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GRADUATE SCHOOL OF DEVELOPMENT STUDIES

**SUPPORT FOR PREGNANT WOMEN, VICTIMS OF INTIMATE PARTNER
VIOLENCE IN TAMALE, GHANA**

A Research Paper presented by:

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(GHANA)

in partial fulfillment of the requirements for obtaining the degree of
MASTER OF ARTS IN DEVELOPMENT STUDIES

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(SJP)

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The Hague, The Netherlands

May 2024

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Table of Contents

Acknowledgement.....	v
List of Acronyms.....	v
Abstract.....	vi
Chapter One.....	1
1.1 Introduction.....	1
1.2 Background.....	2
1.3 Historical Background of the study area.....	5
1.4 Research Objectives and Questions.....	7
1.5 Sub questions.....	8
1.6 Methods of Data-Gathering.....	8
1.6.1 Key-informant interviews.....	8
1.6.2 The unit of analysis.....	9
1.7 Organization of the Study.....	10
Chapter two.....	11
Literature review.....	11
2.1 Introduction.....	11
2.2 Legal Frameworks for Protecting Pregnant Women from IPV.....	11
2.2.1 International Legal Instruments.....	11
2.2.2 National Legal Obligation.....	13
2.3. A Human Rights-Based Approach (HRBA) to Supporting Pregnant Victims of IPV.....	15
2.4 Framework for analysis of the study.....	16

2.4.1 The right to health under international Human Rights.....	16
2.4.2 What is the right to Health?	17
2.4.3 The right to good health and pregnant women	18
2.5 The Role of DOVVSU Institution in Facilitating Access to IPV Services.....	20
2.6 Summary and gaps in the literature	20
Chapter Three.....	22
Methodology.....	22
3.1 Study design and approach.....	22
3.2 Selection and Sampling.....	22
3.3 Study population.....	23
3.3.1 Inclusion Criteria and Justification on Maternal Health Care Providers:.....	23
3.4 Sample Size	24
3.5 Data collection tools	24
3.6 Data collection process	25
3.7 Data analysis.....	25
3.8 Data accuracy and reliability	26
3.9 Ethical considerations	27
Chapter four	28
Results	28
4.1 Awareness of national frameworks by maternal healthcare providers	28
4.2 International frameworks	30

4.3 Healthcare providers role in protecting and supporting pregnant women of IPV	32
4.4 Referral services for pregnant women experiencing IPV.....	34
4.4.1 Accessibility of Services	35
4.4.2 Steps to improve access to referral services	37
4.5 Role of DOVVSU officials	38
4.5.1 Effectiveness of DOVVSU Workers	39
Chapter Five.....	45
Conclusion	45
5.1 Summary of findings.....	45
References.....	48

Acknowledgement

I am most grateful to Almighty God for the knowledge, strength, and guidance He has given me throughout this project. I also express my profound gratitude to my supervisor and second reader Dr. Jeff Handmaker and Prof Dr. Karin Arts respectively for their excellent and invaluable feedback. This journey could not have been possible without their contributions and efforts in guiding me. Additionally, I would like to offer sincere appreciation to the in charges of the TTH hospital and officers of DOVVSU for their valuable input. To my discussant Daisy, Rashad and Belay, a big thank you for the excellent editing help and feedback sessions. My final thanks go to my family for their support and motivation throughout this process.

List of Acronyms

ISDMs	Integrated Service Delivery Models
IPV	Intimate Partner Violence
DOVVSU	Domestic Violence and Victim Support Unit
CEDAW	Committee on the Elimination of Discrimination Against Women
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDS	Institute of Development Studies
GDHS	Ghana Demographic and Health Survey
GSS	Ghana Statistical Service
HRC	Human Rights Committee
HRBA	Human Rights Base Approach
LBW	Low Birth Weight
OHCHR	Office of the UN High Commissioner for Human Rights
UDS	University for Development Studies
UN	United Nations
SDA	Seventh-day Adventist Hospital
SSA	Sub-Saharan Africa
TTH	Tamale Teaching Hospital
WAJU	Women and Juveniles Unit
WHO	World Health Organization

Abstract

Intimate Partner Violence (IPV) is a crucial human right and it's prevalent throughout the world, albeit there is differences in regional severity and prevalence. This study aimed to evaluate both the human rights violations of pregnant women experiencing intimate partner violence and their ability to access remedies, including protection, and psycho-social services in the Tamale metropolis. Key informant interviews were held with 8 maternal healthcare providers and officials of the DOVVSU in the metropolis. The interviews, which were conducted online, focused on how these maternal healthcare providers manage pregnant women who are IPV victims and the challenges they encounter. This study adopts a qualitative research design with a human rights-based framework to explore the complex legal, social, and institutional aspects of protecting pregnant women experiencing IPV. Purposive sampling was used to identify maternal healthcare providers that they had worked with pregnant women experiencing IPV. This study primarily focused on two groups of key informants: The participants comprised maternal healthcare providers and officials of the DOVVSU. Structured and semi-structured interviews were done among the maternal health care providers and DOVVSU, in which both of them were interviewed on the telephone. Analysis of data for this study was done thematically. The present study found that maternal healthcare providers who are in direct contact with pregnant women who are victims of IPV, demonstrated strong familiarity with national legal frameworks such as the Domestic Violence Act and protection orders, but showed less awareness in terms of international frameworks. By contrast, maternal healthcare providers demonstrated less familiarity with international frameworks. The roles of maternal healthcare providers include clinical care, emotional support, coordinated referrals, and legal advocacy. Lack of transportation, financial constraints, and overload of shelters were some of the barriers mentioned to obstruct women from seeking shelters in this study. DOVVSU aids pregnant women who are victims of IPV, a lot of roles were mentioned which include providing legal protection, helping victim's access psychosocial help, and encouraging access to essential services.

Key words: Intimate, Partner, Violence, Pregnant, Women, Support, System, Referrals, Ghana

Chapter One

1.1 Introduction

Intimate Partner Violence (IPV) is a crucial human rights and public health concern. According to 2018 estimates from data collected across 161 countries and regions, about 27% of women aged 15–49 who have ever been partnered have suffered from physical and/or sexual IPV at some point in their lives (Sardinha *et al.*, 2022). Additionally, 13% of these women reported experiencing IPV within the past year (Sardinha *et al.*, 2022). IPV is prevalent throughout the world, albeit there is differences in regional severity and prevalence (Ogum Alangea *et al.*, 2018; Adu, 2023). The prevalence of IPV in Nigeria and Ghana revealed was found to be 27.7% and 24.4% respectively (Ubom *et al.*, 2024). A study in northern Ghana reveals a high prevalence of IPV (84.8%), 38.6% of the studied women mentioned having psychological or sexual IPV, and close to half of the women (44.6%) reported having emotional IPV (Cao *et al.*, 2021). The findings further reveal that in every 10 women 8 of them might have experienced a form of IPV (Cao *et al.*, 2021). Unfortunately, little is known about IPV among pregnant women and much attention has not been given to trace referral services which are crucial for pregnant women experiencing IPV in the Tamale metropolis. While previous studies emphasize the importance of providing comprehensive referral services and shelters, as stated by Auger *et al.* (2022), there remains a significant gap in understanding the specific legal and institutional frameworks that support pregnant women facing IPV in the Tamale metropolis.

As a researcher who is passionate about helping pregnant women concerning their health and enlightening them about their rights to good health, I have spent most of my time during my undergraduate studies in several institutions in Northern Ghana observing how pregnant women experiencing IPV access maternal health care, legal institutions, and their lived experiences. One day, I met a young lady who was looking so depressed during my visit to a local clinic in the Tamale metropolis. The woman confided in me after gaining her trust, that she was a victim of IPV. Nevertheless, she had challenges in seeking support due to fear of retaliation and societal stigma. The woman further told me about how she has been troubled both physically and emotionally as a result of IPV, however her access to support from legal

and institutional support system was limited. I realised that she was not only suffering the violence but also denied her basic right to good health. This experience left a significant impact on me which ignited my commitment to delve deeper into understanding the role of the legal and institutional framework in facilitating access to referral services for pregnant women in the Tamale metropolis.

1.2 Background

Globally, IPV is the most common form of abuse against women (Silva *et al.*, 2015; Elghossain *et al.*, 2019). Studies have indicated that about 36% of the population of Sub-Saharan Africa (SSA) has been affected by IPV, making SSA contribute to 53% of the burden of IPV in Africa (McCloskey *et al.*, 2016). According to the analysis of the 2022 Ghana Demographic and Health Survey (GDHS), 36.4% of the women have experienced some form of IPV in their lifetime, and among them, 31.5% experienced emotional abuse, 17.3% physical abuse, and 7.6% sexual abuse, respectively (Dickson, Ayebeng and Okyere, 2024).

The World Health Organization (WHO) defined IPV as a violent behavior by an ex-partner or intimate partner that results in sexual, physical, or psychological harm, including sexual coercion, physical aggression, controlling behaviors, and psychological abuse (WHO, 2021). Also, IPV is the use of physical, sexual, emotional, or psychological violence inflicted by an intimate partner in the past or present cohabitation setting, in marriage, or in any other formal or informal union (UN, 2018). The rights of women are violated by acts of violence against them; in particular, they experience serious sexual violence, domestic violence, and other forms of violence that compromise their basic right to personal security. In addition, this violence can lead to long-term mental and physical health issues infringing upon their rights to good health. In extreme cases, it can result to death, thereby violating their right to life (Obreja, 2019; Johnson *et al.*, 2022).

IPV is a significant contributor to health problems in women, including reproductive health concerns and health disorders. Moreover, the effects of IPV extend beyond the individual's health, affecting the national economic and social systems. Most often, women suffering from IPV have lower productivity which can affect the economic growth of a country as health issues such as depression can reduce efficiency and output (Willis and Marcantonio, 2021;

Oram *et al.*, 2022; Lutwak, 2024). Given that IPV is known to be linked to poor results for one's physical, social, and sexual health, this is concerning. For example, women who are sexually abused are 1.11 times more likely to participate in several high-risk reproductive behaviors (Aboagye *et al.*, 2024). Perpetration of IPV has also been associated with increased risk of psychological distress, unintended pregnancies, and subsequent violence and victimization (Maxwell *et al.*, 2018). According to one integrative analysis (Liu, Logan and Alhusen, 2020), women who are subjected to IPV are at a higher risk of developing cardiovascular symptoms.

The right to good health is one of the fundamental human rights that includes the ability to live free from discrimination and violence, protection from harmful things, and access to healthcare services (Gutterman, 2023). IPV threatens the right to good health by exposing women to mental and physical harm which could result in severe health challenges. In their systematic review of 127 cases in different jurisdictions, Eikemo *et al.* (2023) pointed out that, despite the fact that IPV during pregnancy is a violation of a number of fundamental human rights in different jurisdictions', it violates key human rights listed in Lex Lata international instruments, including health. According to them, matching the observed facts of documented cases with the criterion of easily seen violations of at least one provision of the Charter, it is possible to confirm 44 such violations of charter provisions. In 82% of the identified version, several obvious violations of multiple chart provisions are reported by Hasselle *et al.* (2020). In support of the legal foundation of the study on IPV incidence in developing countries, it stated that violence on pregnant women, particularly by their partners, is in gross violation of the constitution of most countries and the international human rights instruments (De Vido, 2020). Moreover, Raziani *et al.* (2024) castigated in their conjectural study of 450 pregnant women, most of whom were victims of IPV, that violence against such women offensively interferes with their ability to exercise their fundamental rights and freedoms, especially the maternal and fetal right to health. Social consequences such as community disintegration and isolation, could limit community cohesion and strain social support systems (Willis and Marcantonio, 2021; Oram *et al.*, 2022; Lutwak, 2024).

Apart from possibilities of long-term recovery, referral services provide them with emotional help, immediate shelter, and legal aid (PettyJohn *et al.*, 2023; Rohn and Tenkorang, 2023). Most of the shelters are facing massive challenges in terms of funding and human resources to support anyone who seeks shelter (Wuerch *et al.*, 2019; Klein *et al.*, 2021). Lack of funding often translates into a lack of services that women require for safety and more importantly, the recovery process as they escape from violence. Women also may encounter bureaucratic barriers to entering shelters (Burnett *et al.*, 2016). Shelters in various countries ask victims of IPV to provide identity proofs, police reports or even health-related documents as proof that she is eligible for services (Belisle *et al.*, 2024). These documentations are often required because it is imperative that the identity of the person requesting help be established. As a result, there is less chance of fraud or improper use of resources meant for the victims of IPV. Owing to various incorporated connections between health care access for pregnant women who are experiencing IPV there are various forms of barriers that hinder them from getting the right care they need. A study by Thi *et al.* (2024) show that stigmatization is the main hindrance, a study done on 542 pregnant women showed that 68% of women delayed going for their prenatal care because they felt discriminated against by health care providers. The above study is backed by Testa *et al.* (2023) who conducted an interview with 127 pregnant IPV survivors and found out that they struggled to make an extra coin, 73% could not afford a car to take them to health facilities or to leave their children while attending appointments. Further, Dasgupta (2023) identified that women immigrants with undocumented status have even higher barriers in experiencing healthcare during pregnancy for IPV, including fear of deportation and language barriers; in the study of 189 immigrant women, estimated 82% did not seek healthcare because of reason of legal status. The presence of all these barriers forms an intricate problem that has severe negative impact on maternal health and her safety. The provision of referral services and safe shelters for pregnant IPV victims has gained importance as an important area in advocating for the rights of women and more especially their right to health. According to a study by Auger *et al.* (2022) of 45 domestic violence shelters aimed at pregnant women, it was stated that service interventions including shelter, medical, and psychological support yielded the most positive client outcomes and perinatal conditions. Their study revealed that there was a 64% decrease in pregnancy-related complications among women who got access to the comprehensive shelter as compared to women who never did.

Due to pressure from activists, NGOs, and the international community for the prevention and combat of IPV, the government of Ghana enacted some laws to protect the wellbeing and rights of women. These rights include criminal laws that criminalize different types of IPV: such as physical abuse, sexual abuse, economic abuse, and psychological abuse (AAG, 2019). Despite these actions taken by the government, IPV is still prevalent in the country, and in most cases, it goes unrealized (Ogum Alangea *et al.*, 2018). The Ghana Police Service took a step in 1998 to combat the issue of domestic violence, which at that period was mainly physical assault done by male partners, by establishing the Women and Juveniles Unit (WAJU), which is now known as the Domestic Violence and Victim Support Unit (DOVVSU). Nevertheless, recent data indicates that the DOVVSU in Ghana is challenged by a lack of funding, insufficient administrative and logistical support, undertrained staff, poor visibility and accessibility to DOVVSU offices, and a lack of confidentiality at DOVVSU offices (Rohn and Tenkorang, 2023). The Ministry of Gender, Children, and Social Protection oversaw the creation of a National Policy and Plan of Work for implementing the Domestic Violence Act in 2008.

1.3 Historical Background of the study area

The current study is conducted in the Tamale Teaching Hospital and the DOVVSU center, Tamale Metropolis which is situated in the Northern Region of Ghana and it is the capital of the region and also one of the most burgeoning cities in Ghana. Tamale was chosen for the current study due to the availability of a formal structure system for aiding IPV victims, having a distinct urban-rural mix of challenges, and the sociocultural nature of the area. Also, Tamale Teaching Hospital serves as a referral center for all the hospitals in the northern part of Ghana with the largest capacity of maternal healthcare professionals. The DOVVSU center was chosen since it is the only known center providing support for victims of IPV.

In Tamale, there are cultural barriers that may not allow disclosure of issues related to IPV. Northern Region of Ghana has a relevant history in pre-colonial African Power and the ancient kingdom of Dagbon which was established in the early 14th century for the mainly Dagomba ethnic group that constituted most of the population of the modern-day city (GSS, 2021). Another significance of Tamale based on historical records is that it has always served as a

trading centre between the northern region and the rest of the country and the trans-Saharan trade routes that connected the area with northern Africa. This made it a place that underwent the process of assimilation of various cultures and commerce especially in animal products, cereals, fabrics and several other crafted artefacts. In time Tamale was transformed into an administrative center under colonization which later fostered it to be the administrative capital of Northern Ghana (GSS, 2009).

Demographically, Tamale has expanded tremendously over the last several decades as a result of population growth, conversion to living in urban areas, job search, and movement from rural areas. According to the 2021 Ghana population census, the Tamale Metropolis has a population of more than 370, 000 people and is, therefore, among the largest cities in northern Ghana (GSS, 2021). Another important characteristic of the demographic profile of Tamale is that the population is mainly young. Most of the people living there are below the age of 35 years which makes it have an overall youthful population which is evident from the general population in Ghana. (GSS, 2021).

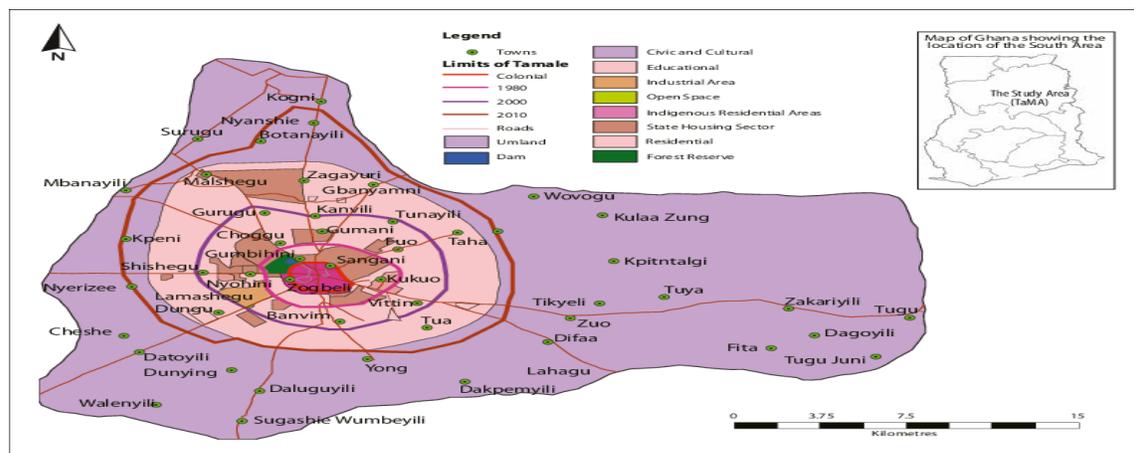


Figure 3.1: Map of Tamale metropolis

Source: (Gyasi *et al.*, 2014)

Tamale Metropolis is diverse, though it is predominantly Islamic, with about 84% of the population identifying as Muslims. This reflects the historical influence of Islamic scholars and traders who brought the religion to the region centuries ago. Alongside Islam, Christianity and traditional African religions are also practiced in Tamale(GSS, GHS and ICF, 2015).

There is also advancement in the education sector owing to the development of institutions such as the University for Development Studies (UDS) which has put the city as one of the Northern Ghana city universities. Some of the healthcare facilities in Tamale include the Tamale Teaching Hospital (TTH), Tamale Central Hospital, Tamale West Hospital, Seventh-day Adventist Hospital (SDA) as well as other clinics that have served as the healthcare providers for the people (GSS, 2021). In northern part of Ghana, forced and child marriages are widely practiced, and they are substantial contributors of IPV. Young girls are mostly married off without seeking their consent in these marriages, to much older men. The age imbalance and lack of consent create power dynamics that can result to higher cases of abuse in these relationships. Also, forced and child marriages limit the autonomy of the girl and expose them to elevated risks of emotional, physical, and sexual violence from their partners, making it one of the major contributors to IPV in these settings (IDS, 2016). Additionally, a recent study has shown that men in this area were more inclined to defend violence against women and showed a higher tolerance for domestic abuse. Referring to the societal acceptability of wife beating, the study by OLA in 2022 also showed that, particularly in the northern region of Ghana, males considered wife-beating friendlier than men from other regions (Ola, 2022).

1.4 Research Objectives and Questions

The study aims to explore how maternal healthcare providers perceive and align themselves with national and international legal frameworks concerning IPV against pregnant women, identify the challenges these women face in accessing referral services—including safe shelters and psycho-social support—assess the role of the Domestic Violence and Victim Support Unit (DOVVSU) in facilitating these services in the Tamale metropolis through a human rights-based approach, and determine whether IPV against pregnant women constitutes a human rights violation while analyzing the implications. This enables me to ask the question: why has the legal and institutional framework in Tamale failed to protect pregnant women from IPV and what referral services are available for the pregnant women?

1.5 Sub questions

1. How do maternal health care providers regard and position themselves in relation to legal obligations contained in national and international legal frameworks?
2. What are the access challenges to accessing referral services, including safe shelters and other forms of psycho-social assistance faced by pregnant women experiencing IPV?
3. How does the DOVVSU facilitate access to referral services for pregnant women experiencing intimate partner violence in the Tamale metropolis, within the framework of a human rights-based approach?
4. Does IPV against pregnant women amount to a HR violation and what are the implications?

1.6 Methods of Data-Gathering

1.6.1 Key-informant interviews

Key informant interviews were held with 8 maternal healthcare providers in the metropolis. The interviews, which were conducted online, focused on how these professionals manage pregnant women who are IPV victims and the challenges they encounter. The key-informant interview guide led the way in questioning the respondents and their responses were recorded on notepads.

The key-informant interview guide were structured into three sections. The first part covered socio-demographic information of participants such as their professions (e.g. Nurse, midwife, doctor, obstetrician, etc) and the number of years they have worked with pregnant women. The second part focused on how health care providers regard and position themselves in relation to these national and international legal obligations. The last part covered the challenges they face in rendering care to these women as well as experiences of the women regarding IPV. The key informant were approached through an online interview technique.

The interviews with officials of the DOVVSU were conducted online to facilitate access, given the logistical and geographical challenges of in-person meetings by the researcher. This formal procedure helped in building trust and ensuring that the interviewees were comfortable and

prepared to participate. The interviewees were purposefully selected due to their position and experiences in DOVVSU, especially those who dealt with cases related to IPV and pregnant women. Among the factors that were considered were the number of years served in the service, whether they engage in community sensitization programs, or if they have worked on cases of gender-based violence. Semi-structured interviews were administered using a purposive sampling approach to make sure that the respondents had an adequate understanding of the study area.

These officials were contacted via formal letters to DOVVSU management, where the research aims were presented and approval given to interface with specific individuals. A formal letter of request to conduct the research was forwarded to the management of DOVVSU accompanied by the proposed research area. The researcher conducted background research on DOVVSU's mandate, services, and experiences. An informed consent was developed and the necessary permissions and ethical approvals were ensured. In addition, to get a detailed response from the officials, open-ended questions were asked of the participants. Non-leading questions were asked to gather detailed insights from respondents. Their experiences, challenges, and successes in dealing with victims of IPV among pregnant women were explored. Critical attention was paid to their responses and body language. Notes were taken and questions were asked for clarifications. Confidentiality and anonymity of the various responses were ensured.

1.6.2 The unit of analysis

The primary unit of analysis was the legal and institutional framework designed to address IPV among pregnant women in the Tamale Metropolis in Ghana. The secondary unit of analysis was maternal health care providers assisting individual pregnant women who have experienced IPV. In other words, the focus was on the resources and infrastructure, especially referral services available to pregnant women who have faced IPV, rather than on their direct experiences of the healthcare system. A tertiary unit of analysis was members of the Ghana police, particularly the DOVVSU, although they were difficult to access.

1.7 Organization of the Study

The thesis is structured into six chapters. The first chapter included the background and context of IPV among the legal and institutional setting, the problem statement, research objectives, and the history of the study setting. The second chapter comprised the literature review which comprises of overview of IPV and its impact on pregnant women, the national and international legal frameworks protecting pregnant women who are victims of IPV, the healthcare providers' roles and responsibilities in addressing IPV, access challenges to referral services for pregnant women experiencing IPV, and human rights-based approach to addressing IPV. Chapter three is on the methodology of the research which entailed the research design and approach (qualitative), the study population and sampling strategy, the data collection methods, the data analysis plan, and the ethical considerations.

Chapter four and five present on the study's findings and discussion. The findings shall be presented in written form. They shall be findings on legal obligations and healthcare providers' roles, analysis of national and international legal frameworks protecting pregnant women who are victims of IPV, analysis of DOVVSU's role in ensuring access to referral services for pregnant women experiencing IPV, maternal healthcare providers' understanding and implementation of legal obligations, and positioning of maternal healthcare providers concerning legal obligations. Chapter five shall be on conclusion which entails a summary of key findings, implications for policy and practice, recommendations for healthcare providers, DOVVSU, and policymakers, and limitations.

Chapter two

Literature review

2.1 Introduction

Chapter two of this study explores IPV against pregnant women and the Human Rights-Based Approach (HRBA); right to good health as a framework for addressing the needs of these women. This study seeks to establish knowledge gaps that exist in the current literature and practice towards addressing pregnancy-related IPV to inform the formulation of more relevant and human rights-responsive intervention measures for the protection of pregnant women experiencing IPV in the Tamale Metropolis.

2.2 Legal Frameworks for Protecting Pregnant Women from IPV

2.2.1 International Legal Instruments

International legal instruments for protecting pregnant women from IPV are available in different forms. These instruments set legal requirements and expectations of states to not only protect but also to prosecute violence against women, including pregnant women—violence that occurs in the public as well as in personal spheres. This section considers these frameworks in more detail with reference to Ghana engagement with and compliance with these international legal instruments.

UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): CEDAW, or the Convention on the Elimination of All Forms of Discrimination against Women that was adopted in 1979, also known as the Women’s Charter of Rights (Freeman, 2019). It prohibits discrimination and violence against women. In accordance with General Recommendation No. 19 (1992) and in compliance with General Recommendation No. 35 (2017). CEDAW defines discrimination in Article 1 as: Any distinction, exclusion, or restriction made on the basis of sex, intending or having the effect of nullifying or impairing the recognition, enjoyment, or exercise of human rights and fundamental freedoms of women (Isa, 2022). It is worth noting that, there is acknowledgement of violence against women, specifically IPV, as a case of discrimination on the basis of gender (Schulz *et al.*, 2022).

Ghana herself has been to CEDAW since 1986 without any reservation; this means that it has agreed to fully implement all provisions of the CEDAW and undertake legislative, judicial, and administrative steps to eliminate discrimination against women (Vitoh, 2023). Under article 16 of the constitution of the Ghanaian government, marriage and family life should be protected, which in a general way covers protection of pregnant women against IPV since they are more vulnerable whenever pregnant (Barnes and Appiahene-Gyamfi, 2019). Ghana has ratified these articles, however, full implementation of these articles is still a challenge with domestic culture and social norms going in contrast to many provisions of CEDAW.

UN Declaration on the Elimination of Violence against Women: Coming into force in 1993 following its adoption by the UN General Assembly, the Declaration on the Elimination of Violence Against Women is an important international legal document that defines violence against women as including physical, sexual, and psychological violence occurring in the family or other equivalent context or in public areas (True, 2020). Whereas it recognizes the situation of pregnant women who are potentially at risk of increased IPV. Even though the Declaration does not contain legal obligations, it sets up a standard that supplements legal documents such as CEDAW (Garcia-Moreno and Amin, 2019). Ghana has remained keen and has participated fully in any activities pertaining to the United Nations on violence against women, and the country has positively voted on any resolution to do with the Declaration. The Declaration also calls on states to take legal steps to prevent violence against women and to punish perpetrators (Article 4). Ghana also has Domestic Violence Act 732 of 2007. The Act is also in agreement with this international framework since it addresses different types of violence; however, the implementation of the Act is a big challenge (Morhe, 2022).

The African Charter on Human and Peoples' Rights Rationalisation and Revision was adopted in 1981 as one of the most important regional human rights instruments that regulates the rights of people in Africa, including women's rights (Odinkalu, 2023). The states are obliged to take measures to protect the family and women's rights, according to Article 18 of the Charter, which is similarly to Article 9 also means the protection of pregnant women against violence (Umozurike, 2023). The Protocol also enhanced the ACHPR to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, known as the Maputo Protocol, signed in 2003. The Maputo Protocol also provides for IPV in Article 4: the right to

freedom from violence, including physical violence, in the family or elsewhere (Geng, 2019). Ghana joined other African nations in endorsing the Protocol in 2007, hence a readiness to adopt the provisions of the Protocol (Geng, 2019; Vitoh, 2023). Article 14 of the Protocol is most suitable for pregnant women since it covers health and reproductive health issues and violence that can cause complications for pregnant women. Domestic Violence Act: Although the legal requirements and provisions of Ghana correspond to the provisions of the Maputo Protocol, the problem of fulfilment of these requirements still remains urgent. It has been realized that these legal standards are hard to implement because of challenges like low legal auditing skills, lack of justice for women in rural areas and other marginalized women, and cultural barriers in addressing IPV (Vitoh, 2023).

2.2.2 National Legal Obligation

The protection of pregnant women from IPV within Ghana is governed by a national legal framework that complements the country's commitments under international and regional areas. The main legal instruments that address IPV in Ghana include the Domestic Violence Act and provision within the Criminal Code regarding assaults. These frameworks are very crucial in making the state and any individual in the fight against IPV, especially regarding vulnerable groups of women who are pregnant. The main domestic violence law of the country is the Domestic Violence Act, 2007 (Act 732) (Damodar, 2022). This law has a wider scope of domestic violence as physical, sexual, emotional, and economic, as do other definitions such as the UN Declaration on the Elimination of Violence Against Women (Geng, 2019). This Act was enacted recently due to the realization in the Ghanaian society that, the incidence of IPV was high. Based on the preamble to the Act, the Act mandates a state to prevent and protect vulnerable persons, such as women and children, from any forms of violence.

Criminal Code Provision on Assault: Under the Criminal Code of Ghana (1960, Act 29), IPV is also protected through the provisions of assault (Mensah, 2024). According to Section 84 of the Criminal Code, an assault means unlawful force on the person of another, and Section 88 explores the aggravated assault, which is an attack that causes bodily harm (Bettinson, 2022). These provisions are important for pregnant women because, in most cases, they are likely to be victims of severe physical violence. Pregnant women who are attacked are likely to suffer

from a miscarriage or preterm birth, apart from other complications in pregnancy and to the future health of the mother and the fetus (Auger *et al.*, 2022). However, what we find is that to some extent these provisions are on the statute books, but in practice the law does not deliver. Research also reveals that most of the affected pregnant women usually experience IPV as confidential family affairs and not as criminal cases (Antoniou, 2020). In a 2019 empirical study, Ofori-Dua *et al.* have observed that most police officers will not wish to bring an assault case to prosecution since the latter is considered a social vice outside the scope of authorities (Ofori-Dua, Onzaberigu and Nimako, 2019). Also, the culture and tradition do not allow women to report cases of IPV, especially during pregnancy, as the cultures always encourage togetherness in a family. Also, the Criminal Code brings exceptions for minor assault that can be excused by provocation, or where the attackers and the attacked ones have a 'domestic conflict.' This makes the legal system open a loophole which may allow injustice to be meted out to pregnant victims (November, 2023). Hulley *et al.* (2023) further stressed that, the same provisions can be manipulated by the perpetrators to avoid receiving a strict punishment, while the victims, who are often faced with numerous barriers to reporting the incidences of violence suffered by them, will still be left helpless.

2.3. A Human Rights-Based Approach (HRBA) to Supporting Pregnant Victims of IPV

A human rights-based approach (HRBA) has become a framework for tackling composite social problems such as IPV against pregnant women (Antoniou, 2020). At its core, HRBA is founded on four key principles: political equality, anti-racism, suffrage, and accountability (European Commission, 2023). A study by Finnbogadóttir et al. (2020) shows that pregnant women are more vulnerable to IPV than other women of childbearing age and urged intervention programs to assess the situations of pregnant women. Their study reveals that pregnant women who are victims of IPV are most likely to develop mental health disorders and pregnancy complications; hence, that is why pregnant women should have equal access to support services.

Another primary work by Agarwal et al. (2023) examines how participatory interventions might be helpful in engaging with the problem. The integration of support programs was made according to the data received from the studies, which involved pregnant women with the experience of IPV for identification and development, and the results of these studies show the reception of the improved outcome and increased participation in services. It also aims as a form of increasing the acknowledgement of victims in interventions, but it also ensures that proper provision is made to ensure that diverse forms of interventions shall cater for diverse identities. Both legal and institutional contexts suggest that there must be channels through which California duty-bearers who are expected to protect the rights of pregnant women subjected to IPV can be held responsible for their actions. Colombini et al. (2020) relied on the analysis of accountability measures in health care institutions and analyzed that standard documentation practices helped identify victims from the hospital sample and pregnant women who were suffering from IPV. Their research aims at establishing systematic responsibility in pregnancy since women should be protected in all health facilities and social work offices.

The Human Rights-Based Approach (HRBA) to supporting pregnant victims of IPV is a multifaceted model that has received growing interest at the global and country levels. The HRBA to supporting IPV pregnant victims is a crucial framework that centers on promoting and protecting individual's rights as a main objective. It acknowledges that IPV is a human rights violation, especially the rights to health, safety, dignity, and equality. Exploring the

enforceability of the legal standards used when applying HRBA, it is important to note that healthcare providers act as key implementers of the concept, as discussed by Agarwal et al. (2023). The current study indicates that synthesis of the four empowering components, equality, participation, accountability, and of empowering pregnant women has been vital in the enhancement of policies and mechanisms that safeguard pregnant women from IPV and avails adequate health and human rights protective responses.

2.4 Framework for analysis of the study

2.4.1 The right to health under international Human Rights

Several international and regional documents and declarations, as well as the majority of the fundamental international human rights treaties, have acknowledged and/or provided for the right to health (UN, 2000). Even though it is acknowledged as a fundamental and independent right, the realization of other human rights—such as the rights to housing, human dignity, life, non-discrimination is closely linked to and dependent upon the right to health (UN, 2000). The United Nations Sustainable Development Goals (SDGs) include health as one of their main objectives. SDG 3 proposes encouraging well-being and guaranteeing healthy lives for people of all ages (Gutterman, 2020)- "The treaty bodies which oversee the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Economic, Social, and Cultural Rights, and the Convention on the Rights of the Child have adopted general recommendations on the right to health and health-related issues." (UN, 2000).

Every state has acknowledged at least one international human rights treaty that acknowledges the right to health, and they have pledged to preserve this right through international conferences, domestic legislation and policies, and international declarations (Commissioner, 2008). The first international document state that everyone has the fundamental right to health, irrespective of their ethnicity, religion, political beliefs, economic condition, or social standing. In the Preamble to its Constitution, the World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1989).

The World Health Organization regarded the "right to health" as "an inclusive right ranging not only to appropriate and timely medical treatment but also to the fundamental factors affecting health, such as access to housing, food, and water, health information, etc."9 States are responsible for taking the required steps to ensure that everyone within the borders has access to health care; nevertheless, the WHO recognized that this can be difficult even in normal circumstances and that a State may become overburdened in an emergency (Purnama *et al.*, 2015). In reference to Article 25 of United Nations' Universal Declaration of Human Rights ("UDHR"), "everyone has the right to a quality standard of living which is appropriate for the good well-being and health of himself and of his family..." (Purnama *et al.*, 2015)

2.4.2 What is the right to Health?

In its General Comment 14, the International Covenant on Economic, Social and Cultural Rights (ICESCR) states that "health is a fundamental human right essential for the fulfillment of other human rights," which include freedom of association, movement, equality, and the prohibition against torture (Comment, 2000; OHCHR, 2008). The right to health, according to the ICESCR, should not be interpreted as "a right to be healthy," but rather as a collection of liberties such as the freedom to manage one's body and health (OHCHR, 2008). According to the ICESCR, the following interconnected and fundamental components make up the right to health in all of its manifestations and at all levels; how these are applied specifically will rely on the circumstances that exist in a given State party according to the Office of the UN High Commissioner for Human Rights (OHCHR, 2008).

Availability: Within the State party, health care services, products, and initiatives must be adequately available. This element often refers to the availability of essential factors of health, such as adequate sanitary facilities, hospitals, clinics, and other health-related services, including referral services for vulnerable groups like pregnant women.

Accessibility: Accessibility is also important within the borders of every State party, health facilities, products, and services are required to be accessible to all people without any discrimination. Knowledge accessibility, economic accessibility (affordability), physical access, and non-discrimination are the four intersecting facets that make up this accessibility.

Acceptability: All healthcare facilities and services must adhere to all the medical ethics and also be culturally suitable. That is, considerate of personal, minority, and community cultures, sensitive to gender and life-cycle needs, and built to protect confidentiality and enhance the health of those involved.

Quality: In addition to being acceptable to cultures, health facilities, products, and services must be clinically and empirically suitable and of high quality. This calls for, among other things, qualified medical staff, and proper hospital equipment like counsel center.

Moreover, misconceptions regarding the right to health have been brought to light by the OHCHR (Commissioner, 2008; OHCHR, 2008). The OHCHR, for instance, stated that the right to health "is NOT the same as the right to be healthy" and that states are unable to ensure that everyone throughout their borders has good health because "good health is determined by multiple factors that are beyond the immediate control of States, such as an individual's physiological make-up and socio-economic situations." States must concentrate on making sure that everybody has access to the range of products, infrastructure, services, and environments required to achieve the best possible level of mental and physical wellness. Although states are not required to ensure general good health, the OHCHR explicitly asserted that states should not be excused from taking action to achieve the right to health because of a challenging economic backdrop, nor should it be viewed as merely a long-term goal (Commissioner, 2008; OHCHR, 2008).

2.4.3 The right to good health and pregnant women

According to the OHCHR, women endure many of the same health problems as males, but in different ways. It went on to explain that a number of factors result in adverse health outcomes for women, including high levels of poverty and financial dependency, being exposed to violence, bias against women in healthcare organizations and society, racial or other discrimination, a lack of control over one's sexual and reproductive health, and a do not have of influence in decision-making (Commissioner, 2008). In addition, the OHCHR emphasized that some women face marginalization, barriers, and discrimination in ways other than discrimination based on gender. Women who live in slums or suburban regions, are refugees or internally displaced, are indigenous or rural, have impairments, or are HIV/AIDS positive are all included in this (Commissioner, 2008). The Convention on the Elimination of All

Forms of Discrimination Against Women stated that "States ought to take initiatives to guarantee that certain groups of people are not discriminated against." This was done in response to the need to address the unique obstacles that women and girls encounter in achieving their human rights (Commissioner, 2008; OHCHR, 2008). In accordance with Article 12(2), states must "provide women with the right services related to pregnancy, childbirth, and the postpartum period, offering free services where required, as well as proper nourishment during pregnancy and lactation." (UNGA, 1979)

In this study, the right to good health which is a human-based approach would be used for the analysis of IPV. This framework focuses on the fundamental rights of pregnant women experiencing IPV and highlights the roles of legal frameworks and institutions to promote, protect, and fulfill this right. The right to good health is known in several international frameworks including ICESCR which highlights health as a state not merely the absence of infirmity or diseases but a state of complete social, physical, and mental well-being (WHO, 1989).

The right to good health involves providing healthcare access as well as social determinants of health. IPV directly violates the right to health as it looks down on social, physical, and mental health. This framework acknowledges IPV as a human rights violation instead of medical and social concern (Kokabisaghi, 2024). The right to health underscores the importance of quality, availability, and accessibility to healthcare for pregnant women with IPV (Ojong *et al.*, 2024). This includes mental health, physical health services, as well as reproductive healthcare which are crucial for tackling the various implications of IPV. The present framework examines the obstacles preventing pregnant victims of IPV from these services such as financial constraints, stigma, or inadequate resources. Also, it assesses how these obstacles infringe on the right to healthcare with equity (Anguzu, 2021). The right to good health which is adopted for the current study realizes that health is impacted by a variety of factors such as environmental, economic, and social factors (Raphael, 2016). Several determinants could compound IPV including poor access to education, poverty, and stigma which prevents IPV victims from achieving proper healthcare. This framework provides an intersection of these determinants and IPV, clarifying that protecting and promoting the health of IPV victims also implies tackling structural inequalities that bring about violence and restrict healthcare accessibility (Raphael, 2016).

2.5 The Role of DOVVSU Institution in Facilitating Access to IPV Services

The DOVVSU of the Ghana Police Service is an important agency combating domestic violence and IPV in Ghana. According to the authors Yalley, (2019) DOVVSU can be considered as a paramount law enforcement agency involved in the investigation and prosecution of cases under the DVSA (Domestic Violence Survivor Assessment) for domestic violence while offering a temporary shelter to the victims. As Tenkorang, (2022) revealed in their qualitative study revolving around 50 IPV survivors, DOVVSU has social roles of offering emergency shelter, medical referral service, and the coordination of legal services for some especially pregnant women.

The operation of DOVVSU under the auspices of the Human Rights Based Approach (HRBA) has been a new way in Ghana to address IPV. As clear evidence of this argument, Osei, (2019) provided an examination of DOVVSU's functional processes disclosing how human rights are embedded into the operations of the unit in dealing with pregnant IPV victims. This research revealed that officers in DOVVSU are trained to advocate for the victims' rights of being provided with qualitative health care, legal aid, and protection and recommended that 78% of recorded cases be provided efficient services.

However, DOVVSU has some operations structures that reduce its effectiveness in delivering its role effectively in society. Another appraisal by Kaburi & Kaburi, (2023) noted serious shortages of assets: for example, out of 167 offices only 70 were considered to have sufficient amenities for special considerations for the victims and investigation processes. In addition, Sedziafa & Tenkorang, (2024) interviewed some DOVVSU officers from five regions, arguing that less funds, personnel, and poor training, negatively impact the delivery of services. Furthermore, Tenkorang, (2022) established that culture is another challenge where a number of the women offered tradition and family interference hence the women cannot report their cases to DOVVSU especially those in the rural areas where the fight is believed to be a family affair.

2.6 Summary and gaps in the literature

Few studies examine the role of legal and institutional frameworks for the support of pregnant women who are IPV victims, especially in regions like sub-Saharan Africa, despite the fact

that there is a wealth of research on IPV and its general health implications. This lack of research makes it difficult to understand the kind and scope of the combined burden of poor maternal health and IPV, as well as to guide policy actions that adequately address both problems. Also, the right to health focuses on the fundamental rights of pregnant women experiencing IPV and highlights the roles of legal frameworks and institutions to promote, protect, and fulfill this right.

Furthermore, there is insufficient information to ascertain how precisely these international instruments have been domesticated and applied in healthcare policies regarding IPV among pregnant women, despite the fact that the UN's CEDAW, and the African Charter on Human and Peoples' Rights all outline women's rights. Agarwal et al. (2023) provide a working example when they state that a policy barrier is that politicians are often unaware of comprehensive information about violence and how it affects maternal health. An important component of both global and regional health strategic planning is this orientation, which is a glaring under-identification of a particular illness.

Chapter Three

Methodology

3.1 Study design and approach

This study adopts a qualitative research design with a human rights-based framework to explore the complex legal, social, and institutional aspects of protecting pregnant women experiencing IPV. This design is appropriate for achieving the study's objectives of understanding institutional responses, and the effectiveness of legal frameworks in addressing IPV. The study focuses on the perspectives of key stakeholders, including maternal healthcare providers, and institutional actors such as the DOVVSU officials, all within the Tamale metropolis in Ghana. Consequently, the study employing qualitative methods is crucial since it would be able to examine how these actors negotiate legal requisites and service delivery in preventing IPV among pregnant women.

3.2 Selection and Sampling

During the selection process, a healthcare provider in the study setting (helped the researcher contact the right hospital administrators and in-charges within the Tamale metropolis. These in-charges, aware of the healthcare professionals within their institutions, recommended appropriate maternal health providers for the study. The researcher, with the assistance of Fayaada Saeed who is a sister to the researcher, administered online questionnaires and telephone calls to the in-charges of the hospital. Some of these in-charges have also helped in identifying maternal health providers who met the necessary criteria of the study.

Purposive sampling was used to identify maternal healthcare providers that they had worked with pregnant women experiencing IPV. This sampling technique allowed for the selection of respondents with practical experience in handling cases of IPV. Having been given by the hospital in-charges, the healthcare providers were then contacted online. This form of communication organization was convenient in a way of reaching consensus regarding schedules for the interview and the times the participants could be available.

3.3 Study population

This study focuses on two group of key informants: The maternal healthcare providers and officials of the DOVVSU. Both groups assume certain roles in managing and treating IPV against pregnant women, which situates them directly in the center of the research aims. Maternal healthcare providers are in a good position to recognize and quickly resolve IPV-risk behavior through high-quality, trust-based patient-physician interactions (Anguzu *et al.*, 2023). Pregnant women could be more likely to confide in these healthcare providers and tell them about IPV to receive the proper support and assistance (Alshouibi, 2022). Gender and their experiences and insights will be very important in determining how IPV cases are handled inside and outside the healthcare legal systems. The clinicians who care for pregnant women are most of the time the ones who first encounter the pregnant woman who is a victim of IPV. They are in a better condition to identify and treat all the physical, psychological, and social impacts that IPV has on pregnant women. Also, DOVVSU sometimes work closely with healthcare professionals, social workers, and counselors to provide a requisite combination of services in confronting IPV. This collaboration also makes sure that as pregnant women are in touch with health care providers, especially for anti-natal checkups, they will be promptly referred to DOVVSU in cases of IPV. The officials at DOVVSU are equally charged with the responsibility of applying the law as well as the legal rights of the pregnant victims of IPV. These tasks include handling complaints, exercising investigation functions, performing victim services, as well as being responsible for the coordination of referrals to legal and social assistance. The insights the officials provide regarding the practical implications of law enforcement pertaining to pregnant women are crucial in evaluating the effectiveness of the law in handling the pregnant victims of IPV.

3.3.1 Inclusion Criteria and Justification on Maternal Health Care Providers:

Maternal health care providers are usually the first point of contact of pregnant women during their antenatal visits and also as they seek medical health care through out the period of their pregnancies, this places maternal health care providers in a unique place to identify signs and symptoms of abuse during pregnancy and offer them appropriate support systems and care services. Also, health care providers are well trained to offer counsel during sensitive

situations, placing them in a significant place to respond to the specific needs of IPV victims. The maternal healthcare providers were chosen based on the following criteria:

1. Midwives, nurses, and doctors involved in maternal healthcare service. Their duties involved direct contact with pregnant women, putting them in a good position to address cases of IPV.
2. Maternal healthcare providers with a minimum of two years of experience in maternal healthcare were selected. Experience of two years guarantees that the healthcare providers may have come across cases of IPV and have developed professional appreciation of the health and psychosocial requirements of pregnant women experiencing IPV.
3. Participants were only selected if they directly had been involved in managing or caring for pregnant women with IPV. Participants who directly deal with pregnant women will be able to provide responses that are relevant to the research objectives.

3.4 Sample Size

Eight maternal healthcare providers and DOVVSU officials were selected; this is an adequate number to include in qualitative research to reach data saturation—a point beyond which no new themes are identified during interviews. This sample size enabled the capture of a wide variety of experiences and perspectives, yet at the same time, it had a manageable amount of data for analysis.

3.5 Data collection tools

Structured and semi-structured interviews were done among the maternal health care providers and DOVVSU, in which both of them were interviewed on the telephone. These guides proved useful in facilitating the collection of more detailed information about the study goals. In order to examine how legal obligations safeguard pregnant women experiencing IPV, a structured interview was conducted with the maternal healthcare providers. The questions focused on what national and international legal requirements they encountered in their profession and what difficulties they experienced when implementing them. An interview schedule retaining some level of structure was used based on which the researchers explored the difficulties

experienced while accessing referral services, including safety shelters and psychosocial support. Interventions described by healthcare providers provided insights into challenges pregnant IPV survivors had to undergo. Regarding the DOVVSU officials, another semi-structured guide was developed to understand their perception of the process through which they help pregnant IPV survivors' access referral services. The questions were directed at how DOVVSU worked with maternal healthcare service providers and other services and what human rights have been violated by against IPV victims.

3.6 Data collection process

Phone interviews were useful in this study because they do not require participants to come to a physical location for data collection, and instead participants can decide when they are ready to be interviewed. The kinds of interviews conducted, which were the phone interviews, made sure the respondents could easily answer the research questions. Furthermore, for developing information on legal requirements for protection of pregnant women experiencing IPV, a structured interview guide was used. This technique entailed asking participants questions to get information from the maternal healthcare providers on their knowledge and utilization of legal instruments. In addition, to elicit more exploratory, descriptive information, especially concerning access and the operation of DOVVSU about the referring service, phone interviews were employed. This technique helped to maintain the spontaneity within the conversation, and consequently, the participants were able to offer elaborate information on their experiences and perceived difficulties, mainly within the framework of addressing IPV cases. In each interview, the participants were asked permission to record the interview to enhance the credibility of the data collected. In addition to the recording of the interviews, notes were also taken during the interviews.

3.7 Data analysis

Data analysis for this study was done thematically; this is a qualitative approach that entails identification, coding, and interpretation of patterns (themes) from phone interviews with the maternal healthcare providers and the DOVVSU officials. Thematic analysis was chosen because of its flexibility in interpreting qualitative data which is crucial when exploring

essential social issues such as IPV. This enabled the researcher to examine the various aspects of IPV support system, and personal experiences. The first method involved playing back the recorded interviews as well as going through the notes made during them. This made it easier for the researcher to go deeper into the data and develop a better understanding of it, as well as the first patterns that came out of the discussions. This particular aspect was followed by transcribing the recorded interviews in a more or less verbatim style to obtain a text-based data set. The transcription was crucial for getting the real words uttered by the participants, which would be later analyzed in a methodical approach. After the transcripts, the next step that followed was coding. This involved reviewing the transcribed content line by line and labeling the text as per code meaningful segments. These codes included topics or concerns voiced by the participants. The different codes were then grouped to form themes. The themes are the wider concepts that merge patterns of concern in relation to the research questions.

3.8 Data accuracy and reliability

To improve the accuracy of the data collected, the researcher got clarifications from the ones undergoing the phone conversations concerning statements that are not clear. It assuredly helped to make sure that the participants' views were interpreted clearly in light of the research objectives. This data was collected from both maternal healthcare providers and DOVVSU officials, enabling the cross-validation of information. The triangulation contributed to the accuracy of the findings by contrasting and comparing the perspectives of different key stakeholders throughout the IPV and maternal healthcare system. Additionally, prior to the main interviews, pilot interviews among 5 participants with similar characteristics like the current population were performed to refine the questions and approach to get proper and similar answers. This step increased the reliability of the interview steps, and the questions were clear and understandable. To ensure the reliability of the data, the interviews were also enough to reach data saturation. This indicates that the collected data is comprehensive and represents the views of the participants.

3.9 Ethical considerations

All the participants were well informed about the study's purpose, their role, and potential use of the data collected. They were also informed that their participation in the study was entirely voluntary, and they can stop the interview process at any time without consequences. Steps were also taken to protect the participants identity. No personal identifiers were included in the final transcripts or analysis. Pseudonyms or anonymized codes were used when quoting participants to protect their identities. Participants were informed about how their data would be used, including its inclusion in research reports, presentations, or publications. They were reassured that their responses would be aggregated and not attributed to them directly.

In addition, the study participants were informed about how the data would be utilized. They were also informed that the responses they provided could be published in research articles, reports, and academic presentations. Also, participants were made aware of the procedures involved in management of the data for data handling and confidentiality concerns which included secure data storage and access given to authorized research person. During the period of the interviews, the participants has access to contact information for the researcher in case they needed any further clarifications or had further questions regarding the study. This was crucial in building trust, prioritizing the comfort and safety of participants, and encouraging open communications.

Chapter four

Results

4.1 Awareness of national frameworks by maternal healthcare providers

Maternal healthcare providers, particularly those in direct contact with pregnant women who are victims of IPV, demonstrated strong familiarity with national legal frameworks such as the Domestic Violence Act and protection orders. These maternal healthcare professionals stated these laws are essential guides in their work, allowing them to help counsel patients when IPV is suspected. They sometimes have to explain legal options to the victims and, to help them, provide shelter referrals like legal aid.

"I know the national laws, and we have procedures about how to act when we see cases of abuse." We say... the Domestic Violence Act... when we advise patients."
(52-year-old, Female, General Practitioner)

"We want to help patients know about the protections, like protection orders, in the laws that protect victims." However, many of them say the legal process is too complicated or intimidating." (Male, Nurse)

The maternal healthcare providers acknowledged necessary legal obligations under the Domestic Violence Act, and one states that its protocols are followed in the case of violence. It is in line with the 'accountability' and 'participation' principles of HRBA (The right to health). The accountability principle necessitated the duty bearers (including maternal healthcare providers) to be aware and follow up with the legal framework to protect the pregnant victims of IPV. In this case, the maternal healthcare providers are fulfilling their roles by referring to the Domestic Violence Act and offering advice and assistance to victims. This means they are helping in upholding the right to health and the right to protection from violence, both fundamental rights are under the international human rights law, including the CEDAW. However, while the presence of protocols and knowledge of the Domestic Violence Act is a positive step, the effectiveness of these protections hinges on how well they are implemented and accessible to the rights holders, in this case, pregnant women experiencing IPV.

The findings also touches on a significant issue highlighted in the HRBA which is the right to good health. The nurse mentions that many victims feel that the legal process, which includes obtaining protection orders, is complicated and intimidating. This shows a gap between legal frameworks and the practical realities of accessing justice and protection, aligning with the right to health's focus on non-discrimination and equality. Pregnant women, as victims of IPV, are entitled to legal protections under the law, but factors such as complex legal procedures, intimidation, and fear can obstruct their access to these protections. The barrier of complexity can be viewed as a human rights violation because it prevents victims from effectively claiming their rights to protection and safety. This suggests that procedural justice is lacking, meaning the law exists, but its practical application may be difficult to navigate, particularly for vulnerable groups like pregnant women. Legal protections are only meaningful if victims can access them without discrimination or unnecessary hardship. In this case, simplifying the legal process, providing legal aid, and offering culturally sensitive guidance to navigate these systems are key recommendations that would better align with a human rights-based approach. Moreover, these legal frameworks directly influence the work of maternal healthcare providers, as many of them are required to report suspected cases of IPV and offer resources to victims:

"It's part of our job to explain to patients their rights and options under the law. Sometimes we facilitate access to legal aid or refer them to shelters, but it's always their choice whether to proceed legally." – (28 year old Female, DOVVSU official)

The current finding contrasts sharply with a previous study where the participating nurses regarded responding to cases of IPV as a personal choice (Briones-Vozmediano *et al.*, 2022). Moreover, the findings of the study show that maternal healthcare providers were not familiar with international frameworks. This could be attributed to the training they receive from the universities and colleges. A prior study conducted to assess the attitudes of Ghanaian nurses towards IPV revealed that there was no mention of IPV in the nurses' training curriculum (Länsberg and Persson, 2013). According to research in 2019, about 20% of the nursing education programs in Spain lacked this subject on IPV (Maquibar *et al.*, 2019). According to a previous finding, an educational program that includes an IPV component strengthens the likelihood that newly graduated students will have the skills they require to handle and support

pregnant women who are victims of IPV when they enter the workforce (Schaefer *et al.*, 2021). Each nurse's professional approach will be influenced by their training, which will ultimately impact how they respond to IPV. But even if training broadened understanding, it might not have done much to remove myths about IPV that hindered the ability of healthcare services to develop a response (Maquibar Landa *et al.*, 2018).

The emphasis on the victim's choice to proceed legally reflects the HRBA principle that rights holders (victims) must be empowered to make informed choices without compulsion. This aligns with the right to self-determination, a core element of human rights, which mandates that individuals have the freedom to make decisions regarding their needs, and preferences. The right to choose is particularly significant in the context of IPV, where victims often experience power imbalances and compulsion in their personal lives. By ensuring that victims are informed of their rights and options, and respecting their decision whether or not to pursue legal action, the social worker is facilitating informed consent. This is critical in maintaining the dignity and agency of pregnant women who may already feel powerless due to abuse. The social worker's role in educating women about their legal rights and directing them to support services also points to the need for stronger institutional mechanisms. The right to health emphasizes the importance of institutional capacity to protect human rights, which in this case includes having trained social workers who understand the complexities of IPV, as well as accessible legal services and supportive shelters. The existence of these services is crucial, but there needs to be more focus on ensuring that these services are effectively used by those in need.

4.2 International frameworks

Maternal healthcare professionals expressed less familiarity with international legal frameworks such as the CEDAW or the Istanbul Convention. Although these frameworks aim to provide comprehensive protections against IPV on a global scale, they were perceived as less relevant to everyday practice.

"I'm slightly aware that international laws are in place to protect women from violence, but in my work, we focus more on the national guidelines. Those are the laws that apply to our cases and that we need to follow." – (Male, Emergency Room Doctor)

"I know international organizations are working to fight gender-based violence, but we rarely refer to those in our practice. It's the local and national laws that affect what we do."
– (Female, Midwife)

The lack of engagement of maternal healthcare providers with international frameworks can have significant implications for patient care. The right to health posits that recognizing and promoting human rights can lead to better health outcomes. If maternal healthcare providers do not know about international standards, then they may not push hard enough for women's rights—their right to health, safety, and freedom from violence. This perpetuates a cycle of no one telling patients of their rights and protections available for gender-based violence. Incorporating education on international human rights law in the professional training of healthcare providers can increase understanding of how those individuals can fully protect women from violence. This is particularly true with the HRBA (The right to health), which articulates that health workers should not only have legal knowledge but also understand the human rights environment in which their practice occurs. When asked how these frameworks influence their work, healthcare professionals emphasized that national laws, in particular, dictate many aspects of patient care, reporting, and referrals:

"We follow the national legal framework guiding how we respond to IPV cases." We're documenting injuries; we're reporting any case of abuse; in certain cases, we refer the patient to legal services. They determine how we behave towards victims."
(32 year old, female, psychiatrist)

"We, however, work hand in hand with law enforcement whenever there is a case of IPV." It's our job to make sure victims are protected by the law, and you know, the system's never always as responsive as it should be." (36-year-old, Male, Nurse Practitioner)

The national legal framework 'defines what the services provided in the cases of IPV are according to,'" as said by the female psychiatrist, that 'defines how it is that we do address

IPV cases.' This is the latter and a human rights obligation of healthcare professionals to protect the rights of their patients. The need for documentation of injuries and reporting of abuse creates an effective mechanism to protect the rights of victims and to give them the required care they need. Healthcare providers who follow these legal laws are acting ethically and professionally and fulfilling their ethical and professional obligations by way back principle of accountability for healthcare settings. Important to understand is the fact that IPV cannot be addressed effectively inside the walls of the hospital or clinic but rather requires the work of every corner of the field, and representation is often the key to achievement of that. This takes on a human rights dimension in that it enables a response to victim's needs, which is a coordinated response.

4.3 Healthcare providers role in protecting and supporting pregnant women of IPV

Maternal healthcare providers perceived their role in protecting and supporting pregnant women who are victims of IPV as multifaceted, involving clinical care, emotional support, legal advocacy, and coordinated referrals. They recognized the heightened vulnerability of pregnant women and stressed the importance of using their position to detect and address IPV.

“We take it into account when women have had a particularly vulnerable pregnancy.” As an obstetrician, I view it as my responsibility to treat their medical needs but equally provide a safe space in which they can come forward regardless of whether abuse is taking place.” (44 year, Female, obstetrician)

“We are uniquely positioned to ask about IPV in the course of a regular checkup.” So it's our role as males or midwives to start that conversation and to make sure they do feel supported.” (35 year, Male, Nurse)

A crucial part of the female obstetrician's knowledge of the link between pregnancy and being extremely vulnerable is their recognition of "pregnancy as a time when women can be especially vulnerable" and the consequently inherent dangers surrounding the issue of IPV. In line with human rights principles, it brings into view the particular needs of vulnerable populations. There are increased chances of women being in abusive situations during

pregnancy, as the emotional and physical challenges during pregnancy are also more. Knowing this vulnerability gives healthcare providers the ability to provide pregnant women the assistance and care they need.

This is in part due to the nurse practitioner arguing that such screening is "it's part of our job," that is, our responsibility to keep patients safe. This is in accordance with the human rights idea of health as a human right. Healthcare providers are screening for domestic violence as they recognize that IPV may touch the physical and mental health of women, particularly when they are pregnant when they are at the highest risk.

‘It’s our job to alert those pregnant women and any other people we screen for domestic violence that they may be at higher risk.’ That’s why we ask the difficult questions because maybe it could save their lives.” (31 year old, female nurse practitioner)

“We offer more than just medical support; we try to offer emotional help — because a lot of these women feel trapped.”(30 year old, female nurse practitioner)

The practitioner's acknowledgment of the requirement to report cases of IPV highlights the dual role of healthcare professionals: Both are advocates for patient safety and enforcers of legal obligations. Mandatory reporting is supposed to protect vulnerable individuals but it poses ethical dilemmas to practitioners and distress to patients. In the context of human rights, such reporting obligation has to be balanced between protecting patients' lives and at the same time respecting their autonomy, and their rights to choose how they will respond in a case of violence.

“A few women do fear it will get worse if they report because they depend on their partner for money or they’re afraid of child protection services” – (33 year old, Male Nurse)

Several healthcare providers expressed concerns that the legal requirement to report abuse might deter some women from disclosing their experiences:

'At times it's hard because when the legal requirements are in place, women become hesitant to open up.' One, they may not want to take legal action, and therefore may fear they'll lose control over the situation. We try to be clear on that, ultimately, it's their safety that is our priority.'(35 year old, Female, Nurse)

The nurse's emphasis on prioritizing patient safety reflects a core principle of the human rights-based approach: safety and security. As women are unlikely to come forward if they feel legal requirements could compromise their safety or autonomy, there is an obvious need to rectify this balance. A supportive environment to promote open dialogue, and showing the patient that his or her well-being is the priority rather than just a legal obligation should be encouraged. Finally, the psychiatrist's descriptions of the tension between legal obligations and compassion in sensitive engagement highlight the requirement for healthcare systems to cultivate specific guidelines that balance these two points.

4.4 Referral services for pregnant women experiencing IPV

Maternal healthcare providers in the Tamale Metropolis mentioned that a cluster of referral services to pregnant women who were victims of IPV, including safe shelters, psychosocial support, and legal help, were available. With this, they pointed out that for these services, accessibility was limited by many barriers, including stigma, lack of awareness, affordability, and infrastructural issues. However, providers also identified a few key services to care for pregnant women with IPV, although they perceived the range of services to be somewhat limited:

'Of course, there are counseling and support groups,' we recommend to our patients, 'as these are psychosocial services.' "We work with social workers who can help pregnant women that are victims of IPV navigate these services." (28-year-old, Male, Obstetrician)

"That includes legal aid services, which are part of what we refer to. We do have connections to other organizations that can help women if they need someone to help them file for protection orders or to get legal advice. Some women do not need help with filing

for protection orders, but they need help getting through court.”– (28 year, Female, Social Worker)

The obstetrician’s statement reflects an understanding of the holistic needs of victims, recognizing that support extends beyond physical health to include mental and emotional well-being. From a human rights perspective, access to these services is vital as it aligns with the right to health, which encompasses mental health care and psychosocial support.

4.4.1 Accessibility of Services

“Most women don’t know about the services until we tell them. Awareness is low, so they don’t even realize that shelters or counseling are options for them.” – (28 year, Female, Midwife)

What is most striking is that the midwife’s statement, ‘most women don't know about the services until we tell them, ‘Highlights that the biggest gap in terms of awareness is who offers what—for shelters and counselling, for example. The human rights-based approach means that everyone is entitled to information that impacts his or her well-being. Women’s right to protection and support is infringed upon by a lack of awareness because this leads to women’s ability to make informed decisions about their safety and health. The principle of non-discrimination makes it a duty to make all services equally accessible to everyone, whatever their economic and social standing. Several barriers, however, highlight the difficulty of accessibility: the shelters are often full, pregnant women have trouble getting there due to transportation issues, etc. Lack of transportation, financial constraints, and the shelters being overloaded are some of these obstacles.

“Even when we make referrals, accessing the services isn’t always easy. The shelters are often full, or women have trouble getting there because of transportation issues.” (Male, General Practitioner)

The maternal healthcare providers also pointed to stigma as a major obstacle preventing pregnant women from seeking or using available services. A previous study discovered that a lack of staff and an excessive workload were the main obstacles to IPV screening procedures

(Musa-Maliki and Duma, 2024). This is typical in the majority of African nations as well as other foreign nations. Hatcher et al. discovered that routine IPV screening of women was not being done in South Africa because of a lack of personnel (Hatcher *et al.*, 2019). The availability of institutional support for IPV aided the maternal healthcare providers in discharging their responsibilities to pregnant women.

“There’s a lot of stigma around leaving a partner or seeking help, especially for pregnant women. They worry about how they’ll be judged by their family and community. That makes it harder for them to accept referrals to shelters or even counseling.” – (Female, Social Worker)

Financial barriers were another significant challenge, with many victims unable to afford transportation to shelters or legal services:

“Most of these women are financially dependent on their partners, so even if they want to leave, they don’t have the money to get to the shelter or pay for transportation to come to appointments.” – (Male, Nurse)

Some providers also mentioned that psycho-social and legal services were often overburdened, leading to delays in assistance:

“Counseling services are available... It’s not uncommon for women to have to wait for appointments or for shelters to be at capacity, leaving them in dangerous situations longer than they should be.” (Female, Psychiatrist)

Prior research has revealed a lack of institutional support for IPV screening, including institutional permissions, approvals, directives, and policies that formalized midwives' screening of pregnant women for IPV as barriers to assisting IPV victims (Musa-Maliki and Duma, 2024). The results of Clark et al. and Kosiak et al. are consistent with this (Clark, Renner and Logeais, 2020; Kosiak *et al.*, 2022). IPV screening was affected by the ambiguity surrounding what to ask, when to ask it, and what to do when IPV was revealed (Kosiak *et al.*, 2022). According to a comprehensive evaluation of screening programs, successful screening programs have a clear screening processes, sound policies, and support from hospital

administration (Alvarez *et al.*, 2017). Although they might not be in practice, the exterior obstacles to IPV screening seem simpler to overcome. Midwives are currently experiencing a rise in burnout and a decrease in staffing. This could be attributed to the reason that more healthcare workers are moving to high-income nations for greater welfare (Onah *et al.*, 2022; Musa-Maliki and Duma, 2024).

4.4.2 Steps to improve access to referral services

Maternal healthcare providers emphasized the need for targeted improvements in both service accessibility and awareness to better support pregnant women experiencing IPV. Solutions suggested included increased financial and transportation assistance, community outreach programs, better coordination between healthcare and legal services, and expanding the capacity of shelters and counseling centers. Some providers also noted successful programs but indicated that more comprehensive, sustainable efforts are needed. Maternal healthcare providers proposed several practical steps to improve access to referral services for pregnant women facing IPV:

“We need more financial support for these women. If there were transportation funds or stipends available, it would make it much easier for them to access shelters or legal aid without relying on their partners.” – (Female, Social Worker)

“Improving awareness is critical. Many women don’t know about the services that exist. There should be more outreach programs, maybe through community health workers or radio programs, so women in remote areas or without formal education know how to get help.” – (Male, General Practitioner)

“There should be more strengthened coordination between healthcare providers, social services, and legal teams. Right now, we sometimes lose track of women after we make a referral. A case management system where we could follow up with social workers or legal professionals would help ensure women don’t fall through the cracks.” – (Female, Midwife)

Increasing the capacity of existing shelters and psycho-social services was another frequently cited suggestion. According to a paper by Rossiter et al. (2020), IPV support workers working in community-based settings in the United States and Canada might not always be compensated fairly, receive health benefits, or be acknowledged for their efforts (Rossiter *et al.*, 2020). IPV specialists often struggle to provide high-quality services because of a lack of funding and policies within the organization, a shortage of community resources, and a lack of information that survivors can easily access (Alani and Stroink, 2015).

“We need more shelters with the capacity to handle the demand. There are too few options, and they’re often full. Expanding shelter space and having specific facilities for pregnant women would make a big difference.” – (Male, Nurse)

Maternal healthcare providers also stressed the importance of addressing cultural stigma through education:

“Cultural education campaigns could reduce the stigma associated with seeking help. If the community understands that IPV is a serious issue and that it's okay for women to leave abusive relationships, more women might feel comfortable reaching out.” – (Female, Obstetrician)

Some maternal healthcare providers highlighted current initiatives that are making a positive impact, though they noted that these programs often require scaling and sustained support:

“With some community outreach programs, for example, social workers going to homes and communities to discuss IPV, we’ve seen some success.” A woman can share more personal information, and it’s easier to build trust, making it easier for women to come forward.” Female: social worker

4.5 Role of DOVVSU officials

According to officials at the DOVVSU, however, the varied nature of their role in assisting pregnant victims of IPV to protect themselves and their unborn babies included providing legal protection, helping victim’s access psychosocial assistance, as well as encouraging access to

essential services such as shelters and counseling. The workers held great commitment to the responsibilities they have; however, they are keen to acknowledge that they are confronted by numerous challenges, such as resource limitations, the huge gauge, and delays in administration conveyance, which straightforwardly adversely influence the general efficiency of the unit. Workers at DOVVSU outlined the key responsibilities they undertake to assist pregnant women experiencing IPV:

"Our role is to take care of the victims and ensure that they are safe." 'We help them to file complaints, have legal support to request protection, and when needed, we do arrange police protection.' – (Female, DOVVSU Worker)

“We also provide emotional support. When women come to us, they are often traumatized. We listen to them and reassure them that they are not alone, and we explain their rights under the law.” – (Female, DOVVSU Counselor)

DOVVSU workers are tasked with guiding pregnant women through the legal process, assisting them in filing complaints, obtaining protection orders, and referring them to other necessary services, such as shelters or legal aid. They also coordinate with law enforcement when the situation requires immediate intervention.

4.5.1 Effectiveness of DOVVSU Workers

While DOVVSU workers strive to fulfill their responsibilities, they noted several challenges that limit their effectiveness. High caseloads and insufficient resources were commonly mentioned:

“The demand is high, and we are often overwhelmed with cases. There are not enough personnel to handle every complaint quickly, which sometimes leads to delays in processing protection orders.” – (Male, DOVVSU Worker)

“We do our best to help every woman who comes to us, but we don’t have enough resources. Shelters are often full, and sometimes there aren’t enough counselors available to provide timely support.” – (Female, DOVVSU Officer)

Despite the crucial role played by the DOVVSU workers, the officials highlighted several challenges that could limit their effectiveness. These challenges include high caseloads, insufficient resources, and slowing down of their work due to legal and enforcement systems. Kaburi & Kaburi, (2023) highlighted shortages of assets that affect the effectiveness of DOVVSU. For instance, the study reported that only 70 out of 167 offices were noted to have enough amenities for special consideration for the victims as well as the investigation procedures. Moreover, Sedziafa & Tenkorang, (2024) interviewed some DOVVSU officers from five regions, arguing that less funds, and personnel, poor training, negatively impact the delivery of services. Tenkorang (2022) also established that culture is another challenge where a number of the women offered tradition and family interference hence the women cannot report their cases to DOVVSU especially those in the rural areas where the fight is believed to be a family affair. Workers also pointed to issues with the legal and enforcement systems that slow down their ability to provide timely assistance:

'Slow legal process is one of the biggest challenges'. 'We help women file for protection orders' (Female, DOVVSU Counsellor).

The role of officials of the DOVVSU is aligned with a human rights-based approach to addressing IPV and their comments about how to improve services for pregnant women IPV victims. DOVVSU's mandate, they said, was consistent with human rights principles as it is meant to protect and uphold the rights of victims, but they admitted that it can be improved through having an understanding to better cater to the needs of pregnant women who are victims of IPV. DOVVSU officials noted that their role is fundamentally aligned with human rights principles, which emphasise the protection and promotion of victims' rights:

“We’re there to protect the rights of victims of IPV, including pregnant women.” It includes working to get them protecting orders, keeping them safe, and helping them access legal and social services. 'We are ready to uphold their human rights.' Female, DOVVSU Worker

'We resist and respect the autonomy of the victims.' "They have the right to know of their rights and options, and we help them do the right thing for their safety and legal actions." (Male, DOVVSU Officer)

According to Yalley, (2019), DOVVSU can be regarded as a crucial law enforcement agency involved in the prosecution and investigation of cases of domestic violence while offering a temporary shelter to the victims. The current finding is consistent with a previous study by Tenkorang, (2022) who found in their study involving 50 IPV survivors, DOVVSU has social roles of offering medical referral services, emergency shelter, and the coordination of legal services for some, specifically pregnant women. The role of DOVVSU is consistent with a human rights-based approach in protecting and promoting the rights of IPV victims, including pregnant women, and providing them with legal and social support. Nevertheless, using more resources and staffing and expanding specialized services for pregnant women were suggested, which includes expanding outreach to and education to the communities; improving coordination with other service providers; and better follow-up systems.

This approach of DOVVSU is in line with offering legal protection, enabling participation in safe shelters, and giving psychosocial support, all of which show it stands to protect human rights. But officials said they aimed to empower victims and foster a supportive environment that recognizes victims' dignity and choices. Despite their alignment with human rights principles, the officials identified several ways DOVVSU could improve its services to ensure better access to referral services for pregnant women:

“To do that, we’d need one major improvement—and that would be to increase our resources and staff.” At this moment we are stretched thin, and this limits our capacity to offer a good sense of timing and follow-up services. ‘We would be able to do more with more funding and personnel,’ (female DOVVSU counselor.)

4.5.2 IPV against pregnant women and human rights violation

In addressing the research question, "Does IPV against pregnant women amount to a human rights violation, and what are the implications?" interviews with maternal healthcare providers and officials from the DOVVSU in the Tamale metropolis revealed several important insights.

These findings, based on first-hand experiences, underscore the profound impacts of IPV on pregnant women's health and access to justice, framed within an HRBA.

4.5.3 Recognition of IPV as a Human Rights Violation

Maternal health care providers and DOVVSU officials consistently acknowledged that IPV against pregnant women directly violates several fundamental human rights which is their right to health which are enshrined in international human rights frameworks such as the Convention on the CEDAW and national laws, including Ghana's Domestic Violence Act.

One maternal health provider stated:

'If a pregnant woman is physically or emotionally abused, then her right to health has been compromised.'

For that reason, it is considered that the unborn child is a living and continuing member of the family. It typically goes hand in hand with pregnancy complications that can be detrimental to her and her baby. It is a violation of their right to health." The findings of this study revealed that IPV meted against pregnant women directly violates several fundamental human rights including the right health, which are enshrined in international human rights frameworks and national laws. The current finding is in line with Eikemo et al. (2023) who revealed that, although IPV against pregnant women is a violation of several basic human rights, it violates key human rights including the right health. Moreover, Raziani et al. (2024) reported in their study of 450 pregnant women, where most of whom were victims of IPV, that violence against such women interferes with their capacity to exercise their basic freedoms and rights; maternal and fetal rights to health.

Similarly, a DOVVSU official remarked:

'IPV is a violation of human rights because it infringes on these women's dignity.' In addition, it deprives them of the services they require: health care or legal assistance; as a result, they fear or are ashamed to pursue.'

Maternal healthcare providers have also observed that severe reproductive health complications from IPV, such as miscarriage, preterm labor, and high blood pressure, are clear threats to the right to health. Additional health impacts identified included psychological trauma, stress, and depression.

A maternal health worker emphasizes:

"Cases have been observed and fear of a partner's violence ultimately ingrained in pregnant women developing high blood pressure or another complication." It affects the unborn child. We considered this an emergency, but many women are afraid to report it and get help."

Implications for IPV amounting to the violation of the right to health

The law recognizes IPV as a crime, but pregnant women often struggle to access justice and support services as a result of stigma, fear of retaliation, and not knowing their rights, officials of DOVVSU said. further, many women do not report abuse because they fear being judged or their economic consequences.

One DOVVSU officer shared:

"Many pregnant women don't feel empowered to come forward because the law is there to protect them." If they leave their abusive partners, they are afraid they will be judged or lose their economic support."

Another added:

"We see cases where women are reluctant to seek help because they depend on their abusive partners financially. They know their rights are being violated, but they feel trapped."

From a HRBA perspective, maternal healthcare providers perceive the impact of IPV on pregnant women's physical and mental health as a violation of the right to health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights) and the right to health

(Article 6 of the ICCPR). A direct violation of these fundamental human rights is when IPV leads to health complications or places a woman and her unborn child in danger of death. The HRBA also imposes the principle of non-discrimination. Women who are pregnant and victims of IPV form a vulnerable group that is further undermined by its gender, dependency on the economy, and social stigma. In this case, the failure to protect these women from violence and to provide them with access to health care and legal recourse is a failure to ensure these women have equal protection under the law. Moreover, there are many women who are afraid or not empowered; they refuse to seek justice or access to health services—violating the HRBA principle of participation.

A study conducted by Zampas et al. (2020) concerning health care reforms where regions implementing a human rights approach to tackle IPV during pregnancy improved substantially by 45% with regards to the capacity of the concerned service providers to offer quality services to victims of IPV. To promote human rights, we should make sure that pregnant women are able to make informed decisions about the health of their unborn babies while also being able to safely report abuses without the risk of retaliation. They found that more work needs to be done to help these women empower themselves and participate in seeking justice. Also, the DOVVSU plays an important role in ensuring that perpetrators face justice and in providing access to justice, which is a core HRBA. The lack of accountability mechanisms can be attributed to the reluctance of many women to report or seek justice for IPV. For effective protection of their rights and the necessary support services like shelters and legal aid these women are already provided by law, the HRBA requires assembling a strengthened legal and institutional framework

Chapter Five

Conclusion

5.1 Summary of findings

In summary, the present study revealed a strong awareness of legal frameworks such as the Domestic Violence Act and protection orders by maternal healthcare providers. The national laws play an important role as it helps them provide appropriate counsel to pregnant women who are victims of IPV. The study also highlighted that pregnant victims of IPV, are entitled to legal protections under the law, however, elements including intimidation, complex legal procedures, and fear can prevent their access to these protections. On the other side, maternal healthcare providers show less awareness in terms of international frameworks. This finding shows that there's also plenty of room for improvement in healthcare practices, as the participants indicated in the study. Health education and training are required to increase awareness and the provision of skills to translate international frameworks into practice. The insights imply that a gap needs to be closed between international frameworks and national practices and requires targeted training and policies to bridge that gap.

The roles of maternal healthcare providers revealed in this study include emotional support, clinical care, coordinated referrals, and legal advocacy. The acknowledgment of psycho-social services, such as counseling and support groups in this study, highlights the importance of mental health and emotional support for pregnant women facing IPV. Financial constraints, lack of transportation, and the shelters being overloaded are some of the barriers reported to prevent women from seeking shelters in this study. Stigma was also a factor which was mentioned to have an effect on pregnant women experiencing IPV in terms of seeking for shelters. Some of the ways that were suggested to aid in improving access to these shelters include community outreach programs, increased transportation and financial assistance, improved coordination between legal services and healthcare, and expanding the capacity of counseling centers and shelters.

Concerning the roles played by DOVVSU helping pregnant women who are victims of IPV, several roles were reported to include providing legal protection, helping victim's access

psychosocial assistance, as well as encouraging access to essential services including counseling and shelters. The DOVVSU officials highlighted that their role is consistent with the principles of human rights (right to health), which emphasise the promotion and protection of victims' rights. Some of the ways highlighted by the officials to improve services include increasing staffing and resources. The DOVVSU officials and maternal health care providers acknowledged that IPV against pregnant women violates the right to health. Some of the complications from IPV that are clear threats to the health of pregnant women include preterm labor, miscarriage, and high blood pressure. Moreover, stress, depression, and psychological trauma are some of the health outcomes of the complication. The DOVVSU officials noted that stigma, fear of retaliation, and not knowing their rights were some of the factors affecting pregnant women of IPV in accessing justice and support services.

Policymakers should therefore strengthen the training and awareness of maternal healthcare providers by providing comprehensive training concerning international frameworks on women's rights and IPV. There should be compulsory IPV sensitivity and human rights training which should be included in the continuing education of the maternal healthcare providers at the TTH. The government of Ghana should also increase funding to expand the capacity of counseling centers and shelters. Moreover, healthcare providers at TTH as well as DOVVSU officials should strengthen their community support and outreach programs. Furthermore, there should be an improvement in the coordination between the healthcare and legal systems by creating a coordinated referral system. Non-Governmental Organisations should also support pregnant women in terms of their transportation and financial needs as they should aid the DOVVSU officials in terms of staffing and resources.

Policy makers should launch campaigns to raise the awareness of the public in terms of IPV prevention and the rights of the pregnant women via national awareness campaign and creating community support networks. Further research should focus on assessing the impact of sociocultural factors on IPV support services, as well as the effect of DOVVSU programs on the pregnant women health outcomes. Finally, studies should examine the effectiveness of programs that are designed to raise the awareness of maternal healthcare providers concerning the international frameworks.

The current study has some inherent limitations which include limited generalizability as it focused on only pregnant women. Also, there is the potential for bias in terms of the responses provided by the DOVVSU officials and maternal healthcare providers. Despite the fact that limited awareness of international frameworks was revealed among the maternal healthcare providers, the study failed to explore some of the challenges and factors that could contribute to the limited familiarity of international frameworks and their practical application at the healthcare facility.

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264.

Appendix I



20241016 - Naayif
Saeed - MA Research



INTERVIEW GUIDE_NAYIF.pdf

ISS Research Ethics Review Form - MA Research

YOU ONLY NEED TO COMPLETE THIS SECTION IF YOU HAVE ANSWERED YES TO ONE OF THE QUESTIONS IN SECTION B2 ABOVE (Questions 5-11)

C) Statement of Research Ethics

Using the background document 'ISS Research Ethics Guidelines for MA students', please address how you are going to deal with the ethics concern identified, including prevention measure to avoid them from manifesting, mitigation strategies to reduce their impact, and preparedness and contingency planning if the risks manifest.

Please number each point to correspond with the relevant checklist question above. Expand this section as needed and add any additional documentation which might not be included in your RP design, such as consent forms.

[TO BE COMPLETED BY MA STUDENT AND DISCUSSED WITH THE SUPERVISOR. IF THE SUPERVISOR FINDS IT NECESSARY TO SEEK FURTHER REVIEW, THE STUDENT MUST SUBMIT THE FORM TO THE RESEARCH ETHICS COMMITTEE]

9. The data about IPV support system will be sought from healthcare providers where an approval will be sought the Tamale Teaching Hospital management and informed consent will be sought from each healthcare staff.

12. Ethical approval will be sought from the management of healthcares and and approval will be sought from DOVVSU.

D) Approval from Research Ethics Committee

*To be completed by the Research Ethics Committee only if

Approved by Research Ethics Committee:  11 July 2024 **Date:** 11 July 2024

Additional comments for consideration from Research Ethics Committee:

 16/10/2024

If the REC needs more information before approving, the REC secretary will be in touch with the MA student. If after requesting more information the REC still has concerns, the REC secretary will ask the supervisor to discuss these with the student. In the unlikely event that there is still no resolution, the REC will refer the application to the Institute Board.

Demography of the participants

Code of participant	Age	Educational level	Religion	Role
GP001	52	Tertiary	Islam	General practitioner
MN002	33	Tertiary	Islam	Male Nurse
FSW003	28	Tertiary	Christianity	social worker
FO004	44	Tertiary	Christianity	Female Obstetrician
FP005	30	Tertiary	Christianity	Female psychiatrist
MO006	44	Tertiary	Christianity	Obstetrician
MM007	28	Tertiary	Islam	Midwife
FNP008	31	Tertiary	Islam	Nurse practitioner
FDW001	-	Tertiary	Islam	
FDW002	-	Tertiary	Christianity	Counselor
FDW003	-	Tertiary	Islam	Officer
MDW		Tertiary	Christianity	Officer
MDW005		Tertiary	Christianity	Officer
FDW006		Tertiary	Islam	Officer
FDW007		Tertiary	Christianity	Officer
MDW008		Tertiary	Christianity	Officer