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Review article

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.

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1. 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),

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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 and 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 and 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 and 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 and 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?

2. 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 and 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.

2.1. 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.

2.2. 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.

2.3. Data extraction and synthesis

Data extraction and synthesis followed Thomas and 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.

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