seekers. Even though it is acknowledged that human beings by nature tend to act with discretion along with emotional sentiments, it has become evident that persistent human rights violations through human behaviour necessitate the inclusion of human rights within the policy and legal framework governing the practices of health professionals. The finding on the various roles of care providers in

infringing the human rights of their clients affirms the growing body of perception that women in childbearing conditions are passive victims of mistreatment and disrespect. It came to the fore that humans, with their own individual sets of morals and beliefs, need to be well educated to adopt and adapt to mutually acceptable behaviour that would be to the benefit of all living in such a society.

Critically, this calls for a consensus effort and a participatory approach in deliberations geared towards mitigating the perception, whether it is true or not, and since both the maternal care seeker and the care professional may not be getting along, both parties can assume roles in making sure that this canker is minimized. This allows for obligations on not only governments but also private individuals to adhere to the responsibilities indispensably linked to human rights. It also empowers those whose human rights are violated to legitimately claim compliance with normative legal imperatives. In addition to expanding on existing scholarly knowledge, these findings introduce new contextual perspectives and the reality of human rights violations on maternal health care seekers by highlighting challenges related to maternal care providers' attitudes. With reference to the persistent occurrence of human rights violations globally, this underscored the gap, despite the widespread acceptance of human rights. Furthermore, findings on the implications of human rights violations on maternal care demand serve as a platform for reviewing and/or developing pragmatic and gendered policy frameworks to sustain women's interest in seeking health services from the formal maternal health setting during their maternal childbearing phase. This keeps the gate open for furthering the debate pertaining to how human behaviour needs to be adopted to realize human rights, at least those pertinent to meaningful human existence, to their fullest potential. Finally, a study of this nature finally satisfies the quest for knowledge on issues related to

maternal health and human rights issues during and post-childbearing phase in the Nanumba North Municipality, Ghana.

5.4 Policy Implications

The findings of this study highlight maternal health seekers' perceptions of how they are treated at maternal health centres. This study reveals serious human rights issues faced by maternal care seekers because of the actions or in-actions of healthcare providers. In conclusion, the findings are important for policy, practice, and subsequent research. The study is expected to draw attention to the human right concerns and with aim to help minimize the future recurrence of human rights abuses of maternal health care seekers.

It is evident from the study findings that MHCPs' attitudes towards maternal health care seekers are of serious human rights concerns in the Nanumba North Municipality. As a result, effective management of identified grievances raised by maternal health care seekers is required to help bridge the nagging gap with maternal healthcare providers. To effectively resolve these concerns of violations, it is imperative that both MHCPs and MHCSs accord each other mutual respect, but the burden lies with the health workers to empathize with the client who could possibly be in pain at the time of visit. Maternal care providers through the public health department can provide regular, detailed, and concise education to all women of childbearing age. This can be organized and facilitated at the various health and community centres. Maternal health officials can also use social media and the traditional media or open themselves up to women's groups to invite them to answer questions and offer education to those who need it.

Moreover, in managing grievances related to perceptions of human rights abuses, there is a need to address perceptions of the volatility of service providers towards their vulnerable clients on inequalities, non-dignity, safety, and autonomy. While assuring clients or care seekers of guarantees for the protection of their rights, encourage them to speak up when they feel aggrieved; this can be done by creating a complaint center. These complaints raised at the complaint centers must be seen as addressed by the complainant, or there must be some degree of improvement. This way, communities are afforded avenues in an attempt to address perceived misconduct by asserting influence over local planning and decision-making processes in the presence of community leaders or through their representatives (chiefs, community, and opinion leaders). The study suggests that there is a lack of information available and less consultation with maternal health seekers, particularly on matters that bother their human rights. To address this, maternal health seekers must receive immediate responses to questions as well as explanations of what is being done or will be done for the patient and why it is being done or should be done. Further, since there was a low level of education among respondents, it is also imperative that such information be translated and understood by local people through frequent dialogue and meetings. This also makes local media, such as radio stations, a key component in information dissemination and translation efforts. Health professionals must ensure a customer friendly attitude from the staff and also serve as a check for each other.

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APPENDIX

IN-DEPTH INTERVIEW GUIDELINE (SEMI STRUCTURED)

Introduction

Thank you for taking time off your schedule to interact with me. My name is Sanusa Bol-Naba, a student of the University of Education, Winneba. For my master study, I conduct research on "women's perspective on human rights aberration resulting from negative attitude of maternal health providers: the case of Nanumba north municipality". For this research, your experiences and perceptions of maternal health services in line with human rights principles will be needed. I would you to share your experiences and specific knowledge with me as a researcher. This interview consists of two parts and each will take about 45 minutes. With your permission, I would like to audio-record the interview in order for me not to miss any of your comments. [Turn audio recording device on] All responses will be kept confidential. You will not be personally identified by name in the report, but as the "respondent". Furthermore, the recording will also be deleted after the study is completed and documented. We hope that this interaction with you help will benefit the women in the community. However, there will be no personal benefits to you individually but also no risk of taking part in the research. I emphasize that you do not have to talk about anything you do not want to. You can stop participation any time and without any explanation. Do you have any questions about this explanation? Are you willing to participate? If you have any questions during our conversations, please do not hesitate to ask.

Start Interview

Human Rights Principles

1. What is your understanding of Human Rights?

2. What does human right mean to you in relation to: ?
   - Being treated well (dignity)
   - Feeling being heard and informed (autonomy)
   - Feeling of being safe in the hands of the maternal service provider (security)
   - Being treated equally by maternal service provider (equality)

Link to Maternal Health

I am interested in the meaning of these principles in the maternal health setting.

3. Could you explain your understanding of your condition at any point of your pregnancy or afterwards? And how did you get that impression?

4. What was your health condition before you visited the designated maternal Health centres?
   - Let's talk about your first visit
   - Why your choice and at what stage?
   - Can you give an example/experience?
   - Was there anything you particularly liked about receiving care there?

5. Can you explain what exactly made you feel like the [*answer given*] in 4. ?

   Probing Questions

- Why did you feel like that?
- Can you describe the situation?
- Can you describe the interaction with health professional or other persons?

6. Can you share with me some experiences in the Attitude of your maternal health attendants and health personnel you took note of while needing maternal care?

7. Can you please situate your experience to the following by giving some examples?
   - Being treated well (dignity)
   - Feeling being heard and informed (autonomy)
   - Feeling of being safe in the hands of the maternal service provider (security)
   - Being treated equally by maternal service provider (equality)

8. Can you explain what exactly made you feel like that [*answers given*]?

Probing Questions:

- Who accompanied you during your visit to the health clinic?

- Can you describe the surrounding of the health facility?
- How many people were at the health facility?
- How was your interaction with the health professionals?
- Can you describe the attitudes and practices of health professionals?
- What of this made you feel like that [*answer given*]?
- Best/Worst experience?

Women's Recommendations

According to your opinion, what should be changed in health facilities in order to ensure you are treated with dignity, autonomy, security, and equality?

End interview

Do you have any additional thoughts you would like to share? Or do you have any comments or questions concerning the interview?

Thank you for your time.