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Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: a qualitative systematic review and thematic synthesis of women's perceptions and experiences

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Abstract

The psycho-social elements of labour and delivery are central to any woman's birth experience, but international efforts to reduce maternal mortality in low-income contexts have neglected these aspects and focused on technological birth. In many contexts, maternity care is seen as dehumanised and disrespectful, which can have a negative impact on utilisation of services. We undertook a systematic review and meta-synthesis of the growing literature on women's experiences of facility-based delivery in sub-Saharan Africa to examine the drivers of disrespectful intrapartum care. Using PRISMA guidelines, databases were searched from 1990 to 06 May 2015, and 25 original studies were included for thematic synthesis. Analytical themes, that were theoretically informed and cognisant of the cultural and social context in which the dynamics of disrespectful care occur, enabled a fresh interpretation of the factors driving midwives' behaviour. A conceptual framework was developed to show how macro-, meso- and micro-level drivers of disrespectful care interact. The synthesis revealed a prevailing model of maternity care that is institution-centred, rather than woman-centred. Women's experiences illuminate midwives' efforts to maintain power and control by situating birth as a medical event and to secure status by focusing on the technical elements of care, including controlling bodies and knowledge. Midwives and women are caught between medical and social models of birth. Global policies encouraging facility-based delivery are forcing women to swap the psycho-emotional care they would receive from traditional midwives for the technical care that professional midwives are currently offering. Any action to change the current performance and dynamic of birth relies on the participation of midwives, but their voices are largely missing from the discourse. Future research should explore their perceptions of the value and practice of interpersonal aspects of maternity care and the impact of disrespectful care on their sense of professionalism and personal ethics.

Research highlights

- Uses women's experiences to explore cultural and social drivers of disrespectful care
- Argues that maternity care is predominantly institution- rather than woman-centred
- Suggests women and midwives are caught between medical and social models of care
- Presents a conceptual framework of the macro-, meso- and micro-level drivers of abuse
- Implicates social hierarchy and exercise of power and control in disrespect and abuse

Key words

Disrespect; abuse; childbirth; sub-Saharan Africa; respectful maternity care; facility-based delivery.

Background

Skilled attendance at birth has been a cornerstone of international efforts to reduce maternal mortality, reflected in the selection of ‘proportion of deliveries attended by skilled health personnel’ as the second indicator of progress for Millennium Development Goal (MDG) 5. A tacit expectation in the safe motherhood discourse has been that this would be best achieved through facility-based delivery (Costello et al., 2006). Yet, despite strong global and national efforts, only 52% of women in sub-Saharan Africa (SSA) accessed skilled attendance at birth; only a small number of countries met the MDG target of 90% coverage by 2015; and the region bore 62% of the global maternal mortality burden (United Nations, 2014). There is increasing attention and wider recognition that many women are deterred from facility-based delivery because the intrapartum care on offer does not satisfy the interpersonal and emotional aspects of this biosocial event. In some settings, care is perceived as dehumanised (Bohren et al., 2014) and a high prevalence of disrespect and abuse is beginning to be documented (e.g. Kruk et al., 2014). A significant factor in the neglect of mistreatment of women has been the maternal health community’s ‘blind spot’ to over-medicalisation of childbirth (Van Lerberghe et al., 2014), despite longstanding evidence of its impact in SSA (e.g. Hillier, 2003; Hunt, 1999).

The ways in which interpersonal aspects of care are enacted or neglected need to be viewed in the context of current health systems. In SSA, as in many other contexts, these are highly centralised, but have also been shaped by their colonial history (Blaise & Kegels, 2004). Hierarchical and bureaucratic systems of ‘command and control’ dominate, intersecting with existing socio-cultural forces of exclusion and discrimination (Andersen, 2004). This is further exacerbated by pre-service training of health workers that can reinforce class and power differentials (Marks, 1994), where health professionals are groomed as a privileged elite (Coovadia et al., 2009). Standardised procedures for efficiency of service provision (Blaise & Kegels, 2004) can exacerbate the dehumanisation of women, by reducing them to cases instead of individuals, and serve to privilege the physical and technical aspects of care over compassion (Pearson et al., 2005). Low government spending on health leaves health systems under-resourced, which is reflected in poor infrastructure and lack of equipment and drugs; while in many countries serious staff shortages have been tackled by the use of generalist nurse-midwife cadres, who may lack the midwifery-specific interpersonal skills needed to operate in the culturally and emotionally sensitive arena of childbirth (Fauveau et al., 2008). Indeed, there has been a tendency to view the psycho-social elements of care as unrelated to quality and safety, and a luxury that is only affordable in high-resource settings.

Although disrespectful care has long been described anecdotally, it has only recently received international attention. A seminal landscape analysis (Bowser & Hill, 2010) identified seven categories of disrespect and abuse, which informed the development of the Charter on the Universal Rights of Childbearing Women (White Ribbon Alliance for Safe Motherhood, 2011). Further efforts have expanded Bowser’s typology, defining individual and structural aspects set in a framework of expectations, normalisation and rights (Freedman et al., 2014). There are growing calls for a paradigm shift towards respectful relationships, tailoring care to women’s needs, and actively strengthening women’s own capabilities (Renfrew et al., 2014).

Studies specifically describing women’s perceptions of their birth experience in low-income contexts are relatively recent. The importance of the psycho-social aspects of care has often

emerged as a smaller element of studies focused on the technical quality of skilled attendance, or has been identified in reviews as one of the deterrents to facility delivery in SSA (Moyer & Mustafa, 2013). Other authors have focused on attitudes and behaviours of healthcare workers (Mannava et al., 2015) or women's satisfaction (Srivastava et al., 2015) but have not addressed the circulating discourses in which provider behaviour is embedded. More recently, Bohren et al. (2015) have produced a comprehensive, evidence-based typology of the mistreatment of women. This has updated and expanded the definition of this phenomenon, as well as identifying the role of systemic failures at the level of the health facility and the health system. Our review complements this work, but moves beyond it, synthesising insights from women's experiences to explore the cultural and social factors which underpin midwives' behaviour, and seeking to understand the dynamics at play when disrespectful care occurs. Although a variety of cadres may provide midwifery services, the bulk of normal deliveries are attended by midwives, so we have employed this term throughout to describe maternity professionals providing facility-based delivery. We have used the small but growing body of descriptive studies of women's experiences of facility-based delivery as the lens through which to ask, what drives the dynamics of disrespectful care and influences midwives to behave in the manner that women report?

Methods

This review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, an evidence-based minimum set of items used for reporting in systematic reviews (Shamseer et al., 2015). It followed Thomas & Harden's (2008) thematic synthesis method and is registered on the International Prospective Register of Systematic Reviews (Ref: CRD42015016182), an international database of prospectively registered systematic reviews in health and social care.

Systematic search and screening

There is little literature on women's experiences of intrapartum care during facility-based delivery in SSA, so a wide search strategy was employed. A version of the PICo model (The Joanna Briggs Institute, 2014) was used to define search terms covering population to be considered, phenomenon of interest and the context. Searches were carried out in May 2015 and covered the period from 1990 to 06 May 2015, using CINAHL, EBSCO (PsychINFO, PsychArticles), OVID (Embase, Global Health, Maternity and Infant Care), Africa Index Medicus, African Journals Online, BioMedCentral, Popline, PubMed, Web of Science and WHOLIS. Grey literature was searched using OpenGrey, Google Scholar, ProQuest Dissertations and Theses, EtHOS and BioMed Central Proceedings; and Conference Proceedings Citation Index-Science (CPCI-S) and Conference Proceedings Citation Index-Social Science & Humanities (CPCI-SSH) (via Web of Science). The NEXUS database of South African dissertations and theses was also searched. 'Cited by' and 'related citations' searches for each included publication were carried out using Web of Science, Google Scholar, Scopus and PubMed, while reference lists were manually searched to identify additional studies. An example of the final search terms can be seen in Table 1. All retrieved items were screened using title/abstract. After removing those that were clearly irrelevant to the review questions, full texts of the remaining papers were assessed by two authors to ascertain whether they met the inclusion criteria (Table 2). A third author was consulted if clear consensus could not be reached. Items were only included if all authors agreed

Table 1. PubMed search strategy

Filter: Humans, from 1990

All terms were searched as Title/Abstract, except MeSH headings

Women's experiences	1. woman* OR women* OR mother* 2. experience* OR perception* OR view* OR opinion* OR attitud* OR perspective* OR satisfaction* OR dissatisfaction OR belie* OR account* OR narrative* OR story OR stories 3. 1 AND 2
Birth	4. "Delivery, Obstetric"[Mesh] OR "Perinatal Care"[Mesh] OR "Parturition"[Mesh] OR "Labor, Obstetric"[Mesh] OR childbirth* OR birth* OR deliver* OR labour OR labor OR "maternity care" OR "intrapartum care" OR "obstetric care"
Interpersonal care	5. "quality of care" OR respectful matern* OR support* OR respect* OR disrespect* OR abus* OR caring OR violen* OR digni* OR neglect* OR psychosocial
Sub-Saharan Africa	6. "Africa South of the Sahara"[Mesh] OR Burundi OR Djibouti OR Eritrea OR Ethiopia OR Kenya OR Rwanda OR Somalia OR Sudan OR Uganda OR Tanzania OR Benin OR "Burkina Faso" OR "Cote d'Ivoire" OR Gambia OR Ghana OR Guinea OR Guinea-Bissau OR Liberia OR Mali OR Mauritania OR Niger OR Nigeria OR Senegal OR "Sierra Leone" OR Togo OR Cameroon OR "Central African Republic" OR Chad OR Congo OR "Democratic Republic of the Congo" OR "Equatorial Guinea" OR Gabon OR Angola OR Botswana OR Lesotho OR Malawi OR Mozambique OR Namibia OR "South Africa" OR Swaziland OR Zambia OR Zimbabwe OR "Cape Verde" OR Comoros OR Madagascar OR Mauritius OR Mayotte OR Reunion OR "Sao Tome and Principe" OR Seychelles
Full search	7. 3 AND 4 AND 5 AND 6

Table 2 Inclusion and exclusion criteria

	Inclusion	Exclusion
Participants	Women of any parity or mode of birth who experienced a facility-based delivery (live or dead)	Women experiencing non-facility-based delivery (e.g. home birth, delivery with traditional birth attendants) or where the site of delivery is unclear Specific focus on perinatal loss, severe maternal morbidity or HIV
Intervention	Women's views, perceptions and experiences of the interpersonal aspects of facility-based intrapartum care, or the impact of this element of care	Ante- or post-natal care Clinical or technical quality of care only Women's experiences described by other actors (e.g. husbands, health workers)
Outcomes	Any	N/A
Study design	Primary qualitative studies (IDI, FGD) including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research, or mixed-methods studies with a relevant qualitative element.	Quantitative studies, RCTs, quantitative findings from mixed-methods studies Open-ended questions in survey-based studies
Study focus	Women's experience and perceptions of (dis)respectful care either as the main focus of the study or as a substantial element of it.	Main focus was not on women's perceptions of intrapartum care Focus is specifically on technical aspects of care
Setting	Sub-Saharan Africa, including Sudan	Algeria, Egypt, Libya, Morocco, Tunisia and Western Sahara
Time period	MDG time period, 1/1/1990 – 6/5/2015	Pre-1990
Language	Only abstracts available in English, French or Portuguese	None
Publication type	Peer reviewed articles, dissertations/theses or research reports	Reviews, opinion pieces, policy documents

Quality Appraisal

Two authors independently carried out quality assessment of all included studies using the Critical Appraisal Skills Programme (CASP, 2014) tool for qualitative research. This uses 10 questions to appraise the research aims, methodology, research design, recruitment strategy, data collection, data analysis, reflexivity, ethical considerations, findings, and value of the research. Studies were rated high, medium or low quality for each domain and were assigned an overall quality score. Quality ratings were: five low quality; seven low/medium; nine medium; and four medium/high quality studies. No study was excluded because of low quality, but a sensitivity analysis was performed to make their contribution to the synthesis and review findings transparent.

Data extraction and synthesis

Data extraction and synthesis followed Thomas & Harden's (2008) thematic synthesis method, which allows the synthesis to 'go beyond' the content of the original study findings to develop analytical themes and bring fresh interpretations. This facilitates drawing conclusions based on common elements across otherwise heterogeneous studies. All study results and findings, including participant quotes, were imported verbatim into NVivo 10 for data analysis.

Findings

Search results

Electronic databases identified 4,048 papers. After screening title/abstract, 52 papers were selected for full text review, comprising 36 items from database searches plus an additional 16 identified from 'cited by' or 'related articles' or known to the review team. Of these, 27 were excluded, the majority because the study's key focus was on a different aspect of women's experience. Twelve studies were excluded as they had used mixed focus group discussions (FGDs) where the voices of women who had experienced facility-based delivery could not be isolated from those of other participants. Search results can be seen in Figure 1. The majority of studies included in the final analysis (20/25) were peer-reviewed journal articles. One PhD dissertation and four Master's theses were included as they provided primary qualitative research on the topic, but care was taken to not allow their extended format to dominate the analysis or the themes that emerged. Instead, they were used to add fine-grained detail to the narrative. The study characteristics for included items can be seen in Table 3. Six studies were based in South Africa, five in Ghana, four in Tanzania; two each in Ethiopia, Kenya, Malawi and the Gambia; and one each in Zambia and Zimbabwe. Studies used unstructured, in-depth (IDI) or semi-structured (SSI) interviews, or focus group discussions (FGD). Where mixed groups of participants were interviewed, data are only presented for women who gave birth in a facility.

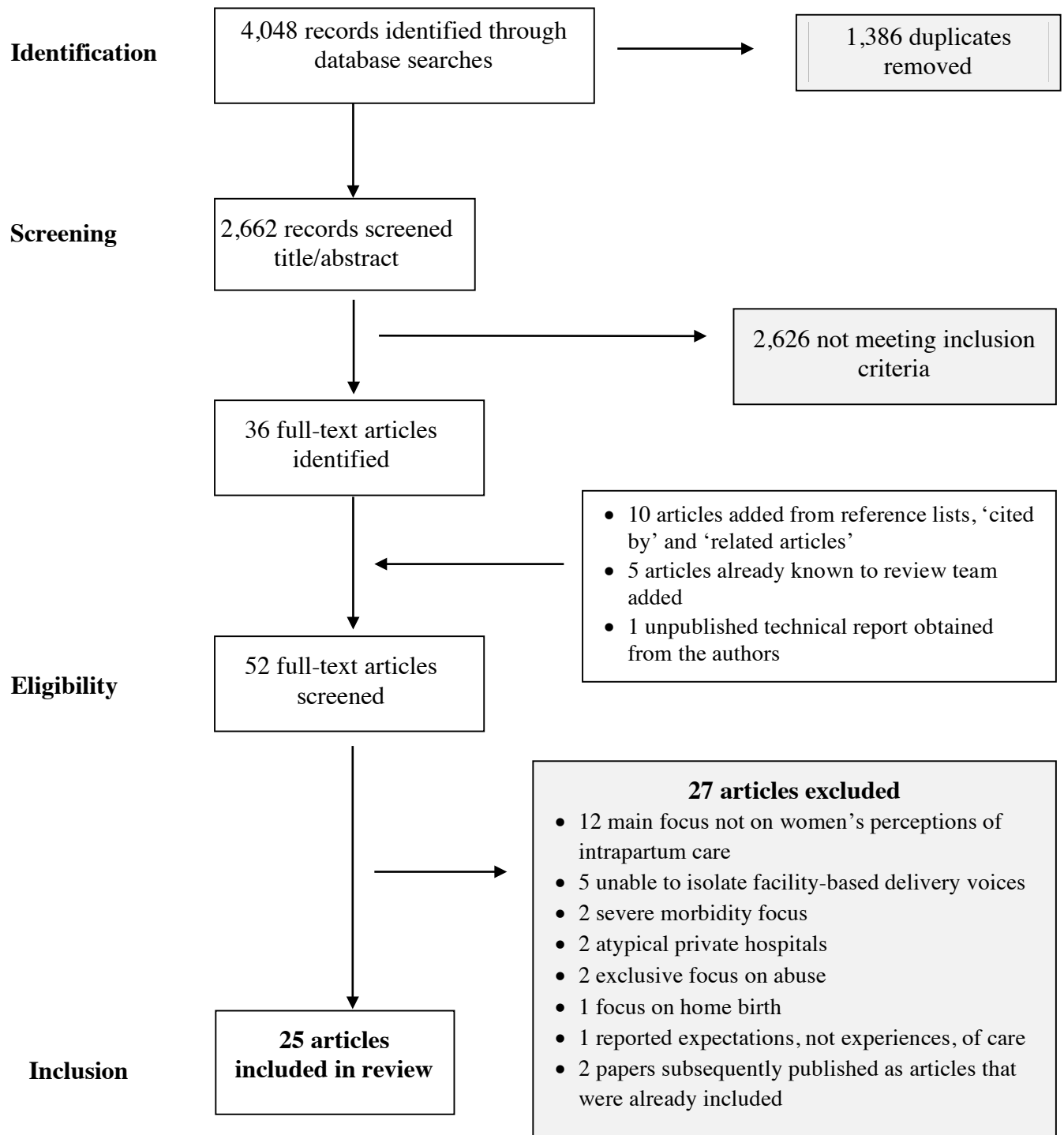


Fig. 1. Search statistics

Table 3 Characteristics of included studies

Study	Country	Study aims	Participants, setting, post-natal time to interview	Study design, data collection and analysis	Quality
1. Angelshaug, 2013	Ethiopia	• Explore women's and health workers' experiences and perceptions on barriers and facilitators for health facility delivery	• 21 women, age 20-38, some with experience of health facility birth • North Gondar, Amhara region • Not stated	• Qualitative approach • SSI • Thematic content analysis	M
2. Bazant, 2008	Kenya	• Describe women's experiences of quality in delivery care and factors associated with these experiences	• 58 women from 2 informal settlements outside Nairobi, varied parity and ethnicity, mostly primary education only • Public and private facilities • Up to 6 months	• Not stated • IDI and FGD • Constant comparison method and framework analysis	L/M
3. Chadwick et al., 2014	South Africa	• Explore factors associated with negative birth experiences from the perspective of women's birth narratives	• 33 low-income women from peri-urban informal settlements, majority parity 1 or 2, age 18-42, mostly Afrikaans speaking and of mixed racial descent • Public maternity sector, Cape Town • Up to 4 weeks	• Narrative methodology • Unstructured interviews • Thematic narrative analysis	M
4. D'Ambruoso et al., 2005	Ghana	• Investigate women's accounts of interactions with health care providers during labour and delivery and assess the implications for acceptability and utilisation of maternity services	• 21 women, plus 2 groups of women, parity 1-4, age 18-38, basic or no education • Mix of public and private facilities, suburbs of Accra • Up to 5 years	• Constructivist paradigm • IDI and FGD • Thematic analysis	M
5. Duggan and Adejumo, 2012	South Africa	• Explore adolescent maternity clients' perceptions of maternity care and identify important characteristics of an adolescent-friendly maternity service	• 18 adolescents, age 15-19, 15 x Black, 2 x Coloured, 1 x Indian racial groups • Public hospital and rural community polyclinic, Kwa-Zulu Natal • Antenatal or immediate post-natal period	• Grounded theory approach • FGD and SSI • Grounded theory	L
6. Dzomeku, 2011	Ghana	• Assess the care and satisfaction of expectant mothers during labour, birth and lying-in period	• 12 multiparous women, age 22-37, mostly limited education • Mampong District Hospital Maternity Unit,	• Not stated • IDI and FGD • Content analysis	L

				Ashanti region		
				• IDI within 48 hours, FDG after 2 weeks		
7.	Eustace and Lugina, 2007	Tanzania	• Explore mothers' perceptions of midwives' caring and supportive behaviours during labour within the context of the midwife–woman interaction	• 12 women, one group each of primiparas and multiparas • Public hospital, Dar es Salaam • Not stated	• Qualitative element of a cross-sectional study • FGD • Open coding	L
8.	Floyd et al., 2014	Ghana	• Explore women's experiences to identify which factors contributed to a positive or negative birth experience	• 11 women, parity 1-4, age 21-40 • Tertiary referral hospital, Accra • Within 24 hours	• Exploratory, qualitative approach • SSI • Thematic analysis	L/M
9.	Jallow, 2007	The Gambia	• Explore and describe factors hindering utilization of health care institutions for delivery	• 38 women, age 14-43 • One rural and one urban district • Up to 2 months	• Qualitative element of a cross-sectional study, using grounded theory • FGD • Not stated	L/M
10.	Jeng, 2008	The Gambia	• Assess practices and quality of delivery care during normal birth and explore the views of postpartum women about the care they received	• 15 postpartum women, parity 1-9, age 19-43 • Delivery ward of the Gambia's only teaching hospital, Banjul • Up to 6 months	• Qualitative methods • IDI • Content analysis	L
11.	Jewkes et al., 1998	South Africa	• Explore why nurses abuse patients, based on findings of research on health seeking practices	• 32 women, parity 1-7, age 17-40, Coloured or Xhosa speaking Africans, range of socio-economic status • Obstetric public health services around Cape Town • Throughout pregnancy and after delivery	• Ethnographic methods • IDI and FGD • Analysed 'ethnographically'	M/H
12.	Kruger and Schoombee, 2010	South Africa	• Explore the psychological experience of motherhood	• 93 low income women from one semi-rural community • Maternity ward of the local state hospital • During pregnancy; then a few days, 3 months and 6 months after giving birth	• Qualitative approach • Interviews • Social constructionist grounded theory and Foucauldian discourse analysis	M

13.	Kumbani et al., 2012	Malawi	Describe women's perceptions of perinatal care	14 women, parity 1-11, age 15-44, rurally based, primary education only - Chiradzulu District Hospital, Southern region - Up to 7 days	- Descriptive qualitative - IDI - Thematic inductive analysis	M
14.	Kwaleyela and Kearns, 2009	Zambia	Explore views and experiences of women users of low-risk maternity care services	11 women, parity 1-5, age 18-28, mixed educational background - Maternity centres offering 24-hour labour and delivery care, Lusaka 5-6 hours	- Explorative qualitative - Interviews - Modified grounded theory	M
15.	Maputle and Nolte, 2008	South Africa	Explore and describe experiences of mothers during childbirth	24 women - Tertiary hospital in Capricorn district, Limpopo Province - Within 24 hours	- Phenomenological - IDI - Tesch protocol	M
16.	McMahon et al., 2014	Tanzania	Understand experiences with and responses to abuse during childbirth	49 women 4 districts of Morogoro Region - Up to 14 months	- Qualitative, cross-sectional - IDI - Grounded theory	M/H
17.	Mensah et al., 2014	Ghana	Explore expectations of women relating to their labour and delivery needs	9 multiparous women, age 23-34, varied educational and economic status 37th Military Hospital, Accra - Within 48 hours	- Generic or non-categorical qualitative - SSI - Rubin's framework	L/M
18.	Mirkuzie, 2014	Ethiopia	Explore inequities in maternal health care among migrant women	8 migrant woman, plus others in FGDs, parity 1-8, majority from the Gamo tribe - Gulele sub-city, Addis Ababa - Within one year	- Qualitative community based - IDI and FGD - Framework and content analysis	M/H
19.	Murira et al., 2010	Zimbabwe	Find out primiparous women's experiences of labour	10 teenage, primiparous women - Maternity units, Harare - One week	- Retrospective qualitative - Interviews - Modified grounded theory	L
20.	O'Donnell et al.,	Malawi	Explore perceptions of maternity care	33 women, age 16-36	Not stated	L/M

	2014		from the point of view of the mother and the healthcare provider	•Four hospitals in Mangochi district •Within 7 days	•IDI and FGD •Thematic framework approach	
21.	Okwako and Symon, 2014	Kenya	•Explore women’s expectations and experiences of childbirth	•7 multiparous women •Level 4 public hospital in western Kenya •In post-natal ward	•Interpretative phenomenological •SSI •IPA	L/M
22.	Sambou, 2012	Ghana	•To assess practices and quality of delivery care during normal childbirth	•35 post-partum women, parity 1-9 •Soma Major Health Centre, rural setting •Not stated	•Qualitative element of a retrospective and prospective cross-sectional design •IDI and FGD •Content analysis	L/M
23.	Shimpuku et al., 2013	Tanzania	•Describe women’s perceptions of childbirth support	•25 women, parity 1-7, age 19-38, mostly farmers with primary education •Mixed government– missionary hospital in a rural district •Within 24 hours	•Qualitative descriptive •SSI •Auerbach & Silverstein’s framework	M
24.	Spangler, 2011	Tanzania	•Explore social exclusion and embodied inequality at childbirth	•48 women •25 villages in Morogoro region •Up to 6 months	•Ethnography •SSI •Not stated	M
25.	Tebid et al., 2011	South Africa	•Explore and describe immigrant mother’s experiences during pregnancy, labour, birth and the postpartum period	•9 primagravida, immigrant women, living in inner Johannesburg •Four Government Hospitals in Gauteng province •Up to 6 weeks	•Exploratory, descriptive phenomenological •Phenomenological interviews •Tesch’s data analysis method	M/H

Synthesis results

Informed by women's accounts of their facility-based birth experience, two overarching analytical themes emerged – 'Power and Control' and 'Maintaining Midwives' Status'. The core themes are inter-linked and overlapping as they reinforce and feed back into each other. For example, some of the behaviours outlined in the theme Power and Control reflect midwives' efforts at Maintaining Status, but both are drivers of disrespectful care. The core analytical themes are presented below, along with their constituent sub-themes (Table 4). Finally, a conceptual framework, drawing together macro-, meso- and micro-level contexts and drivers, is developed. All quotes are from participants in the original studies.

Table 4. Analytical themes and sub-themes

Analytical themes	Sub-themes
1. Power and Control	1.1 Controlling bodies 1.1.1 Pain 1.1.2 Pushing 1.2 Controlling knowledge 1.2.1 Overriding embodied knowledge 1.2.2 Withholding information 1.2.3 Bystander, not participant 1.3 Rules, compliance, resistance
2. Maintaining Midwives' Status	2.1 The midwife's role 2.1.1 Care during the first stage of labour 2.1.2 Response to women's call 2.2 Social distance and 'othering' 2.2.1 Social inequality 2.2.2 Sexual shaming 2.2.3 'Dirty work'

1. Power and control

This analytical theme describes underlying meso-level drivers of disrespectful care and how these are exercised in midwives' attempts to assert their professional identity and take charge of both women and the birth process. The mechanisms through which these were achieved were various forms of discipline and punishment. These were major themes emerging from the review and underpinned many of the behaviours and power dynamics that constitute disrespect and abuse in the maternity setting.

1.1 Controlling bodies

Women's bodies were the focus of midwives' work, and as such were also the focus of midwives' attempts to assert power and control. Controlling women's bodies – specifically, how women physically behaved during labour - was a key strategy midwives used to assert control over women in their care. There appeared to be specific trigger points for such behaviours, in particular women's expressions of pain, and the timing and direction of the pushing stage of labour.

1.1.1 Pain

Women's experiences revealed that midwives' responses to their pain often precipitated disrespectful care. Midwives shouted at women who vocalised pain, or told women to be quiet, or made judgemental or sexually shaming comments. Ignoring women's pain, a lack of empathy and the absence of explanations or tips on how to manage pain were common and caused unnecessary distress. *"...when you are in pain and somebody shouts at you, you feel like its cruelty."* (O'Donnell et al., 2014, n.p.). In one study, women were forced to walk the hospital corridors until they were fully dilated, leaving some struggling to manage intense pain (Kruger & Schoombee, 2010). Those at the margins of society experienced the worst treatment, and this common phenomenon is discussed in more detail in the later section on 'social distance and 'othering''. Specific groups, such as immigrant women, felt they were actively denied pain medication (Tebid et al., 2011) and teenagers felt ignored (Murira et al., 2010).

Whilst this kind of behaviour appeared to simply offer midwives an opportunity to demonstrate that they were in charge, two studies in Kenya (Bazant, 2008; Okwako & Symon, 2014) offered alternative explanations for midwives' responses to pain that took account of the wider local cultural understandings of labour pain. Bazant's work with women in informal settlements (p.125) suggested that crying out in pain violated a social norm of stoicism during labour and delivery. *"When you...feign that you have more pain than the rest and start screaming, the [providers] will leave you, but if you persevere, you will get the best treatment from them."* Okwako & Symons' (2014, p.118) participants also suggested that enduring the pain of labour was expected, as it meant women were obeying God's command, and punishment ensued for a woman who was overwhelmed. *"The pain was too much and I could not walk...She became angry and told me that I was stubborn and not cooperative then she walked away."*

1.1.2 Pushing

One specific trigger point was pushing, a time when the midwife's technical role came to the fore. Pushing in unmedicated labour is an overwhelming reflex that cannot be easily resisted, yet women reported that their pushing urges were frequently countermanded. *"...they said 'No, don't push' but I feel like, so I push and then they are shouting, 'Sister, why are you pushing? I said don't push!' I said, 'I feel like I want to push' they said 'No! I didn't say push!'"* (Chadwick et al., 2014, p.864) In other cases, asking whether they should push did not necessarily spare women. *"I asked her whether I should push. She retorted 'What are you lying there for?'"* (D'Ambruoso et al., 2005, n.p.) Others were threatened for not pushing properly. *"When I was pushing, she told me that if I didn't push, she would slap me."* (Shimpuku et al., 2013, p.473)

On a related theme, pressure points also frequently centred on the timings of these different stages of labour. Two studies reported tensions when midwives decided that women arriving at the facility were not actually in labour, so were sent away, only to deliver outside the facility or on the way home (Angelshaug, 2013; Jallow, 2007). This situation was exacerbated by space constraints within the facilities. Women's awareness of when they were ready to give birth was also disregarded, with some women, particularly at night, told they were not ready to deliver and left unattended (Bazant, 2008; Chadwick et al., 2014; Duggan & Adejumo, 2012; Jewkes et al., 1998; Kruger and Schoombee, 2010).

1.2 Controlling knowledge

1.2.1 Overriding embodied knowledge

Midwives' control over women's pushing can be understood both as a control over women's bodies, but also as an assertion of authoritative knowledge. Authoritative knowledge is the knowledge that 'counts' within a particular social environment (for example, a health facility) and which forms the basis for decision-making and action within that environment (Jordan, 1997). It was clear in many women's accounts that midwifery staff were overriding women's embodied knowledge and that the urge to push, a woman's bodily, tacit knowledge of what her body needed to do, could be ignored or dismissed. This demonstrated that authoritative knowledge about the process and progress of labour was institutional and technical, mediated via the midwife. As one woman in Zambia remarked, *"...they cannot give you a chance to give your opinion because they think they know it all, although at times they are younger and have not given birth before."* (Kwaleyela & Kearns, 2009, p64).

1.2.2 Withholding information

Women's accounts demonstrated that this assertion of what counted as authoritative knowledge and who was privy to it played out in a number of ways. Of concern was the deliberate withholding of information about the progress of labour or the baby's health, with reports of women being scolded and threatened for asking questions (Chadwick et al., 2014; D'Ambruso et al., 2005; O'Donnell et al., 2014; Okwako & Symon, 2014). *"Nobody came, the pains got stronger...then I went to one sister and asked her like, 'Won't she check me to see how far I am, how many centimetres I am'...she said 'No um, does she, do I want one, one of them to get angry with me?' they are going to get angry and scold me if I now ask...then I left it and then went back to the room because I didn't want big trouble...and nobody checked me."* (Chadwick et al., 2014, p. 865). Many women reported a lack of information support, where examinations were carried out without explanation or women were not provided with feedback afterwards (Angelshaug, 2013; Chadwick et al., 2014; Dzomeku, 2011; Floyd et al., 2014; Jeng, 2008; Kwaleyela & Kearns, 2009; Maputle & Nolte, 2008; Murira et al., 2010; O'Donnell et al., 2014; Okwako & Symon, 2014; Sambou, 2012). *"I was not involved and not informed about my progress, the midwives will examine me and I will only overhear them giving each other the report, but not telling me so that I can participate."* (Maputle & Nolte, 2008, p.59).

1.2.3 Bystander, not participant

The effect of all of these forms of control and assertions of power was that some women perceived that they were relegated to the role of bystander, not participant, in their birth

experience. This status of women as bystander reflects the underlying ideology and practice of labour and delivery services as institution- rather than woman-centred.

Some of the aspects that render women bystanders (such as withholding information or not supporting them through the first stage of labour) also serve to maintain the hierarchies and control of women's bodies that are symptomatic of the medical model of birth that prevails in SSA health systems. Many of the studies described women who had been left waiting for attention or to be told what to do. The experience of a primigravida exemplified this passivity. *"Then I asked that other girl [patient] 'Don't they come and check your thingies [centimetres dilated]...then she said, 'No, you must just wait till they come and say you are going to give birth'".* (Chadwick et al., 2014, p.865). Limited participation and collaboration (Jeng, 2008; Maputle and Nolte, 2008) and poor relationships with healthcare providers (O'Donnell et al., 2014) hindered women's decision-making and left them feeling powerless, anxious and invisible. Adolescent women in Zimbabwe were described as shocked by elements of the birth process. *"You can have three or more people examining you. They never ask for your permission or tell you why they must all take a turn. They do not tell you what they are feeling for or what they have found. They take you for granted because you have come to them desperate for help."* (Murira et al., 2010, p.76). These experiences are very distressing for women and can have long-term ramifications. A study of immigrant women's experiences in Johannesburg (Tebid et al., 2011, p.972) observed that mothers still displayed signs of being traumatised six weeks later. A woman who had an episiotomy without warning or consent said, *"...the whole experience was horrible, it was so traumatizing... As I am talking to you right now, I still feel this pain right inside me."* Whilst not the predominant experience, it is however important to note that for some women, dependence on healthcare staff was welcome and they were happy that the midwife knew best (Maputle & Nolte, 2008) or trusted midwives even when their wishes were disregarded (Kwaleyela & Kearns, 2009).

1.3 Rules, compliance, resistance

Women's descriptions showed that power and control were maintained via rules of how women should behave, many of which were implicit, or opaque to women, while some seemed capricious in nature. Punishment, often in the form of scolding, was meted out for many of the bodily 'misbehaviours' women described: presenting to the health facility too early or too late, or pushing too soon or not hard enough (McMahon et al., 2014), delivering without a midwife or on the floor (Jewkes et al., 1998) or in the wrong place (Bazant, 2008), or getting off the bed to move around in labour (Jeng, 2008). Rules were also concerned with asserting the authoritative professional knowledge of biomedicine, such as village women being scolded about their use of traditional midwives or harangued for using herbs (McMahon et al., 2014). In addition, they upheld organisational processes. For example, in a South African study, more serious punishments, such as being made to wait a long time for attention or being left to deliver alone, were reserved for women who had not booked to deliver at the facility to which they presented in labour (Jewkes et al., 1998). Arrival without the requisite supplies was another cause for punishment, which affected poorer women. In Tanzania, a woman who arrived at the facility without a full delivery kit was scolded for being irresponsible, disobedient and lazy, and her husband was told, *"She can deliver here when you find the vifaa [delivery supplies]. Until then, she can wait."* The woman subsequently delivered alone in an empty room (Spangler, 2011, p.485).

More than half the studies related women's experiences of overtly hostile and threatening behaviour from midwives. This most frequently took the form of shouting and scolding, often overlapping with threats of physical abuse. Women were also threatened with being left unattended, or harm and poor outcomes for the baby. In this atmosphere, women experienced rude and aggressive behaviour and a degree of harshness and unkindness that left many emotionally distressed and frightened, while their vulnerability meant they felt forced to comply in order to safely navigate labour and delivery. Some did as they were advised, in order to be seen as 'good clients' (Kwaleyela & Kearns, 2009). In Malawi, women worried that angering or disagreeing with midwives could incur poor outcomes (O'Donnell et al., 2014). In South Africa, immigrant women felt *"This is a foreign country. I thought that I just need to accept the little that I could get"* (Tebid et al., 2011, p.971). Others were angry with how they were treated, but knew *"They will do bad things to you but you cannot say anything because you are in pain..."* (Jeng, 2008, p.93). Women were silenced by fear of retaliation, not knowing what steps to take and future denial of service (McMahon et al., 2014). However, not all women were compliant and some studies reported examples of resistance. Women avoided contact with abusive providers (D'Ambruoso et al., 2005) or planned to deliver at home or to bypass poor services (McMahon et al., 2014). Others did not think this was a safe option so, as a last resort, planned to arrive at the facility as late as possible for future deliveries (Dzomeku, 2011).

2. Maintaining midwives' status

Our analysis showed that much of the behaviour women experienced could be understood as a strategy for midwives to maintain their professional, technical and social status in their interactions with women. The power relationships played out in the hospital were a reflection of those in wider society, where technical skill, professional education and the ability to speak English, for example, were held in high regard. Midwives maintained their own status by reinforcing the social distance between them and the women in their care. The strategies they used to do this can be grouped into two main themes:

1. Midwives' decisions about what constituted a midwife's role;
2. Their attempts to maintain status through social distancing and 'othering'.

2.1 The midwife's role

This theme encompasses how the midwife's professional role impacted on the care given, including (a lack of) care in the first stage of labour, and how midwives responded to women. Women's narratives revealed that a clear area of contention concerned the demarcation of the midwife's professional role. This informed midwives' understanding of what was required as well as women's expectations of the care they would receive. A clash was evident in the studies between the expectations of women and the actual care they received. Women thought that midwives would guide and inform them throughout labour and delivery, and this was cited as an important element of good care. However, midwives' behaviour showed that they expected women to already know what to do and expressed irritation at their lack of knowledge (D'Ambruoso et al., 2005). This was particularly distressing and anxiety provoking for primiparous women and adolescents (Murira et al., 2010). Positive perceptions were described when women experienced encouragement and support from midwives who were present, attentive, explained what was happening, and treated them with respect.

2.1.1 Care during the first stage of labour

The discrepancy between women's expectations and the reality of their birth care was brought into sharp relief when women described how they were treated during the first stage of labour.

One of the most disturbing elements of the review was the finding that so many women spend a considerable amount of time labouring without a midwife (Chadwick et al., 2014; Floyd et al., 2014; Jallow, 2007; Jeng, 2008; Kruger & Schoombee, 2010; Kumbani et al., 2012; McMahon et al., 2014; Murira et al., 2010; Okwako and Symon, 2014; Sambou, 2012; Shimpuku et al., 2013; Spangler, 2011) or birthing alone (Bazant, 2008; Chadwick et al., 2014; Eustace & Lugina, 2007; Jallow, 2007; Jewkes et al., 1998; Kruger & Schoombee, 2010; Kumbani et al., 2012; McMahon et al., 2014; Shimpuku et al., 2013; Spangler, 2011). In many contexts, women only received the midwife's attention when the baby's head was out.

"She'll do nothing for you, except when they see that the baby is for birth. Then they come." (Kruger & Schoombee, 2010, p.89) Other studies (Chadwick et al., 2014; Jallow, 2007; Kwaleyela & Kearns, 2009; Sambou, 2012; Shimpuku et al., 2013) agreed that the focus of midwifery care was on pushing and delivery, not on supporting women during the first stage of labour. In Zambia, one woman's voice echoed the feelings that permeated many of the narratives. *"Some midwives do not put heart to the care they give ... until the baby is coming out."* (Kwaleyela & Kearns, 2009, p.64) In Tanzania, some women took the precaution of moving from the bed to the floor or transferring the mattress onto the floor to protect the baby from falling in case they delivered by themselves (McMahon et al., 2014; Spangler, 2011); others reported sending out for local traditional midwives to assist with the delivery (McMahon et al., 2014). In some cases, the midwife was simply not available or was very busy and some women articulated their understanding of the midwife's situation. *"She is usually alone or maybe with another nurse...you can't blame anyone. That nurse's condition is hard..."* (McMahon et al., 2014). However, the impact on women's perceptions of the utility of facility-based delivery when a skilled attendant is not guaranteed, was summed up by one participant in The Gambia who said, *"Some times they come when the baby have already delivered. So home and hospital delivery is the same...in fact delivering at home may be safer as there you will always have someone by your side."* (Jallow, 2007, p.44)

For many women, labouring alone was extremely difficult and they would have appreciated the option of having a family member or partner present (Angelshaug, 2013; Chadwick et al., 2014; Duggan & Adejumo, 2012; Floyd et al., 2014; Jeng, 2008; Maputle & Nolte, 2008; Okwako & Symon, 2014; Sambou, 2012; Shimpuku et al., 2013). Some institutions did not allow a labour companion at all (Bazant, 2008; Floyd et al., 2014), while others did not permit companions in the delivery room (Angelshaug, 2013; McMahon et al., 2014). Even when companions were permitted, women were not informed that this was an option (Maputle & Nolte, 2008). Denying women social support can be seen as another example of midwives' efforts to retain 'Power and Control' and serves to maintain midwives' authority over women. In one South African study, more than half of the participants (i.e. 17 women) laboured and birthed with no companion present at any stage of the process (Chadwick et al., 2014); in another, less than 15% (14/93) reported support from non-medical personnel (Kruger & Schoombee, 2010). Given the number of studies that report women labouring without midwifery presence, this means significant numbers of women were effectively going through labour completely unsupported. This was also a safety concern, as in circumstances

where hospital protocols relied on a woman notifying the midwife when she feels the birth is imminent, a labour companion could have intervened if the woman was unable to raise the alarm herself.

2.1.2 Responses to women's calls

A further key element of the midwife's role was how providers responded to women's calls. Women perceived that their needs, such as expressions of pain or requests for assistance, were an irritation to midwives (Jewkes et al., 1998) or were ignored (Bazant, 2008; Dzomeku, 2011; Floyd et al., 2014; Jewkes et al., 1998; McMahon et al., 2014; Murira et al., 2010). Many said that midwives were impatient with them (Chadwick et al., 2014; D'Ambruoso et al., 2005; Eustace & Lugina, 2007; Jallow, 2007; Maputle & Nolte, 2008) or that they felt rushed to deliver and that midwives were in a hurry (Bazant, 2008; Chadwick et al., 2014; Floyd et al., 2014; Kruger & Schoombee, 2010). In some cases, midwives' concerns were considered to be more important than caring for women. One woman said, *"they told me I should not interrupt their lunch"* (McMahon et al., 2014, n.p.); others asked delivering women to wait while they passed urine, watched TV or took a phone call (Jewkes et al., 1998) or were sleeping while on duty (Bazant, 2008; Jallow, 2007; Jewkes et al., 1998; McMahon et al., 2014).

2.2 Social distance and 'othering'

The majority of studies paid very little attention to the wider context in which (dis)respectful care is embedded, focusing mainly on the mother-midwife dyad. Only three studies (Jewkes et al., 1998; Kruger & Schoombee, 2010; Spangler, 2011) explicitly examined the power dynamics and social context involved in this relationship, although many of the themes uncovered were identified in the background of other papers.

2.2.1 Social inequality

The social dynamics at play in the hospital did not occur in isolation, but mirrored those in their wider societies. Women's perceptions of midwives was of trained experts possessing technical skills and expertise for when things went wrong. They were often well respected, but this respect was, in some cases, tinged with fear. Migrant women in South Africa described being too afraid to approach midwives for help (Tebid et al., 2011); and in Ethiopia women felt embarrassed or too inferior to ask questions (Angelshaug, 2013). In some contexts, social distance was reinforced by the midwife's perceived educational status. For example, Malawian midwives were described as fluent in English and very well educated compared to the often illiterate women they served (O'Donnell et al., 2014); and Ethiopian midwives excluded women by speaking a mixture of English and Amharic (Angelshaug, 2013). Other women did not feel able to approach staff for help. In Tanzania, (Spangler, 2011, p.489) an unmarried girl suffered a retained placenta during a night time delivery at home but did not dare present at the health facility until the morning because *"Can you imagine? A daktari [doctor] or nesi [nurse] disturbed in the night by someone like me? The health facility is not for people like me."* Women's sense of being entitled to be in the labour ward seemed to be strongly associated with assessing intrapartum care as good and feeling respected. Positive experiences included being greeted (Duggan & Adejumo, 2012), midwives who *"make you feel at home"* (Mensah et al., 2014, p.31) or who *"treated me as her own daughter"* (Jeng, 2008, p.79). However, some women thought providers were unfriendly (Maputle & Nolte, 2008) and unhelpful (Kwaleyela & Kearns, 2009).

Participants, across a range of settings, described discrimination either in access to services or in how care was delivered. Those who were likely to have been the most stigmatised in their communities, experienced the same relative stigma in the health facility. Single (Sambou, 2012) or immigrant women (Tebid et al., 2011) found their reception unwelcoming. Teenagers were routinely verbally abused (Jewkes et al., 1998), not taken seriously or told they were too young (Duggan & Adejumo, 2012), while multiparous women were castigated for having too many babies (McMahon et al., 2014) or described being spoken to as if they were children (Jewkes et al., 1998; Kumbani et al., 2012). Women of lower socioeconomic status described lack of timely access to care and being forced to wait while women of higher status were seen first (McMahon et al., 2014; Spangler, 2011). Distancing from poorer women was expressed in verbal form. Village women were humiliated by personal comments accusing them of having a “*stinky smell*” (Chadwick et al., 2014, p.864) or being scolded for wearing dirty clothes (McMahon et al., 2014). In Ethiopia, rural women felt they were treated differently. “*...people from rural places, they do not even consider them as human beings.*” (Angelshaug, 2013, p.47). In other cases, they were derided for not presenting as ‘modern’ in terms of clothing or for preferring a standing delivery position (Angelshaug, 2013; McMahon et al., 2014; Spangler, 2011), while others dressed up when attending the health facility to give the impression they were well off and thus deserving of respect (Spangler, 2011). “*They take a look at you and when your clothes are like this and this they chase you away. Yes, they say, ‘You are supposed to have special clothes for pregnancy!’*” (McMahon et al., 2014, n.p.). Conversely, being known to health workers or hailing from the same ethnic group was perceived as resulting in favouritism and more attention (McMahon et al., 2014; Shimpuku et al., 2013).

For women who faced multiple oppressions, such as racial stigma as well as poverty, the results could be very unpleasant. This was more pronounced in countries with extreme social inequalities, particularly South Africa, than in other countries with less structural social disparity. Women perceived as deviant were publicly scolded to serve as an example to others (Jewkes et al., 1998), while a study with “Coloured low-income women” (Kruger & Schoombee, 2010, p.99) revealed they were blamed for acting like savages or told “*not to give birth like a barbarian.*” (p.94) Participants in this study also articulated the particular verbal and physical violence meted out to Black girls. “*Then they are rough with you. And especially the black girls. They are sommer [sic] hit, if they do not want to open their buttocks or if they don’t want to push, then they’re hit between the buttocks.*” (p.95) In Johannesburg, migrant women felt their care was culturally insensitive and disrespectful, reporting constant referrals by South African staff to ‘our’ medication, ‘our’ hospital and ‘us’ (Tebid et al., 2011).

2.2.2 Sexual shaming

Women’s accounts demonstrated that some of this discriminatory behaviour involved a degree of sexual shaming, laced with moral judgement, including comments about sexual activity when women vocalised their pain during labour. Teenagers in South Africa (Jewkes et al., 1998, p.1786) were told “*you didn’t shout like that when the men were on top of you*” or were asked intrusive questions unrelated to their medical status. Moral judgement was evident in the harsh treatment meted out to unmarried girls (Kruger & Schoombee, 2010), while in Tanzania, a sex worker was threatened with denial of care (Spangler, 2011). The subtext of these comments was that women’s pain was a deserved punishment for their sexuality and that they were judged as undeserving of care. In some contexts, discrimination

and sexual shaming spilled over into physical abuse, including slapping, pinching and rough handling.

2.2.3 Dirty work

'Dirty work', that which involves working with bodily fluids, is usually seen as culturally low in status (Kirkham, 2007). Sociological literature on 'dirty work' has long described attempts by various healthcare professions to delegate such work to those of lesser status (Twigg 2000). An unwillingness to do such work at all, or making others do it instead, is a strategy to improve one's professional and social status. This was a common theme in the literature reviewed. Women described being blamed for making a mess, and being ordered to clean up after themselves (Bazant, 2008; Chadwick et al., 2014; D'Ambruoso et al., 2005; Jewkes et al., 1998; Kruger & Schoombee, 2010; McMahon et al., 2014), sometimes even when birth was imminent (D'Ambruoso et al., 2005; Jewkes et al., 1998). A South African woman was threatened with violence if she did not fetch a sheet to deliver on (Jewkes et al., 1998), while a participant in Ghana said, *"She said because of the pushing I had soiled my pad and so she ordered that I should go and dispose of it myself...I had to crawl to the disposal bin."* (D'Ambruoso et al., 2005, n.p.). Only two studies reported positive instances of dirty work care. A Malawian participant said, *"The nurse was not disgusted that I was soiled, she wiped me clean...Therefore I see that I was properly cared for."* (Kumbani et al., 2012, n.p.). In Ghana, a woman praised her midwife, saying, *"She was the one who treated me kindly, performed the episiotomy and sutured it. When I bled on the floor, she cleaned."* (D'Ambruoso et al., 2005, n.p.).

The 'dirty work' element of the midwife's role was not just confined to the bodily elements of care but was also mirrored in social distancing from women deemed to be in some way inferior. This was manifest in examples such as a midwife refusing to allow a woman in pain to touch her (D'Ambruoso et al., 2005) or midwives physically removing themselves from women. *"...they didn't take note of us, they did their own thing, walked away, went and sat there on a couch, far away from us..."* (Chadwick et al., 2014, p.865).

Conceptual framework

Our synthesis of the literature uncovered a number of different ways in which women reported disrespect and abuse at the hands of midwives during labour and birth. Disrespectful 'care' appeared to primarily act to improve midwives' social standing in relation to women and occurred at two different levels. Firstly, in the direct assertion of power and control over women's bodies and knowledges; and secondly, by influencing their relative social status. These acts did not occur in isolation from their surrounding communities and societies. Inevitably, the inter-personal dynamics at play within the health facilities reflected the wider influences of local social norms and structures, a colonial legacy and the structure of wider health systems. In this way, the micro-level dyadic mother-midwife relationship was mediated by a number of meso- and macro-level factors.

In Figure 2 we have laid out these meso- and macro-level influences to show how they encircle and shape the inter-personal dynamics happening at a day-to-day micro-level. The flow of influence moves from the outside of our circle to the centre and shows how the disrespect and abuse of women by midwives is not simply a phenomenon in isolation and

neither can it simply be blamed on, or attributed to, individual healthcare practitioners. Our framework includes structural dimensions underpinning disrespect that are often neglected in discussing mistreatment of women. These macro-level causes are captured in the outer layer of the framework (Colonial legacy, Structural inequality and Health system – policy & drivers). The next layer reflects the meso-level influences (Medicalisation of birth, Midwifery history & training, Hierarchical & institution-centred, Work environment & resources, Poverty & inequality, Gender inequality/status of women). The inner layers echo the themes emerging from the synthesis, where the micro-level effects are played out in the woman-midwife encounter. These are Power and control (Controlling bodies and Controlling knowledge) and Maintaining midwives' status (The midwife's role and Social distance and 'othering').

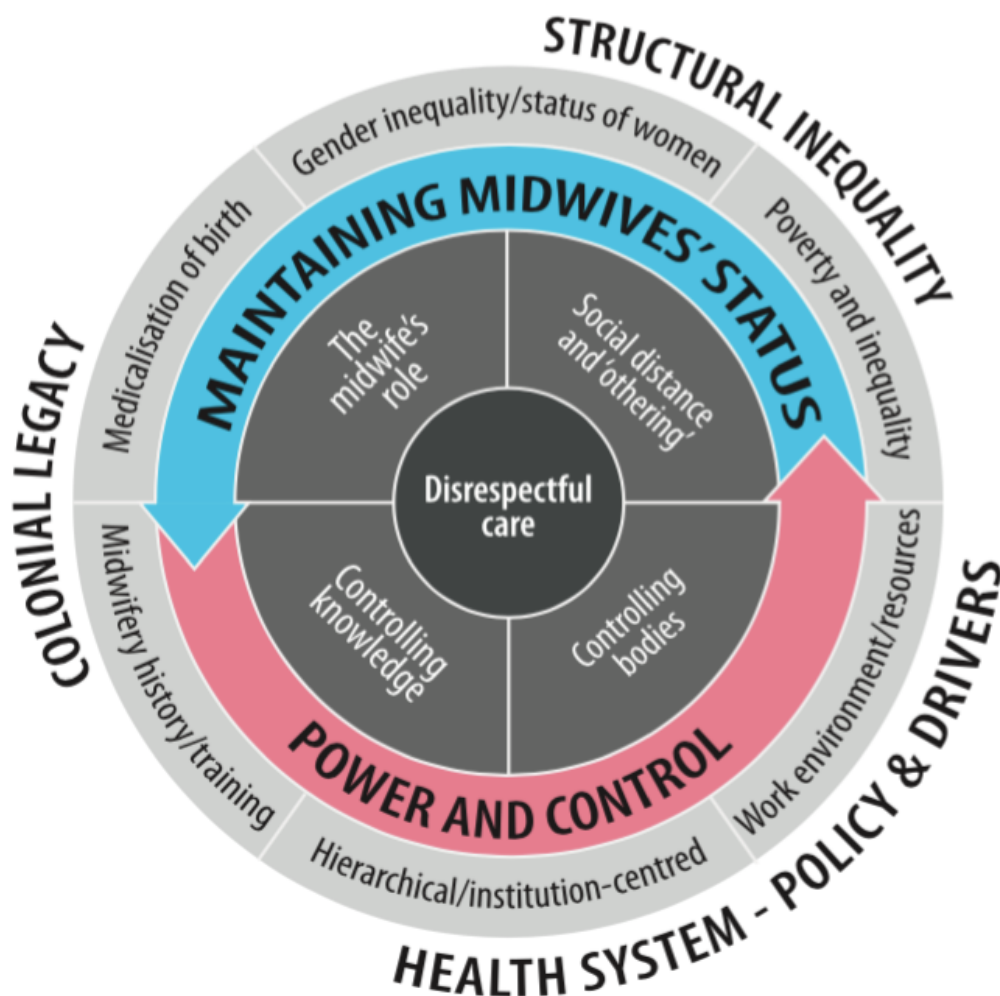


Figure 2. Conceptual framework - drivers of disrespectful care during facility-based delivery

This conceptual framework adds to the discourse by situating disrespectful care within a broader framework, which is cognisant of the multiple social and cultural factors that interact to drive disrespect. It can provide a useful starting point to unpack the most salient factors for different contexts and may aid our understanding of how and why different actors do or do not abuse women in their care.

Discussion

Our meta-synthesis used an interpretive approach to generate a more robust understanding of factors driving disrespectful maternity care in sub-Saharan African health facilities. The findings complement and support those of recent reviews on women's experiences (Bohren et al., 2015; Mannava et al., 2015; Srivastava et al., 2015), but move beyond these works to provide a conceptual framework that situates midwives' behaviour within the wider historical, social and health systems context. Using the interlocking and mutually reinforcing themes of Power and control and Maintaining midwives' status allowed us to examine more closely how macro- and meso-level drivers collide and interact at the micro-level of professional-patient relationships to drive the dynamics of disrespectful care. Our analysis chimes with calls from Latin America to reframe over-medicalisation and disrespectful care (obstetric violence) within a broader framework of structural inequality and violence against women, by making visible the power dynamics at play (Sadler et al., 2016).

Our synthesis revealed a prevailing model of maternity care that was institution-centred, medicalised and hierarchical, where the exigencies and rules of the institution were played out on women in demonstrations of power and control. The complexity of the social, cultural and biological aspects of childbirth was routinely ignored. Birth was situated as a purely medical event, a message reinforced by standards and initiatives promulgated by global agencies (Stone, 2009) and reflected in institutional control and handling, where women felt obliged to passively acquiesce and obey (Hillier, 2003). The enactment of the medical model in post-colonial contexts converged with the low status of women and with other forms of inequality to render women incidental to the birth process. Within this framework, authoritative knowledge rested with the institution, via its midwife intermediary, delegitimising and overriding women's embodied knowledge and thus allowing their needs to be ignored (Jordan, 1997). Facility norms and expectations subjected women to institutional control and handling, robbing them of agency and control, while the lack of recourse or accountability left women with no option but to comply.

The majority of studies included in this review (23/25) took place in former British colonies. One of the legacies of colonialism in SSA was to warp the process and experience of childbirth, denigrating traditional knowledge and ways of birthing. In the imperialist project, birth became an object of colonial governance, providing an opportunity to exercise demographic and social control (Hunt, 1999), while the superiority of Western medicine and education was part of a socialisation process aiming to eradicate 'barbarity' and unacceptable customs (Kanogo, 2005; Thomas, 2003). The Christian missions were, and often remain, key actors in training nurse-midwives, using technically focused, European curricula and models of care, historically rooted in notions of moral and social superiority (Marks, 1994), modernity and progress. These ideas continue to manifest in the judgement, sexual shaming and punishment reported by women in this review and in discriminatory actions against women deemed unworthy. Efforts to maintain status, particularly in South Africa, may reflect the struggle of Black African midwives for legitimacy in the face of colonial systems whose notions of race and gender limited their role and agency (Coovadia et al., 2009; Marks 1994).

Although not explicitly stated in the papers, structural violence (Galtung, 1969) was a shadow in the background of many studies, particularly those based in South Africa, which correspondingly has the largest social inequalities of all of the countries represented.

Women's race, poverty or status overtly influenced the timeliness and quality of care they received. Women deemed 'modern' or 'worthy' often received preferential treatment and deliberate decisions were made to actively withhold, neglect or ignore women deemed 'other'. Using their discretionary powers in this way, midwives act as street-level bureaucrats (Lipsky, 1980), attempting to marry the care needs of women with the demands of the institution and their own overwhelming workloads. These discriminatory practices can become normalised when accountability is lacking (Harris et al., 2014). In such circumstances, midwives effectively become a conduit for disrespect and abuse, which in hierarchical health systems may also serve to reaffirm midwives' own insecure status (Leape et al., 2012).

The nexus between the medical model and midwives' attempts to secure their status is the fragile professional role of midwives. Although women reported high regard for midwives, it remains the case that midwives are at the lower end of the medical hierarchy, caught between the lower status women in their care and the higher status cadres in the health system. This is crucial in understanding the power dynamics at play in disrespectful care. In health systems hierarchies, lower cadres carry out intimate body work (Twigg, 2000), such as the polluting and 'dirty work' of labour and delivery (Callaghan, 2007; Kirkham 2007). In some women's accounts, this aspect of care was delegated to the women themselves, even at extremely vulnerable points during birth. Further, there was a tacit understanding, evidenced across many countries, that midwives would be present and take action only when women reached the second stage of labour. This can be viewed as a mechanism for midwives to demonstrate their professional, clinical role. Elements of care such as emotional support appear to be considered unskilled and the role of non-professionals, such as traditional midwives or family members. By *not* carrying out this element of care, midwives relegate the lower status role of being 'with woman' to someone else (Witz, 1992).

In addressing the issue of disrespectful care it is important to move beyond blaming individual health workers to try and understand the drivers and context. Many aspects of poor care may legitimately be ascribed to the prevailing difficult circumstances health workers face and some participants appreciated the challenging situation in which midwives are working. Chronic staff shortages, lack of resources and inadequate supervision and support are the reality across much of SSA (Chen et al., 2004) and their role in disrespectful care has been well documented in a recent review (Bohren et al, 2015). Limited resources make power issues more visible, throwing them into sharper relief, but also interact with inequality to exacerbate the power dynamics at play. These health systems constraints also undermine midwives' performance and professionalism and are a source of considerable distress (Bradley et al., 2015). Organisations that do not respect or support their health workers are unlikely to prioritise respectful care for women either. The lack of facility-level accountability also makes it easier for disrespect and abuse to be normalised and tacitly sanctioned. Dissonance between midwives' view of themselves as professionals and the often impossible situations in which they work may exacerbate the distancing behaviour described by women in our analysis. Further dissonance may be experienced by midwives whose practice preference would tend towards being 'with woman' in a hierarchical context where being too nice can undermine status and where strictness and not showing emotion are part of the professional persona. This may be particularly potent when there is a large social gap between marginalised women and educated health professionals. Distancing may

thus be construed as an act of self-preservation that helps buffer midwives from emotional demands and an institutional-centred, medicalised ideology (Hunter, 2004).

Future research

Our review looked at the dynamics of disrespectful care using the lens of women's experiences. Largely missing from the literature is the voice of the midwife. We lack an understanding of midwives' perceptions of the value and practice of women-centred care in SSA, yet any efforts to change the current performance and dynamic of birth will rely on their participation. Nor is there much literature on the impact of disrespectful care on midwifery staff in this context, although it is difficult to imagine the current power differentials and dynamics do not harm them too. Midwives regularly face the reality of maternal death, poor outcomes and blame, and there can be negative consequences for them as well as for the women in their care. Overtly negative media attention, combined with external pressures from international organisations (e.g. WHO) and international advocacy agencies (e.g. WRA) have left many midwives feeling unappreciated and demotivated. If respectful interpersonal care is part of 'good' midwifery, then the impact of not providing it may be detrimental to midwives' sense of professionalism, personal ethics and humanity. Further research is needed to explore how professionalism is defined and conceptualised in African contexts and how it may intersect with the psycho-emotional aspects of obstetric care. Such evidence can help to identify the drivers of, and barriers to, respectful maternity care, and be used to inform locally and regionally appropriate strategies with the potential to improve the obstetric care environment for both women and midwives.

Methodological considerations

Using the CASP tool to assess studies was a challenge. Some scored well on methodological technique, but had faults in terms of how data were collected, such as interviewing women within the health facility (D'Ambruoso et al., 2005; Duggan & Adejumo, 2012; Dzomeku, 2011; Floyd et al., 2014; Jeng, 2008; Kumbani et al., 2012; Maputle & Nolte, 2008; Mensah et al., 2014; Okwako & Symon, 2014; Shimpuku et al., 2013). Others demonstrated a lack of attention to reflexivity, yet produced rich data (Chadwick et al., 2014; McMahon et al., 2014; O'Donnell et al., 2014). A sensitivity analysis revealed that lower quality studies (Duggan & Adejumo, 2012; Dzomeku, 2011; Eustace & Lugina, 2007; Jeng, 2008; Murira et al., 2010) made only a modest contribution to the synthesis and provided few unique findings, but removing them had no impact on the main themes of the synthesis.

Those studies that were situated in former British colonies could be expected to have a similar colonial educational system and history of midwifery training. It is likely that our analysis reflects women's experiences and the drivers of disrespect in other SSA countries that were formerly under British rule. However, there are differences in the degree of inequality in some of the countries included. This is most notable in South Africa, which is somewhat of an anomaly in the region as it has pockets of considerable privilege, reflected in differences in the quality of interpersonal care between private and public health facilities. The two remaining studies were carried out in Ethiopia. One (Angelshaug, 2013) identified many of the main findings seen in the main cohort, but to a lesser degree; while the other (Mirkuzie, 2014) reported better care at the health centre than at the hospital. The dearth of studies capturing women's voices in francophone or lusophone countries warrants further research.

Western researchers have been critiqued for investigating women's experiences without considering the impact of colonial legacy, power and social inequalities in the woman-midwife relationship (Kumar, 2013). Our focus on SSA and the inclusion of texts from authors within the region and across a range of publications (including smaller journals and student theses) allowed the voice of women to be more authentically captured. Further, the authors' positionality as feminist, critical realists, who view social reality as historically and culturally constructed and situated, underpins the synthesis. This reflexivity makes transparent the awareness that themes distilled from the analysis represent a reality that is partial, positional and fragile (Reid et al., 2009).

Conclusion

Midwives are caught between a medical model of birth, written into and reflected in the way services are organised, influenced by macro-level social forces and the traditional, social model of birth. Women are caught too. Global efforts to encourage facility-based delivery too often force women to trade the psycho-emotional care they would receive from traditional midwives for the technical care that midwives are currently offering, when in reality they should receive both. The care that many women experienced did not match their needs for compassion, presence and safety. The absence of a midwife (and frequently any companion at all) during the first stage of labour and the harshness of their treatment, disproportionately meted out to more marginalised women, justifies their continued eschewal of facility-based delivery or a calculated, but risky, decision to arrive at the facility as close to delivery as possible. The false compartmentalisation of technical quality and safety from the interpersonal aspects of care has done women in resource-poor settings a considerable disservice.

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