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Disrespect and abuse in maternity care: individual consequences of structural violence

Andrea Solnes Miltenburg [a], Sandra van Pelt,[b] Tarek Meguid,[c] Johanne Sundby[d]

a PhD student, Institute of Health and Society, Department of Community Medicine and Global Health, Faculty of Medicine, University of Oslo, Blindern, Norway. *Correspondence*: a.solnesmiltenburg@gmail.com

b Registered Nurse, Project Coordinator at Women Centered Care Project, African Woman Foundation, Mwanza Region, Tanzania

c Consultant Obstetrician and Gynecologist, Department of Obstetrics & Gynaecology, Mnazi Mmoja Hospital, Zanzibar, Tanzania

d Professor at Institute of Health and Society, Department of Community Medicine and Global Health, Faculty of Medicine, University of Oslo, Blindern, Norway

Abstract: *Disrespect and abuse of patients, especially birthing women, does occur in the health sector. This is a violation of women's fundamental human rights and can be viewed as a consequence of women's lives not being valued by larger social, economic and political structures. Here we demonstrate how such disrespect and abuse is enacted at an interpersonal level across the continuum of care in Tanzania. We describe how and why women's exposure to disrespect and abuse should be seen as a symptom of structural violence. Detailed narratives were developed based on interviews and observations of 14 rural women's interactions with health providers from their first antenatal visit until after birth. Narratives were based on observation of 25 antenatal visits, 3 births and 92 in-depth interviews with the same women. All women were exposed to non-supportive care during pregnancy and birth including psychological abuse, physical abuse, abandonment and privacy violations. Systemic gender inequality renders women excessively vulnerable to abuse, expressed as a normalisation of abuse in society. Health institutions reflect and reinforce dominant social processes and normalisation of non-supportive care is symptomatic of an institutional culture of care that has become dehumanised. Health providers may act disrespectfully because they are placed in a powerful position, holding authority over their patients. However, they are themselves also victims of continuous health system challenges and poor working conditions. Preventing disrespect and abuse during antenatal care and childbirth requires attention for structural inequalities that foster conditions that make mistreatment of vulnerable women possible.* DOI: 10.1080/09688080.2018.1502023

Keywords: Disrespect and abuse, maternity care, quality of care, structural violence

Introduction

Tanzania has made slow progress in reducing maternal mortality, failing to achieve Millennium Development Goal 5.[1] Significant progress between 1999 and 2015, however, was achieved in increasing facility births (from 47% to 63%).[2] While this is a reason for optimism, over recent years several studies have reported evidence that raises concerns about the poor quality of care women receive in some of these Tanzanian institutions, including frequent experiences of disrespectful and abusive treatment by health providers during childbirth.[3–5]

Disrespectful and abusive treatment during childbirth is a violation of women's fundamental human rights, can negatively influence birth outcomes and discourages women from seeking future care.[6] Numerous individual practices and behaviours of health care providers can be considered as disrespectful and abusive, depending on the definitions that are used. Examples range from behaviour being non-supportive (such as not providing information) to physically harmful practices (such as slapping or beating).[7]

Supplemental data for this article can be accessed at https://doi.org/10.1080/09688080.2018.1502023

Mistreatment of women in health facilities is rooted in pervasive gender inequalities and power imbalance between health providers and women.[8] Therefore, disrespect and abuse can be viewed as a consequence of structural violence.[9] Structural violence refers to social forces that create and maintain inequalities within and between social groups, which make way for conditions where interpersonal maltreatment and violence may be enacted.[11,12] Although the term "violence" speaks to the physical nature of disrespect and abuse in childbirth, the essence of structural violence lies in the indirect, systematic and often invisible infliction of harm on individuals by social forces that disable individuals from having their basic needs met.[11] We may be tempted to analyse this phenomenon in a narrower framework, such as seeing women as "victims" and health workers as "perpetrators" of abuse.[13] However, the mistreatment of women in health facilities is systemic and requires a more structural analysis to look at the issue as a consequence of women's lives not being valued by larger social, economic and political structures.[14,15]

Despite 30 years of action at the global level to improve care for women during pregnancy and birth, many countries, including Tanzania, have never been able to make the financial investments required.[14] Instead, expenditures for maternal health over the past decades have increasingly relied on household contributions.[1] In response to structural adjustment policies, the Tanzanian government introduced cost-sharing and decentralisation and reduced the already limited number of health workers and their salaries. Up until today, the human resource scarcity remains a major bottleneck.[16] At the same time, the population has doubled, increasing the burden on a fragile health system. HIV/AIDS and more recently non-communicable diseases have contributed to this fragility.[17] It is not surprising that increasing resource challenges and overload of health facilities have resulted in decreased health worker morale, lack of compassion, fatigue, and sometimes burnout, which are often reported to be underlying reasons for mistreatment of women.[18,19]

Over a decade ago it was suggested that ensuring respectful, high-quality care for all women was a matter of political will to value the lives of women and newborns.[20] Nevertheless, the Safe Motherhood policy discourse remained focused on technical solutions and scaling up simple disease-specific interventions, particularly a focus on skilled birth attendance and access to emergency obstetric care.[21–23] Simultaneously, health system challenges, including limited resources, insufficient training and poor working conditions of health providers, continued and/or deteriorated even further. Disrespect and abuse during childbirth occurs in an impoverished social and political context, in which women's broader needs during pregnancy and birth have been systematically ignored or devalued. In this paper, we describe how and why women's exposure to disrespect and abuse in health facilities should be seen as symptomatic of structural violence.

Methods

Study setting

The study took place from September 2015 to February 2017 at two health centres and one district hospital in the Lake Zone in Tanzania. Facilities were selected based on our previous involvement in the district, ensuring familiarity with the leadership and health professionals. All three facilities were assessed in terms of basic infrastructure, staffing, resources and quality of service provision as part of a district-wide emergency obstetric care assessment. None of the facilities in the district performed in accordance with international guidelines, primarily influenced by lack of available resources and an insufficiently functioning health care system.[24] Some basic characteristics of the three health facilities are provided in Table 1.

Researchers positioning

ASM (a medical doctor) and SP (a nurse) both speak Kiswahili and spent several years in the study area. Both authors were involved in setting up and managing a community-based project and volunteering at different health facilities in the study area. During the data collection period, both spent a total of 52 days at the antenatal care (ANC) clinics or maternity wards of these facilities, observing and participating in care provision. For ASM, this sometimes meant active participation in the form of providing ANC and assisting births. SP remained as an observer but also assisted with minor tasks. JS and TM supervised the study and both have extensive experience working in similar settings in sub-Saharan Africa. All authors were trained in a high-income setting and approached this study from a biomedical perspective. This study was performed with attention to

Table 1. Basic characteristics of health facilities

	Health center 1	Health center 2	District hospital
Location	30 km from district town center, access via tarmac road, centrally located	30 km from district town center, rural location, rough road	In the district town center
Staffing	1 assistant medical officer, 4 clinical officers/assistants, 14 nurses and 4 medical attendants (total staff)	2 clinical officers, 6 nurses and 2 medical attendants (total staff)	ANC clinic: 2 enrolled/registered nurses and 2 medical attendants. Maternity ward: 3 nurses and 2 medical attendants (daily presence, morning shift)
Basic facility statistics 2015/ 2016 (monthly average)	153 ANC visits, 58 births	149 ANC visits, 75 births	550 ANC visits, 262 births

respectful maternity care as defined by the World Health Organisation.

At many of the health facilities visited, the authors observed a lack of respectful maternity care. ASM and SP's long-term involvement in the study area revealed the challenging working conditions of health providers that compromised their ability to provide quality care. Many of the health facilities were in a state of collapse and the basic infrastructure allowed for little room to ensure patient privacy. Health providers frequently shared their struggles in terms of their working environment, underpayment and long working hours. With few exceptions, ASM and SP experienced that all health providers intended to provide good care, aiming for good outcomes and thus this paper, does not indicate health provider perspectives or intentionality of their behaviour.

Study population

Fourteen women were purposively selected with different obstetric backgrounds, age groups and poverty levels. All women had a vaginal birth and half of the women gave birth at home. They were followed up throughout their pregnancy, birth and post-partum period. Recruitment was done in a staggered way to ensure researchers did not follow more than four women at the same time. Women's characteristics are presented in Table 2. Socio-economic status was categorised based on a number of indicators including possession of assets (mobile phone, livestock, furniture) and living conditions (e.g. housing structure, electricity, type of water source). Additional details can be found in Supplementary File 1.

Data collection process

Following selection of women during observations at the ANC clinics, ASM and SP scheduled subsequent observations at the clinics for the expected days of women's return visit. In total, 25 antenatal visits of these women were observed. On some occasions, visits were not observed because women did not show up, did not receive services, or were attended to while the authors were unable to be present. Additionally, observation days were scheduled at the maternity wards for women's expected dates of delivery. Aspects of the birth process were observed for three of the seven women that gave birth in the health facility. In total, 92 in-depth interviews were held with all women, scheduled 1–2 weeks after each of their clinic visits and after birth. Additional interviews were held if further clarification was needed. Interviews were conducted in Kiswahili, lasted 1–3 hours and took place at the women's home, or a location of their choosing. As a starting point, the focus of the interview was on women's perceptions and experiences related to their previous visits at the health facility, discussing both clinical and interpersonal aspects of care provision. Probing questions were asked based on the women's antenatal cards and on the observations. The way women define and explain events is influenced by their background and previous experiences,[25] therefore interviews included questions

Table 2. Overview of individual characteristics, health care seeking behaviour and outcome

Name[a]	Age	No of observations	No of interviews	Years in school	Work	Marital status	SES[b]	Age first birth	Previous birth location	Facility distance	ANC visits	Birth location	Newborn Outcome
Rory	22 years	2 ANC visits Birth partial	6	11	Yes	Married	3	18	1F 0H	1–5 km	4	District hospital	Alive
Diana	30 years	3 ANC visits	8	7	Yes	Married	4	22	2F 0H	<1 km	5	District hospital	Alive
Jessica	25 years	3 ANC visits	8	6	No	Married	2	18	1F 3H	5–10 km	5	District hospital	Alive
Angel	22 years	1 ANC visit	5	7	No	Married	3	17	1F 0H	1–5 km	3	Health centre	Stillbirth
Flora	21 years	2 ANC visits	7	7	No	Married	1	19	0F 1H	5–10 km	4	Health centre	Infant died at 3 months
Jane	18 years	0 ANC visit Birth	5	9	No	Relationship	3	-	- -	1–5 km	3	District hospital[c]	Infant died at 6 months
Tara	37 years	0 ANC visit Birth assisted by researcher	6	5	No	Relationship	2	16	5F 1H	<1 km	2	Health centre	Alive
Maria	22 years	2 ANC visits	7	7	Yes	Relationship	3	14	0F 1H	<1 km	2	Home	Alive

(*Continued*)

Table 2. Continued

Bea	29 years	2 ANC visit	5	11	Yes	Married	4	24	2F 0H	1–5 km	3	Home	Alive
Pili	19 years	4 ANC visits	8	7	No	Married	3	17	1F 0H	>10 km	4	Home	Alive
Naima	19 years	1 ANC visit	7	7	No	Married	1	16	1F 0H	>10 km	3	TBA home	Alive
Mariam	32 years	1 ANC visit	6	7	No	Married	2	22	3F 2H	1–5 km	4	Home	Alive
Paulina	37 years	2 ANC visits	8	5	No	Married	1	16	3F 4H	>10 km	5	Home	Alive
Helena	31 years	2 ANC visits	6	4	No	Married	3	17	2F 4H	1–5 km	3	Home	Alive

Note: ANC: antenatal care; No: number; SES: socio-economic status; F: Facility; H: Home.
[a]Names are pseudonyms.
[b]All women are poor, but category for socio-economic status is determined based on a number of indicators including possession of assets, living conditions and personal background. Category levels range from very poor category 1 to more well off category 4.
[c]She was transferred from the health centre to the district hospital with the ambulance.

about women's childhood, their first pregnancy, marriage and subsequent pregnancy experiences, if any. Previous and current choices the women made in relation to care seeking or with regard to other major life events were discussed, providing information about women's perceptions of their self-efficacy, their social identity and the influence of their social networks.

Data collection tools

Observation of behaviour is highly subjective and challenging, particularly if conducted in a cultural setting different from the observers, since behaviour can be enacted differently across cultures.[26] However, health providers in Tanzania are expected to perform according to standards of professional conduct.[27] These standards include guiding principles that must be followed when caring for patients, such as ensuring to obtain patient consent before providing care and protecting confidential information. To reduce the influence of the author's personal judgment, observation guidelines were developed in line with these standards to provide some level of standardisation to the interpretation of what was observed. Few instruments exist for observation of interactions and behaviour of health providers in maternity care in low-income settings.[28] Considerably more work has been done in high-income countries, often limited to intrapartum care, or with reference to nursing care in non-maternity settings.[29] Based on existing literature reviews,[7,28,30–32] categories and sub-dimensions for both supportive (Table 3) and non-supportive behaviour (Table 4) were developed. The categories of disrespect and abuse as defined in previous studies have a tendency to be either too narrow,[31] or too comprehensive[7] for practical use. For these categories, complex concepts were avoided (e.g. non-dignified care), potential overlap between categories was reduced (e.g. physical abuse, sexual abuse) and the total number of categories was limited.

Analysis

Analysis of observations and interviews occurred continuously throughout the data collection period. Detailed reports were written after each observation day. All interviews were recorded and transcribed in Kiswahili and translated into English by a research assistant. Transcripts and observation reports were synthesised and, in dialogue with the women, were placed in chronological order based on the timeline of women's lives.

Through this, we developed detailed narratives of women's reproductive lives and interactions with the health facility during their current pregnancy. Narratives can be a tool to unravel the unconscious structures, conventions and norms through which people make sense of and cope with their lives.[33] For the purposes of this paper, we analysed the narratives in two phases. First, we performed a deductive thematic analysis of narratives, whereby we coded situations exemplifying supportive care and non-supportive care. Second, we looked at women's daily experiences through the lens of structural violence. We analysed women's exposure to non-supportive care in relation to the social context, deconstructing the categories of care and their meanings, forming overarching themes.

Validity

We took several measures to ensure the validity of the development and interpretation of the narrative text. First, the increased familiarity between the researchers and the women resulted in increased confidence and trust in the researchers. Women shared personal details they had left out initially and offered less socially desirable answers. Second, conducting several interviews allowed us to revisit previously discussed issues, gain clarification and further explore questions that arose during the writing of the narrative. The intervals between the interviews also allowed both the researchers and the women time for reflection. Third, the authors encouraged women to think

Table 3. Categories and sub-dimensions of supportive behaviour

Category	Sub-dimension
Emotional support	Observes, identifies and responds to signs of emotion, stress, fatigue, pain. Makes statements to reassure and encourage woman. Is friendly, open and gentle. Introduces self, smiles, has a pleasant facial expression. Positive laughter, joking, social chitchat, humour. Uses words, phrases and non-verbal expressions to express concern and empathy. Relaxed calm demeanour, soft calm voice. Keeps company with no tasks being performed, showing undivided attention (eye contact, woman-direct gaze, leaning forward). *Birth specific:* Active engagement and encouragement during contractions, verbal- and non-verbal, expressions affirming woman's ability, praise.
Physical support	Assists patient gently and in a culturally sensitive way during examinations. *Birth specific:* Offers, checks, encourages and assists woman to take fluids/food, go to toilet regularly, changes clothing and linen, showers or bathes. Provides pain medications, encourages relaxation or other ways of support (counter pressure, assists in walking, assuming different positions). Coaches through labour such as with breathing and relaxation or touch (holding hand, massage).
Effective communication	**Gives explanations**: Explains to woman when to contact the midwife, explains what needs to be done in case a complication occurs. Explains procedures or treatment, what is done and why and informs of findings. **Gives information**: Provides update on progress of pregnancy and birth. **Gives instructions**: Instructs woman what to do during pregnancy including how to cope with normal pregnancy symptoms. Informs woman where to go if supplies are not available. *Birth specific:* instructs patient during and after birth how to participate to improve outcome, information on how to cope with pain, coaching during pushing. Advises patient to change position, walk around, breath in and out for comfort. **Involves**: Provides woman with options and involves in decision-making. Asks woman if she has questions and encourages her to ask questions.
Nursing proximity	Is accessible, comes quickly when woman or family member calls, expresses accessibility verbally, encourages woman to request assistance and express needs, faces the woman and position at the same level.
Privacy respected	Ensures privacy and confidentiality: uses curtains, sheets, and positions to avoid exposure, discusses privately with client or with colleagues or with family, minimises interruptions.
Consent	Asks for permission before performing examination or medical procedures.

Table 4. Categories and sub-dimensions of non-supportive behaviour

Category	Sub-dimension
Psychological abuse	Verbal aggression such as shouting/scolding, threats, insulting, laughter (negative belittling humour or sarcasm), name-calling. Dominant behaviour such as preventing woman from doing certain things she wants or forcing certain actions. Demanding woman to clean after delivery. Discriminatory behaviour such as not providing care for reasons related to race, gender, age, HIV status, marital status.
Physical abuse	Pinching, slapping, pushing, beating, poking, sexual harassment or rape. Forced (unnecessary) examinations, excessive and inappropriate medical interventions, episiotomy and stitching without anaesthesia.
Non-support	Includes behaviour which is not necessary harmful [in contrast to with physical or psychological abuse] but is also not supportive: ignoring of cues, ignoring contractions (talks, discusses, performs actions during contractions), loud/harsh/cold tone, undermining efforts, nervous restless demeanour, cold or angry facial expression, criticism of woman's behaviour, doubts expressed about woman's ability. Absent behaviour such as no introduction, no discussion of wishes of woman, no explanations or information given, no encouragement, no expression of empathy.
Abandonment	Woman is ignored when seeks or asks for care, neglected when asks for help, left unattended, gives birth alone. Delay in receiving intervention when needed, failure to provide supplies even if supplies are available, failure to offer services when staff are adequate and on duty.
Privacy violation	Medical information shared with other patients or family members (such as HIV status shown to others, discuss issues with other clients present). Being unnecessarily uncovered during clinical examination or labour, no use of available screens or lack of attempt to provide privacy. Sharing of beds with other patients. Frequent interruptions and attendance of different staff members.
Non-consented care	No permission obtained before examination for medical procedures.

more critically about the interpersonal behaviour of health providers in relation to norms and values of social interactions in daily life. We explored local perspectives on the interpretation of behaviour through discussion of the narratives with a small group of local health professionals including a male Tanzanian gynaecologist/obstetrician and a female midwife. The group also included a young mother (ICT specialist) with both positive and negative birth experiences. The group was consulted in relation to the observation guidelines mentioned above. As women were included gradually and data collection and analysis occurred simultaneously, discussions with the group guided our focus with women who were subsequently included.

Ethics

Ethical approval was granted by the National Institute of Medical Research in Tanzania (MR/53/100/103-349-399) and a research permit was granted by the Tanzanian Commission for Science and Technology (No. 2015-255-ER-2013-32). The Regional Committee for Medical and Health Research Ethics, Section A, South East Norway (2015/1827), and the Norwegian Social Science Data Service (44482/3/MHM) both reviewed the study and agreed that it was in accordance with the Norwegian Personal Data Act. Health workers and participating women gave written informed consent. We ensured anonymity in note taking and pseudonyms are used for participant names.

Findings

All women were exposed to both supportive and non-supportive care, including instances of disrespect and abuse, throughout their pregnancy and birth. Half of the women described similar experiences during previous pregnancies and births. Tables 5 and 6 give an overview of both supportive

Table 5: Examples of exposure to supportive care in the current pregnancy

Name	Type of supportive care	Examples
Rory	*ANC:* Effective communication	Received quick services during her second ANC visit and was asked if she has any problems.
	Birth: Physical support	During admission for birth one nurse escorted her to the waiting area and helped her find a bed.
Diana	*Birth:* Emotional support, nursing proximity, effective communication	During birth she was attended gently and in a friendly way. Nurse came when she asked her to and she experienced the nurse to be with her at all times during the birth. Was given instructions on how to push.
Jessica	*ANC:* Emotional support	She was given priority when she came with her husband during her first ANC visit. She liked that she was allowed to sit on the front bench and was given services quickly. She was approached in a friendly way.
	Birth: Emotional support, physical support, effective communication	During birth she felt she got very good service. The nurses were gentle and friendly to her. She was explained what was causing her to delay giving birth and nurses directed her what to do after they ruptured the membranes. They helped her to carry her things, cleaned her and carried her baby.
Angel	*ANC:* Effective communication	During one ANC visit a nurse was providing health education about HIV prevention and testing, was giving explanations and involving women.
Flora	*ANC:* Emotional support, effective communication	During her second visit, she was given good services. It was discovered she was HIV positive. Nurses ensured they were sitting in a private place. The nurse used humour, a soft tone of voice and had regular eye contact. She was given explanations and instruction about her condition and the medication.
Jane	*ANC:* Emotional support, effective communication	She was happy with the services during the first ANC visit, nurses were swift in providing care and helped each other when it was busy so that she did not have to wait long. During her third visit, she was told the baby was doing fine.
	Birth: Physical support, emotional support	Upon arrival at district hospital for birth, the nurse assisted her to get on the bed and instructed her how to lie. When the nurse noticed the examination was painful, she tried to comfort Jane, told her in a soft tone of voice to try to relax and keep her bottom down on the bed.
Tara	*ANC:* Emotional support	The ANC clinic was closed one day when she went for a check-up outside of her scheduled visits because she was feeling sick. She was instead directed to be seen by the doctor.
	Birth: Emotional support	During birth the nurse was considerate for her HIV status and made sure the person accompanying her did not find out. Was given good services after birth. Was told to lie down to rest for a while after birth and not get up immediately. (Note: The researcher assisted this birth.)
Maria	*ANC:* Effective communication	During her second ANC visit, nursing students asked her for consent before performing physical examination. They were polite and friendly to her.

(*Continued*)

Table 5: Continued

Bea	*ANC*: Effective communication, nursing proximity, emotional support	During her first ANC visit, a nurse was providing health education about HIV prevention and testing, was giving explanations and involving women. She was seen immediately by a doctor who asked her name and spoke about her problem. He looked at her while asking and expressed a friendly attitude; he was gentle and listened to her.
Pili	*ANC*: Emotional support	During second and third ANC visit she had positive social talk with the nurses.
Naima	*ANC*: Effective communication	During her second ANC visit she was told the baby was fine and that he was playing inside. Was instructed to go and see the doctor if she was having pains or other complaints.
Mariam	*ANC*: Effective communication	Was told everything was fine during all her ANC visits.
Paulina	*ANC*: Emotional support	During her third ANC visit, she was listened to with regard to her symptoms and allowed to change her HIV medication.
Helena	*ANC*: Emotional support, effective communication	During her first ANC visit, she was informed about the condition of the baby and given an explanation together with her husband on what to bring during birth. The nurse ensured privacy during HIV testing, closed the door and asked for consent and explained the procedure.

and non-supportive care that women were exposed to during their recent pregnancy and birth.

Normalisation of absence of care

Women and health providers often interacted in complete silence and care provision was frequently devoid of any form of verbal communication. Women were rarely greeted or welcomed and were not addressed beyond simple instructions such as "*simama hapa*" (stand here), "*panda*" (climb) or "*kaa*" (sit). This is a cultural deviation, as greetings are very important in all social interactions in Tanzania. Women were not always informed about the findings of examinations or results of laboratory tests and they rarely received information about the system of care provision. Additionally, women's concerns, opinions and knowledge were frequently ignored.

"They check and see what they see, they don't tell us whether it is positioned well or not, they don't say, they just measure." (Paulina, interviews)

"I don't like it […], but that's how it is. Does she [nurse] listen [to us]? […] She asks, we listen, it's just normal." (Helena, interviews)

"Those nurses, even if you tell them, they don't care […] because when you tell them they don't really concentrate on what you are telling them, they are just doing their business and just looking at you as if you are nothing and then continue with their business, with other work." (Pili, interviews)

Some of the women were not believed when they informed the nurses about their last normal menstrual period, resulting in conflicting opinions on the gestational age. Even if they disagreed, most of the time women did not argue with health providers. They did not want to risk being scolded or blamed for "thinking they know it all", putting them at risk of not receiving care. If women were feeling sick their symptoms were sometimes dismissed as being irrelevant. Most of the time, however, women would not inform nurses if they were having problems, partly because they did not expect much from them:

"Even when you tell them, with what will she help you, even when you talk it will stop you from telling them […] even if you tell them they don't have medicine, […] these nurses … it is just a waste of time […] I don't think they will advise me." (Pili, interviews)

Table 6: Examples of exposure to non-supportive care in the current pregnancy

Name	Type of non-supportive care	Examples
Rory	*ANC:* Psychological abuse, non-supportive care	During her first ANC visit she decided to keep quiet when she heard nurses speak harshly towards other women. She was placed at the end of the waiting line because she did not come with her husband. She was unnecessarily sent back and forth between different rooms without receiving services. She was not welcomed, lack of communication including no information provision about the wellbeing of her baby or herself. No consent or information provision during HIV testing. Was given a return date on a national holiday.
	Birth: Physical abuse, non-supportive care, abandonment	Forced vaginal examination during birth despite protest and expressing physically and verbally that it was painful. Not welcomed upon arrival at the facility. Her card was taken from her without any communication. No information provision after examination other than "later", meaning she needed to go to the waiting area because birth was not imminent. Nevertheless, she gave birth 30 min later. Despite calling repeatedly for the nurse to help her, the nurse remained at a distance only to come closer when the head was crowning.
Diana	*ANC:* Non-supportive care	During her first ANC visit she had to wait unnecessarily long, was sent back and forth and left to wait uninformed until she was told to come back tomorrow without explanation why and for what. General lack of communication during other clinic visits without information on the wellbeing of her baby and herself.
	Birth: Non-supportive care	Other than being told birth was not until "later" she remained both at the waiting area and labour ward for a long time (total 24 h) without information about the progress of labour or condition of the baby or herself despite her own expressed worries about the amount of blood she had lost.
Jessica	*ANC:* Non-supportive care, privacy violation, non-consented care, psychological abuse	During her first ANC visit she was not given explanation of the findings of laboratory investigation. Was ignored when she informed the nurse about her complaints (stomach ache). She was given a return date on a Sunday. During physical examination at her first visit, there were many interruptions by students coming in and out. Was reprimanded for coming too late to her second clinic visit and threatened she would not receive services. HIV test was performed without counselling or asking for consent.
Angel	*ANC:* Non-supportive care	During her first ANC visit she was not provided with the ANC card and therefore had to buy and bring a notebook. She had been seen for ANC the morning of the day that she delivered a stillbirth. During this visit her stomach ache was dismissed as being part of normal pregnancy symptoms, she was not informed about her condition or that of the baby.
Flora	*ANC:* Abandonment, non – supportive care	For her first attempt to visit the ANC clinic she was refused services because she did not come with her husband During her actual first visit she was not welcomed, no explanations were given about the service received, no safe space to express her symptoms of pain and cough.

(*Continued*)

Table 6: Continued

	Birth: Psychological abuse, abandonment, non-supportive care	Upon arrival at the facility for birth, the nurse responded annoyed and aggressive upon arrival at the facility, wanted to send her to another hospital for unclear reason. The nurse was angry at her for having squatted above the basin and said that she would have lost her job if the baby had been born in the basin. She was told to clean up after birth and was threatened not to get back ANC card or would not be allowed to go home if her sheets were not washed. Was not taken seriously when she told the nurse she felt to push. Was left alone for 4 hours without any check-up. Eventually, the head was born without nurse present.
Jane	*ANC:* Non supportive care, abandonment.	During her first ANC visit she was not believed when she told the nurse her last normal menstrual period. Her information was dismissed and the nurse gave her an estimated date of birth two months beyond what Jane believed to be true. No education or information provision on measurements or what to expect during pregnancy and birth despite it being her first pregnancy. Was refused services at her second clinic visit because this day was not for her village.
	Birth: Psychological abuse, physical abuse, non-supportive care, abandonment, non-consented care	Upon arrival for birth she was not welcomed at the health centre, instead she was ridiculed by the nurse because she was not adequately responding to the nurse's comments. The nurse had told her firmly not to drop her clothes on the floor. Was told her son almost died because she was not pushing well. Was told firmly to stop crying without attention for the reason why she was crying. Vaginal examination and interventions were done without consent and forced while restraining her if she resisted. She was told she was not relaxing, she was not doing what she was supposed to do. Received directions on what to do in a firm way "keep arm straight", "don't move", but no explanation on what was going on, why she received interventions and no consideration for her pains or her fear. Was refused to drink water as this was thought to reduce contractions. Was ignored when she arrived at the health centre until her family member provided the necessary gloves to the nurse. Vaginal examination and interventions including fundal expression and episiotomy without consent.
Tara	*ANC:* Non supportive care	During her second ANC visit, the nurse was ranting about her working conditions while performing services and scolded another woman because she said she could not hear her well.
Maria	*ANC:* Psychological abuse, non supportive care, privacy violation	During her first ANC visit she received belittling comments when she was unable to answer all the questions related to danger signs. During her second visit, other women who came with their husbands were prioritised and she was told to go back in line. Nurses laughed at women complaining about long waiting time. Asked the researchers to change her return date on her ANC card after she had not shown up, she feared she would be scolded if she would go next time. No explanation given on findings, no follow-up provided despite being diagnosed with low haemoglobin level. Interruptions when other students walked in and out during physical examination.

(*Continued*)

Table 6: Continued		
Bea	*ANC:* Non-supportive care, abandonment	Nurses refused to give her an estimated date of delivery because she could not remember her last menstrual period; however, this was complicated because of her use of contraceptive method. Was refused care during her expected fourth visit because the nurses expected to receive training.
Pili	*ANC:* Psychological abuse, abandonment, privacy violation, non-supportive care	Threatening language during health education. The nurse was informing people what to bring for birth, explaining that women will get HIV if they don't bring their own sheet and that they will be refused if they don't bring everything. Pili felt this was normal and good health education because some women don't know how to behave. No explanation about medication which was given or tests which were performed. Refusal of service for her first visit because they only see women for their first visit on Mondays. Also refused services during her fourth visit because the nurse who was doing the clinic had to escort a woman in labour to the district hospital. Frequent interruptions during the clinic visit.
Naima	*ANC:* Psychological abuse, non-supportive care, privacy violation	Naima felt she was not allowed to be seen during her second ANC visit. Nurse told all waiting women that "if you do not have a husband with you, there is no checking at the clinic". During the visit her cues of being sick were ignored, not asked about. For her third ANC visit, other women were prioritised which caused her to wait for a long time, she was not feeling well and had a crying toddler with her, she could not cope and left without being attended. Interruptions by other health provider during physical examination looking for supplies.
Mariam	*ANC:* Non supportive care	She said the nurse was harsh during the first ANC visit, performing her work angrily. Was not taken seriously in relation to her own expectation of when she thought she would give birth.
Paulina	*ANC:* Non supportive care:	Had to go to another clinic several times to collect her HIV card number. Was getting severe side effects of her new HIV medication but was not taken seriously at the ANC clinic which resulted in her stopping taking her ARVs, despite going back to the ANC clinic outside of her scheduled visits. She explained the nurse did not inform her about the condition of the baby or herself.
Helena	*ANC:* Non-supportive care, abandonment	Was refused services during her first visit because she had not brought her husband with her. During ANC she was told she was wrong about the length of her pregnancy. Received a return date on a national holiday. Received another vaccination for tetanus even though she had finished it, was not believed and given the injection anyway. Nurse was annoyed she came late for her third ANC visit, was reprimanded and threatened not to receive services. Was refused services during her 1st visit because she had not brought her husband with her.

Despite women expressing disapproval about how they were treated at facilities, women frequently referred to services being "*kawaida tu*" (only normal), "*nzuri tu*" (only good), because it is how it always is. Women routinely attended their scheduled visits at the clinic. They expressed that this was their responsibility and a necessity to know if everything was normal. Even though some women had performed a pregnancy test, it was not until a nurse at the clinic confirmed this that they embraced the full truth of being pregnant.

"It is important to go there; […] it is my task to go there. […] There is gain for the pregnant woman herself and the child […]. It is necessary for advice as well, advice on how to care for your child. […] The nurses they know, when my pressure goes up or goes down, how will I know how it is? No that is why the one who knows more is the nurse […] the one who measures is the one who knows." (Maria, interviews)

Justification of punishment and rewards

Younger, less experienced women were more likely to experience disrespect and abuse, mostly because they did not behave as they were expected to, for example, if they did not bring the necessary "*vifaa*" (supplies or materials) for birth, if they did not dress properly or if they did not follow the system of care provision. Sometimes women were reprimanded or scolded if they did not do as they were told. When Flora was admitted to the labour room, the nurse repeatedly told her to lie on her side and instructed her not to push, even though Flora felt it was already time.

"When she [the nurse] left the room, I asked my relative to hand me the basin, so that I could pee. I squatted down and the bottle broke [membranes ruptured] and the door [of the labour room] was opened and then one of the women came to help me on the bed. […] So when she [her relative] saw the head started to come she ran away to call the nurse. […] When the nurse came she saw the water in the basin and shouted: 'Do you want me to be fired?' [Flora imitating the angry voice.] I told her: 'You say the contractions are not yet ready so that's why I came down'. The nurse said: 'It is better you pee on the bed because if you pee here I'll be fired and also the other nurses they will be kind of surprised, why do you allow her to walk, why did she deliver in the basin. So it's better to pee in the bed, […] now just be strong and start pushing because the head is out". […] Then I pushed like three times and the baby came out." (Flora, interviews)

After birth Flora cleaned the bed and was instructed to clean her sheets, otherwise she would not get her ANC card back. Some women deliberately took precautions to avoid being confronted with disrespectful behaviour. Women said they would "keep quiet", refrain from asking any questions and make sure not to attract any unwanted attention. Particularly for younger women, acting as more confident and experienced could result in better treatment. For example, when Pili entered the ANC room, the nurses did not greet her but instead directly asked her for the name of her village. Pili responded swiftly and confidently while asking the nurse: "Did you forget?" During the interview, when asked how she presented herself in the clinic, she said:

"I am entering there [at the facility] very confident, like a true woman […]. I am doing that because if you are scared you will feel they are bad but if you go in a charming way you are just like them. You see them they are good." (Pili, interviews)

During health education sessions, stories about what happened to women if they did not behave well often resulted in laughter from both the nurses and the women. Not only was such behaviour by nurses considered "normal", it was a necessity because "some women don't know how to behave". Some women justified health providers' strict language, threatening behaviour and verbal or physical acts for disciplining, for example:

"Then I felt like the baby is coming out, and then she tells me 'keep pushing'. She was [standing] far […]. Then I felt like I want to go to the toilet. I was calling her, 'nurse come', and then she told me 'aah just keep pushing'. […] Then she came a bit [closer]. They don't care, some of them they think you are just scared, [that you are] not yet having [pushing] contraction. So when she starts to see the head of the baby then she is starting to help you. […] When you are screaming, maybe they can start to kick you, to slap your face [Rory started to laugh]. Because the noise it does not help you. She slaps you to stop. It is okay to slap them because some of them are really making noise. But me I don't scream." (Rory, interviews)

Whose effort counts?

At times, several women were unable to receive services while attempting to attend the ANC clinic.

On some occasions women were refused services because they were too late, did not come with their husband or because their type of service was not available on that particular day. Sometimes clinics were closed unexpectedly due to lack of available staff, during national holidays or when health workers were receiving supervision or training. Often these closures seemed arbitrary, as we observed that attending to the pregnant women would have been possible. For example, when Bea was unable to attend her fourth visit, the following was observed:

> At 8 a.m. there were three women at the entrance of the ANC clinic, including Bea. At the reception two nurses were sitting and resting their head in their hand, another nurse was lying down with her head on the table. One of the nurses approached the women and said there would be no service today because they were expecting to receive special education. Women were instructed to come back after the weekend. […] When walking back to the bus stand Bea said this was a bad situation and that she wasn't happy. She came with the 'daladala' [taxi bus] but now she needs to come back next week. […] The following hour and a half, while the nurses were waiting for the training to start, one more woman was told there was no clinic today, another woman was helped with measuring the weight of her baby and a pregnant woman was assisted to collect antiretroviral tablets. (Bea, observation notes)

Bea was already far into her pregnancy and never managed to attend to a fourth visit because she gave birth at home the following day. When women were unable to receive services, there was rarely an empathic reaction or apology for the inconvenience. Women's efforts using their time and personal resources to come to the facility in vain seemed not to be valued. In contrast, the women nearly always appreciated nurses' efforts, even if this meant women needed to tolerate physical and verbal abuse. For example, the following events were observed during Jane's birth:

> Two nurses [medical attendants], walked towards Jane deciding to help her. Nurse Esther stood at the right side and Nurse Dynes stood at the left side of Jane. Dynes supported Jane's head while Esther actively spread Jane's legs and told her to push. 'We are using traditional methods now' she said. Esther and Dynes folded a 'kanga' [a local fabric] on the stomach of Jane like a belt and when Jane had a contraction they pushed the kanga down and screamed 'push!!' The head of the baby slowly became visible. Esther put her fingers in the vagina and said to the doctor who was present: 'Look, look there is space, mama is not pushing! There is a lot of space.' She moved her fingers around in Jane's vagina with force, around the head of the baby and repeated this several times. No one spoke with Jane, she gasped heavily, was sweating and looked tired but the nurses did not pay attention to her. Another contraction came and Jane pushed while Esther hung with her full body weight on Jane's abdomen to push the baby down. Esther screamed 'you are not pushing, mama push, you let us do all the work!' Dynes asked for a scissor, placed it at the perineum and made the cut. Jane was not informed and let out a piercing scream. Both Esther and Dynes took a part of the kanga at one side of Jane and, created a rhythm with their voices. 'Push, push, push, push, push' while pushing the kanga down. Jane looked exhausted. She was gasping for air with her eyes wide open. Every time she wanted to take a breath someone told her to push. 'You don't speak! PUSH', they said. […]. (Jane, observation notes)

Jane explained later she was afraid her baby would die, she had been in pain, but was mostly worried about her child. She thanked God he survived.

"She [the nurse] was just giving me normal service, that is good service […] because the nurses worked at it, they attended me." (Jane, interviews)

Discussion

Women's narratives revealed how they were repeatedly exposed to disrespect and abuse in their interactions with health providers, during ANC, during childbirth, and from one pregnancy to the next. All women, regardless of their age or socio-economic status, experienced both non-supportive and supportive care (see Table 5), sometimes by the same nurse within the same setting. Women's experience of such conflicting treatment is further complicated by the manifestation of non-supportive care. Our findings reveal how normalised and legitimised non-supportive care has

become over time, with women lacking power or opportunities to confront this experience.

The majority of women in our study grew up in poverty and were still living with grave economic insecurities. Many of them were pushed into early marriage due to teenage pregnancy and were unable to continue their education. Few women had an independent income. The majority of women therefore relied on their husbands to provide for the necessary expenses to access care. In Tanzania, many young girls and women experience abuse in school (Tanzania allows corporal punishment)[34] or are exposed to intimate partner violence.[35] Health care institutions reflect and reinforce dominant social processes in their society.[36] The way women are treated in health care settings correlates with their position in society and vice versa. It should not be a surprise that such frequent and normalised abuse in everyday life leads to equal normalisation of similar poor treatment in health care institutions.[37]

For many women, their first experience of disrespect in a health facility is the absence of greeting by health providers and of a welcoming reception. This might seem of little relevance in the greater debate on abuse and disrespect during childbirth. However, the absence of greeting is a rejection of social rules that health providers outside the health institution abide by. In health institutions, women appear to lose their social identity, and "lose their right to be respected".[38] Women frequently expressed disapproval of such interpersonal behaviour but at the same time felt disempowered to change this. Normalisation of non-supportive behaviour is symptomatic of an institutional culture of dehumanised care. In such a context, women have to accept a deplorable physical environment, inadequate (human) resources, and to endure disrespectful and abusive treatment.[39] Repeated exposure to such non-supportive care ultimately weakens women's agency, including their self-esteem and sense of safety.[40]

Regardless of low levels of education or socioeconomic status, women are aware that they deserve better, and do not simply submit themselves to poor treatment.[41] They were consistent in attending ANC, even if they were frequently disappointed or if their knowledge or opinion was dismissed. Women frequently expressed that they trusted nurses to know what was best for them. The active suppression of women's knowledge and women's firm belief in what nurses represent is referred to by Jordan as "authoritative knowledge".[42] Health providers may act in disrespectful or abusive ways, in part because they are in a powerful position and represent a powerful system.[32] Their level of education and technical biomedical knowledge confer superior social status[38] in relation to their female patients[43] and this power imbalance influences how they behave towards women. Women are expected to adopt behaviour imposed by the nurses and to abide by these rules when they come to the facility for services or to give birth. Consequently, if women don't comply, or are unaware, they are perceived to be disobedient, and are themselves held responsible for poor outcomes. To regain control, health providers can turn to abusive measures to force compliance.[43] Women justify this behaviour even though they fear exposure to it.[10] Our findings illustrate how women use tactics to avoid mistreatment and are proud if they are able to do so. Such submissive behaviour symbolises how women through their oppression have internalised the prescribed behaviour.[44]

Addressing the mistreatment of women in health facilities is finally gaining momentum in the global field of maternal health, leading to the integration of respectful maternity care in critical guidelines.[45] But within the current global health culture of relying on metrics,[46] such guidelines risk oversimplifying individual women's needs. The search for universal definitions of disrespect and abuse in child birth, as well as clear typologies of what this includes, can result in misleading or narrow dichotomies which devalue the routine and often subtle nature of women's suffering and the complexity of what drives it.[10]

Nurses are themselves confronted with hierarchical power structures within their work. Medical doctors or others in leadership positions can undermine nurses' authority and decision-making ability.[47] Predominantly female health providers have gone through the same abusive educational system and their ability to provide quality care is seriously compromised by a lack of resources and support, and the perceived threat of losing their jobs in case of poor outcomes. Similarly to the women they provide care to, they are unable to change their situation due to their perceived lack of voice, both within the nursing education system and within the health system as a whole.[47] Nurses may act as oppressors, while also being oppressed by the same social forces that maintain structural violence.

The global maternal health community needs to be more self-critical and reflect on how global health interventions may contribute to women's mistreatment. Examples include women being refused services if they come without their husband, or finding the clinic closed due to supervision visits or skills training. The lack of recognition of women's efforts to get to the health facility, often in vain, contributes to the complexity of this situation. Global statistics on antenatal coverage are a representation of services that are provided but do not reflect the true picture of women's care seeking. Women seek services, but do not always receive good quality care, nor are they always treated with respect.[39] Acknowledging disrespect and abuse of women in health facilities as a consequence of structural violence requires us to move beyond viewing disrespect and abuse as a primary problem during childbirth. Mistreatment of women should be holistically tackled across the continuum of care, through structural interventions. Preventing disrespect and abuse at its core requires an approach beyond improving health workers' skillsets and achieving organisational changes at institutions level. Societal conditions that keep women's status inferior must be addressed,[32] policy and funding priorities must be discussed,[21] and collective efforts are needed to establish accountability mechanisms whereby the appropriate authorities are held responsible for women's lack of access to respectful care.[14,48]

Limitations

Although we attempted to keep much of the original wording of participants, the narratives are a product of our subjective interpretation of the situations and thus particular and incomplete. The knowledge generated can therefore not be generalised.[49] However, following Fathalla's story "Why did Mrs X die?" presented during the launch of the Safe Motherhood movement in 1987,[15] there are lessons which can be garnered from individual stories. Some authors argue that to determine if certain behaviour is "abuse", it needs to be subject to variation based on culture, context and personal expectation or experience.[5,21] Freedman et al[21] proposed that local consensus as to what constitutes disrespect and abuse helps to determine behaviour within local norms.[21] For this reason, we consulted with a local group of health professionals for the analysis. However, reflecting on behaviour based on local consensus risks ignoring that disrespectful acts can be invisible manifestations of inequality engrained in the fabric of society.[12] It is therefore possible that we interpreted situations as disrespectful or abusive, while these were not experienced as such, not intended as such and not considered as such by local standards.

Conclusion

In this study, all women experienced disrespect and abuse starting from their first obligatory and expected visit to the health facility for ANC and during birth. From the perspective of structural violence, non-supportive care is symptomatic of systemic gender inequality in society, which is manifested in health providers' interactions with women. Disrespect and abuse in health facilities has been normalised and legitimised as a consequence of women's lives not being valued. Health providers, however, are also victims of structural violence, even though at the same time they can be perpetrators of abuse. To achieve respectful maternity care for all, interventions to prevent disrespect and abuse cannot be implemented without recognition of structural inequalities that foster the conditions that make mistreatment of women possible.

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Conflict of interest

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ORCID

Andrea Solnes Miltenburg http://orcid.org/0000-0003-4681-7043

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Résumé

Les patients, en particulier les femmes en couches, souffrent effectivement d'un manque de respect et de maltraitance dans le secteur de la santé. C'est une violation des droits fondamentaux des femmes et peut être considéré comme une conséquence du peu de cas que font les structures sociales, économiques et politiques plus larges de la vie des femmes. Nous démontrons ici de quelle manière cet irrespect et cette maltraitance sont pratiqués à un niveau interpersonnel dans l'ensemble des soins en République-Unie de Tanzanie. Nous décrivons comment et pourquoi l'exposition des femmes au manque de respect et à la maltraitance devrait être vue comme le symptôme de la violence structurelle. Des récits détaillés ont été préparés sur la base d'entretiens et d'observations des interactions de 14 femmes rurales avec des prestataires de santé depuis leur première visite

Resumen

En el sector salud ocurren falta de respeto y maltrato de las pacientes, especialmente de las mujeres en proceso de parto. Esto es una violación de los derechos humanos fundamentales de las mujeres, que puede ser considerada como consecuencia del hecho de que la vida de las mujeres no sea valorada por mayores estructuras sociales, económicas y políticas. Aquí demostramos cómo la falta de respeto y el maltrato son aplicados a nivel interpersonal a lo largo del continuum de atención en Tanzania. Describimos cómo y por qué la exposición de las mujeres a la falta de respeto y al maltrato debe ser considerada como síntoma de violencia estructural. Se elaboraron narrativas detalladas basadas en entrevistas y observaciones de las interacciones de 14 mujeres rurales con prestadores de servicios de salud, desde su primera consulta prenatal hasta después

prénatale jusqu'à après la naissance. Les récits étaient fondés sur l'observation de 25 visites prénatales et 92 entretiens approfondis avec les mêmes femmes. Toutes les femmes ont été exposées à des soins non positifs pendant la grossesse et l'accouchement, y compris des violences psychologiques, des mauvais traitements physiques, un manque de soins et des violations de leur intimité. Les inégalités sexospécifiques systémiques rendent les femmes excessivement vulnérables aux abus, exprimés comme une normalisation de la maltraitance dans la société. Les institutions de santé reflètent et renforcent les processus sociaux dominants et une normalisation de soins non bienveillants est symptomatique d'une culture institutionnelle des soins qui est devenue déshumanisée. Les prestataires de santé peuvent agir de manière irrespectueuse parce qu'ils sont placés dans une position de pouvoir, exerçant une autorité sur leurs patients. Néanmoins, ils sont eux-mêmes aussi les victimes des défis continuels du système de santé et des mauvaises conditions de travail. Il est impossible de prévenir l'irrespect et la maltraitance pendant les soins prénatals et l'accouchement sans porter attention aux inégalités structurelles qui favorisent les conditions permettant la maltraitance des femmes vulnérables.

del parto. Las narrativas se basaron en la observación de 25 consultas prenatales y 92 entrevistas a profundidad con las mismas mujeres. Todas las mujeres fueron expuestas a atención sin apoyo durante el embarazo y el parto, tales como maltrato psicológico, maltrato físico, abandono y violaciones de privacidad. Debido a la desigualdad de género sistémica, las mujeres son excesivamente vulnerables a sufrir maltrato, expresado como normalización del maltrato en la sociedad. Las instituciones de salud reflejan y reafirman los procesos sociales dominantes, y la normalización de atención sin apoyo es sintomática de una cultura institucional de servicios de salud que se han dehumanizado. Los prestadores de servicios de salud pueden actuar de manera irrespetuosa porque son colocados en una posición poderosa, con autoridad sobre sus pacientes; sin embargo, también son víctimas de retos continuos y malas condiciones laborales del sistema de salud. No se puede prevenir la falta de respeto y el maltrato durante la atención prenatal sin prestar atención a las desigualdades estructurales que fomentan las condiciones que permiten el maltrato de mujeres vulnerables.