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Women's trust in maternal health care

A qualitative interview study about nurses' experiences within primary health care in Ghana

Kvinnors förtroende för mödrahälsovården

En kvalitativ intervjustudie om sjuksköterskors erfarenheter inom primärvården i Ghana

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ABSTRACT

Background: In Ghana, many women die every year due to preventable causes related to pregnancy and child birth. Several national strategies have been made to improve women's access to essential maternal health care. Still there is a significant inequality in the number of women attending to maternal health care in between different parts of the country. An important determinant that affects women's utilization of the subsidized maternal health care is the quality of health care, including the health providers' attitudes to their patients. **Aim:** The aim of this study was to describe nurses' experiences of interacting with women in a maternal health care context within primary care in Ghana. **Method:** Five qualitative semi-structured interviews were conducted at three different primary health care clinics. Content analysis was used to analyse the data. **Results:** Three main-themes, *patient compliance, building trust* and *nursing strategies* and ten sub-themes were identified. **Conclusion:** Although the nurses expressed a desire to have more women attend maternal health care, they seemed unaware of how their own behaviour might contribute to the current underutilization. A hierarchical power imbalance within the nurse-patient interactions, where the patients were perceived and treated as subordinate passive receivers of the nurses' expertise, was identified. The nurses' lack of critical approach towards their own actions might be at the source of this underutilization. **Suggestion for further research:** The authors recommend further studies to explore nurses' ability to allow self-reflective critical thinking and also how implementation of a more patient-centred approach in Ghana would affect the quality of health care.

Key words: interactions, Ghana, maternal health care, nurse-patient relationship

SAMMANFATTNING

Bakgrund: Varje år dör många kvinnor i Ghana på grund av förebyggbara komplikationer relaterade till graviditet och förlossning. Flera nationella strategier har genomförts i syfte att ge fler kvinnor tillgång till nödvändig mödrahälsovård. Trots det råder en signifikant skillnad i andel kvinnor som söker mödrahälsovård mellan olika delar av landet. En viktig faktor som påverkar utnyttjandet av den subventionerade mödrahälsovården är vårdkvaliteten, inklusive vårdpersonalens bemötande. **Syfte:** Syftet med denna studie var att beskriva sjuksköterskors erfarenheter av bemötande av kvinnor i en mödrahälsovårdskontext inom primärvården i Ghana. **Metod:** Fem kvalitativa semistrukturerade intervjuer genomfördes vid tre olika primärvårdskliniker. Innehållsanalys användes for att analysera insamlad data. **Resultat:** Tre huvudteman, *patientföljsamhet*, *bygga förtroende* och *omvårdnadsstrategier* och tio underteman hittades i resultatet. **Slutsats:** Trots att sjuksköterskorna uttryckte en vilja att få fler kvinnor att nyttja tillgänglig mödrahälsovård så verkade de omedvetna om hur deras eget agerande skulle kunna bidra till att kvinnorna väljer att inte söka vård. En hierarkisk maktobalans inom sjuksköterskornas vårdrelation med patienterna framträdde genom intervjuerna, där patienterna sågs och bemöttes som underordnade, passiva mottagare av sjuksköterskornas expertis. Sjuksköterskornas brist på kritiskt förhållningssätt till egna insatser kan göra att de oavsiktligt arbetar emot sina egna mål. **Förslag på fortsatta studier:** Ytterligare studier för att utforska sjuksköterskors förmåga att tillämpa kritiskt tänkande rekommenderas samt vilken nytta det skulle vara för kvaliteten på omvårdnaden om ett mer patientcentrerat förhållningssätt implementerades inom vården i Ghana.

Nyckelord: bemötande, Ghana, mödrahälsovård, samspel mellan patient och sjuksköterska

GLOSSARY

ANC – Antenatal Care

CDs – Communicable Diseases

CHPS – Community-based Health Planning Services

CHO – Community Health Officer

CIA – Central (Socialstyrelsen, 2015) Intelligence Agency

CPR – Contraceptive Prevalence Rate

HDI – Human Development Index

ICN – International Council for Nurses

LMIC – Low and Middle Income Country

MAF – MDG Acceleration Framework

MDG – Millennium Development Goal

MMR – Maternal Mortality Ratio

NCDs – Non-Communicable Diseases

NHIS – National Health Insurance Scheme

PBL – Problem Based Learning

PMMP - Prevention of Maternal Mortality Programme

PNC – Postnatal Care

SBA – Skilled Birth Attendant

TBA – Traditional Birth Attendant

UNDP – United Nations Development Programme

WHO – World Health Organisation

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INTRODUCTION

Before going to Ghana, a country in which neither of us had ever set foot, we studied the national report of the Millennium Development Goals to get an overall picture of the health situation in the Sub-Saharan country. The report revealed some quite impressive improvements in public health during the last decades in many areas. What caught our attention was not the remarkable enhancements though, but the failure of reaching the goal set for decreasing maternal mortality and morbidity – despite intense efforts of increasing access to fundamental maternal health care. More intriguing was that Ghanaian women accused health care providers of treating them poorly, making them reluctant to attend provided care. This phenomenon made us curious. Being trained as nursing students in a context where interactions with patients based on patient autonomy and person-centeredness form the foundation of care, we were eager to find out more about the interactions between nurses and patients in this situation.

BACKGROUND

Maternal health in the world

Maternal health in this paper is referring to the health of women under the ante- and postnatal periods as well as childbirth (World Health Organisation [WHO], 2016).

Maternal mortality – an inequitable global burden

While motherhood is supposed to be a positive and joyful experience, for too many women it is correlated with suffering, morbidity and even death (WHO, 2015a). Approximately 800 women around the world die from conditions related to pregnancy and childbirth every day. Postpartum haemorrhage, hypertensive disorders, sepsis, unsafe abortions and obstructed labours are the main direct causes for these deaths; complications that are preventable. By providing women access to antenatal care (ANC), skilled care during childbirth and postnatal care (PNC) after delivery, most maternal deaths could be prevented (ibid.). Access to contraceptives and adequate family planning, along with safe abortions are other important elements in promoting women's health in the world (WHO, United Nations Children´s Fund, United Nations Population Fund, World Bank & United Nations Population Division, 2015). The high prevalence of maternal deaths in some parts of the world thus reflects inequities in access to health services and highlights the gap between the rich and the poor. Over 99 percent of all maternal deaths occur in developing countries, more than half of them in Sub-Saharan Africa (Say et al., 2014).

There are major disparities between countries and also within countries (WHO, 2015a). The risk for maternal mortality is significantly higher for women living in rural compared to urban areas. WHO (2004) advocates the presence of a skilled birth attendant (SBA) at every childbirth. A SBA is someone who has been adequately trained in skills required to manage adequate maternal health care. In 2014, in the Sub-Saharan region only 38 percent of all live births in rural areas were supervised by SBA, while 77 percent of all deliveries conducted in urban regions had access to SBA (United Nations Development Programme [UNDP], 2015a). Economic status, traditional believes and level of education are assumed to be the main factors causing disparities in maternal health globally. Due to scarcity of data on births, deaths and health in general, mainly in low- and middle income countries (LMICs), it is hard to draw any accurate conclusions. More than 80 percent of the maternal deaths in Sub-Saharan Africa have no registered and identified cause (ibid.).

Improving maternal health worldwide

Even though maternal mortality still is considered a prioritized global issue, progress has been done (UNDP, 2015). Improving maternal health globally was one of eight Millennium Development Goals (MDGs) adopted in 2000. Through MDG 5, countries over the world committed to reduce maternal mortality by three quarters between 1990 and 2015. This undertaking concluded in almost halving the maternal mortality ratio (MMR) worldwide by the end of that period from 430 to 230 maternal deaths per 100 000 live births (ibid.). By supporting country-led health plans, strengthening of health systems, increasing the quality of health services and improving monitoring and evaluation of actions the new aim is to reduce global MMR to less than 70 per 100 000 live births by 2030, and no country should have a higher MMR than twice the global target (Ki-Moon, 2015).

About Ghana

History and politics

Ghana is a country located on the west coast of Africa (UNDP, 2014). It was a midpoint for trade of slaves and gold in colonial times. On 6th of March 1957, Ghana was the first country in the Sub-Saharan region that gained independence from Britain. Kwame Nkrumah became Ghana's first president in 1960. He was deposed in a coup in 1966 and the following years Ghana was mostly ruled by the military. Air force lieutenant Jerry Rawlings staged the second coupe in 1981. Economic stability and democracy was then beginning to develop. A multi-party system was approved in April 1992, which ushered in a period of democracy. Ghana is often seen as a model for political and economic reform in Africa (ibid).

Health profile

The population of Ghana is 26 327 649 people and is spread over the total area of 238, 533 square km (Central Intelligence Agency [CIA], 2015). The density of the population is 118 population per square kilometres (The World Bank, 2015). The main religions in Ghana are Christianity and Islam, where 71,2 percent of the population are Christians and 17,6 percent are Muslims (CIA, 2015). Ghana has a growing population where the urban areas, mainly Kumasi and Accra, are increasing. The population has a growth rate of 2,18 percent per year. The birth rate is 31,09 and the crude death rate is 7,22 per 1000 population. The total fertility rate is 3,9 children per woman. Just over half of the population live in urban areas and 3,4 percent move to urban areas annually. Almost one third of Ghana's inhabitants live in relative poverty and the distribution of income reveals inequity within the country. Ghana has a Gini

index of 42,3, where 0 resembles maximum equity and 100 maximum inequity of income distribution, placing the country between Burundi and Russia. Compared to rest of the world, Ghana is on place 53 of 144 (ibid.). On the Human Development Index (HDI), based on level of health, education and income in a country on scale from 0 to 1, Ghana scores 0,579 (UNDP, 2015). In relation to other countries in the world, where the country with the highest value is on first place, Ghana is number 140 out of 188 countries (ibid).

Communicable diseases (CDs) are causing the major burden of disease in Ghana (Adams, Darko, & Accorsi, 2004). Non-communicable diseases (NCDs), such as hypertension and cardiovascular diseases, account for 10 percent of the attendance rate at hospitals among the elderly (ibid.). The top ten causes of death in 2012 were lower respiratory infections, stroke, malaria, ischaemic heart disease, HIV/AIDS, preterm birth complications, diarrhoeal diseases, birth asphyxia and birth trauma, meningitis and protein-energy malnutrition (WHO, 2015b). The leading causes of death in children under 5 years in 2013 were malaria, prematurity, acute respiratory infections, other causes and birth asphyxia. Although the number of CDs has decreased slightly, the number of NCDs has increased significantly in Ghana (ibid.). The relatively high prevalence of new and re-emerging infectious diseases as well as the increasing burden of chronic diseases and injuries create a situation of double burden of disease for the country (Adams et al., 2004).

Community-based Health Planning Services

Community-based health planning and services (CHPS) was adopted in Ghana in 1992 with the aim to reduce the barriers of geographical admittance to health care (Nyonator, Awoonor-Williams, Phillips & Jones, 2005). The initial focus was to get community-based care provided by a resident nurse in rural areas and the programme is now regarded as a method for reaching isolated zones. The CHPS programme is a part of the national program to reduce poverty. Cooperation between health service and the local community forms the foundation of CHPS. For the concept to work, the traditional leaders of the community must accept CHPS and commit themselves to supporting it. The CHPS commits to compliance e.g. through mobilization of health service delivery. Community Health Officers (CHOs) are the health staff who provide mobile health care services to the doorstep of the communities. The CHOs travel on motorcycles to cover a compound of approximately 3000 individuals. The services that the CHOs offer are immunizations, family planning, supervising delivery, antenatal- and postnatal care, treatment of minor ailments and health education. There are community

volunteers who assist the CHOs with community mobilization, the maintenance of community registers and other essential activities (ibid.). The number of CHPS facilities in function was about 900 in 2009 and had doubled in 2011 (Johnson et al., 2015).

Health insurance

To be able to finance health care and ensure that also low income individuals can afford it, Ghana established a National Health Insurance Scheme (NHIS) in 2003 (Jehu-Appiah, Aryeetey, Agyepong, Spaan & Baltussen, 2011). Since then 66 percent of the population have enrolled in the NHIS. A vast majority of the people who are not enrolled in the NHIS live in rural areas. The insurance provides risk protection to the households against the cost of illness (ibid.). NHIS covers 95 percent of the illnesses that afflicts the people of Ghana (Goverment of Ghana, 2016). Basic diagnostics and treatments of CDs, ulcer, hypertension, diabetes and the most common types of cancer are included. All stages in maternity care, oral health, eye care services and all life threatening emergencies are also included (ibid.).

Maternal health indicators

Though maternal health care in Ghana has improved over the past decades, progress has been slow and maternal morbidity and mortality continues to be a prioritized public health issue (Moi Thompson, 2015). Complications in childbirth and pregnancy is the leading cause of death for women in reproductive age (15-49). In 2015, the estimated MMR in Ghana was 358 per 100 000 live births – double the MDG target. Only half of all deliveries were supervised by SBA, and the inequalities between different regions are striking. In the urban Greater Accra region 92,1 percent of all births had SBA, while the coverage in the rural Northern region was not more than 36,4 percent (ibid.). Attendance rates for maternal health care and family planning services are considerably lower in rural compared to urban areas, among the poorest women and those with no education (Ministry of Health, 2014a). According to national surveys in 2014 only two thirds of all pregnant women attended ANC the recommended four or more times prior to delivery. Not even half of the women attended PNC within 48 hours after childbirth. The estimation of unmet need for contraceptives among women in reproductive age is at least 30 percent (ibid.). The contraceptive prevalence rate (CPR) among married women in Ghana was in 2015 averagely 27 percent (Moi Thompson, 2015).

Maternal health promotion

Comprehensive primary health care, through CHPS, forms the foundation of maternal health promotion and prevention of maternal morbidity and mortality in Ghana (Ministry of Health, 2014b). National strategies have been focusing on increasing accessibility to quality maternal care, expanding access to SBA at delivery and improving facilities for ANC and PNC (Ministry of Health, 2012). The recently developed MDG Acceleration Framework (MAF) involve the same strategies but also emphasize implementation of free maternal health care and family planning services (UNDP, 2016). A number of health promoting programmes and projects has been developed to implement these strategies, e.g. Prevention of Maternal Mortality Programme (PMMP), Safe-Motherhood Initiative, Making Pregnancy Safer Initiative and Prevention and Management of Safe Abortion Programme (ibid.). Despite these efforts, the healthcare system has failed to ensure equitable provision of health care, and the inequity in maternal health within Ghana continuous to widen (Moi Thompson, 2015).

Factors affecting attendance to maternal health care

There are several acknowledged determinants affecting women's utilization of maternal health care. Costs, location and quality of provided health care matters, as well as the women's socioeconomic status including wealth, living environment, education, autonomy, cultural norms and religious beliefs (Say & Raine, 2007). Women in rural areas with low income and no education represent the population with lowest attendance rate in maternal health care (ibid.). Also women who are less autonomous in decision making and those living in communities with negative attitudes towards health care services, utilize maternal health care to significantly lesser extent (Speizer, Story & Singh, 2014). WHO urges the need of health care services focusing on the diverse needs and expectations of the patients, to promote universal health coverage (WHO, 2015c).

The first national exemption policy regarding costs for maternal health care was introduced in Ghana in 2004, but it has not proven to increase the attendance rates sufficiently (Ridde & Morestin, 2010). Evaluation of the CHPS implementation showed that improved geographical provision of health care increased women's utilization of skilled birth care to some extent, but still far below expectations (Johnson et al., 2015). Even though Ghanaian women unwilling to deliver at health facilities, have been given access to SBA for home delivery and presented all motivating conditions, a significant number have not employed it (Smith, Tawiah & Badasu, 2012).

Disrespectful, neglectful and abusive treatment of women in maternal health care is a recognized problem, all over the world (Bohren et al., 2015). A systematic review of women's experiences of seeking maternal health care in LMIC indicate that health care providers' attitudes vastly effect the women's level of attendance (Mannava, Durrant, Fisher, Chersich & Luchters, 2015). Reported negative experiences of patient interactions far outweighed the positive ones. Negative behaviour from providers of maternal health care was characterized by verbal abuse, rudeness, ignorance and neglect. Studies also documented physical abuse, absenteeism, lack of regard for privacy, unwillingness to accommodate traditional practices and authoritarian attitudes (ibid.). Two different studies conducted in rural Ghana, where the attendance rates for maternal health care are the utterly lowest in the country, highlighted women's experiences of intimidation, physical and verbal abuse, neglect, denial of traditional customs and lack of privacy (Yakong, Rush, Bassett-Smith, Bottorff & Robinson, 2010; Moyer, Adongo, Aborigo, Hodgson & Engmann, 2013). The negative impact that nurses' relational practices have on women's utilization of maternal health care services and the need for more research about nurses' perspectives of relational care have been emphasized (Yakong et al., 2010).

Nurse – patient relationship

Bemötande is a Swedish term describing the way a person behaves towards someone or something. In this paper, *bemötande* has been translated to the English word *interactions*, referring to the nurse's behaviour when meeting with the patient. The International Council of Nursing (ICN, 2012) stress that all *interactions* with patients should be exerted with respect for patient's integrity and promote patient's autonomy in health care.

The importance of interpersonal caring

The relationship between nurse and patient is advocated by the ICN as the core of quality nursing, especially within maternal health care (Usher-Patel, 2013). Positive attitudes among health workers and adjustment of provided health services to suit women's individual needs enhances empowering for health promotion (ibid.). Interpersonal caring has also been found to be the very essence of experienced quality of care for patients within maternity care (Larson et al., 2015). When 3003 women in Tanzania were asked to prioritize among preferred health care attributes of their delivery facility – including medical equipment, medical knowledge, attitudes, organization and cleanliness, access to privacy and costs – kind and respectful treatment from the health provider was ranked as the most important (ibid.).

Power and trust in the nurse-patient relationship

The professional relationship between nurse and patient is not naturally built on voluntariness and equality in the same way as a relationship between friends (Delmar, 2012). It is characterized by an evident imbalance in power, where the patients' part is distinguished by dependence. A traditional paternalistic perception of the patient as a passive recipient of care provided by the nurse in the role of the expert enhances the asymmetric power structure. This can lead to patients' experience of "being a burden", resulting in dishonest responses without complaining in interactions with the nurse, maybe to be polite or to show gratitude (ibid.).

A positive nurse-patient relationship care is depending on trust (Dinc & Gastmans, 2011). Striving towards trust in the relationship can be challenging (Berg & Danielson, 2007). Making the patient maintain dignity and confidence when interacting demands compassion and awareness from the nurse. Trust is a continuous process that is built on *both* parts specific competence and reflected by their expectations and outcomes of provided care (ibid.). Improving and maintaining trust in the nurse-patient relationship requires interpersonal as well as professional competence, vigilance, time and effort (Murray & McCrone, 2014).

Autonomy, patient-centred care and cultural competence

Patient autonomy in the nurse-patient relationship resembles the contradiction to a passive and recipient patient and is emphasized by the ICN (2012) as one of four ethic principles of nursing care. The concept of autonomy in nursing involves seeing the patient as a person and empowering patients to participate in their own health care process as well as making patients obligated to take responsibility for their own actions (Lindberg, Fagerstrom, Sivberg & Willman, 2014). Promotion of patient autonomy requires a holistic approach to patients' needs and above all sensitivity for patients' individual cultural norms, values and believes (Leever, 2011).

Patient-centred care and cultural competency are closely linked movements within health care, both aiming to improve health care quality (Somnath, Beach & Cooper, 2008). Patient centeredness is a complement to the focus on measuring quality of health care through performance benchmarks. It aims to improve quality for all patients by emphasizing individual experiences and personal relations with patients. Cultural competency focuses on balancing inequity and reducing disparity by improving quality of care for disadvantaged populations (ibid.). A case-study in Ghana indicated that nurses were unable to meet the

patients' cultural and religious needs, which significantly affected women's utilization of maternal health care (Kuumouri Ganle, 2015). Cultural competent nursing involves knowledge, attitude and skills (Truong, Paradies & Priest, 2014). Interventions to elevate cultural competency in health care have been found to improve patients' satisfaction and trust as well as physiological health outcomes and utilization of health services (ibid.).

PROBLEM STATEMENT

In Ghana, suffering and death among women because of complications related to pregnancy and childbirth remains to be an important public health issue. The inequity gap in maternal health within the country continues to widen. The causes of the maternal deaths are largely preventable and predominately related to an insufficient healthcare system. Despite national efforts to increase the access to maternal health care, many women still do not attend adequate care. Furthermore, prevalent mistreatment and negative attitudes from care providers has been shown to greatly influence women's utilization of provided maternal health care. Several studies have been conducted concerning women's experiences of seeking maternal health care in Ghana, however none to our knowledge have been aiming to describe the nurses' perspectives about their interaction with these women. In a country such as Ghana, that has failed to meet the MDG 5, it is of main importance to study the nursing care in relation to maternal health.

AIM

The aim of this study was to describe nurses' experiences of interacting with women in a maternal health care context within primary health care in Ghana.

METHOD

Design

This study was conducted using a qualitative empirical approach based on semi-structured interviews with nurses and midwifes working with maternal health care in three different primary health compounds (CHPS-clinics) in the Birim Central Municipal District of south Ghana. Priebe and Landström (2012) suggest the use of empirical studies when the aim of the research is to gain understanding of a specific phenomenon. Qualitative interviewing allows the participants to describe their experiences using their own words.

Sample

The method of convenience sampling was used for this study (Bryman, 2011). To obtain a broader perspective of the studied phenomenon, a heterogeneous sample of participants is preferable (Danielson, 2012a). The sample of participants were consciously selected according to the inclusion and exclusion criteria described below, using Morse's method for identification of good informants (Whiting, 2008). According to Morse a good participant should have knowledge about the topic, be able to reflect and provide detailed experience and also be able to communicate this information. The inclusion criteria were: 1) to actively work as a nurse or midwife at a CHPS-clinic and; 2) to have at least two years of working experience in the working field. Nurses and midwives who were not in professional contact with women seeking maternal health care were excluded.

Three different CHPS-clinics were visited during clinical primary health care practise within the nursing education, one month before this study was conducted. At the CHPS-clinics, contact was established with nurses and midwives, who were suitable for partaking in the study. The selection of participants was made aiming to achieve a diverse sample in regard of age, education, working experience and gender.

All five respondents accepted to take part in the study. The participants were represented by four nurses and one midwife working at three different rural CHPS-clinics. Four of the participants were women and one a man. The youngest participant was 26 years old and the oldest was 59. Three of the nurses and the midwife had completed Community Health Nursing Training, one on certificate level and the other three on diploma. One of these nurses had also completed the postgraduate CHO training. The fourth nurse had a general nursing education. The midwife had also graduated from a midwifery training school. The mean experience of working with women seeking maternal health care among all participants was 7 years (3 years to 20 years).

Data collection

The data was collected through semi-structured interviews. According to Danielsson (2012a) qualitative interviews are used to reveal peoples' experiences of a certain situation or studied phenomenon. Open-ended questions encourages participants to provide more unrestrained answers, less enclosing than questions demanding more specific replies. These kind of semi-

structured interviews should be performed based on a prepared guideline containing a few topics or main questions of relevance for the aim of the research.

The semi-structured interviews included an interview guide containing six personal and eight reflective questions with open-ended follow up questions (Appendix 1). The guideline also included prepared paraphrases of the main questions in order to decrease the risk of participants misunderstanding the meaning of each question. General follow up questions such as “Could you please tell me more about…!” or “What happened when…?” or “Why did you…?” was used throughout the semi-structured interviews to clarify or further explore the given answers.

Danielson (2012a) advocates the use of pilot interviews in the process as it allows testing the prepared questions fit to the aim of the study. It also provides opportunity for the researcher to gain confidence in the role as interviewer. Two pilot interviews were carried out to try out the questions for this study. In order to find participants for pilot interviews, gatekeepers from a nursing training school in the district of the study were used (ibid.). The gatekeepers arranged contact with a fourth CHPS-clinic where one nurse and one midwife agreed to participate in two separate pilot interviews. The researchers performed one whole interview in the role as interviewer and another as note-taker in order to determine who was more suitable for each part. The interviewer asked the questions and took notes of non-verbal expressions such as body language and changes of voice during the interview. The other researcher wrote down the main content of the conversations during interview together with important quotes. After the two pilot studies the interview guide was evaluated and refined to make the questions more comprehensible and relevant for the study’s aim. The pilot studies were not included in the result of this study.

To make it more convenient for the participants, all semi-structured interviews were conducted at the clinics where the participants worked. The semi-structured interviews were performed in secluded rooms at the compounds, where the participant could talk in private with the interviewer and note-taker.

Danielsson (2012a) emphasize that the participant needs to feel comfortable in the presence of the interviewer as it can impact the quality of the interview. When the participant feel uncomfortable in his or her position, it may affect the given answers. Every interview session was preceded with informal conversations before beginning with a few general questions. In

order to make the participant feel more at ease during the semi-structured interviews, the interviewer had an encouraging approach to what the participant said, without ever evaluating the given answers. The semi-structured interviews were in depth and lasted between 25 and 40 minutes. All interview sessions were audio recorded.

Data analysis

A reflexive iterative process of data management suggested by Halcomb and Davidson (2006) was used to transcribe the collected qualitative data. After every interview, all notes were reviewed and impressions of emerged topics and expressions were discussed before writing down reflective notes. The immediate analysis creates a more complete picture of all information given throughout the interview. When all semi-structured interviews were conducted and recorded, the full audio recordings were listened to three times, while amending the notes to ensure that they captured the interactions of the interviews thoroughly. This step was followed by reading and evaluating the accuracy of the written reflections made after every interview session (ibid.).

The content analysis was carried out using an inductive approach (Danielsson, 2012b). First, all notes were read several times and the text was divided into *meaning units*. The meaning units were then condensed into the essence of its' meaning. After that, the *condensed meaning units* were labelled with a *code*, describing the content. The hitherto described steps of the analysing process were made with the whole text. Afterwards, similar codes were grouped into *sub-themes*. The sub-themes were then arranged under the emerged main *themes* of the findings (Figure 1).

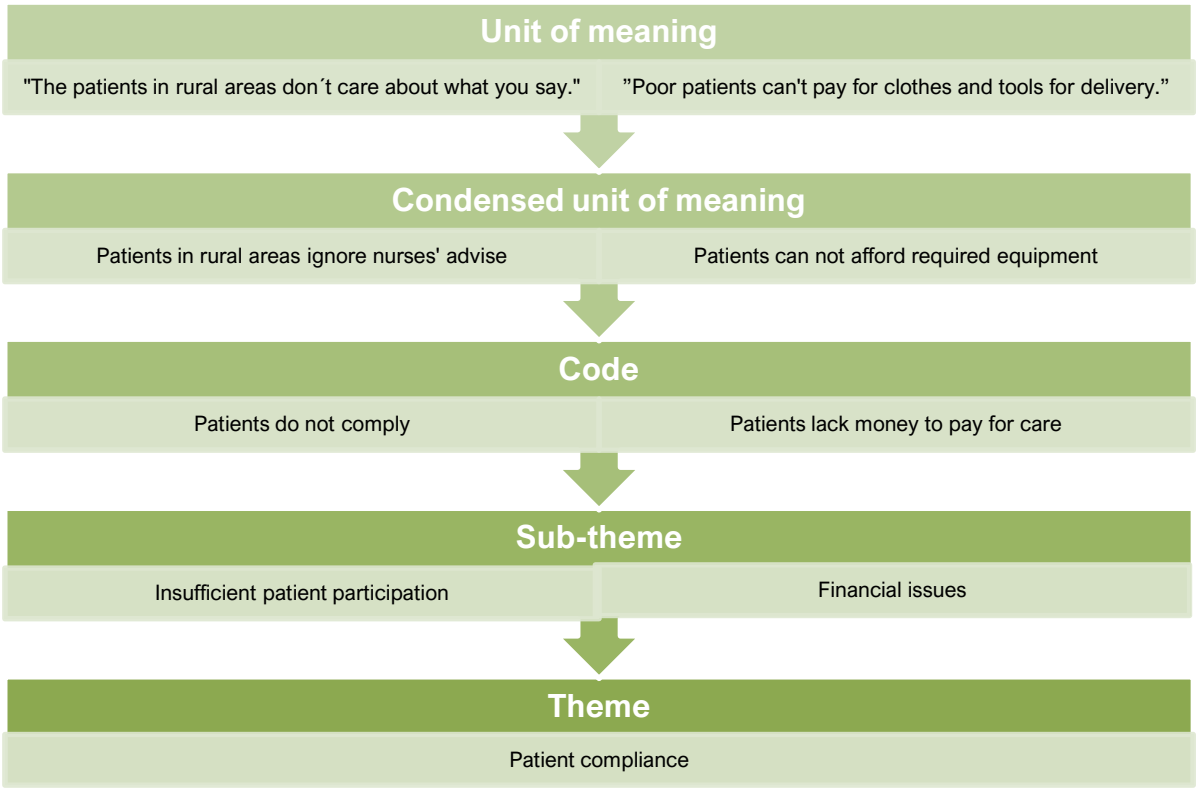

Figure 1 – Example of the analysis process.

Ethical considerations

The ethical considerations of the Helsinki declaration has been used in this study (World Medical Association, 2013). The requirements of the declaration are information, consent, confidentiality and purposeful use of the data.

Informed consent was given from all participants in this study. Before every interview session, each participant had to give an informed consent to part taking in the study. Informed consent means that the participants voluntary participate in a study after been given information about the aim, methods, potential risks and the anticipated benefits of the study (World Medical Association, 2013) The participants also have the right to cancel the participation without any given reason at any time during the study. Precaution must be and was taken to keep confidentiality and privacy about the participants (ibid.). Written information about the aim and process of the study were send out to the participants (Appendix 3). The letters also informed about voluntariness and confidentiality of part taking in the study as well as every participants' right to cancel participation at any time during the interviews, without need for explanation. The full information repeated orally before every interview and the participant, in order to ensure that the participant had understood the content

correctly. They were also asked if they had any further questions regarding the study and its' process before being asked to consent to participating orally. Asking participants to sign a consent may create pressure to fulfil the participation against the will, thus was the informed consent collected from all participants orally, but audio recorded, before the beginning of each interview. All collected information was handled anonymously and held confidential. Every participant received a code consisting of a letter and a number, which was used to label the notes and audio recordings from the semi-structured interviews.

Collected data has only been used in a scientific way for the purpose of this research. Another requirement is that all studies have to be approved by an ethical committee (ibid.). Since this is a bachelor thesis an approval from a committee is not necessary, however consideration a letter signed by the principal of the nursing school in Ghana was sent to the Municipal Director of Ghana Health Service asking for permission to conduct the study (Appendix 2). After gaining approval, written information was send out to the participants.

RESULTS

Altogether three main themes and eight sub-themes emerged in this study describing nurses' experiences of interacting with women in a maternal health care within primary health care in Ghana (Figure 2).

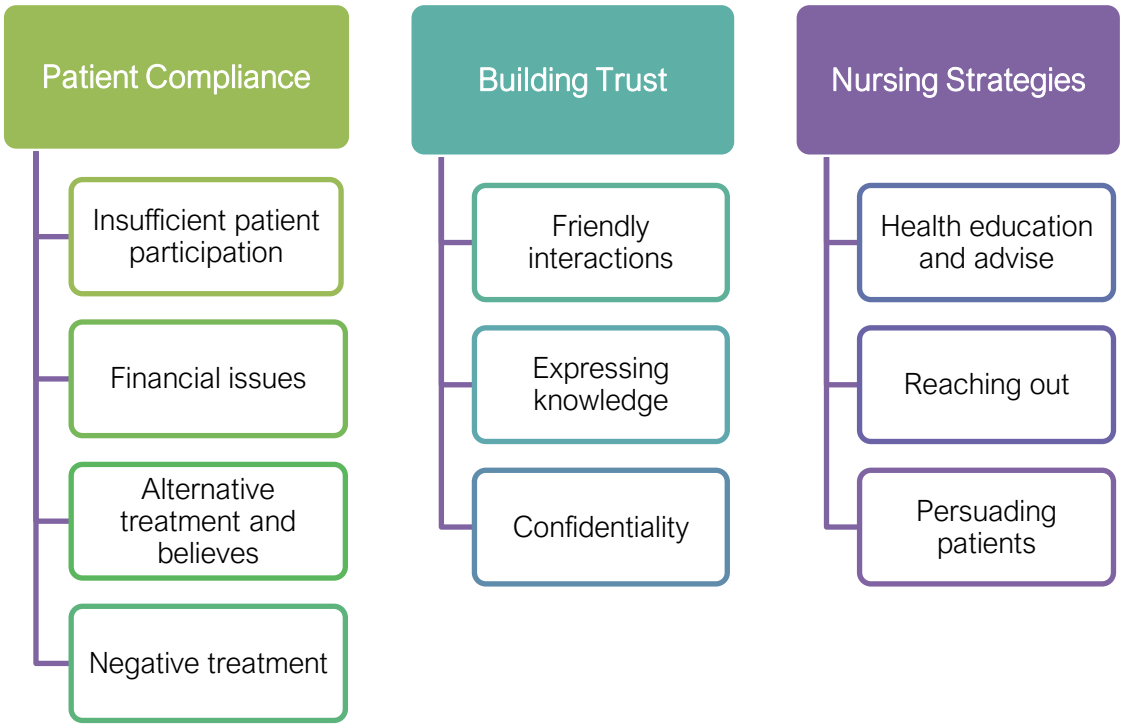

Figure 2 – The findings of the semi-structured interviews as main- and sub-themes.

Patient compliance

When asked to describe quality maternal health care, the nurses stressed the importance of making all pregnant women utilize provided maternal health care services. This question also revealed the main reason for experienced problems in their patient interactions: patient compliance. Women's insufficient participation, financial issues and alternative treatment and believes were identified as the main topics that was related to patient compliance. The nurses did not show much insight about how their own professional behaviour and attitude could contribute to the unsatisfactory utilization of provided maternal health services.

Insufficient patient participation

A prominent reason for problems within the nurse-patient relationship was the patients' lack of compliance. The nurses experienced that patients showed reluctance to participate in their provided maternal health care services. Many attending patients did not seem interested in listening to health education. According to the nurses they appeared ignorant by asking irrelevant questions and/or ignoring recommended treatment or given advice.

> They don't have time to come here for check-ups. And then when they come, they ask irrelevant questions! They don't listen when we explain to them and tell them what they should do. They don't care about what we say. (Nurse A1)

Irrelevant questions were described as those not directly connected to maternal health care or questions with no apparent relevance for the patient. It was further reported that some pregnant women would stop attending ANC as a result of not comprehending health information given by the nurses. When the patients experienced predictable issues related to side effects of prophylactic treatment in their pregnancy, they would stop taking their drugs and/or seek alternative care. Women's negative attitudes and disbelief towards evidence based maternal health care services was ascribed as main contributors to the insufficient attendance rates by the nurses.

Financial issues

Although maternal health care is free of charge, poverty was stressed as a problem in making women utilize provided health care services. It was too common that pregnant women did not have a valid health insurance, which is a requirement in order to receive the care without any costs. This resulted in some women not attending necessary maternal health care because they

could not afford it. The nurses explained that they did a lot of efforts trying to help exposed women getting their insurance cards. They assisted in filling in application forms and arranged paid transport from rural areas to the closest health insurance office, but still some women remained uninsured. The nurses shared experiences when they had felt obliged to pay for uninsured patients in urgent need of professional maternal health care.

> On a home visit to a pregnant woman in the village, I discovered she was severely anaemic. Very pale. She had no insurance and couldn't pay for a car to the hospital. What could I do? I took her to the hospital and paid for her treatment (…) she would have died if I didn't. (Nurse B1)

All pregnant women were further expected to purchase required delivery material (e.g. pads, bed protecting cover) prior to the childbirth and bring to the clinic when they were due. When patients appeared at the clinic in time of labour without the requested items, the nurses or midwives had to deduct the cost for the material from their own salary. Even though the nurses emphasized that patients' lack of compliance often was connected to poverty, none of them ever described a situation where they chose not to pay out of their own pocket for a patient in need of money for care.

Alternative treatment and believes

In some areas the nurses experienced that women preferred alternative maternal health treatment provided in prayer camps. The attitudes of relatives and social traditions of health care in the village was according to the nurses affecting the women's choice of maternal health care service. Many prayer camps were offering supervision of childbirths in homes by traditional birth attendances (TBAs). The nurses claimed that the TBAs typically lacked required training to be authorized as SBAs. They further stressed that women seeking alternative care for health promotion in pregnancy most times still would turn to their clinics in case of complications.

> The families sometimes have the tradition that the women give birth at home, then they don´t go to clinics. The pregnant women also go to prayer camps when they feel bad (…) but then they get worse and they come to us. (Nurse O1)

In many cases the women would be severely ill when turning to the CHPS-clinics, in urgent need of help. Sometimes it would even be too late.

Negative treatment

The interviewed nurses and midwives could not describe how health professionals' actions could contribute to patients' experiences of negative treatment in health care. Even when asked specifically about nurses' contribution to patients' negative experiences of seeking maternal health care, none of the nurses reflected critically about their own attitudes. Two of the nurses explained that nurses might seem agitated in some situations, but it would merely be a reflection of concern or stress. One nurse mentioned that some women feel questioned when nurses ask them about why they do not participate in the recommended maternal health program or follow given health advice.

> Some nurses lose their temper when they are stressed and they can sound harsh. The women maybe also feel like we treat them bad when we ask questions. Why didn't you come? Why didn't you do the ultra-scan? They feel questioned. (Nurse A1)

This last expression was the only one made during the interviews, relating critically to the nurses' role in negative nurse-patient interactions. The nurses' reflections about patients not complying were all focusing on criticising the attitudes and resources of the patients.

Building trust

Achieving patients' trust was the most mentioned element within caring interactions during the semi-structured interviews. Building trust in the nurse-patient relationship helped revealing health problems, which enabled the nurses to provide necessary maternal health care for their patients. The nurses emphasized the importance of friendly interactions, confidentiality and expression of knowledge when communicating with patients in order to gain the patients' trust.

Friendly interaction

The nurses focused on having a positive attitude and establish good communication to make their patients feel comfortable. The women seeking care should always feel welcome to the clinic. Two of the nurses and the midwife highlighted the importance of also letting the patient talk in order to build trust. They would enact polite dialogues by asking personal questions e.g. about the patient's family. The questions were not prominently aiming to identify health issues but rather to create a friendly atmosphere. The nurses expressed it as lowering themselves to the women's level.

> When you get down to the patients' level, she will feel like she can trust you. She will tell you her problems if you are nice and listen to her. She will come to you for help and to get advice. (Nurse B1)

By diminishing the status difference between nurse and patient, the nurses were striving to make their relationship more open and welcoming. All nurses emphasized friendly interactions as a key to building trust.

Expressing knowledge

The nurses described the importance of expressing good knowledge to the patients in order to gain their trust. They emphasized that the women must feel confident in nurses' professional skills in order to turn to their clinics in need of care. Demonstration of their nursing expertise helped ensuring patients of their competency of caring for them. "Knowing your patients" was further a frequently used expression, which did not refer to a person-centred caring relationship but rather to having a good general knowledge about the maternal health of women living in the residence. Information about (potential) patients was retrieved through interactions with the residents during outreaching activities in the community. The nurses' monitoring work was mainly focused on detecting pregnancies. They explained that being well-informed of the health situation in the community made them more trustworthy in the eyes of their patients. By consciously showing up a knowledgeable approach to their patients, the nurses strived to make the patients trust their ability of providing excellent care.

Confidentiality

Since health problems related to pregnancy or maternity could be delicate, the nurses valued confidentiality within interactions with patients. This was manifested by emphasizing their full secrecy when talking to patients. The nurses also made sure to use quite environments for having private conversations.

> Sometimes she hides her problems (…) Confidentiality is important, to reveal her problems. You have to have good, quiet environment. She needs to feel like she can tell me everything she has on her mind, so I can help her. (Nurse A2)

Highlighting nurses' professional confidentiality was used as a way to make patients feel safe to open up and disclose more delicate maternal health issues.

Nursing strategies

The strategies of nurse-patient interactions was rooted in the nurses' perspectives of themselves as givers and the patients as passive receivers of their nursing expertise.

Experienced problems in patient compliance was mainly solved by talking to the patients making them aware of the risks of not accepting recommended treatment. Outreaching activities was used to spread health information to women not attending the clinics. If education was not enough to make an unwilling women accept recommended treatment, the nurses would do everything in their power to make her change her mind.

Health education and advice

Health education was the prominently most mentioned strategy used to make patients follow the nurses given advice. One-on-one health talks were given to women attending ANC and PNC, where the main focus was to advice the women in choice of lifestyle and promote relevant examinations and treatment during their pre- and postnatal period.

> We advise women in safe pregnancy and health. We tell them about risks in pregnancy and make them come to important examinations. They don't know what's best for them and their babies. We have to tell them, explain to them. (Nurse A1)

The nurses stressed the importance of making women aware of the risks of not attending to recommended examinations. The provided health education was explained as a one-way communication, where the patients was to receive advice and information from the nurses.

Reaching out

The nurses explained it as their duty to always signal accessibility when interacting with patients and to persist in reaching out with their services to the whole community. At the most remote CHPS compounds, there would always be a phone number available for the patients to call for help – even outside of opening hours.

> It´s important to visit the communities often. I go to them every day. When I´m there I give my number to my patients to call. They can call me at any time. Even in the night if they need any help. (Nurse O1)

For women not attending maternal health care at the compounds, mobile clinics and home-visits were arranged in order to spread health education in the community. This aimed to improve the women's health literacy and to advocate utilization of evidence-based maternal health care. One nurse felt that these activities caused negative effects on women's utilization of maternal health care provided at clinics. The nurse meant that the policy of visiting pregnant women not attending to the clinics in their homes, more women were encouraged not to attend the clinics for convenient reasons. All other nurses were very positive to using outreaching activities as a main nursing strategy.

Outreaching activities were mainly described as unidirectional health education directed to patients outside of the clinic. Cooperation with the community and alternative care settings were not mentioned when the nurses explained their outreaching strategies. Only the CHO nurse stressed the importance of cooperation with alternative care settings in the community when reaching out. The nurse emphasized that the benefit of this would not only be reaching out to even more patients but also to improve the level of safety in alternative care methods through basic health care education to other health providers, e.g. TBAs.

> They don't think about safety. They use dirty blades to cut the cord with… And they don't even clamp on both sides! I give them new blades and talk to them about it. Show them how to do it right. (Nurse B1)

While most nurses would use one-way communication when reaching out, this one nurse highlighted the advantage of having a dialogue and collaboration with the community in order to reach a common goal.

Persuading patients

When education was not enough to make patients accept treatment, persuasion and pleading was used to convince them. The nurses described how they would make everything in their power to make pregnant women in their district attend to required examinations and treatments.

> If she's not coming to the clinic, we will call her and visit the house. We will do everything in our power. Call and visit. Try to talk to her. Make her change her mind. (…) She will change her mind. (Nurse A1)

Chasing unwilling women by persistent phone calling and home visiting was considered as an effective strategy to improve the attendance rate at the clinics. The nurses explained that the pregnant women do not know their own good, and it was their duty as nurses to make them aware. It was also described as their obligation to make patients change their minds about health affecting decisions that was considered as wrong by the nurses. When asked about their proudest moment as maternal health professionals, the nurses mentioned situations where they persuaded a patient to not to abort an unwanted pregnancy.

> A good memory… When I convince a woman to keep her baby. She comes here and doesn't want the baby, but I talk to her. Many times. Make her change her mind. Support her. Then she and the baby are happy after. They thank me. (Nurse A1)

The nurses considered it to be their responsibility as experts to ensure that their patients made the right decisions. When interacting with un-complying patients, persistence and endurance was described as virtues.

DISCUSSION

Method discussion

Aiming to describe nurses' experiences of interacting with women in a maternal health care context, a qualitative study using semi-structured interviews were conducted. In a qualitative study using content analysis, the procedure in relation to the results of the study should be evaluated for the study to be trustworthy (Graneheim & Lundman, 2004). In order to demonstrate various aspects of trustworthiness, we have discussed credibility, dependability and transferability of the study.

The adequate number of participants in qualitative interview studies is based on the reach of saturation during data collection (Mark, 2010). Saturation is reached when there is no new category or theme appearing during the interviews (ibid.). Since this study had a limited timeframe the number of interviews was decided beforehand. This creates a limitation in transferability of the results since more categories or themes might have appeared if there had been more conducted interviews. Another factor influencing the small sample size was the limited access to respondents. Focus groups was first considered as a more efficient method of data collection, aiming to increase the sample size and gain more nuanced information (Doody, Slevin & Taggart, 2013). The gatekeeper could only provide access to two respondents per interview session. This was not enough to achieve the beneficial group dynamics during the semi-structured interviews that Doody et al. (2013) describes. Doody et al. (2013) suggest the use of individual semi-structured interviews when requiring personal information and experiences that may be sensitive to reveal in groups. Danielson (2012a) highlights that diverse characteristics of participants forms a social hierarchy in groups and may influence the interactions negatively in heterogeneous focus groups during interviews. It is thus beneficial to use individual semi-structured interviews when aiming to diversify the characteristics of the participants, especially when the sample size is small.

Two researchers were present during every interview. Having the researchers' inexperience of data collection by semi-structured interviews in mind, the presence of both seemed

appropriate in order to comprehend as much information as possible of the study. One person was leading the interview and making notes of relevant non-verbal communication while the other person was translating the main content of the verbal conversations into notes. Aiming to reduce the potential bias of taking turns interviewing the respondents, two pilot studies was used as a basis to determine which researcher was better suited for each role (interviewer or note-taker) during the interviews of the study. As a result of the researchers getting into their specific roles the quality of the later interviews may have been better than the earlier ones. This may in turn have affected the dependability of the study in a negative way. According to Redman-MacLaren et al. (2014) the presence of more than one researcher contributes to a more reflexive understanding of the data, but it may also make the respondent feel uncomfortable, affecting the answers in a negative way. Effort to make the nurses feel confident in the position of respondent was therefore made in correlation to the semi-structured interviews.

Halcomb and Davidson (2006) argues that the method of concurrent transcribing, which is applied in this study, is favourable when using an interview guide approach. It allows the interviewer to comprehend more information given in the interaction with the respondent, without the disruption of writing notes. The more conventional verbatim transcribing method costs a lot more time and has been criticized for misinterpretations by not including significant content of non-verbal information. Considering that none of the respondents spoke English as their native language, the use of the combined reflexive method of transcription suggested by Halcomb and Davidsson (2006), including the none-verbal information given in the interviews, increase the credibility of the results of this study.

A discussion about the authors' experiences and preconceptions about interactions within the nursing context in Ghana was made before the study was conducted. Prior understandings were written down and analysed in relation to interpretations of information given during the interviews. This was made to decrease the risk of authors' bias to the final result.

Result discussion

The important nurse-patient relationship

As mentioned earlier in this paper, the underutilization of maternal health care is a complex problem related to many factors beyond the nurse-patient interactions (Say & Raine, 2007). The colonial history of Ghana delayed a stable development of welfare for the population in

the country, making socio-economic contributors such as widespread poverty and low level of health essential in this context (UNDP, 2015b). One may also consider how centuries of oppression under the Europeans may have affected Ghanaian women's trust in the provided maternal health care, founded in a health care system implemented by the colonizers. Kennedy, Mathis and Woods (2007) emphasize the importance of establishing trust for the health care system after historical events causing people to disbelieve. The findings in this study may none the less highlight a need to improve nurse-patient interactions, in order to achieve quality nursing and also to build trust in provided maternal health care.

Altogether three themes emerged under the core of nurse-patient relationship in the findings. The importance of achieving a quality caring relationship build on *patient's trust* was emphasized by all nurses. *Patient compliance* and women's insufficient utilization of provided maternal health care services represented the main focus of the nurses' and midwives' interactions with their patients. Prominent *nursing strategies* used in their work within maternal health care were also explained.

Building trust without patient-centeredness

The result shows that the nurse-patient relationship within maternal health care was considered as of main importance within the nursing profession. Building a relationship based on the patient's trust for the nurse and provided health care was described as indispensable for their work. Murray and McCrone (2014) suggest that trust is build in the nurse-patient relationship by interpersonal skills, moral competence and vigilance. Patient-centered care is a main factor to build a qualitative interpersonal relationship (Somnath et al., 2008). To use patient-centered care the health care provider should see each patient as unique. Cultural competence is closely linked with patient-centered care and aims to understand the importance and meaning of culture. The nurses in this study expressed that demonstration of knowledge and competence in nursing interactions together with creating a positive atmosphere was key to gain patients' trust. They did not mention patient-centered care or cultural competenceas important factors at all. A desire to build a trustworthy relationship emphasized, but the nurses did not seem to use appropriate strategies to build it.

Nurses power and (lack of) patient empowerment

The findings further suggests that by approaching the patients as subordinate and passive receivers of the nurses and midwives expertise, the asymmetric power structure within the

nurse-patient relationship was enhanced (Delmar, 2012). The nurses in this study explained that they had to "lower themselves to the patients´ level" in order to achieve the desired amicable interactions. On one hand this illuminates an aspiration to equate the power imbalance between the nurses and patients, which may be seen as positive. On the other hand it clearly establishes their perception of patients as inferior to nurses, which has a negative effect of the nursing outcome (Berg & Danielson, 2007). The described nursing strategies constituted of one-way health communications, where the nurses urged the patients what to do. The nurses further outlined their role as experts by using phrases such as "making women understand" and that the patients "don't know what is best for them". Våga, Moland, Evjen-Olsen, Leshabari and Blystad (2013) argues that authority in some cultural contexts is conceived as an expression of knowledge and that nurses who strive to empower patients to decision-making in health care may seem less competent in the eyes of the patients. This perspective was also reflected in the findings of this study. The nurses explained that having an expert approach when interacting with patients helped establishing trust. Yakong et al. (2010) however illuminate that nurses' expression of dominance makes patients feel mistreated and have a negative impact on women's utilization of maternal health care services. Moyer et al. (2013) suggest that socio-economic differences between nurses and patients contribute to the power imbalance in their interactions. In rural places where patients generally are economically vulnerable and have a lower level of education than nurses, the already existing power imbalance in the nurse-patient relationship was enhanced. Michaelsen (2012) highlights that manifestation and reinforcement of social boundaries between patients and health care practitioners may serve as a defence mechanism. By distinguishing from the patients, the nurses are able to cope with emotional stress from their work.

The ethical dilemma of unwilling patients

Patients' incompliance emerged as a prominent cause of the frustration within the nurse-patient interactions in the findings. The nurses and midwives expressed a lot of annoyance over women's unwillingness to participate in their provided maternal health care and reluctance to follow given health advice. Their strategies to increase utilization were focused on outreaching activities, convincing women to participate and/or comply. This may not come as a surprise considering that all participants of this study practised at CHPS-clinics, which pronounced aim is to enhance access to health care and uptake of patients (Nyonator et al., 2005). What may be more interesting is the level of pronounced persistence within the

outreaching activities. “Persuading”, “chasing” and even “forcing” unwilling patients by e.g. continuous phone calling and home-visits was disclosed as the nurses’ main policy in the issue. The nurses expressed it as their duty to do everything in their power to make sure that all pregnant women attended acquired ANC. Their approach when interacting with women not participating in the recommended maternal health care services was described as authoritarian and forceful. There is a significant difference, both ethically and attitude wise, between reaching out to offer patients increased access to health services compared to imposing health care to reluctant patients. Bull and Sorlie (2016) illuminate the ethical dilemma of maintaining respect for the patient’s integrity when interacting with patients refusing necessary health care. Nurses was forced to decide whether to ignore patient’s autonomy in favour of performing essential care measures or to respect the patient’s will and await treatment with the consequent feeling of passive contribution to the patient’s suffering or even death. But even though women’s incompliance and lack of utilization of provided maternal health care may cause a lot of frustration, showing respect for the patients’ autonomy is emphasized as a cornerstone in the nursing profession (ICN, 2012).

Attitudes towards alternative health care

The findings further revealed nurses’ disbelief in the quality of provided alternative maternal health care. They expressed great confidence in that women would come to their senses and seek help at the CHPS compounds when they experienced the inefficiency of the traditional care. No reflections of how the representation and quality of their provided care could contribute to making patients prefer alternative maternal health care emerged from the findings. Gyasi et al. (2015) define factors pulling patients towards utilization of alternative care in Ghana, as well as factors pushing them away from the evidence-based care. Fewer side effects of treatment, tradition, cultural beliefs and credibility are factors perceived as benefits of using alternative health care. Health care providers’ negative attitudes, poor communication with the patients and more side effects of treatment are factors considered as poor of the evidence-based health care, pushing patients away.

It also became clear during the semi-structured interviews that the nurses did not strive to improve cooperation with alternative health care providers in order to improve the maternal health. Vyagusa, Mubyazi and Masatu (2013) highlights the problem of consulting TBAs for delivery, by revealing that TBAs in Tanzania have remarkably inadequate level of knowledge in obstetric care. Most TBAs did not have adequate knowledge about symtoms and signs of

pregnancy complications and the methods of assisting childbirth were found to be unsafe for the health of the women as well as themselves. In this study, only the CHO nurse mentioned the benefits of working together with the TBA, to achieve a common goal. It might be relevant to notice that this nurse worked at the CHPS compound with the lowest rate of unsupervised home deliveries of the three clinics represented in this study.

Nurses uncritical approach

Even though there is alerted evidence illuminating how nurses' and midwives' negative attitudes and intrusive approach cause insufficient utilization of health care services (Bohren et al., 2015; Larson et al., 2015; Kuumouri Ganle, 2015; Yakong et al., 2010; Speizer et al., 2014; Say & Raine, 2007) only two nurses mentioned this at all in the findings. Critical reflections about the nursing practise influence on experienced incompliance and insufficient utilization of maternal care was not expressed by any nurse. A critical approach within evidence-based nursing is advocated by the ICN (2012) to ensure and improve quality of care. Chang, Chang, Kuo, Yang and Chou (2010) showed that nurses' critical thinking was positively correlated to their ability of caring, communicating, teaching, managing, researching and self-development. Having a critical approach in nursing practise promotes a self-supervising way of nursing, which reduces the incidence of errors, enhances learning from own mistakes and leads to making nursing strategies more efficient. Chang et al. (2010) further stress the nursing educations crucial role in development of critical thinking. Nurses with longer university education and more working experience have a more developed ability of critical thinking. None of the nurses in this study had education equivalent to university, as the nursing- and midwifery education in Ghana is vocational training. Described nursing experiences were noticeably task-focused and lacked the desired critical approach. It was prominent in the semi-structured interviews that when the follow-up questions were focusing on the reason to a described problem or experienced situation, the nurses' answers became very brief. Kong, Qin, Zhou, Mou and Gao (2013) suggest implementation of problem-based learning (PBL) in nursing education to enhance critical approach in nursing.

Conclusion

The findings in this study may suggest that nurses are unaware of their own contribution to negative nurse-patient interactions. The nurses' and midwives' interactions with patients were focused on building trust for provided care, aiming to increase the utilization of provided maternal health care. The findings might imply that a hierarchical power structure are forming

the nurse-patient interactions, where nurses treat their patients as subordinate passive receivers of their expertise. Nurses' communication with patients was described as unidirectional and characterized by advices and exhortations. The nurses expressed motivation to provide quality maternal care in the best way possible, but by lacking a critical approach to their own attitudes within interactions with their patients, they might unintentionally oppose their own objectives.

Clinical significance

By describing the nurses' lack of insight about how their own behaviour counteracts intentions of building a good relationship with their patients, the findings of this study may contribute to gaining more knowledge about how maternal health care may be improved. Improving the quality of maternal health care is necessary in order to fight maternal mortality.

Suggestion for further research

More research to validate the findings of this very limited study would be recommended. It would be interesting to explore the nurse-patient relations using a more observational method. Further examining nurses' abilities of critical thinking and its relevance for improving quality of provided care would also be suggested. It may also be relevant to study the potential benefit of implementing a more patient-centred approach and shared decision-making power within nursing care in Ghana.

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Appendix 1

Interview guidelines

Introduction

We are nursing students from the Red Cross University in Sweden. As part of our education we are writing a bachelor thesis in nursing science. In our thesis we want to focus on nursing within maternal health care. **The provisional aim of our study is to describe nurses' experiences and perspectives about their interactions of women seeking maternal health care in Ghana.** Because of your experience in working with maternal health care we would like to ask you to participate in this interview, to collect data for our thesis. This interview will approximately take 30 minutes. The interview will be recorded. **Your answers will be anonymous and held strictly confidential.** Participating in this study is voluntarily and you can at any time during the interview cancel your participation. Do you have any questions before we begin with the interview?

Personal questions

Male/female?
What is your age?
What education do you have?
Where have you been working after graduating as a nurse/midwife?
How long have you been working in these places as a nurse/midwife?
Why did you become a nurse/midwife?

Reflective questions

If I say '**good maternal health care'** what does it mean to you?
If you want to give the best possible maternal health care, what does it look like?

Within your professional experience in maternal health care, what did you ever do, that you feel extra proud of?
Tell me about a memory that you feel very proud about within your work as a nurse/midwife in maternal health care!

Within your professional experience in maternal health care, what did you ever do, that you regretted?
Tell me about a time when you did something as a nurse/midwife, which you afterwards felt that you should have done differently!

What problems have you experienced in communicating with or treating women seeking maternal health care?
What kind of problems in talking to patients, or treating patients, have you experienced, within maternal health care?

- How do you and other nurses handle these problems/situations?
- How do you and other nurses handle women who can not or do not want to participate in the recommended maternal health programme?

Tell me about a time when you interacted with a woman who did not want to deliver at a health facility.

Tell me about a time when you, as a nurse/midwife, met a patient who did not want to give birth at a health clinic.

- What happened?
- Where were you?
- Why did you do so?
- How did it turn out?
- Would you have done anything differently, if you could?

What do you think is a '**good nurse-patient relationship'**?

If you would describe the best possible nurse-patient relationship, what would it look like?

- Is the nurse-patient relationship important within maternal health care?
- Why is it/ is it not important?

Why do you think some patients experience negative treatment from health personnel?

Some women feel like the nurses and midwives at clinics treat them in a bad way, why do you think that is?

- What actions from the nurses and midwives contribute to negative practise towards the patient? What do you think health workers do, that make patients feel treated in a bad way?

What can nurses do to contribute to making maternal health care into a positive experience for the patients?

How can nurses and midwives help to make women feel positive about attending maternal health care?

Appendix 2

Permission to conduct study

Dear Madam,

This is to introduce to you Cecilia Nordin and Elin Eklund who are student nurses from the Swedish Red Cross University College (SRCUC). As part of their academic requirements for awarding Bachelor degree, they are to undertake a research work.

They are to conduct research on "Nurses experiences and perspectives about their interactions with women seeking maternal health care in Ghana". They intend to collect data through semi-structured interviews from nurses caring for pregnant women in both bigger and smaller health facilities. The data collection will start from 10th to 30th of March 2016. A total of five nurses will be interviewed and all participants will be given both written and oral information regarding the study. From all participants an informed consent form for participation in the study will be collected. Information given out shall be treated confidentially.
It would be appreciated if you could give them your necessary support and assistance.
Thank you.

…….

Principal NN

Appendix 3

Letter of information to participants

Nurses experiences and perspectives about their interactions with women seeking maternal health care in Ghana

Dear Participant,

You are invited to participate in a research study that focuses on nurses' experiences and perspectives about their interactions with women seeking health care.

We would be very grateful if you could participate in this study since you are currently working as nurse and takes care of pregnant women.

If you agree to participate, you are kindly asked to respond to the following questions which will take 30 minutes.

The participation in this study is voluntary. You can choose to refuse to answer some questions and you can, without giving any reason, stop at any time. The answers are confidential which means that you cannot be identified.

If you have questions, you are welcome to contact us directly and send us an email to:

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