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Midwives' perspectives on the practice, impact and challenges of delivering respectful maternity care in Malawi

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Declaration

I, Susan Bradley, confirm that the work presented in this thesis is my own.

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Abstract

In low-income countries, lack of respectful maternity care (RMC) is a key deterrent in women's access to, and satisfaction with, facility-based birth, undermining global efforts to tackle maternal mortality. Much of what we know about RMC and disrespect in the labour ward has been informed by women's perspectives. Midwives' voices are largely missing from the discourse.

This thesis poses two overarching questions: How do Malawian midwives conceptualise, practice and value RMC? What constraints and enablers do they face in providing RMC? I used a qualitative, critical realist approach to foreground midwives' voices. Narrative (n=21) and critical incident technique (n=23) interviews with midwives were supplemented by 26 key informant interviews. The theoretical frame of postcolonialism provided the key anchor point for interpreting the data.

Many midwives aspire to RMC but face significant challenges. A clash between traditional values and democracy manifests in poor attitudes to the public sector, inadequate leadership and lack of accountability, while student recruitment processes allow entry of 'just a job' midwives - both factors allow poor behaviour and attitudes to become normalised. Midwifery's low status and professional invisibility under a dual-qualification nurse-midwife model, plus lack of a united vision for the future of midwifery, leave midwives feeling unvalued and demotivated. Unconducive work environments, low staff numbers, lack of support and horizontal violence block professionalism and good practice at facility level.

Policies to strengthen health systems and strategic consideration of the midwifery profession's future are needed, as well as explicit attention to fostering teamwork and positive organisational cultures. Malawi's labour ward dynamics are contingent upon the historical, cultural and health systems factors prevailing in this postcolonial context. An inter-disciplinary perspective to research in this area has been lacking but is crucial to frame and devise more appropriate interventions to improve the intrapartum experience for both women and midwives.

Abbreviations

AMAMI	The Association of Malawian Midwives
CHAM	Christian Health Association of Malawi
CIT	Critical incident technique
COM	College of Medicine
D&A	Disrespect and abuse
DHMT	District Health Management Team
EHRP	Emergency Human Resources Programme
EmOC	Emergency obstetric care
ENM	Enrolled nurse-midwife
FIGO	International Federation of Gynecology and Obstetrics
HRH	Human resources for health
HRM	Human resource management
HRO	Human resource officer
ICM	International Confederation of Midwives
KCN	Kamuzu College of Nursing
MCHS	Malawi College of Health Sciences
MDG	Millennium Development Goals
MOH	Ministry of Health, Malawi
MSCE	Malawi School Certificate of Education
NGO	Non-governmental organisation
NMCM	Nurses and Midwives Council of Malawi
NMT	Nurse-midwife technician
NONM	The National Organisation of Nurses and Midwives of Malawi
RMC	Respectful maternity care
SAP	Structural adjustment programme
SDG	Sustainable Development Goals
SRHR	Sexual and reproductive health and rights
SRNM	State registered nurse-midwife
SWAp	Sector-wide Approach
TBA	Traditional birth attendant
WHO	World Health Organisation
WRA	White Ribbon Alliance for Safe Motherhood

1. Introduction

This thesis explores the barriers to, and enablers of, provision of respectful maternity care (RMC) from the perspective of midwives in Malawi, a low-income, postcolonial country. RMC addresses the interpersonal and relational aspects of maternity care (WRA, 2011) and is an important component of efforts to increase utilisation and quality of services. It is grounded in a rights-based approach, captured in the White Ribbon Alliance for Safe Motherhood (WRA)'s Respectful Maternity Care Charter (WRA, 2011), which emphasises women's entitlement to: freedom from discrimination, harm and mistreatment; provision of information, choice, consent and companionship; care that respects and maintains women's dignity, privacy and confidentiality; as well as autonomy and access to timely, quality healthcare. A range of other terms are also used to categorise women's treatment during childbirth. In Latin America, 'humanised care' tends to focus on de-medicalisation and on birth as a normal event (Dixon, 2014), while in the UK and Australia, for example, a philosophy of 'woman-centred care' focuses on holistic care that addresses the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations (Leap, 2009). As well as discrete differences between these constructs, there are also significant overlaps[1]. However, RMC is the most commonly operationalised term in Africa. In Malawi, significant advocacy efforts, spearheaded by the WRA Malawi and reflecting the WRA Charter and language, have started to focus attention on improving the interpersonal care offered to women. This makes RMC an increasingly familiar construct to most senior midwives and many labour ward staff, so I have used this term and definition throughout my work.

Global efforts to reduce maternal mortality have centred on increasing the proportion of women who birth in a health facility with a skilled birth attendant. Substantial evidence has emerged documenting women' unhappiness with the type of birth care on offer, supported by low rates of facility-based delivery in sub-Saharan Africa despite high rates of women attending antenatal care (e.g. Magoma et al., 2010; Anastasi et al., 2015). A routine lack of attention to the sociocultural and psycho-emotional salience of birth and the intersection with structural inequality manifests in behaviours that are deemed dehumanised and disrespectful. The disrespect and abuse (D&A) of women during birth is a significant global public health issue. It spans a range of behaviours that do not respect a women's autonomy, culture, bodily integrity, and dignity; violates women's human rights; and is a form of gender-based violence. D&A intersects with other forms of structural violence and gender inequality, disproportionately affecting the most vulnerable: women who are poor, rural, marginalised, or facing multiple oppressions. There is growing momentum to address D&A and ensure women receive RMC.

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[1] For example, in the Lancet Series on Midwifery (http://www.thelancet.com/series/midwifery, accessed 16 Sep 2014) Van Lerberghe et al. (2014) explored the limited attention paid to the way in which midwives can be supported to provide *"respectful woman-centred care"*.

My specific focus is on the dynamics of care during labour and delivery as these mark a critical juncture in the maternal health journey for both women and midwives. Although the need to ensure RMC and decrease D&A is an issue across the entire childbirth continuum, advocacy and intervention efforts have paid particular attention to the intrapartum period. In part, this is due to women's increased vulnerability during birth and the impact of immediate and long term physical and psychological consequences for individual women. However, this focus also recognises that birth is not just a biological act, but is culturally and socially situated and defined, involving a complex interplay of physiological and psychological mechanisms that are deeply influenced by the social environment and processes by which birth is managed. Therefore, quality midwifery care is not only about the provision of care, but also how it is experienced by women (WHO, 2016b). D&A during childbirth is a red flag for low-quality care (Kruk et al., 2014) and has profound implications for trust in health systems more broadly (Gilson, Palmer and Schneider, 2005). Further, the quality of intrapartum care is a sensitive barometer of overall health system functioning (WHO, 2004), as well as an indicator of the value a society places on its women, writ large in the allocation of resources and attention given to the treatment women receive. In the face of women's reluctance to avail of facility-based delivery, the Government of Malawi has focused in on childbirth, banning the traditional birth attendants (TBA) many women preferred. These efforts are designed to encourage women to accept the medicalised model of birth, but instead serve to coerce women into a birth experience that does not satisfy their psychosocial and cultural needs, and where the tensions between cultural norms and health care policy are sharply delineated. The steeply rising number of births in health facilities, combined with extreme shortages of staff and harsh working conditions, leaves midwives struggling to provide quality care (Ministry of Health Malawi, 2011a). These factors result in a perfect storm, where the challenges of the health system, the increasing numbers of deliveries, the clash of medical and social models of birth, poverty and lack of resources, collide in the labour ward to make power issues more visible, but also interact with existing inequalities to exacerbate the power dynamics at play.

Recent global shifts in attitudes to maternity care provision in low-income countries have been reflected in advocacy efforts to ensure RMC and eliminate D&A. Central to this are calls to professionalise and invest in a dedicated midwifery workforce in countries such as Malawi.[2] In common with much of sub-Saharan Africa, the staff providing intrapartum care in Malawi are dual-qualification nurse-midwives; however, all the staff interviewed for this thesis were labour ward midwives, so I have used 'midwife' throughout (unless specifically addressing staff carrying out both roles).

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[2] See http://whiteribbonalliance.org/national-alliances/malawi/ for details of the White Ribbon Alliance's campaigning in Malawi.

1.1 Why Malawi?

Malawi is one of the poorest countries in the world (United Nations Development Programme, 2016), whose shortage of health professionals is acute, even by sub-Saharan African standards. Despite strong political commitment and a series of ambitious initiatives, in 2012 it was estimated that the health sector was operating with only 20% of the workforce time required to deliver pregnancy-related services, including labour and delivery (United Nations Population Fund, 2014). It is unlikely that this situation has improved in the interim. The most important cadres for provision of basic obstetric care are nursing officers and nurse-midwife technicians (NMT). Conditions for both these cadres are extremely challenging. In 2010, only 28% of the required nursing officers and 45% of the required NMTs were available (Ministry of Health, 2011b); in 2016 in-country contacts consistently quoted vacancy rates of approximately 65% during data collection; and the latest census of midwives estimated there were only 3,420 midwives, with a shortfall of over 20,000 against WHO recommendations (WRA, 2016). Government efforts to increase facility-based delivery, including banning TBAs and fines for women who use them, have seen skilled attendance at birth rates rise sharply from 54% in 2008 to 91% in 2015/16. Many rural health facilities lack a full-time midwife. Where midwives are in post, they face substantial patient loads which compromise their ability to provide quality care. It is not uncommon to find one midwife managing multiple deliveries simultaneously. In these circumstances, it is unsurprising that the maternal mortality ratio is intransigently high at 634/100,000 live births (National Statistical Office, 2017). Midwives face the stress associated with maternal death and the frustration of not being able to provide adequate care due to lack of an enabling environment (Bradley et al., 2015). Other research has detailed a lack of supervision or support (Bradley et al., 2013) and demoralization caused by lack of adequate backup from management, overwhelming workloads, insufficient remuneration, lack of physical resources (Bradley and McAuliffe, 2009; Chimwaza et al., 2014) and poor referral systems (Thorsen et al., 2014). These factors coalesce to make it extremely challenging to provide quality care, with negative consequences for midwives and women.

My engagement with Malawi began in 2006, when I spent four weeks collecting primary data for a Masters in Global Health from Trinity College Dublin. I navigated alone around a series of rural hospitals to interview mid-level providers of emergency obstetric care. My aim was to explore their challenges in providing maternity care in the context of the constraints facing them, and to identify the factors affecting their performance and retention (Bradley and McAuliffe, 2009). For the next seven years I worked on research projects focused on sub-Saharan Africa. I interviewed midwives (and other cadres with midwifery skills) in Malawi; had discussions with the same cadres in Tanzania and Mozambique; and analysed a significant amount of qualitative data from all three countries, giving me an insight into the reality of the contexts in which midwifery staff operated.

Amongst the poverty and lack of resources, I was struck time and again in Malawi by midwives' passionate commitment to their profession and their drive to help their fellow

citizens. Many clearly articulated the difficulties and stresses they faced when what **should** be done, according to personal and professional standards, clashed with what **could** be done within their specific context. People quietly told me shocking stories of managing overwhelming numbers of women *in extremis*; of feeling abandoned by their supervisors; being responsible for lives without the necessary equipment or resources to perform; or having to look inside themselves to see if they dared to work outside their scope of practice to try and save lives when referral to the next level of care was too slow or the situation too urgent, then having to face the consequences (personal as well as professional) regardless of which option they chose. I have no wish to romanticise their plight, but rather to highlight the reality of the constraints under which they worked and to contrast this with the prevailing rhetoric on the international stage which, when I started this PhD journey, was largely negative and centred on abuse and disrespect. This mirrored the 'inspection and blame' paradigm of existing monitoring and supervisory processes in Malawi that I had previously explored (Bradley et al., 2013) and made me reflect on how I might feel if I were a midwife doing my best in such difficult circumstances? What impact might this negative gaze have on my motivation and sense of professionalism? One of my daughters is a midwife in the UK. It was striking to see the parallel challenges she and her colleagues faced, although clearly to a significantly different degree, with midwives I had talked to in Malawi - too few staff, not enough time, an often fault-finding media gaze, and the stress and demotivation of not always being able to meet personal and professional standards.

Much of what we know about RMC has been informed by the women's perspective. Midwives' voices are largely missing in the literature. Having been privileged enough to be given a window into Malawian midwives' working lives, I felt an obligation and urge to reciprocity, to try and bring their voices and perceptions into a debate whose tone of 'bad midwives', in my view, did not speak sufficiently to the dedication, selflessness and difficulties on the ground.

Childbirth is one of life's most vulnerable but transformative experiences and it is crucial that women receive appropriate, respectful, quality maternity care. Midwives are the key. They are at the sharp end of a system in Malawi that often fails to support them as skilled, valued professionals and leaves them vulnerable too. Listening to midwives' voices is one step towards improving the intrapartum care environment for them and for the women in their care.

1.2 The global backdrop

Skilled attendance at birth is a cornerstone of international efforts to reduce maternal mortality, but evidence from low-income countries shows when care is perceived as disrespectful or unkind, women are discouraged from facility-based delivery[3] (e.g. Seljeskog, Sundby and Chimango, 2006; Kumbani et al., 2013). In many contexts, a Western

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[3] Facility-based delivery is birth in a health facility, at any level of the health system, that is designated to provide obstetric care.

technocratic model of obstetric provision prevails, which privileges technical approaches measured in short-term 'deliverables', such as number of caesarean sections and maternal mortality ratios. 'Soft' outcomes related to the emotional, social and psychological aspects of maternity care, such as women's satisfaction and the longer-term outcomes associated with positive birth experiences, have been neglected. In many contexts, the medical model of care on offer, and the way in which it is delivered, is seen as disrespectful and dehumanising (Bohren et al., 2014). The literature on RMC cites numerous gaps in accountability, service provision, skills, and prioritisation of women's needs (e.g. Freedman and Kruk, 2014; Miller and Lalonde, 2015; Rosen et al., 2015). Even when outcomes are good for mother and neonate, the aftermath of disrespectful treatment can leave many women and their peers reluctant to revisit the hospital or health facility for future pregnancies (Faye, Niane and Ba, 2011). This has been reflected in stagnating facility-based birth statistics and intransigent maternal mortality figures in some contexts (Warren et al., 2013; McMahon et al., 2014), while in contexts where traditional birth attendants have been banned, such as Malawi, women are left with little choice about where to birth.

In a radical turnaround from what has been described as the international community's 'blind spot' on the quality dimension of respectful, woman-centred care (Van Lerberghe et al., 2014), there has been a recent shift in attention, away from a predominantly technical focus on simply 'what to do', towards examining 'how to do it well'. This includes considering the non-clinical, interpersonal elements of maternity care. The campaign for RMC has gained significant global momentum in the past few years, following Latin American efforts to use a humanising childbirth lens to stem the tide of rampant human rights abuses of labouring women. The Charter on the Universal Rights of Childbearing Women (WRA, 2011) and the WRA's robust advocacy have helped to spur other agencies to step up and act. Recent years have seen a flurry of important actions. Most notable are the World Health Organization's (WHO) influential statement on the prevention and elimination of D&A (WHO, 2014); the International Federation of Gynecology and Obstetrics' (FIGO) criteria and indicators for Mother and Newborn Friendly Birthing Facilities (2015); and the high-profile, critical examination of global midwifery in the Lancet Series on Midwifery[4]. There has also been a range of publications outlining typologies and prevalence of disrespectful behaviours during facility-based delivery (e.g. Abuya et al., 2015; Bohren et al., 2015; Vogel et al., 2015; Sando et al., 2016); a proliferation of small studies exploring women's experiences of facility-based delivery[5]; and, more recently, an emerging literature on midwives' perceptions[6]. One outcome of this has been pressure on low-income countries, such as Malawi, to

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[4] Available at: http://thelancet.com/series/midwifery [Accessed 16 September 2014]
[5] The first meta-synthesis (Bradley et al., 2016) described in Chapter 3 of this thesis brought together these small studies to generate a more solid understanding of what is driving the dynamic of disrespectful maternity care.
[6] The recent literature on midwives' perceptions forms the basis of a second meta-synthesis (Chapter 3).

professionalise midwifery and improve the quality of the interpersonal aspects of the intrapartum care that they provide by explicitly addressing RMC.

Many of the workplace factors challenging midwives are also implicated as drivers of D&A in maternity care (Bowser and Hill, 2010). West (2001: 41) has suggested, "*The quality of patient care may be related in an important way to the quality of life experienced by staff at work.*" Evidence from Malawi shows that staff delivering obstetric care operate in a climate where punitive measures are used to control performance, managers treat them unfairly and they feel that there is a lack of concern for their welfare (Chimwaza et al., 2014). Other studies show that nursing cadres experience disrespect from managers and colleagues (Maluwa et al., 2012). These are all negative drivers of motivation, job satisfaction and work performance. The impact of institutional context and the role of disrespectful facility management on health workers' treatment of patients cannot be overlooked. There are serious questions to ask about how staff operating in such environments can be expected to behave in a different manner.

1.3 Impact on midwives

Concerns about the dehumanisation of childbirth are not limited to their impact on women. There is a small body of evidence that providing good quality care has tangible effects on health workers too. In Western contexts, the impacts of building a relationship with women and of continuity of care have long been established as important to midwife satisfaction (see for example Hundley, Cruickshank and Milne, 1995; McCourt and Stevens, 2008), as well as being associated with greater safety and more positive clinical outcomes for women (Sandall et al., 2016). Brazilian health workers who were trained to humanise childbirth (defined as empowering for women and providers, and based on respect, dignity and choice) were reported to have increased self-esteem, greater commitment and improved teamwork (Misago et al., 2001). In Benin, introducing a humanised birth programme was reported to have benefits for midwives that included improved self-esteem, confidence and professional value (Fujita et al., 2012). Midwives also reported tangible effects on recognition of their skills by other cadres and managers, and improved trust and appreciation from women and their families. Recognition is a core non-financial incentive impacting on health worker motivation and job satisfaction (Mathauer and Imhoff, 2006; Willis-Shattuck et al., 2008). More recently, Ratcliffe et al. (2016b) demonstrated improvements in providers' job satisfaction, attitudes and pride when involved in a participatory intervention in Tanzania to promote a culture of RMC.

1.4 Knowledge gap

Missing from the literature is an understanding of midwives' perceptions of the value and practice of RMC in low-income countries, yet any efforts to change the current performance and dynamic of birth rely on their participation. We lack a deep understanding of the complexities and constraints under which she (and it usually is 'she') currently operates. How can we move from an individual 'blame the midwife' focus to one where systems failures and

power differentials are addressed, without input from the staff at the frontline of maternity care? If RMC is part of 'good' midwifery, then the impact of **not** providing it may be detrimental to midwives' sense of professionalism, personal ethics and humanity. This is an important aspect of this PhD research study. 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,[7] combined with external pressures from international organisations (e.g. the WHO) and international advocacy agencies (e.g. the WRA) have left many midwives feeling unappreciated, demotivated and worried.[8]

1.5 Research questions - aims and objectives

This study aimed to bring the voice of Malawian midwives to the fore, to examine the reality of RMC from their perspective and explore any dissonance with emerging expectations from the global community. It invited midwives to tell their stories of respectful and disrespectful maternity care and reflect upon its impact. Use of a narrative approach allowed exploration of behaviours and dynamics in Malawian labour wards, which were largely normalised and unexamined. Specifically, the research aimed to:

1. Explore how 'good' midwifery was defined and conceptualised in the Malawian context.

2. Describe midwives' practice of RMC during labour and delivery.

3. Explore midwives' perceptions of the value and impact of RMC for midwives, women and the health facility.

4. Describe constraints and enablers of professional practice and RMC in this context.

For all objectives, I compared the views of midwives with the organisational and professional expectations of national and local stakeholders and reported these throughout the findings chapters. It was anticipated that this research would help identify drivers of, and barriers to, RMC which could inform locally and regionally appropriate strategies with the potential to improve the maternity care environment for both women and midwives. The insight and evidence gained could be used to increase our armoury of options for improving the situation for women during labour and delivery **and** to empower midwives to be agents of change, working with women to provide RMC.

An overview of the results chapters is presented in Table 1.1. This provides a map of the chapters where the findings for each objective are described.

1.6 Theoretical frames

In this section, I introduce two theoretical frames that underpinned my exploration of RMC and the context in which midwives operated in Malawi. The first of these, postcolonialism,

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[7] Malawi's Nation newspaper regularly includes negative media coverage of 'uncaring' midwives.
[8] Personal communications with midwives, Malawi, August/September 2015

provided the key anchor point for this thesis. It was a significant element of my thinking from the outset, informing the focus of my research and its design and execution, from the methods I used, to the ways in which I collected and analysed data (Chapter 4). A postcolonial sensibility is reflected in my awareness and accounting of myself in the research process (Chapter 5). Many of the dynamics at play within Malawian labour wards are contingent upon Malawi's colonial history, the legacy and reverberations of which still manifest in the current day; newer forms of colonialism intersect with and may exacerbate these. Explicit attention to these postcolonial factors provided an effective and more nuanced explicatory mechanism to explain the drivers of respectful and disrespectful maternity care in this context, in contrast to existing, and sometimes rather superficial, explorations focused on the interactions of the mother-women dyad.

Table 1.1 Research objectives and corresponding results chapters

Research objective	Chapter and content
	9. Relationships with women
1. Explore how 'good' midwifery is defined and conceptualised in the Malawian context	Section 9.1 covers midwives' definitions of 'good midwifery', captured in an ideal model of RMC.
2. Describe midwives' practice of RMC during labour and delivery	Section 9.1. describes behaviours and attitudes that constitute RMC in this context.
3. Explore midwives' perceptions of the value and impact of RMC for midwives, women and the health facility	Section 9.3 describes midwives' perceptions of the impact of RMC for women and for midwives. Section 9.4 outlines the impact of RMC on community perceptions of midwives and facility-based delivery; describing the dynamics involved and outlining efforts to reach out and improve relationships with the community.
4. Describe constraints and enablers of professional practice and RMC in this context	**7. Betwixt and between - the broader postcolonial context**
	Sets out the broader macro-level context in which maternity care is situated and factors that hinder the realisation of women's rights to RMC during labour and delivery.
	8. Becoming and being a midwife
	Explores some of the meso-level and health systems factors that affect midwives' efforts to provide RMC in the labour ward, including the model of/entry into midwifery in a hierarchical system, challenges in pre-registration training, and professionalisation as an enabler of RMC.
	9. Relationships with women
	Section 9.2 focuses in on the micro-level factors and labour ward dynamics that challenge the provision of RMC.
	10. Caring for the carers
	Moves back to the meso-level, foregrounding the realities for midwives of the work environment and resources, lack of institutional support and organisational culture, and their impact on RMC.

A secondary theoretical frame that emerged from the data was that of oppressed groups theory. This provided a useful analytical lens during data collection and analysis. It arose from participant insights from the formal data, but was in large part informed by an unanticipated opportunity to engage in informal observations, corroborated during off the record conversations with midwives. Oppressed groups theory complements a postcolonial perspective as the dynamics both frames describe share common features.

Insights gleaned from nursing and midwifery literatures have relevance as the midwife in Malawi is a nurse first, then a midwife. I have drawn from both where appropriate.

1.6.1 Postcolonialism

Postcolonialism is an important theoretical frame for this research. It provides a lens to focus attention on the micro-politics and macro-dynamics of power in the Malawian context, situating these in their broader historical, cultural and social context. Definitions of postcolonialism are contested, with no singular definition. As a discipline, it covers multiple political, economic, cultural and philosophical responses to colonialism (Hiddleston, 2009), with a diverse range of theoretical orientations and values that are informed by other critical perspectives, including postmodernism and feminism (Chrisman and Williams, 1994). The term is often used to refer to the historical period after the dismantling of the European colonial empires in the second half of the twentieth century, but also addresses resistance to, and critique of, imperialism, its impacts and repercussions (Childs and Williams, 1997). It also examines new forms of colonialism (such as globalisation and neoliberalism) and the ongoing challenges arising from the colonial legacy (Sherry, 2012). Important components are analyses of domination and subordination based on emancipatory ideals, issues of voice, and the broader power dimensions that affect areas such as public health and gender. *"Critical perspectives such as postcolonialism equip us to meet the epistemological imperative of giving voice to subjugated knowledges and the social mandates of uncovering existing inequities and addressing the social aspects of health and illness."* (Kirkham and Anderson, 2002: 1).

While the experiences of African countries under colonial rule varied, there were important commonalities in the legacies left behind. Olaniyan (2005) described the imperial domination of physical space, where the European colonial powers carved up the continent across indigenous ethnic, linguistic and cultural groups. This had significant impacts on nationhood, stability, and the power of African states to shape and direct their affairs. The imposed, dictatorial, colonial state was accountable only to the metropole; today existing governance structures in many African countries are still based on these colonial systems, with all the challenges for accountability to the local population that this entails.

The colonial project was not just concerned with economic and territorial expansion, but also damaged the psyche and self-image of those who were colonised (and their colonisers). The colonisation of the mind subverted national identity and robbed people of their self-image as capable of independent action (Fanon, 1968). Said (1993) argued that dominance was

demonstrated by 'othering' and promoting images of non-Western peoples in binary opposition to the 'superior' traits of Westerners, which legitimised colonialism's 'civilising mission' and was underpinned by an ideology that 'the West knows best'. Key agents were, and to a large extent still remain, the Christian missions and the education system. Academic success involved education in the coloniser's language, was grounded in Western viewpoints, and marginalised local knowledges; a situation that persists in many countries of southern Africa (Kayira, 2015). The introduction of colonial education systems also had a negative impact on the pre-existing communal worldview, unique to southern and central Africa, of *uBuntu* (known as *uMunthu* in Malawi's Chewa language). *Ubuntu/uMunthu*[9] is often expressed as *'I am because we are, and because we are, therefore, I am'* (Mbiti, 1969). It sees personhood as located in community, grounded in interconnectedness and based on values of respect, compassion, empathy and responsibility, expressed in social, political and economic areas of life (Tambulasi and Kayuni, 2005). The arrival of missionary education, premised, *inter alia*, on individualism, was seen as responsible for the move away from *uMunthu* as the basis for education (Musopole, 1994). A postcolonial critique views the continued dominance of Western viewpoints and the marginalisation of local ways of being and knowing as a form of neocolonialism, where the West continues to impose economic and cultural standards (e.g. Kayira, 2015). Fanon (1968) cautioned that adopting colonial languages and cultures created new elites and dispersed privilege on particular groups, mediating existing inequality. For example, in the Malawian context, the perpetuation of colonial governance structures, the embrace of the neoliberal paradigm, and the continued use of English as the language of government and commerce, have left the majority of the population alienated from the formal sector, with little say in running their society (Matiki, 2001). A pro-British bureaucratic elite remains in charge (Lim, Anderson and McGrath, 2012). However, some countries in sub-Saharan Africa, such as Malawi, function as hybrid 'neopatrimonial' states. In patrimonial authority, an individual of personal prestige and power rules, with the rest of the populace deemed part of the 'big man's' household. Authority is not codified in any system of laws, but is personalised and shaped by the ruler; stability and personal political survival are maintained by distribution of material benefits and favours to loyal followers (Bratton and van de Walle, 1997). A modified version of this system persists in many African postcolonial contexts where bureaucratic institutions have been established, but elements of patrimonial and rational bureaucratic states are mixed (Cammack and Kanyongolo, 2010). *"…there is a framework of formal law and administration but the state is informally captured by patronage networks. The distribution of the spoils of office takes precedence over the formal functions of the state, severely limiting the ability of public officials to make policies in the general interest."* (Booth et al., 2006: viii). In the Malawi context, this is manifest in the blurring of boundaries between private, state, and ruling party resources, effectively leaving government authority and resources as private property. Booth further described the inequality and large power asymmetries that characterise social

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[9] The meaning of *uMunthu* I have used here has been drawn from the work of Sharra (2006) who synthesised the views of other Malawian scholars.

relationships, where: "*…hierarchy is expected, inequality is desired and anticipated, less powerful people are expected to be dependent on more powerful people, women defer to men, subordinates envisage being told what to do, and the according of privileges and status to members of the elite is expected and welcome.*" (p. viii). Neopatrimonialism and the personal relationships it entails are a core feature of African politics, mirroring social organisation in precolonial times, but are seen to be incompatible with democracy (Bratton and van de Walle, 1997).

The colonial 'civilising mission' was strongly demonstrated in attitudes to childbirth. In the imperialist project, birth became an object of colonial governance, providing an opportunity to exercise demographic and social control (Hunt, 1999). Birth became medicalised and moved from the private, social and largely female sphere, into health facilities. The superiority of Western medicine and education was part of a socialisation process that aimed to eradicate 'barbarity' and unacceptable customs (Thomas, 2003; Kanogo, 2005), where Black African midwives struggled for legitimacy in the face of colonial systems whose notions of race and gender limited their role and agency (Marks, 1994; Coovadia et al., 2009). Traditional knowledge and ways of birthing were denigrated. The legacy of these attitudes persists. The adoption of the rituals of facility-based birth and its obstetrical procedures reflect core values of modern (i.e. Western) societies that have transformed African rites of birth into "*a medically dominated initiatory rite of passage through which birthing women are taught about the superiority, the necessity, and the 'essential' nature of the relationship between science, technology, patriarchy, and institutions.*" (Hillier, 2003: 57) At the same time, birth's social and cultural significance are suppressed and devalued. Training of nurse-midwives uses technically focused, European curricula and models of care, which are historically rooted in notions of moral and social superiority (Marks, 1994), modernity and progress. The overt message is that birth is a medical event, not a natural process – a message that is reinforced by standards and initiatives promulgated by global agencies (Stone, 2009), whose expectations may not be achievable or acceptable in local contexts and which Hillier (2000: 147) characterises as: "*a high technology ideology without the high technology equipment. The Emperor's new clothes.*"

Sub-Saharan Africa's colonial history has also had a significant impact on the shape of health systems. The three main elements that formed their configuration were vertical services to deal with major diseases; relatively sophisticated hospitals sited in urban areas to cater for the needs of colonial cadres and elites; and a smaller network of hospitals, often staffed by missions, with peripheral health centres under their aegis (Blaise and Kegels, 2004). This pattern is largely still in place. Administration and planning remain highly centralised and are organised hierarchically in a 'command and control' model. Standardised procedures theoretically allow efficiency of service provision e.g. delegation of tasks to lower qualified staff, but the top down control of health workers through a powerful hierarchy leaves front line staff with limited decision space. Additionally, the use of standardised routines in the

absence of skilled assessment, risks exacerbating the dehumanisation of women, further distancing them from their provider by reducing them to cases instead of individuals, and serves to privilege the physical and technical aspects of care over compassion (Pearson, Vaughan and FitzGerald, 2005).

Another enduring legacy of colonialism in Africa, which has a significant impact on the health system, is economic underdevelopment and dependence (Olaniyan, 2005). After independence there was a period of progress in the health situation in sub-Saharan African, but the ramifications of the 1970s oil crisis and subsequent severe international economic recession in the 1980s had serious negative consequences for health across the region (Soucat, Schleffier and Ghebreyesus, 2013). Austerity measures, including Structural Adjustment Programmes (SAP), forced debtor governments to scale back their social sector spending. At the same time, they had to liberalise their economies and promote private sector provision of basic services which had up till then been the responsibility of the state. The financial efforts to rein in debt in African countries forced governments to defund their public sectors, leading to the virtual collapse of both the health (Breman and Shelton, 2001) and education systems (Federici and Caffentzis, 2017) Many studies found this to be disastrous for health in Africa, leading to stagnation or reversals of gains made in the previous two decades (Breman and Shelton, 2014). Health expenditures were already extremely low and the further restrictions imposed on social sector spending had negative effects on health (WHO, 2001).

This legacy is still felt today as Olaniyan's conclusion, more than forty years after independence, shows. *"Although that colonisation is formally over, the basic inequality which subtended it - and which sponsored everything from economic exploitation to racism, destruction of indigenous African institutions, and epistemological dependency - is still firmly in place."* (Olaniyan, 2005: 280) Colonial plunder continues in the guise of globalisation and international capitalism. Disinvestment of African countries means they remain a source of raw materials and cheap labour, the economic value of which benefits the West, not their own populations (Federici and Caffentzis, 2017). Poverty, inequality and debt leave governments subject to the dictats of external actors, such as the World Bank and the International Monetary Fund, and at the mercy of the international aid architecture.

The financial power of aid agencies and non-governmental organisations (NGOs) and the acute need for support in many public sector arenas in Africa, combine to give external actors undue power and influence over national health agendas. *"The underdeveloped areas are construed as objects of elite benevolence, rather than as historical subjects possessing their own unique worldviews, interests and passions. Aid given to such countries to improve and grow has to meet conditions set by the donor."* (Kayira, 2015: 107) While some agencies exert financial power or access to resources to shape global health priorities, others exercise epistemic and normative power to shape the global discourse and influence policy in low-income countries (Shiffman, 2014). Shiffman's critique of knowledge, moral claims and the exercise of power in global health suggests that structural power, based on medical or ethical

expertise, defines the status and relationships between actors; and productive power creates meaning and legitimises certain categories of activity or ways of thinking about problems and solutions. This has profound implications for which issues are prioritized (e.g. disrespectful maternity care or professionalisng midwifery), how they are framed, and whose voices are included in the discussion. The role of state and non-state actors in shaping the priorities and actions of aid recipients, where *"…few have interrogated the impact of productive power in global health whereby purveyors of "truth" emerge, gain legitimacy and define the validity of certain problems and solutions"* (Lee, 2015: 158) and concerns about the increasing political influence of international NGOs as agents to influence local policy environments, rather than allowing locally owned and led ownership (Storeng et al., 2018), are pertinent factors in postcolonial contexts. On the international stage, commitments, such as the Monterrey Consensus[10], to engage in poverty reduction and development provide a framework for discussion and, hopefully, for action. However, many of the key commitments remain unfulfilled and questions need to be asked about the balance of power if governments are receiving even more of their basic funds from the international donor community. The international governance architecture needs to address fundamental issues about health, its nature, and who is responsible for its delivery and regulation. Valid concerns exist over vested interest, the plight of the poor and ideologies that see health as a technical deliverable, rather than a core social institution (UN Millennium Project, 2005).

The focus in this thesis is on the care of women in childbirth, but also on the experiences of the women (as they are mostly women) in a gendered profession who provide care, and so feminist perspectives on colonialism are relevant. Postcolonial feminists are concerned with the way in which colonialism's gendered history affects the status of women, citing the double colonisation of women by imperialism and male dominance, and are united in their goal to give voice to those who have been silenced in the dominant social order. However, criticisms have been levelled against Western feminism for ethnocentric bias, situating their experience as the norm, and a failure to adequately engage with the differences in women's experiences across culture, economic conditions and contexts, effectively homogenising women's experience as 'third world woman' (Mohanty, 1988).

1.6.2 Oppressed groups theory

Oppressed groups theory (Freire, 1972) has long been used as an explanatory mechanism for aggression and bullying in nursing (e.g. Roberts, 1983; Freshwater, 2000; Taylor, 2016) and midwifery (e.g. Leap, 1997; Kirkham, 1999) in high-income contexts. The theory proposes that dominated groups internalise the values and beliefs of their oppressor and come to view their own identity and culture as inferior. The subsequent feelings of self-hatred and low self-esteem this generates need to be vented, but it is not possible to express these negative emotions to the dominant group. Instead, oppressed groups direct their

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[10] An agreement between governments worldwide made at the UN International Conference on Financing for Development (March 2002) to strengthen the global partnership needed to achieve the MDGs.

frustrations and dissatisfactions towards each other. Fanon's (1968) writings on the psychological impact on the Algerian populace under colonial domination suggested the intergroup conflict and violence he witnessed were manifestations of these negative emotions, which he dubbed 'horizontal violence'. Horizontal violence is a response to a system that excludes oppressed groups from power, rather than a characteristic of oppressed groups themselves (Roberts, 1983), and has particular resonance in this postcolonial context.

Nurses and midwives can be conceptualised as oppressed groups. Kirkham (1999) describes how midwifery has been subject to gendered institutional values, where caring is culturally coded as female work, so afforded less status in the medical hierarchy. At the same time, male-cultured values of control, competition and mastery, are reflected in medical and managerial domination, a medical model of birth, and the relocation of birth to the hospital. The tensions this produces are released in horizontal violence, a term that is used interchangeably with lateral violence, bullying, aggression, incivility and disruptive behaviour in the nursing and midwifery literature (Taylor, 2016).

A review by Vessey et al. (2010) described bullying, harassment and horizontal violence as "*a common and pernicious problem and a persistent, occupational hazard within the global nursing workforce.*" (p.141) Although much of the research on oppressed groups theory and horizontal violence in nursing and midwifery has been undertaken in high-income countries, emerging work in sub-Saharan Africa suggests high levels of workplace violence between nurses in both South Africa (Khalil, 2009) and Malawi (Banda, Mayers and Duma, 2016). Leap (1997: 689) listed behavioural manifestations that included *"...overt and covert nonphysical hostility, such as sabotage, infighting, scapegoating, back-stabbing and negative criticism. The failure to respect privacy or keep confidences, non-verbal innuendo, under-mining, lack of openness, unwillingness to help out, and lack of support…"* Leap also described the role of middle-managers as perpetrators, citing examples such as substandard management styles or skills, and failing to reward staff for work well done. Hunter (2005), too, noted problematic behaviour from senior to junior midwives, some of which was driven by differing midwifery ideologies or was triggered by non-conformity. Significant evidence documents a range of negative sequela of horizontal violence behaviours, with impacts at organisational and individual levels. Vessey et al.'s review (2010) identified poor teamwork, staff attrition and absenteeism, as well as a range of physical and psychological harms to individuals that result in reduced job satisfaction, disengagement, reduced professional confidence and damaged self-esteem. These factors are likely to impact on quality of patient care and outcomes.

Other authors have critiqued the narrow application of oppressed groups theory to behaviour such as bullying, suggesting that this fails to include downward bullying of juniors/patients and upward bullying of seniors/managers by nurses and also fails to address the organisational factors at play. *"Within the horizontal violence framework, nurses belong to a violent oppressed group. This stance risks apportioning blame solely to nurses, and obscures the role of power relations within organisations, inadvertently reinforcing the oppression of*

nurses.” (Hutchinson et al., 2006: 123). More recently Hutchinson et al. (2008) have developed a model of bullying in nursing which suggests organisational tolerance, informal work alliances, and misuse of legitimate authority, processes, and procedures, are antecedents to bullying behaviour and its normalisation.

The following chapters include reference to many of the factors implicated in driving horizontal violence and oppressed group behaviours, as well as the specific postcolonial context that shapes some of the behaviours discussed by midwives.

1.7 Structure of this thesis

Following on from this introductory chapter, Chapter 2 is the first of the literature review chapters. This situates the research question in the context of the global discourse on (dis)respectful maternity care, identifying current models and conceptualisations. The international human rights architecture, models of midwifery care and applying RMC standards in the sub-Saharan African context will be discussed.

The second literature review chapter, Chapter 3, presents the results of two systematic reviews exploring (dis)respectful care during facility-based delivery that were carried out as part of this PhD research. The first used women's experiences, while the second synthesised a newly emerging body of literature from the midwife's perspective. This chapter also describes the conceptual framework developed during this process that was used for the data analysis.

Chapters 4 and 5 are the accounts of 'the plan' and 'the reality' of the methodology and methods. Chapter 4 outlines the study's genesis, philosophical underpinnings, justification of research design and methods, and data collection. Chapter 5 situates me in the research encounter, making visible my reflexivity and awareness of the relational, ethical and representational dimensions of the data collection journey.

Chapter 6 describes the setting, giving an overview of the Malawian context. It demonstrates how the geopolitical and socioeconomic landscapes intersect with the contours of the health system in a low-income context. Government policy and the drive to institutionalise birth are discussed, as well as the status of midwifery provision and training.

Chapters 7-10 are the results chapters. Chapter 7 applies a postcolonial lens to capture key informant perspectives on the broader cultural, organisational and professional context in which maternity services are currently embedded. Its purpose is to situate and clarify a series of 'Betwixt and betweens' at the macro-level which constitute key contextual drivers affecting the provision of respectful maternity care (Obj. 4).

Chapter 8 moves to the meso-level, describing some of the main health systems factors affecting the practice, ethos and identity of midwives in the postcolony. This chapter's role is to explore the impact of the inherited dual-qualification model of midwifery and the implications for midwives of being part of a hierarchical health system. It also outlines challenges in pre-registration training, as well as the implications of efforts to professionalise

midwifery and the potential of role models as enablers of RMC and quality more generally. (Obj. 4)

Chapter 9's focus is on the micro-level of midwives' relationships with women. It describes emerging insights into midwives' perceptions of an ideal model of RMC (Obj. 1), their practice of RMC (Obj. 2) and the challenges they face in providing it at this level (Obj. 4). Midwives' rationales and legitimisations of disrespect are described, counterbalanced by their awareness of the benefits of RMC (Obj. 3) and the implications of this for recognition and respect from the community.

The final results chapter, Chapter 10, moves back out to the meso-level to foreground the plight of the midwife and the need to care for the carers, who feel abandoned in an unconducive working environment where no one is listening and they lack institutional support. Using the lens of oppressed groups theory, I describe the role of organisational culture in hindering or facilitating professional behaviour, including RMC (Obj. 4). The chapter also addresses horizontal violence which, in the absence of external controls that demand professional standards, can lead to good midwives giving up and the normalisation of low-quality care and disrespect of women and of colleagues.

Chapter 11 offers a synthesis of the key findings, moving from the macro-level postcolonial context, through meso-level aspects of the midwifery model, the hierarchical system, education and professionalsing agenda, down to the micro-level of relationships with women, finishing with a consideration of the midwife's situation. Finally, I end with a critique the strengths and limitations of the study.

Chapter 12 is the concluding chapter, where I draw out the significance of my findings, and highlight the study's relationship with, and contribution to, the literature and to theory. I then make recommendations for policy and practice that can be achieved within Malawi's existing resources, before closing with suggestions for further research.

2. The global RMC discourse

This chapter provides an overview of the main areas of concern in the current discourse on RMC. Firstly, it introduces the broad parameters of this discourse. It then looks more specifically at the human rights architecture for sexual and reproductive health, key milestones in realising those rights, and issues of accountability and power. Models of care are discussed, followed by some key factors to consider when applying RMC models and guidelines in the sub-Saharan African context.

Introduction

Achieving the Millennium Development Goals (MDGs) on maternal health (MDG5a[11]) relied on skilled attendance at birth and facility-based delivery; however, by the end of the MDG period, it was clear that insufficient progress had been made and many low-income countries failed to reach their targets (United Nations, 2015). Critiques suggested the MDGs' interpretation and implementation was too limited, particularly with respect to sexual and reproductive health and gender-based violence (Berer, 2011; Allotey and Reidpath, 2014). The Sustainable Development Goals (SDG) (United Nations, 2017) now provide an opportunity to build on the MDGs, and address these critiques. Of particular resonance for RMC is the more cross-cutting focus of the SDGs, including gender equality and empowerment of women (SDG05) and reducing maternal mortality (in SDG03), which together have the potential to improve the provision and experience of maternity care.

International attention has historically focused on improving the quality of care at facility level as one mechanism to increase uptake of facility-based delivery but, until recently, has tended to rely on clinical and technical quality measures, despite evidence emerging from low-income countries of the importance of maternity care that addresses women's psycho-socio-cultural needs. Even in countries that have successfully scaled up midwifery care and decreased their maternal mortality ratios, there has been little or no attention to over-medicalisation and the way in which midwives can be supported to provide respectful woman-centred care (Van Lerberghe et al., 2014). Paying attention to how women experience care, particularly D&A, is crucial as it is an indication of low-quality care (Kruk et al., 2014). Furthermore, it is no longer viable for governments to ignore the growing chorus of voices. The spread of technology and growing awareness among populations of their rights has led to rising expectations and more pressure to address this issue (Van Lerberghe et al., 2014), at least in situations where service users are able to voice their concerns. One way in which dissatisfaction with poor services is enacted in low-income countries is in women's reluctance to comply with government efforts to increase facility-based delivery. D&A is a key deterrent and undermines a community's trust in health services (Gilson,

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[11] MGD5a aimed to reduce by three quarters, between 1990 and 2015, the maternal mortality rate. Its metrics were 1) maternal deaths per 100,000 live births, women aged 15-49); and 2) proportion of deliveries attended by skilled health personnel, tacitly expected to occur in a health facility.

Palmer and Schneider, 2005) - if women do not trust their local health facility they will go elsewhere or deliver at home (Kruk et al., 2009).

A 2010 landscape analysis, Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth (Bowser and Hill, 2010), documented evidence that had been known anecdotally for some time, giving international voice to NGOs (e.g. the Centre for Reproductive Rights), women and advocates who had long been concerned about how ill-served women were - across geographic and socioeconomic boundaries - by birth practices that abused, disrespected and excluded women's full participation in the birth process. In the absence of any operational definitions for this behaviour, the authors developed seven categories, based on the evidence they had gathered. The categories, which may overlap and occur along a continuum from subtle disrespect to outright violence, are: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. Since then, there has been ongoing work to refine, measure and operationalise typologies of D&A (Abuya et al., 2015; Bohren et al., 2015; Vogel et al., 2015; Sando et al., 2016). The timing of Bowser and Hill's report was crucial to it gaining traction and an international audience. The MDGs were drawing to a close, persuading woman to access facility-based delivery had not been very successful, and there was criticism of the limited progress made on MDG5 despite over 20 years of the Safe Motherhood Initiative. These factors seem to have coalesced to make the time right for D&A to be picked up by actors, such as the WRA, a coalition of advocates, NGOs and donors who campaign on women's rights to safe motherhood and are one of the key actors in the RMC field. Their impetus has been instrumental in bringing the RMC discourse to a wider audience, developing Bowser and Hill's seven categories into The Charter on the Universal Rights of Childbearing Women (WRA, 2011). These are: freedom from harm and ill treatment; right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice wherever possible; confidentiality and privacy; dignity and respect; equality, freedom from discrimination and equitable care; right to timely healthcare and to the highest attainable level of health; and liberty, autonomy, self-determination and freedom from coercion. The Charter has been endorsed by FIGO[12] and others, who are now advocating for the establishment of 'women friendly birthing facilities'. This rather begs the question of why it has been acceptable to have women **un**-friendly services up until now, when as early as 1998 Fathalla argued, *"The question should not be why do women not accept the service that we offer, but why do we not offer the service that women will accept."* (Fathalla, 1998).

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[12] The International Federation of Gynecology and Obstetrics

2.1 Human rights and maternal health

2.1.1 Health rights architecture

The reproductive health rights of women are enshrined in human rights declarations and legislation. In 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights as the first of a series of human rights instruments (subsequently critiqued as being gender blind), which have since been augmented by additional instruments and treaties. Those of specific relevance to maternal health are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (CESCR). These developments in the global human rights project have allowed the generation of lists of rights, categorised into positive aspects (e.g. rights to respect, autonomy, dignity) and negative elements or violations (e.g. women should not be treated in a certain way or discriminated against). In some respects, this is mirrored in the current language of the global discourse on maternal health rights, which is divided into RMC and D&A - effectively two sides of the same coin.

Individual states make legal and political commitments to international human rights structures and understandings, which are given voice in membership in international human rights treaties and the development of national laws (Cook et al., 2001). These can then be used to oblige midwives and other health professionals to behave in certain ways in order to respect women's rights. The right to health requires health services that are available, accessible, acceptable and of good quality (CESCR 2000). Technical guidance has been developed to assist policy makers in improving women's health and rights to reduce preventable maternal morbidity and mortality (UN Human Rights Council, 2012). There are tensions between the human rights ideals, which have human dignity at their core, and the challenges of translating these ideals into changes in the daily lives of people around the world, particularly where women's sexual and reproductive health and rights (SRHR) are concerned. This is made more difficult when some of the leading global actors in this arena (e.g. USA) have not ratified key international treaties like CEDAW. It is also important to note that the human rights discourse is not just interested in tangible rights, such as the right to health, but in the processes and interactions that are involved in realising those rights. Disrespectful treatment of women is a violation on both these fronts.

2.1.2 Key milestones in sexual and reproductive health and rights (SRHR)

The RMC discourse is supported by a long history of action to realise women's SRHR. The Programme of Action of the International Conference on Population and Development in Cairo in 1994[13] and the Beijing Platform for Action in 1995[14] represented a paradigm shift in conceptions of SRHR. They moved the debate from an existing focus on vertical population programmes controlling women's fertility, to the broad-based promotion of universal access

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[13] See http://www.unfpa.org/icpd
[14] See http://www.un.org/womenwatch/daw/beijing/platform/

to SRHR as human rights, through strengthening of health services and dealing with the underlying social determinants of health. This was underpinned by a commitment to human rights and gender equality as critical contributions to sustainable development and the fight against poverty, setting a global policy framework to advance gender equality, which confirmed the universality of women's human rights, recognised sexual rights and reaffirmed women's reproductive rights.

In 2000, the Millennium Declaration was adopted by 191 states, without the direct participation of NGOs or civil society. The MDGs focused on measurable targets and use of indicators as a basis for planning narrow goals, based on perceptions of best practice and pragmatism. For maternal health, these included decreasing the maternal mortality ratio and increasing skilled attendance at birth, with facility-based delivery playing a key role. Activists and feminists were disappointed by the MDG's focus on outcomes and indicators, without addressing the complexity and interconnectedness of the issues and their failure to operationalise gender justice and women's empowerment as cross-cutting issues - key concerns that developed through the international conferences. Other critiques of the MDGs suggest that they failed to sufficiently engage with the underlying social attitudes, values and human rights violations that affect women (Allotey and Reidpath, 2014). The broader context in which women's experiences are embedded are key aspects underpinning D&A, and must be considered if we are to move away from simplistic focus on the mother-woman dyad and find meaningful ways to achieve more respectful interactions between women and midwives.

2.1.3 Accountability and power

Mechanisms for accountability within the RMC literature range from holding individual actors to account to taking legal redress against the state, but too often there is insufficient or vague articulation of who is being held accountable to whom, for what, and how this will be done. Efforts to categorise elements of RMC include the WRA's charter which has a human rights approach, and the work of Averting Maternal Death and Disability and the Population Council (Freedman and Kruk, 2014; Warren et al., 2013) who are carrying out research to operationalise the concept of D&A to enable a more rigorous assessment of its prevalence. Efforts to generate a typology of D&A may have started with d'Oliveira's earlier work on violence against women in health care institutions (d'Oliveira, Diniz and Schraiber, 2002). Codifying standards and norms for RMC is one step in the process of progressively realising the human rights that underpin these norms. They provide a mechanism for institutional and country accountability, as they clearly outline providers' obligations and women's entitlements. Much of the work currently being done aims to generate sufficient public awareness and momentum to make these standards an integral part of maternity practices globally.

Human rights legislation, conventions and standards are set by professional bodies and premised on notions of accountability. Much of the discourse is about blame and redress, with increasing use of legal systems to hold countries to account for violations of women's

basic rights, particularly where a maternal death has occurred. There are also instruments generated within countries - in 2007 the new legal term 'obstetric violence' was introduced in Venezuela, described as:

> *...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.* (D'Gregorio, 2010)

This law has provisions to fine and discipline health workers for a range of acts, including untimely and ineffective attention to obstetric emergencies; not allowing women to choose vertical delivery where this is possible; impeding early attachment of infant and mother; accelerating normal labour when this is not indicated; and performing C-sections when a vaginal birth is possible. The latter two can only be performed with expressed, voluntary and informed consent from the woman. Concerns were expressed by the Society of Obstetrics and Gynecology of Venezuela that the work environment makes it difficult to achieve some of these goals, leading to a situation where legal redress could be instigated against individual health workers for situations which are actually institutional responsibilities (D'Gregorio, 2010). D'Gregorio also suggests that laws should be tailored to reflect obstetric practice in each country, but this is of concern where such practice does not accord with internationally accepted best practice (e.g. only teaching supine delivery in medical schools). One of the few voices advocating for a more positive approach is that of Freedman (2003) who suggests the notion of 'constructive accountability' which refers to "*'developing a dynamic of entitlement and obligation"* and using *"…the impetus provided by human rights law to move beyond the legal realm into the realm of good, evidence-based, rights-conscious medical and public health practice."* (p.111)

Some of the discourse seems to suggest that patient empowerment and voice are necessary for RMC to be implemented. A key element of the Bamako Initiative (1987), which aimed to improve primary health care in sub-Saharan African, was to encourage social mobilisation to improve participation of local people in the provision of health care services, often using health committees in oversight, voice and accountability. This has had mixed success. Firstly, the bottom-up approaches, laid down in government acts and policy papers, which were intended to facilitate this process did not always translate into practice on the ground. In Tanzania, for example, local government authorities have become implementers of national policies, with local preferences only taken into account if they accord with central plans, thus leaving the community without downward accountability and little confidence that the process will address their needs (Mollel, 2010). Secondly, the choice of community representatives is not usually democratic or transparent; it favours the elite and marginalises women, so the existing power structures serve to exclude the very people who are most vulnerable and whose voices need to be heard (Mehrotra and Jarrett, 2002).

Freedman and Schaaf's (2013) work on accountability suggests there is a divergence between the way problems in SRHR are framed among global actors and the reality facing women on the ground. Firstly, they suggest there is a false belief that the forging of global goals (such as the declaration on RMC) will have an impact on change at the grassroots level. Secondly, they critique the idea that change can happen without addressing power, and echo Berer's (2011) calls to re-politicise SRHR, interrogating women's lived experience of the health system and its gendered and other sociopolitical dynamics. This is based on the International Conference on Population and Development's paradigm shift that urged a move beyond 'freedom from' and 'freedom to' debates to a real engagement that challenges fundamental social meanings around reproduction, gender and power. Finally, the authors underscore the idea that the health system is more than the sum of its parts; systems thinking is needed to move understandings of accountability towards that of an 'emergent' quality set in a system of multiple accountability relationships and a culture of transparency, rights, responsibility and solidarity.

2.2 Models of care

Current maternity care practices are dominated by a technocratic, biomedical model of birth, predicated on the Cartesian duality that sees women's pregnant bodies as machines separate from women themselves, which need to be controlled and maintained by (male) experts. Oakley characterised this as *"the colonisation of reproductive care by medicine"* (1980, p.34). The prevalence of technology is commonplace in high resource settings, particularly the US, and conveys psychological implications and expectations of birth as a technocratic, rather than normal, process. It is characterised by rising rates of intervention, where fear and risk avoidance (or better still, elimination) override normal physiological birth. In techno-birth, the woman is passive, an object, who is expected to hand over her responsibility and authority to an expert who will use aggressive intervention to avoid risk or death (Davis-Floyd, 2001). However, even within overtly technocratic models, there are differences between discourse (i.e. how people think) and practice (i.e. what they actually do), such as midwives' attempts to provide more respectful or woman-centred care. An example is Mexican midwives' critique of the hypermedicalisation of birth, and their efforts to reframe it in terms of 'violence and violation' (Dixon, 2014). Conversely, systems and practitioners may espouse woman-centred values but operate in contexts that actively work against realising this ideal by being institution-focused and technologically heavy (Kirkham, 1999). In both contexts, actors within the system may have practices that reflects their reality, rather than the dominant ideology.

An alternative model of care is reflected in the humanised birth discourse emanating from Latin America, as one thread in the global efforts to address technocratic and invasive birth practices and bring humanistic practices back into the birthing arena. It has been a significant social movement since the mid-1990s, with shared roots in the social justice movements of Paulo Freire (1972). The movement gained substantial momentum with the

International Conference on the Humanization of Childbirth in Brazil in 2001. Brazil is one of the few countries where feminists are actively engaging with childbirth issues and demanding humanised care (Berer, 2012). There are questions to be asked about why the mistreatment of women during birth has been largely ignored by feminists elsewhere, compared to other kinds of violence (such as sexual or domestic violence). In the context of childbirth, 'humanised' care is defined in terms of being fulfilling and empowering to women and health workers, and promoting women's active participation and decision-making in all aspects of their care (Misago et al., 2001). Others suggest it refers to a *"woman-centered, nature-oriented and appropriate-technology approach to childbirth care"* (Onuki, 2002). The humanised birth literature seems to have been an early area where the idea of RMC started to gain traction. Bowser and Hill's use of 'respectful care' is seen as corresponding to humanised care (Fujita et al., 2012) and these two approaches overlap to a considerable degree. A common thread is the central importance of positive interpersonal care in the labour ward dynamic.

Respectful maternity care is enshrined in the midwifery policies of many Western countries, particularly in community-based and midwifery-led units. However, it is significantly marginalised in other contexts and often a source of emotion work and contention for midwives practising in hospital settings where they are obliged to work within the exigencies of a more medicalised ideology of birth (Hunter, 2004). The partnership between midwives and women is a central element, clearly (though marginally) articulated in internationally agreed core skills and abilities (WHO, International Confederation of Midwives, FIGO, 2004). More recently, this has been brought into sharper focus and expanded by the Lancet Series on Midwifery where the core characteristics of skilled midwives are defined, *inter alia*, as *"…optimising normal biological, psychological, social and cultural processes of reproduction…respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families."* (ten Hoope-Bender et al., 2014).

In the Scandinavian context, research demonstrating key components of woman-centred care has been amalgamated into a cohesive, dynamic model (Berg, Ólafsdóttir and Lundgren, 2012). Elements of this model nicely articulate many of the key elements one would wish to see in a model of RMC, and closely echo the woman-centred care that is an expectation of the International Confederation of Midwives (ICM) core competencies (ICM, 2013). Evidence from 12 studies was synthesised, then validated via focus group discussion with 30 practising midwives. Three central themes were agreed: 'reciprocity' in the relationship between midwives and women (presence, affirmation, availability and participation); creating a 'birth environment' of calm, safety and trust, where women are empowered and normality is supported; and the midwife's 'grounded knowledge' that is theoretical, experienced-based and sensitive (intuitive), and embodied as a lived, genuine part of the midwife's daily work. In a move forward from the ICM's definitions, these are set within the cultural context whose norms can hinder or promote woman-centred care, and are

identified at the levels of the woman herself, the institution and the health system as a whole. For midwives, this involves a balancing act as they navigate the woman's needs and individual circumstances, workplace constraints/expectations and philosophical differences in the approach to birth, but ultimately this balancing act *"…may also enable the physiological social approach and the medico-technical approach to exist side by side."* (Berg, Ólafsdóttir and Lundgren, 2012, p.85)

There is growing evidence of researchers in low-income countries generating their own models of women-centred care. In South Africa, Maptule and Donavon (2013) have developed a framework that is set within the context of an existing government platform, the Batho Pele initiative (Department of Public Services and Administration, 1997). The initiative aims to improve public service delivery via principles of consultation, service standards, access, courtesy, information, openness/transparency and redress. The authors generated a list of four criteria (mutual participation and responsibility; sharing information and empowering; open communication and listening; and accommodating mothers' choices and preferences) with corresponding behaviours that could be used to guide, facilitate and evaluate the implementation of woman-centred care in childbirth units. This leads to the question of whether models of RMC, as envisaged by 'calls to arms' such as the WRA's Charter on the Universal Rights of Childbearing Women (2011) and the WHO's Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth (World Health Organization, 2014), can be meaningfully translated as they stand into low-income contexts.

2.3 Applying RMC standards and models in the sub-Saharan African context

2.3.1 Workforce factors

In Section 1.6.1, I described the postcolonial context and its implications for the history and shape of health systems in sub-Saharan Africa, as well as the disastrous impact that austerity measures have had on the functioning of those systems. Economic constraints, brain drain (in the form of internal and external migration), and general poverty have compromised primary health care provision in many low-income countries, particularly in rural areas where significant percentages of the population live. A range of factors have serious consequences for the performance of quality care, including shortages in absolute numbers of staff or maldistribution of the existing health workforce (e.g. Chen et al., 2004; Brown et al., 2011), as well as inadequate skill mix or non-use of the obstetric signal functions[15] (Lobis et al., 2011). Poor work environments that are characterised by inconsistent supplies of basic commodities and supplies make it challenging for staff to provide optimum care (Penfold et al., 2013), with all these factors often set in a context of weak knowledge systems for policy, planning and management (Chen et al., 2004). It is unsurprising that health workers are reported to have

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[15] The 'signal functions' are a list of life-saving services that define a health facility with regard to its capacity to treat obstetric emergencies. They include procedures such as administration of uterotonics or anticonvulsants, assisted vaginal delivery and caesarean section.

low motivation and perform poorly, and difficult to see how RMC can be implemented without significant changes in how the health system functions.

2.3.2 A focus on technical care

Commentators have critiqued the international community's focus on the technical aspects of care (competence and equipment), rather than employing multi-dimensional models that also encompass the interpersonal (respectful, inclusive) parameters, situated within the organisational context in which maternity health care occurs (ten Hoope-Bender et al., 2014). Others suggest that the clinical focus on tangible and concrete outcomes has saved lives - but only of those women who make it to the facility. *The critical point is that the focus on the endpoint has been at the cost of the importance of the route taken during the journey*." (Allotey and Reidpath, 2014). Technological birth in facilities has become so normalised and overused that it has dehumanised care and moved the expectations of delivery to a medical model, with unexpected or unhelpful consequences for women hoping to have a normal delivery (Bohren et al., 2014). Others go as far as to suggest that the technocratic, Western obstetric model should *"…never be exported to developing countries."* (Wagner, 2001: S25) but in many cultures it is seen as 'modern' and feeds into a colonial mindset that denigrates indigenous ways of knowing and doing.

2.3.3 Multi-purpose health workers or midwives?

There is an increasing emphasis on not just **what** is done, but also **where** and by **whom**, with some of the discourse starting to explicitly call for a woman-centred agenda, emphasising the primacy of midwives in making this happen (e.g. ten Hoope-Bender et al., 2014). However, the critical shortage of human resources for health in sub-Saharan African has had two detrimental effects on woman-centred and respectful maternity care. Firstly, staff shortages combined with the MDG5 focus on reducing maternal mortality by increasing facility-based delivery, have fostered an 'emergency' focus on life-saving interventions and increasing coverage. These were entirely necessary, but have led to the erosion of 'normality', a concentration on the medical model, and a lack of attention to psychosocial elements of care. Secondly, the fiscal constraints that are a core driver of the human resources crisis in countries, such as Malawi, have been used to justify/encourage policy efforts to produce generalist cadres i.e. nurses who also have midwifery skills, instead of investing in a dedicated midwifery workforce. In these contexts, midwifery skills are seen as an 'add-on'. The value of skilled, professional midwives is not understood and the specific interpersonal skills that they need to operate in the culturally and emotionally sensitive arena of childbirth are woefully neglected (Fauveau, Sherratt and de Bernis, 2008). Mid-level providers, who were introduced in the colonial and immediate post-colonial periods, carry out the majority of obstetric care in countries such as Malawi. These are health care workers who undertake roles and tasks that are more usually the province of internationally recognised cadres, but whose pre-service training is usually shorter and who possess lower qualifications (Dovlo, 2004). In Malawi, they include registered midwives and country-specific cadres of nurse-midwife technician, enrolled nurse/midwife, along with 'clinical' cadres of clinical officer and

medical assistant. They have historically been regarded as a temporary fix, so have not been properly integrated into health systems, are seen as having low status and do not have adequate supervision or management. Renfrew et al.'s review addressed both these concerns with the generation of a new framework for maternal and newborn care, advocating *"…a system-level shift from fragmented maternal and newborn care focused on identification and treatment of pathology for the minority, to skilled care for all"* (2014: 1130). Central to this are *"educated, trained, licensed, and regulated"* midwives providing supportive care, optimising normal birth, and managing emergencies when necessary, to improve outcomes and lead to more efficient use of resources. A key paradigm shift is the focus on respectful relationships, tailoring care to women's needs, and actively strengthening women's own capabilities.

2.4 What about the midwife?

The disrespect and abuse suffered by labouring women has been characterised as *"the symptom of fractured health systems and locally expressed power dynamics that conspire against both patients **and providers**"* (Freedman and Kruk, 2014: e43, my emphasis). This viewpoint rightly acknowledges the negative impact on maternity care staff, the majority of whom are female, of power and gender dynamics that undermine their professionalism and do not allow them to deliver the humanised care that women want (McConville, 2014) and which they may very well want to provide. Indeed, the global focus on RMC is allowing the space to investigate the professional, social and economic barriers facing female maternity care staff, including gender-based and institutional hierarchies, and the hostile and insecure environment in which many of them operate (Filby, McConville and Portela, 2016).

Some commentators are widening the discourse from poor behaviour on the part of individuals to identifying the health system itself as a vehicle for D&A. This links to work by Leape et al. (2012) who cite typologies of disrespect, such as organising services so that patients must wait and other forms of unintentional abuse caused by the system, but set these within the context of organisational disrespect and the pervasive negative impact this has on health workers. Exogenous drivers of disrespectful care, such as health sector cultures whose hierarchical nature allows disrespect to reaffirm status and organisational cultures at individual facility level where this is *"the way we do things here",* are implicated in sapping meaning and satisfaction for health workers but also block quality of care and patient safety efforts (Leape et al., 2012). This reminds us of the key consideration that human rights apply to health workers too. In maternity care, core human rights are dignity and non-discrimination. Freedman (2001) makes the point that it is unreasonable to expect health care staff to treat patients with dignity and respect if they are not receiving these themselves.

A counter argument is that power and hierarchy in low-income countries strongly favour health professionals and discourage any active voice or community engagement. There is a lack of accountability for individual staff, mitigating excuses (e.g. overwork, understaffing) are given to excuse D&A, and there are limited efforts to actively use existing mechanisms to

hold the system to account, such as supervision, transparency or complaints procedures (Human Rights Watch, 2011). Critiques from Latin America also discuss violence against women in terms of professional power and socialisation, where training reinforces norms of expected behaviour (d'Oliveira, Diniz and Schraiber, 2002). D'Oliveira and colleagues also note that medical professionals occupy positions of higher status and power than the women they 'serve' and violence is legitimised as a mechanism to reassert authority and ensure compliance and cooperation, particularly when women do not want to obey. Violence can also demonstrate professional power and can punish those whose behaviour is seen as morally unacceptable. The cultural context is also relevant here, as the low status of women means they are seen as needing to be controlled and disciplined for their own good; while nursing and midwifery are among the few opportunities for able women who cannot afford university, who may resent or not value the 'menial' tasks that are elements of good care and therefore not carry them out.

A body of research on abusive maternity care in South Africa agrees that in the stressful and hierarchical world of resource-constrained health systems, nurses[16] use abuse as a way of maintaining power, asserting control and increasing their professional identity by distancing themselves from patients (Jewkes, Abrahams and Mvo, 1998; Schoombee, Van der Merwe and Kruger, 2005). Indeed, in both studies caring is implicitly and explicitly conceptualised as taking control of women, while Jewkes et al.'s (1998) influential paper also revealed an underlying ideology of patients as ignorant and inferior, thus justifying their poor treatment. In the absence of a woman-centred model of maternity care, these behaviours become normalised and tacitly accepted. Indeed, there is evidence that health workers may have no awareness that their behaviour has such a negative effect on women's perceptions of their maternity care (D'Ambruoso, Abbey and Hussein, 2005). A further study (Kruger and Schoombee, 2010) suggests that the destructive impact of this dynamic, where neither group feels in control and cannot care or be cared for, can only be changed when both nurses and women are empowered. Research from Mozambique also found that health workers are not motivated to respect women when they are not respected themselves (Fonn et al., 2001).

Summary

Even when D&A is widely publicised and governments make efforts to take action (if only on paper) the problems persists. Many of the causes and drivers of D&A are known, and it may not be necessary to wait until disrespect can be categorised and operationalised before the process of addressing it begins. Top-down initiatives, standards and guidelines from the global community have their place, but need to be informed by the health workers who will be tasked with implementing them. Missing from the discourse is the voice of midwives in low-resource settings.

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[16] Health workers providing maternity care in these studies were referred to as nurses, not midwives.

The literature shows how disrespectful care impacts on women, but less is understood about its impact on midwives. The meta-syntheses that are the subject of the next chapter have started to address this knowledge gap. Firstly, a review of women's experiences of facility-based delivery identifies some of the dynamics driving disrespectful care. A second review explores what is happening from the perspective of midwives across sub-Saharan Africa. However, many questions remain, including: considerations of the appropriateness of existing models of care; how these intersect with professional ideals and aspirations; and the constraints and possibilities given the realities of midwives' work environments and the prevailing cultural dynamics. Although broad patterns exist, answers to these questions will be influenced by contextual factors that need to be taken into account. The current study aims to address this knowledge gap in Malawi by exploring how midwives there view and understand respectful care.

> *…if we are serious in saying that quality starts with what women need and want, then quality of care efforts must start where women live and labour. These efforts need to confront the often harsh realities at the front line of resource-constrained health systems by supporting and reinforcing the agency of women and communities to demand better care and empowering health workers and managers to make necessary changes.* (Freedman and Kruk, 2014: e43)

3. Perceptions of (dis)respectful intrapartum care

Introduction

This chapter reports on the results of two qualitative systematic reviews which were conducted to inform this research. The first review (reported briefly here) provided a thematic synthesis of 25 articles exploring women's experiences of (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa (Bradley et al., 2016)[17]. It was completed in late-2015, at a time when there was very little literature exploring the perceptions of midwives on this element of care. Instead, women's experiences were used as the lens through which to explore the drivers of disrespectful care, to try and understand what caused midwives to behave in the manner that women reported. However, by early-2017, a small body of mainly descriptive studies had started to emerge, exploring this issue in sub-Saharan Africa. A second systematic review was undertaken to synthesise midwives' perceptions. The aim was to identify areas of convergence and divergence between our earlier inferences and the views of midwives themselves.

3.1. Methods

3.1.1. Searching and screening

The two reviews followed similar methods, with only minor amendments, as the same phenomenon was being explored, but from different perspectives. A robust and rigorous process was used. Methods for the first review can be seen in the published paper (Bradley et al., 2016); those for the midwives' review are briefly summarised here, with the full detail and additional tables available in Appendix C. Due to time constraints, a decision was made to use fewer databases for the second review, limiting to CINAHL, PsychINFO, PsychArticles (all EBSCO platform); Embase, Global Health, Maternity and Infant Care (all OVID platform); and PubMed. Two other amendments were to modify the population search string to replace terms related to 'women' with terms related to 'midwives'; and to change the inclusion/exclusion to reflect the different participants. The broad inclusion criteria were: studies that explored women's/midwives' experiences of facility-based delivery; described from their own perspective rather than through the opinions of other actors; qualitative studies where these perspectives formed a substantial element of the study; based in sub-Saharan Africa; and published from 01/01/1990.

Only references that satisfied all three reviewers were included in each review. A particular aim of the second review was to hear directly from midwives. However, many authors had reported medical and midwifery staff's perceptions together, in a generic 'health worker' or 'provider' category, so did not satisfy the requirement for the midwife's voice to be clearly identified. A decision was made to include four of these papers (from two studies) where a only small amount of data could be ascribed directly to midwives (Bohren et al., 2016; Baldé,

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[17] The review of women's experiences was published in Social Science and Medicine in September 2016 and is included as Appendix A. This chapter draws in places from this published work.

et al., 2017a; Baldé, et al., 2017b; Bohren et al., 2017), but their contribution to the synthesis results was limited.

3.1.2. Critical appraisal, data extraction and synthesis

In both reviews, two reviewers independently assessed the methodological rigour of all included studies using the Critical Appraisal Skills Programme (CASP) tool for qualitative research (Public Health Resource Unit England). Studies were rated high, medium or low quality for each domain and assigned an overall quality score. However, study quality was not used to exclude studies with the potential to answer the review question. Quality ratings for the midwives' review were: one low quality; one low/medium; seven medium; and five medium/high quality studies.

The review of women's experiences followed Thomas and Harden's (2008) thematic synthesis method, which allowed the synthesis to 'go beyond' the content of the original study findings to develop analytical themes and bring fresh interpretations. The synthesis results were used to develop a conceptual framework (described below, Figure 3.1) which was subsequently used in the analysis of the papers covering midwives' experiences. In this second review, a coding framework was constructed using the individual domains of the conceptual framework as top-level nodes at the macro-, meso- and micro-levels[18]. Line-by-line coding of each article allowed data relevant to the domains to be captured, while any data that did not fit the framework were inductively free-coded into new nodes. Three papers were independently coded by reviewers to identify themes arising and to assess how well these mapped onto the framework. This facilitated a transparent and flexible process where convergence or divergence between the insights gleaned from women's experiences and those of midwives could be clearly identified.

In both cases, all study results and findings, including participant quotes, were imported verbatim into NVivo 11 software for data analysis.

3.1.3. Search results

The search results for the women's review can be seen in Appendix A. For the midwives' review, 14 articles (11 studies) were eligible for inclusion and their study characteristics can be seen in Table 3.1. Ten papers had aims that were negatively framed: eight explicitly focused on mistreatment or abuse: (Kruger and Schoombee, 2010; Yakubu et al., 2014; Warren et al., 2015; Bohren et al., 2016; Baldé, et al., 2017a; Baldé, et al., 2017b; Bohren et al., 2017; Rominski et al., 2017); one looked at the psychological stress of caring (Schoombee, van der Merwe and Kruger, 2005); and another reported midwives' perceptions of barriers to quality perinatal care (Pettersson et al., 2006). In contrast, Fujita et al. (2012) reported on the implementation of a humanised care intervention. Only three papers explored midwives' experiences of intrapartum care from a neutral position (Jeng, 2008; Maputle and Hiss, 2010; Adolphson, Axemo and Hogberg, 2016).

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[18] See Figure 4.1 in Section 4.5.1 'Analysis' for an example of the coding framework constructed using the individual domains as top-level nodes.

Table 3.1 Characteristics of included studies

Only midwifery participants are recorded. Interviews: IDI = in-depth; SSI = semi-structured

Study	First author, year	Country	Study aims	Participants*, setting	Study design, data collection* and analysis	Quality
1.	Adolphson et al., 2016	Mozambique	• Explore midwives' perspectives of working conditions, professional role and attitudes towards women	• 9 midwives (6 x medium, 3 x basic level) • Urban, suburban, village and remote areas in 3 southern provinces	• Qualitative methods • SSI • Content analysis	M
2.	Baldé, et al., 2017a	Guinea	• Understand social norms and acceptability of scenarios of disrespect	• 13 midwives • Maternity ward of an urban regional hospital and a peri-urban district-level hospital	• Qualitative methods • IDI • Thematic analysis	M
	Baldé, et al., 2017b		• Explore midwives' perceptions and experiences of mistreatment during birth			L/M
3.	Bohren et al., 2016	Nigeria	• Explore acceptability of four scenarios of mistreatment during childbirth	• 17 midwives • Maternity ward of one urban and one peri-urban facility	• Qualitative methods • IDI • Thematic analysis	M
	Bohren et al., 2017		• Explore midwives' experiences and perceptions of mistreatment			M
4.	Fujita et al., 2012	Benin	• Determine how the practice of humanised care affects midwives; implementation, understanding and factors influencing change in practice.	• 6 midwives • Tertiary hospital in the capital city, Porto-Novo	• Qualitative, descriptive • IDI • Grounded theory	M
5.	Jeng, 2008	The Gambia	• Assess the practices and quality of delivery care during childbirth	• 5 midwives, 3 x student midwives • Delivery ward, Royal Victoria Teaching Hospital	• Qualitative methods • IDI • Content analysis	L
6.	Kruger & Schoombee, 2010	South Africa	• Explore experiences of being nurses in a maternity ward	• 8 'Coloured', middle-class, Afrikaans speaking females	• Social constructionist grounded theory • SSI	M/H
	Schoombee et al., 2005		• Explore maternity nurses' psychological and emotional experiences	• Maternity ward of the local state hospital		M/H

Study	First author, year	Country	Study aims	Participants*, setting	Study design, data collection* and analysis	Quality
7.	Maputle & Hiss, 2010	South Africa	• Explore and describe the experiences of midwives managing women during labour • Inform development of a woman-centred care model to be integrated into the Batho-Pele Principles	• 12 midwives • Tertiary care hospital in the Limpopo Province	• Exploratory, descriptive, contextual and inductive • IDI • Open coding (Tesch)	M
8.	Pettersson et al., 2006	Mozambique	• Explore midwives' perception of factors obstructing or facilitating their ability to provide quality perinatal care	• 16 midwives • Labour ward, Maputo Central Hospital	• Qualitative • IDI • Grounded theory	M/H
9.	Rominski et al., 2017	Ghana	• Examine disrespectful and abusive treatment towards labouring women	• 83 final year midwifery students • 15 public midwifery training colleges in all 10 of Ghana's regions	• Not stated • FGD • Thematic analysis	M/H
10.	Yakubu et al., 2014	Ghana	• Explore attitudes, beliefs, and self-reported behaviours of midwives to improve understanding of maltreatment during facility delivery	• 7 midwives • Small rural hospital, Central region	• Cross sectional, qualitative • SSI • Thematic analysis	M
11.	Warren et al., 2015	Mali	• Explore both respectful and disrespectful and abusive behaviours towards women in labour	• 33 auxiliary midwives • Continuing education session at a regional referral hospital • 31 x rural, 2 x urban practice	• Cross sectional mixed methods • SSI • Qualitative description	M/H

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3.2. Synthesis results - women's experiences

The synthesis of women's experience of facility-based delivery revealed a prevailing model of maternity care that was institution-centred, rather than woman-centred. Two overarching analytical themes emerged: 'Power and control' and 'Maintaining midwives' status'. 'Power and control' described midwives' attempts to exert control over women and the birth process. Controlling women's bodies and how they physically behaved during labour focused on the trigger points of expressions of pain and the timing and direction of the pushing stage of labour. Controlling women's knowledge included two elements. Firstly, authoritative knowledge[19], where a woman's embodied knowledge of what her body needed to do was overridden; and secondly, withholding information so that women did not know what was happening. Together, these controls relegated women to the role of bystander, not participant, in the birth. Control was achieved using various forms of discipline and punishment.

The second major theme was 'Maintaining midwives' status', where midwives attempted to maintain their own professional, technical and social status by reinforcing the social distance between them and the women in their care. The strategies they used to do this were grouped into two main themes. One covered decisions about what constituted a midwife's role, with an emphasis on the technical care during the second stage. The other described midwives' attempts to maintain status through social distancing and 'othering', using social inequality, sexual shaming and an unwillingness to do 'dirty work'[20].

The acts women described 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. The synthesis findings are reflected in the conceptual framework of the drivers of disrespectful care in the sub-Saharan African context (Figure 3.1). This aimed to describe how micro-level interactions in the labour ward were mediated by meso- and macro-level influences. In the model, the flow of influence is from the outside to the centre, situating disrespectful care within a broader framework of the structural dimensions underpinning disrespect that are often neglected in discussions of the mistreatment of women. The framework is a useful tool as it provides a starting point to unpack the most salient factors for different contexts, helping to focus understanding on the larger circulating discourses on how and why different actors may, or may not, abuse women.

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[19] 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).
[20] 'Dirty work' involves working with bodily fluids and 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).
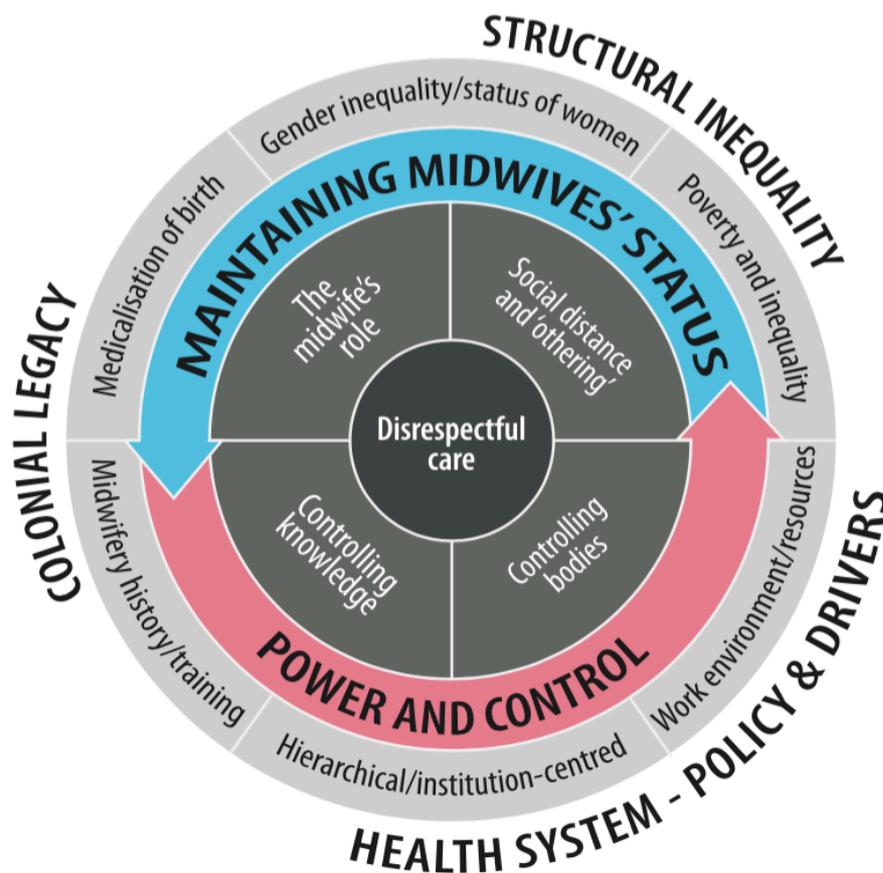
Figure 3.1 Conceptual framework of the drivers of (dis)respectful care in the sub-Saharan African context

3.3. Synthesis results - midwives' experiences

Authors' analyses in the majority of papers largely focused on the micro-level interactions between midwives and women. During the synthesis, these were mapped onto the overarching analytical themes of 'Power and control' and 'Maintaining midwives' status'. Only two of the meso-level themes identified in our framework derived from women's experiences were represented in this synthesis of midwives' perceptions. These were 'Work environment/resources', and 'Midwives' position in the health system hierarchy' which is nested under the conceptual theme of 'Hierarchical/institution-centred'. Additional emerging themes added were 'Midwives' perspectives on respectful care' and 'Impact on midwives'.

3.3.1. Power and control

Controlling bodies

The synthesis showed that midwives clearly wanted women to do as they were told and that controlling their bodies was a core component of care. For many midwives, this control involved restrictions on what women were allowed to do, such as confining women to the bed despite knowing the benefits of ambulation, or not permitting fluid and food intake. In one case this was to prevent vomiting in the second stage (Jeng, 2008), while in another it had been standard practice prior to a humanising care initiative. *"Previously, women were left*

alone and naked in the labor room and could not take a walk, drink or eat. But now, women can drink and eat yogurt if they want to. When women are relaxed during labor, the delivery goes smoothly without complications." (Fujita et al., 2012: 423)

Control of pushing was a key trigger point for midwives, mentioned in half the papers. Midwives spoke of having no choice but to yell, slap or neglect women to motivate them to push, using language like '*need to*' or '*forced to*' when describing their actions. While some student midwives thought there was no justification for abuse, others were vocal about the necessity to use coercion to avoid bad outcomes. A quote from a student midwife typified a prevalent view among participants.

> *One time I was conducting a delivery and the woman was not pushing. I have said everything. I have done everything, she would not push. And I don't know what else to do, so I just called the in-charge, she came, shouted at her some few minutes, beat her, then she started pushing. In some few minutes, the baby came out. So, if I have just left her, after explaining everything to her, I have just left her like that, the baby would have come out asphyxiated, and I could not do anything about it. So sometimes, we just have to use a little bit of force, and then they will comply.*
> (Rominski et al., 2017: 220)

Qualified midwives expressed their awareness that this behaviour was not acceptable, but was still prevalent among colleagues. *"...we are not supposed to use our hand ... to beat the woman. The way am taught...there are better ways to communicate to her...But sometimes, you see midwives beating patients, 'you want to kill the baby!' Pow! Pow!! Pow!!!"* (Bohren et al., 2017: n.p.)

Pain represented a small sub-theme in 'Controlling bodies'. The ability to alleviate pain was a source of pride for some midwives (Adolphson, Axemo and Hogberg, 2016), but for others, pain was a trigger for women to become difficult to control (Schoombee, van der Merwe and Kruger, 2005). In one study midwives described women physically lashing out in pain. *"They are so naughty that you shout on them…"* (Yakubu et al., 2014: 387) However, it was notable how few midwives showed empathy for women's pain. One midwife in Mozambique (Pettersson et al., 2006: 153) described women as *"often desperate with pain"*, while a midwife in South Africa voiced concerns when colleagues verbally abused adolescents during labour, *"when actually it is a time they need support, when they are in pain"* (Schoombee, van der Merwe and Kruger, 2005: 400). Midwives in Mali used a strategy of soft cajoling ("Nègènègèn"), one of whose aims was to alleviate pain and help women to cope (Warren et al., 2015). Pain was sometimes understood as an explanation for why women did not cooperate, but not to spare them from punishment. *"Sometimes when you tell them* [women] *to do something…they would not mind you because they are in pain, so you are forced to neglect them and go and sit somewhere. Until they are willing to do what you want them to do, we will not come there."* (Rominski et al., 2017: 220)

Controlling knowledge

Withholding information

One study explicitly addressed decision-making, information sharing, informed choice and communication (Maputle and Hiss, 2010), where midwives viewed their role as supporting women's decisions and trying to strengthen their participation. Despite this, midwives in the study felt that women did not have sufficient information about birth and what to expect. *"Most women who are in labour look confused and don't listen to the instructions carefully…"* (p.9). Some midwives were aware of the importance of communicating information to women (Fujita et al., 2012; Adolphson, Axemo and Hogberg, 2016), although this was sometimes a challenge. For some, this was due to time pressure (Pettersson et al., 2006), but in other cases, it was down to the discretion of the midwife and was couched in terms of women doing what they were told:

> *…they must **just listen to what I say, and do as I tell them**…Sometimes **I just leave them**, let them do their own thing, but usually I prefer for them to know…**so I explain to them** before labour what to expect and **how they must behave**. Then things go well. Otherwise it is a complete mess, and…and a stressful experience.* (Schoombee, van der Merwe and Kruger, 2005: 394, authors' emphasis)

The idea that women did not know what to do fostered an attitude that midwives were justified in shouting or hitting them to prevent harmful behaviour (Yakubu et al., 2014). However, when better communication was established with women and their families, as in the humanised birth intervention in Benin (Fujita et al., 2012), midwives felt, *"It is nothing difficult or surprising'* (p.423) and the authors reported higher motivation among midwives as a consequence.

Overriding embodied knowledge

Overriding women's bodily knowledge was another way of exerting control over them, emphasising that authoritative knowledge over birth and its various stages was technical and institutional. A key aspect of this theme, birthing position, was mentioned in seven studies (Schoombee, van der Merwe and Kruger, 2005; Pettersson et al., 2006; Jeng, 2008; Maputle and Hiss, 2010; Fujita et al., 2012; Baldé, et al., 2017a; Bohren et al., 2017). This was usually treated inflexibly and dictated by midwives, even if they thought the woman should have a choice. *"Anyway, the position that the woman prefers should be adhered to…but here we* [midwives] *tell them* [woman in labour] *to lie in lithotomy position* [legs up the bed poles]*…Secondly I have not seen woman in labour who had ever requested for any position they want."* (Jeng, 2008: 87) In the South African context, delivering on all fours was linked to socioeconomic and racial discrimination.

> *…they don't listen to you, they just do their own thing. Especially, and I don't want to discriminate, but the **black** people.* [last part in whisper]*…they push on all fours. And that makes things a bit difficult because you have to be here underneath them…And it makes you a bit angry sometimes, because they…they don't cooperate, and anything*

can happen if they, because they are upside down." (Schoombee, van der Merwe and Kruger, 2005: 399, emphasis in original)

This uncertainty about the skills needed to safely assist a woman and the persistence of lithotomy position was supported in Fujita et al.'s (2012) discussion of hesitation and difficulties in implementing humanised care. *"In the beginning, we did not have enough skills to assist freestyle birthing positions, and some perineal tears resulted. Some midwives had back pain or knee pain. But after learning through watching videos and practicing, the tears have now decreased." (*p.423)

Only three papers reported accommodating women's preferred positions for birth, such as equipping midwives with the necessary skills (Fujita et al., 2012), moving mattresses to the floor (Baldé, et al., 2017a), or supporting women's choices to squat if they preferred, unless there were difficulties (Maputle and Hiss, 2010). In Nigeria, however, one paper described an extreme mechanism to force a woman to deliver on the bed. *"She will rather get up and stand! When she starts having contractions she will climb up the couch and remain there, so eventually when we were able to bring her down…I had to call her relations and then bring the bed and put still ropes to hold her legs."* (Bohren et al., 2017: n.p.)

Bystander, not participant
The convergence of physical and informational control served to relegate women to the role of bystander, not participant in the birth process. This was clearly underpinned in some midwives' accounts by a belief that the midwife knew best (Maputle and Hiss, 2010; Yakubu et al., 2014). Some expected women to just obey instructions, while others performed procedures without involving the woman.

> *I am not sure how much the women in labour are informed of what is going on…e.g. why the examination is being done…how soon she might deliver…why she is being admitted…This sort of information is never given to the women…No explanation of what the women to do when they feel something…They* [nurses, midwives and doctors] *don't tell the woman what to expect.* (Jeng, 2008: 93)

Respondents in Maputle and Hiss' study (2010) suggested women did not necessarily want to participate in their care. *"Women in labour very easily put themselves into the hands of the midwives…But at times there is an attitude in our society that says a pregnant mother is ill and must leave all the responsibility to the midwives because they know best."* (p.9) However, some felt that this was *"…because some women are from a cultural environment where the women is not used to expressing her wishes as this is not allowed."* (p.9)

More positively, there were references for midwives to view women as participant, not bystander, with women and midwives working together (Pettersson et al., 2006). *"When a woman has enough information about herself during pregnancy or delivery, she can make appropriate decisions. Our job is to help women understand themselves, and empower themselves."* (Fujita et al., 2012: 424)

Rules, compliance and resistance

Exertion of power and control over women was enforced by the use of discipline and punishment. Midwives described widespread use of shouting or yelling, particularly around the time of pushing, that was normalised and often routine. Others used neglect, such as leaving women alone during labour (Rominski et al., 2017; Bohren et al., 2017) or second stage (Kruger and Schoombee, 2010; Baldé, et al., 2017b). Intersecting with controlling women was the perception that certain categories were more difficult to control than others (Schoombee, van der Merwe and Kruger, 2005) and that some women brought disrespect upon themselves by not obeying the midwife's instructions. *"She doesn't want anyone to do her vagina examination so we decided to hit her so that she opens up her leg to do the V.E."* (Rominski et al., 2017: 220)

Discipline intersected with notions of instruction. In Ghana, some students justified physical abuse of women if they had done something wrong, but suggested the midwives should explain why, *"…so the next time the woman is coming to deliver, she will bear it in mind."* Another student thought there was a better alternative. *"And it* [yelling] *is far, far better than the beating. So, instead of midwives beating, I think we should yell, and after yelling, you let the woman understand why you yelled at her, next time she wouldn't repeat it again."* (Rominski et al., 2017: 219) The two papers based on a study in South Africa (Schoombee, van der Merwe and Kruger, 2005; Kruger and Schoombee, 2010) showed midwives using moral judgements of younger women who were pregnant to justify shouting and verbally abusing them.

In Ghana, the relationship between midwives and women was described as analogous to a mother-daughter dynamic, which manifested positively as, *"Encourage her, talk to her, be friendly with her. If you are very close to the patient…I think, she will not be naughty. Talk to her friendly, as a mother or a sister, hey this is, you can do this, you can go like this."* However, if the woman did not comply, discipline was meted out. *"When you hit, you know it's not right…You have to discipline her to do the right thing. So, it's a kind of discipline that we are doing."* (Yakubu et al., 2014: 387)

3.3.2. Maintaining midwives' status

Social distance and 'othering' - social inequality

The use of social distance and 'othering' was a significant element of the synthesis of women's experiences, but only one of its constituent sub-themes, social inequality, emerged in the midwives' data. No papers mentioned the themes of sexual shaming and dirty work which had emerged from the women's accounts.

Comments and perceptions from three papers demonstrated 'social inequality' as a key driver of some of the disrespectful care meted out by midwives. Two papers were from the same study in South Africa (Schoombee, van der Merwe and Kruger, 2005; Kruger and Schoombee, 2010), which featured in our earlier meta-synthesis. In the original study, women clearly articulated discriminatory behaviour based on race, age and class, yet

interviews with midwives only mentioned poor treatment of adolescents (Kruger and Schoombee, 2010). However, a second set of interviews with midwives in the hospital delved deeper and asked them to articulate the psychological experience of being a maternity ward nurse (Schoombee, van der Merwe and Kruger, 2005). Their interviews revealed a strong hierarchy of patients and how they were cared for. There were ambivalent attitudes to private patients who, on the one hand, *"…pay that little bit more than a, than a normal patient. And then they expect to have a little bit more attention or whatever…"* (p.402) but, on the other, could be neglected for long periods of time if they were seen as too demanding. Adolescents were subject to scolding and moralising, while one midwife said of HIV positive patients, *"I get angry!...And and I get really, I get **angry** at* [HIV positive] *people who... [have babies]."* (p.401, emphasis in original) However, racial discrimination was the most commonly mentioned form of 'othering'.

The only other paper that overtly spoke of social inequality was Rominski et al. (2017), where some students were aware that poorer clients would need *"more care than ever"* but had witnessed behaviours that did not embody this. *"But the midwife did not treat her well because she…*(thought she) *was one of those women who sleep by the street."* (p.220) In contrast, Yakubu et al. (2014) concluded that maintaining social distance was not a primary motivator for midwives in their Ghana study.

The midwife's role

Care during the first stage of labour

Positive references were made to the midwife's role during the first stage of labour. Two papers reported midwives showing empathy or adjusting care to the woman's needs (Adolphson, Axemo and Hogberg, 2016) or the importance of the initial contact. *"For me when they come I received them and after receiving them I do an examination…I make them comfortable, get their things that they need around them. And then I leave the patient to rest."* (Jeng, 2008: 79) In Ghana, midwives said neglect was due to staff shortages. *"They* [the women] *always want the midwife to be on their side when they are in labor. And there are only so many midwives on duty…That is why…we can't stand by the patient until the time she delivers."* (Yakubu et al., 2014: 387) Other studies referred to the use of labour companions, with differences in whether this was permitted. In the Gambia, midwives thought companionship was helpful, but could not accommodate it due to infrastructural constraints (Jeng, 2008). Midwives in Maputle and Hiss' study (2010) had differing perceptions. One 'allowed' it because the partner *"…will support by soothing and massaging to the mother"*, but others felt it was an obstacle as *"The presence of the partner interferes with the mothers' decision, especially in cultures where husbands are the decision makers."* (p.10) This study also reported that midwives' felt their role was to support women's decisions, but also that women were passive and dependent on them.

3.3.3. Meso-level concerns

Only two of the meso-level themes identified in our framework were represented in this synthesis: 'Work environment/resources', and 'Midwives' position in the health system hierarchy' which is a sub-theme of 'Hierarchical/institution-centred'.

Work environment/resources

The dominant meso-level theme represented in the data was the issue of the work environment and its impact on whether or not midwives could provide respectful or quality care, which was raised by midwives in 11 of the 14 articles. Their largest concern was human resources, with nine papers specifically mentioning this. Even when there was management support for humanised care, such as in the Benin intervention, midwives still worried about the practicalities. *"When we practice humanized care, we are close to the women and families, and talk to them. I am happy to do that. But if there are too many women in the labour room, it is difficult."* (Fujita et al., 2012: 426) Other papers spoke of midwives' tiredness, frustration (Adolphson, Axemo and Hogberg, 2016) or stress (Schoombee, van der Merwe and Kruger, 2005), or how women birthed alone or were neglected (Pettersson et al., 2006; Yakubu et al., 2014) when there were insufficient staff for the workload. Student midwives noted that being overworked and under-resourced could lead to disrespectful care. *"If you are due and they tell you to push and you are not pushing and the situation is let's say one midwife to about five clients so if you are not ready to push it is either she hits you or something so that brings about those things."* (Rominski et al., 2017: 218) However, some midwives felt that human resource issues were used as an excuse. *"I tell you some of these times, nothing is happening, it's not overcrowding, it's not work...but at times these things just happen even when the place is really calm."* (Bohren et al., 2017: n.p.) Others described their colleagues as lazy or unwilling to work (Schoombee, van der Merwe and Kruger, 2005; Pettersson et al., 2006: Jeng, 2008).

In smaller facilities, the lack of staff meant some midwives had a broader scope of practice, which was a source of job satisfaction, but also stress (Adolphson, Axemo and Hogberg, 2016). However, the broad consensus was that lack of material resources, poor infrastructure and shortage of staff compromised midwives' ability to provide the highest attainable standard of care. Midwives voiced their concerns about lack of support, with many left alone and others making requests that were not answered. *"They* [hospital administration] *are aware of this problem but when you complain to them they will tell you what can we do."* (Jeng, 2008: 80) This left some midwives feeling powerless to change their situation, either personally or collectively (Pettersson et al., 2006), despite their awareness of productive changes that could be made.

Midwives' position in the health system hierarchy

A new sub-theme that emerged under the theme 'Hierarchical/institution-centred' was midwives' perspectives on their own place in the health system hierarchy (Schoombee, van der Merwe and Kruger, 2005; Pettersson et al., 2006; Jeng, 2008; Fujita et al., 2012; Rominski et al., 2017). This has great relevance for the overarching analytical theme of

'Maintaining midwives' status'. A particular focus was on the superior status of doctors and lack of recognition for midwives' contribution. Midwifery students in Ghana were aware they were not respected. *"I also think that some of the doctors especially look down on the nurses and midwives, the doctor comes to the ward they don't even consider what you are doing, they just shout on you as if you don't know what you are doing, you don't know your left from your right…"* (Rominski et al.,2017: 219) In Mozambique, midwives felt they had low status in the obstetric team and their opinions were ignored by physicians (Pettersson et al., 2006). However, this status was temporally located. Senior staff only worked during the day, so at night midwives were trusted to make decisions. Midwives in the Gambia engaged in covert resistance when their professional judgements clashed with those of the doctor.

> *…doctors, they like giving pitocin too much...If you advice* [sic] *them that the woman is high parity or had previous caesarean section (C/S), they* [Doctor] *just give 2.5 units pitocin…Augmenting this previous C\S women is very dangerous, you end up losing that mother and the baby…Anyway you just tell them yes, but you do something else.* (Jeng, 2008: 83)

The possibility for positive changes in professional relationships between cadres was described by Fujita et al. (2012) in Benin. After introduction of the humanised birth initiative, midwives expressed improved self-esteem because their professional expertise was now being recognised, and they felt more supported by obstetricians and the management team. This had constructive impacts on teamwork. *"Normal labor and delivery is our job. When a cesarean is needed or a complication happens, we work together with obstetricians. We trust obstetricians and have no problems with our relationship."* (p.425) Only two other papers (Pettersson et al., 2006; Adolphson, Axemo and Hogberg, 2016), both set in Mozambique, mentioned the importance of teamwork, despite it being a critical element of maternal health care provision.

Difficulties in the perceived status of midwives were not just limited to their interactions with doctors. Schoombee and Kruger (2005) reported numerous and complex power struggles between different grades of midwives too. These were reflected in downward behaviours such as senior midwives (sisters) scolding junior staff, but also in upward hierarchical interactions where even midwives who held positions of authority sometimes feared to exercise this and hold others to account because subordinates would blame them and initiate informal sanctions, such as withholding cooperation.

Negative hierarchical relationships in the health facility have profound implications for midwives and women. In Mozambique, midwives felt silenced by the critical nature of their interactions with the rest of the obstetric team, making them fearful of admitting any inadequacies. This negatively influenced their performance, while *"If you are scolded in front of other colleagues or even worse the laboring women, you have no authority left to perform your work."* (Pettersson et al., 2006: 155). Elsewhere, midwives were stressed and unhappy about aggressive treatment from their colleagues, which made them fear speaking up about

poor care. *"I've often seen that...seen a sister scold a patient. And then, I am unhappy about it, but I don't talk about it, I keep it to myself."* (Schoombee, van der Merwe and Kruger, 2005: 402)

3.3.4. Midwives' perspectives on respectful care

Despite the strong focus on mistreatment and abuse in the majority of studies, many authors reported positive conceptualisations of RMC. Midwives spoke of trust and two-way communication (Maputle and Hiss, 2010; Fujita et al., 2012), treating women as individuals (Rominski et al., 2017), empathy and commitment (Adolphson, Axemo and Hogberg, 2016), or always putting the patient first (Schoombee, van der Merwe and Kruger, 2005). In Mali, some midwives had a strong focus on positive strategies to manage women. *"I give them counseling and I sweet talk them. I say 'please' and 'I am not hurting you' and 'I just want to see how you are progressing'. I can also say, 'Stand up and walk around, it makes it go faster', and 'If you don't give bir*th the pain won't stop'." (Warren et al., 2015: 1077) Among student midwives, RMC was often conceptualised by what it was **not**. For example, one midwifery student said, *"The basic knowledge I have about respectful patient care, is irrespective of the race, the social status, the background, or whatever of the client. You...must not discriminate against them* [women] *because of who they are."* Another stated, *"When we talk about respectful patient care I think it means caring for the patient in a respectful manner like not insulting the patient, or beating her or teasing her, you care for her emotionally and everything so that she can deliver safely."* (Rominski et al., 2017: 218) However, another student noted the reciprocal nature of care, where both woman and midwife subjected themselves to what the other needed them to do. In a different study, there was an awareness of the contradiction between what some midwives say about respectful care and what they do. *"…few days ago we asked three midwives "what makes a midwife to be a good midwife". All of them said that it is important to show empathy and attend to the woman's needs and so on…They answer it but we can't see that in them…*[she laughs].*"* (Jeng, 2008: 92)

Although midwives did not use the language of professionalism when discussing (dis)respectful care, it was implicit in some descriptions of their behaviours and motivations, and was mentioned explicitly by some authors. For example, one of the overarching themes reported by Adolphson, Axemo and Hogberg (2016) was 'commitment/devotion', with examples given purporting to reflect midwives' hard work, independent scope of practice and pride in their work. In Pettersson et al.'s study (2006), a sense of professional inadequacy and inferiority was a key thread, intersecting with the theme of 'Maintaining midwives' status' in our synthesis. Two studies suggested mechanisms to improve professional growth and value, including recognising limitations and asking for advice (Pettersson et al., 2006), and introduction of humanised care (Fujita et al., 2012).

3.3.5. Impact on midwives

Appreciation and recognition from the community were important factors for many midwives. *"…after the mother has pushed out she says, 'Thank you for supporting us, nurse', and every*

time I feel more motivated, I feel more enthusiastic." (Adolphson, Axemo and Hogberg, 2016: 98) Others were aware of the importance of word of mouth, that respectful care and good behaviour would encourage women to come to the facility (Warren et al., 2015). *"…it matters so much because, the attitudes of the health work*[ers] *makes the pregnant women go to the TBAs and other places."* (Rominski et al., 2017: 218) Providing humanised care was also reported to benefit health workers. All six midwives interviewed in Fujita et al.'s study (2012) described increased satisfaction and motivation, and there were also reports of improved confidence and self-esteem. *"I am like the mama of mamas. The woman and her family trust me and ask me to attend a future delivery or tell me that they will introduce me to their friends. I am so proud of this."* (Fujita et al., 2012: 424) However, concerns about the inadequacies of staffing and the working environment left some midwives feeling frustrated and inadequate when they could not provide the care they wanted to (Pettersson et al., 2006; Adolphson, Axemo and Hogberg, 2016).

Some midwives described troubling negative emotions when dealing with birth, many of which were linked to their efforts to control women's bodies. Lack of cooperation or failure to push generated angry and sometimes violent emotions (Schoombee, van der Merwe and Kruger, 2005; Kruger and Schoombee, 2010; Rominski et al., 2017). *"Sometimes if, then the patients are difficult, they don't want to cooperate…then you just feel…you're not allowed to assault a patient…But sometimes you just feel like, then you think, oh, you just want to assault that patient, if the patient won't push and so on* [strong emotion]*."* (Kruger and Schoombee, 2010: 95) This intersected with feelings that women, the community or line managers would hold midwives responsible for poor outcomes, regardless of the woman's behaviour. This dynamic of blame was explicitly implicated as a driver of disrespect in three papers (Yakubu et al., 2014; Warren et al., 2015; Rominski et al., 2017). In Ghana, the weight of responsibility meant midwives felt they needed to do "whatever it takes" (Yakubu et al., 2014), while student midwives thought it was better to shout at or hit women than to let them fail to push or cooperate (Rominski et al., 2017). In Mali, one approach was to *"…transfer her to a higher level before she kills the baby, if she is not following my instructions. I send her to go to* [my supervisor] *because I don't want to get in trouble."* (Warren et al., 2015: 1077).

3.4. Discussion

Two metasyntheses were carried out to explore perceptions of facility-based delivery. The first was carried out at a time when there was very little literature from the midwife's perspective, so used women's perceptions of their birth experience to try to understand the dynamics driving disrespectful care. Until this point, the importance to women of the psychosocial aspects of care had often emerged as a smaller element of studies focused on the technical quality of skilled attendance, or had been identified in reviews as one of the deterrents to facility delivery in sub-Saharan Africa (Moyer and Mustafa, 2013). Other authors had explored attitudes and behaviours of healthcare workers (Mannava et al., 2015) or women's satisfaction (Srivastava et al., 2015) but did not address the circulating

discourses in which provider behaviour was embedded. More recently, Bohren et al. (2015) produced a comprehensive, evidence-based typology of the mistreatment of women. This 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. The first review on women's experiences complemented this work, but moved beyond it, synthesising insights from women to explore the cultural and social factors which underpinned midwives' behaviour, and seeking to understand the dynamics at play when disrespectful care occurs. It showed disrespectful care acted to improve midwives' social standing in relation to women; firstly, through direct assertions of power and control over women's bodies and knowledges, and secondly, by impacting on midwives' relative social status.

The second synthesis, focused on midwives' perceptions, demonstrated substantial convergence with our previous interpretation that controlling women was a powerful dynamic at work in the labour ward, reinforcing the message that birth was a medical event mediated by experts. In many of the contexts included in the review, it was clear that midwives, not women, were at the heart of the birth process. Midwives felt women did not know what to do, controlled where they could go and how they behaved, and overrode women's embodied knowledge (and sometimes facility guidelines) to dictate how women should birth. In this model, women were largely rendered passive, expected to comply with instructions or allow procedures to be carried out without explanation or permission. Yet they were also blamed for not knowing what to do. Failure to obey or transgressing the rules elicited punishments such as neglect, shouting and beating.

A key trigger point, identified by both women and midwives, was the effort women were perceived to put in to pushing, one of what Yakubu et al. (2014) called "precipitating events" for disrespect and abuse. An interesting new element was midwives' perceptions that women were intentionally 'being naughty', with limited empathy demonstrated for their pain or situation. This contrasts with the results from the women's review, where pain was a major cause of distress and lack of control, which women expected midwives to assist with and advise upon. Assisting women to deal with pain is a significant issue as resource constraints in many sub-Saharan African countries mean availability of pharmacological analgesia is extremely limited (Size, Soyannwo and Justins, 2007). However, synthesising midwives' perceptions added to our understanding as it revealed that many felt driven to maintain control of women in order to avoid bad outcomes for which they would be blamed.

Our interpretation of women's experiences had concluded that a significant driver of the behaviours midwives exhibited was an attempt to increase social distance and maintain status. This emerged less strongly when hearing from midwives directly, although some were candid in discussing differential treatment of women across socioeconomic, ethnic or disease axes. One study (Yakubu et al., 2014) suggested social distance was not an issue, describing instead a 'mother-daughter' relationship. This could, however, be interpreted as a way of increasing midwives' status by infantilising women and rendering them powerless in the birth dynamic. Indeed, participants in the study likened physical abuse of women to

mothers disciplining a naughty child. In addition, this review revealed midwives' focus on their own insecure and ambiguous position in the health system hierarchy, particularly in relation to doctors, with perceptions that midwifery was not valued. Midwives' feelings of their professional judgement being overridden by medical staff uncomfortably mirrored their own exertion of authoritative knowledge over women's bodily knowledges. There were also reports of hierarchical bullying between different levels of midwives. This topic remains relatively unexplored in the literature on midwifery in low-income contexts, but has significant impact for the dynamics at play in the labour ward. It may intersect with feelings of professionalism, which are already compromised in the challenging circumstances in which midwives operate. Yet professionalism was rarely mentioned in the studies. This provides a rich vein for future research.

In the two papers that were more positive about interpersonal care (Fujita et al., 2012; Adolphson, Axemo and Hogberg, 2016), the data were collected by doctors, which raises issues of social desirability bias. Elsewhere, midwives seemed candid about D&A, supporting other literature suggesting these behaviours are normalised and widespread (e.g. Kruk et al., 2014; Abuya et al., 2015). Missing from the included studies was an exploration of midwives' understanding of the impact of D&A on women or on themselves, and only limited attention to the benefits and impacts of RMC, for both groups.

Many of the challenges in the labour ward that drive D&A or block RMC are contingent upon the historical, cultural and health systems factors prevailing in the postcolonial context. Researchers have been critiqued for investigating women's experiences without considering the colonial legacy, power and social inequalities (Kumar, 2013). The majority of studies paid very little attention to this wider context in which (dis)respectful care is embedded and focused only on the midwife-woman dyad. Only four papers alluded to gender-based violence (Warren et al., 2015; Bohren et al., 2016; Rominski et al., 2017; Baldé, et al., 2017a); Bohren et al. (2016) discussed structural gender inequality and the similarities between mistreatment during childbirth and intimate partner violence; while Rominski et al. (2017) mentioned the broader social and political dynamics. Kruger and Schoombee (2010) discussed power and control in the context of the medical model of birth and hospital hierarchy. Serious consideration of the legacies that have shaped the health system, such as models of care and training, and the prevailing cultural norms within which these are nested, is vital to move beyond a micro-level focus.

Summary

The meta-syntheses revealed women's unhappiness with the disrespectful care they received, and midwives' feelings of powerlessness and desire for status and control. However, we still lack a fine-grained understanding of what it means to be a good midwife, or how RMC is conceptualised and valued in specific contexts. Nor do we appreciate the impact D&A may have on midwives or their sense of professionalism and how this intersects with issues of hierarchy and status. The conceptual framework that was developed adds to

the discourse by situating disrespectful care within a broader framework, allowing us to interrogate the historical, social and cultural factors that interact to drive disrespect. The following chapters describe the methodology, plans and reality of carrying out research to explore these gaps and to understand the context-specific factors driving respectful and disrespectful maternity care in Malawi.

4. Methodology and methods – the plan

Introduction

In this chapter I describe the overall methodological approach and design I have used to address the study's research aim which was to explore conceptualisations of respectful maternity care (RMC) from the perspective of midwives working in Malawi. Specifically, my objectives were to:

1. Explore how 'good' midwifery was defined and conceptualised in the Malawian context.

2. Describe midwives' practice of RMC during labour and delivery.

3. Explore midwives' perceptions of the value and impact of RMC for midwives, women and the health facility.

4. Describe constraints and enablers of professional practice and RMC in this context.

The chapter covers what I planned to do and is divided into five sections. Each one describes a different aspect of the research methodology. The first section presents the research design, describing the study's philosophical underpinnings and the methods I considered and ultimately used. The second section describes the study population, while sections three to five cover data collection, data management and data analysis, respectively.

4.1 Research design

4.1.1 Philosophical underpinnings - critical realism

My aim in this section is to present the philosophical and epistemological basis from which I approached this research, in order to give credibility and coherence to my chosen methods. I knew that to answer the questions I was interested in would mean delving into the largely subjective and experiential nature of RMC, so this demanded a qualitative approach to directly explore the perceptions and views of the personnel involved. Their behaviour, and any possible interventions they suggested, could only be understood within the context in which they occurred.

Until this point my role in research had been applied (i.e. getting the research completed) rather than theoretically or philosophically informed. My work had involved using *a priori* theories to guide data analysis (usually project mandated, rather than my choice), but my personal research had a much greater emphasis on emerging themes and understandings of participants' views in their context. I have been schooled in a relatively positivist paradigm (biology degree) where 'natural reality' can be measured in a (theoretically) objective, replicable way, and I am comfortable with an objective and scientific approach. However, at the same time I live and feel with a critical, feminist sensibility, that views 'social reality' (including my own) as historically and culturally constructed and situated, and sees language as the cornerstone in our attempts to construct, interpret and describe reality.

Critical realism provided a bridge between my own ontological and epistemological positions. Originally conceptualised by philosopher Roy Bhaskar (1997), critical realism considers reality as layered, with three ontological levels. The 'empirical' covers what can be experienced or observed; below this is the 'actual' which regulates the empirical even if it cannot always be observed; while both are underpinned by the 'real' which is made up of 'generative mechanisms' or tendencies that ultimately have an impact at the 'empirical' level (Walsh and Evans, 2014). Thus, in the case of RMC during labour and delivery, a midwife slapping a labouring woman is an empirically observable event (empirical level), while the pressures that influenced her behaviour, such as workload or financial worries, may or may not be observable ('actual' level). However, her behaviour is rooted in deeper structures and mechanisms, such as socially constructed views on the status of women ('real' level). This integration of realist ontology (the world exists independent of us and our beliefs) with a constructivist epistemology (we construct and interpret its complexity from our own vantage point) reflects my view of the world. Further, it acknowledges that our understanding can only ever be partial (Maxwell, 2012; Walsh and Evans, 2014).

Much of the research on disrespectful care in sub-Saharan Africa has tended to focus on the empirical level, addressing manifestations or prevalence of disrespect (e.g. Abuya et al., 2015; Sando et al., 2016). However, I agree with Danermark, Ekstrom and Jakobsen that this is not sufficient. *"If we are to attain knowledge about underlying causal mechanisms we must focus on these mechanisms, not only on the empirically observable events."* (Danermark, Ekstrom and Jakobsen, 2001: 5). Some researchers have begun to address this, to identify drivers of these overt behaviours at the 'actual' level. For example, Bohren et al.'s (2015) comprehensive, evidence-based typology of the mistreatment of women updated and expanded the definition of this phenomenon, but added to the discourse by also including the role of systemic failures within the health system. More recently, efforts have begun to move beyond the health system (e.g. Warren et al., 2017), but there has been limited attention to situating RMC and D&A within the deeper social, cultural or historical mechanisms in which they are rooted. Yet, as Walsh and Evans note, *"From an ontological perspective, neither racism, patriarchy nor globalisation are 'real' in the sense of possessing materiality but are 'real' in their power to shape experience at the empirical level."* (2014: e3). This could equally apply to post-colonialism, gender and the status of women in Malawi.

The philosophical principles of critical realism have utility beyond the methodological for this research, as there are links between Bhaskar's conception of critical realism and a value base that aspires to human flourishing and freedom (Maxwell, 2012). A key driver for me, which informed the research study's methodology and rationale, was the absence of voice for the midwife caught in the spotlight of the negative gaze. Intellectually, I wanted to find out what reality looked like for midwives in Malawi, how the RMC and D&A that they experienced/created were understood; how this interacted with or was influenced by their position in society (both personally, professionally and as gendered beings); and what factors constrained or facilitated the actions of the midwife in her context. These are all questions

with which a critical realist perspective can engage. Practically, I wanted there to be a purpose to my research, for the findings to have the potential to inform change or be used to improve midwives' (and women's) experiences of intrapartum care. This reflected a feminist aim (for the midwife is almost always 'she'), underpinned by the idea that regardless of research methods, women's lives are important (Reinharz, 1992). Critical realism can help to understand the social structures ('generative mechanisms') that drive oppression and control, raising awareness and facilitating action and agency which may effect change at the empirical level (Walsh and Evans, 2014).

My epistemological 'uncomfortableness' served another purpose in that it allowed me to make full use of the tools available to facilitate rigorous research processes and analyses (e.g. systematic sampling, data collection and analysis; use of software and computers to aid analysis) while at the same time grappling with the multiple meanings emerging from participants' perspectives and recognising my own role in shaping these interpretations (Creswell, 2007). The ethical dilemmas involved in representation and women's voice will be covered in Section 5.3 on Ethical considerations.

How the theoretical frames informed the research

Approaching this research as a critical realist, it was imperative to have a frame of reference that surfaced the historical, cultural and socially embedded underpinnings of RMC and D&A. From the outset it was clear that postcolonialism would be the key theoretical lens and it informed the entire research process. Firstly, it drove the research design, influencing me to select qualitative methods (described in detail in the next section) that would allow the broader circulating discourses to emerge. Secondly, it pervaded my manner and positioning during data collection where every encounter was infused with my awareness of the postcolonial legacy and power dynamics, reflected in my detailed reflexive accounting in Chapter 5. Finally, a postcolonial perspective pervaded the conceptual framework used for data analysis. This was part of the literature review (described in detail in Chapter 3) that synthesised the drivers of (dis)respectful care in the sub-Saharan African context. The conceptual framework was developed towards the end of the data collection period in Malawi and strongly brought out the importance of the colonial legacy as a driver of disrespect. It recognised that acts of (dis)respect did not just occur at the micro-level of woman and midwife. They were embedded in and influenced by the surrounding social norms, existing structures of exclusion and inequality, a colonial legacy, and the shape and history of the health system.

The theoretical frame of oppressed groups theory did not inform the research design but did form an important element of the data analysis. It was an emergent perspective that arose from the data, which, until this point had largely been hidden. The intra-midwife dynamics and 'tall poppies syndrome' that were described by participants had previously been unfamiliar to me, but application of an oppressed groups theoretical lens had strong explanatory power for many of the dynamics that were reported.

4.1.2 Methods

The complex, contextual and sensitive nature of the research topic necessitated the use of a number of tools to provide appropriate opportunities for midwives in labour and delivery wards to examine, articulate and reflect upon their experiences of (dis)respectful maternity care. A range of possibilities were available for a qualitative study of this nature. In this section, I discuss the following data collection methods:

- Those I planned to use from the outset - narrative interviews, critical incident technique and key informant interviews;

- One that I planned, but was unable to use - focus group discussions; and

- An unplanned and emergent opportunity in the field to carry out informal observations.

The instruments I had decided to use were consistent with a critical realist approach and my own thinking about the underlying philosophy, reflecting my position on the continuum from post-positivist archetype to constructivist archetype. They also reflected my efforts to explicitly address the context and my outsider status (on multiple levels), with the necessity of an approach that used different tools to elicit different perspectives, therefore allowing me to investigate interpretations of reality among the complexity of factors and multiple truths that were brought to bear. My expectation was that these would also allow me to investigate any differences between midwives' professional responses (what should be done) versus personal feelings (what they would want if it was them or one of their family).

Due to the context and the sensitive nature of the research topic, flexibility and responsiveness were needed in designing the research instruments. My decisions about suitability and content were informed by a piloting exercise that I undertook during an initial field work visit in August/September 2015 (which will be described further in Section 5.1.1). Delays in ethical approval meant I was only able to carry out one critical incident and two narrative interviews, plus a focus group discussion. However, the findings were extremely useful in assessing the appropriateness of the tools and making fine-grained decisions about question order and construction.

The final tools I used are outlined in the relevant section and the interview guides can be seen in Appendix D.

A narrative approach with midwives

I considered using semi-structured interviews with midwives to explore what constituted 'good' midwifery in this context (see Byrom and Downe, 2010). Although I had successfully used these in the past, the context made me reluctant to impose structured questions, as these would inevitably have been shaped by my understandings of what constituted 'good' midwifery and RMC. Further, I felt that the inherent challenges of my perceived status in a post-colonial, hierarchical context could generate social desirability effects that would distort midwives' responses. I needed to use a tool that would allow me to focus on the broad area I

was interested in, but which was fluid enough to provide participants with the freedom to open up about instances of poor or unethical practice and the feelings that these generated. Inviting midwives to provide narrative accounts of their experiences could help to address some of the power differentials inherent in the research interaction (Elliott, 2005), but would also improve the likelihood of obtaining the data needed to address my research questions. The more unstructured format of a narrative approach gave participants the space to choose what they wanted to talk about, which could be revealing in itself. In addition, the concept of caring has been described as ill-defined, complex and contextual, making a narrative methodology appropriate as it enables a focus on what is real for the narrator (McCance, McKenna and Boore, 2001).

I gave careful consideration to the interview questions needed to allow a narrative flow to emerge and to make it as easy as possible for people to articulate difficult or ambiguous thoughts and emotions, particularly to a stranger. I also wanted to give participants the flexibility to focus on the specific components of their work that were most important for them. I used a number of broad questions to explore salient elements of the midwife's conceptualisations of the importance and value of RMC. The first question invited midwives to tell me the story of how they decided to become a midwife, in an effort to 'ease' them into the interview and allow them to relax and find their voice and rhythm. Further questions asked them to: describe their motivation to become a midwife; identify aspects of practice that were the most satisfying/rewarding; recount in detail one really good delivery and one that was a challenge, where good care could not be delivered; and suggest any changes they would make to delivery care if it was them or their wife/sister/daughter in labour instead of a local woman.

Critical incident technique (CIT) interviews with midwives

To complement the narrative interviews I considered using vignettes, as they are a useful device to facilitate discussions about values, beliefs and norms, and can be particularly powerful for tackling sensitive topics (Finch, 1987; Hughes and Huby, 2002). Vignettes offer short, often fictional, scenarios in which a credible protagonist faces a social situation about which respondents are asked to comment and make suggestions on what action should be taken. Questions can be phrased to distance any personal judgement by asking "What should **these people** do next?" rather than asking the respondent what they would do themselves (e.g. Finch, 1987). However, the more participatory methods for generating vignettes (Participatory Learning and Action or FGD with stakeholders) were likely to be too time and resource consuming within the constraints of a PhD project. As an outsider, I also felt that it would be difficult to generate authentic stories without considerable input from fieldwork friends or key informants. Instead, I opted to use the critical incident technique (CIT) (Flanagan, 1954) as these, in effect, ask participants to generate their own vignettes.

CIT uses retrospective self-report for data collection, providing a widely-used, pragmatic solution when participant observation would be difficult or unethical (Butterfield et al., 2005). It can be used to elicit midwives' descriptions of their own practice and emotions, but can also

be a useful tool for describing the behaviour of other midwives or identifying causal factors and consequences of situations where midwives felt unable to provide professional maternity care. In this study, the CIT respondents were first asked to describe a specific birth they remembered where a woman in labour received really good interpersonal care, and then a second situation where the interpersonal care was really poor. Midwives were asked to describe: who was involved and what happened; why it was an example of really good/poor interpersonal care; the factors/reasons that made it possible/not possible; how they felt about the incident; and any impacts the incident may have had on themselves and on the woman giving birth. These questions also facilitated a move away from an 'I' focus to one that described what everybody did in the situation, allowing a degree of distance if the personal focus was too uncomfortable in this context. Framing the questions in terms of both a good and a poor example generates a more rounded and robust appreciation of the constructs under examination and avoids negative polarisation of results (Norman et al., 1992). The 'critical' nature of the incidents that participants are invited to recount usually means they hinge upon a moment of high salience for the participant, often emotionally demanding, so tend to be vividly described and well recalled.

In its initial inception, the critical incident itself was the unit of analysis, led by Flanagan's suggestion that the sample size should be based on the number of critical incidents recounted, not the number of participants sampled. However, there are differences in what is considered to be a critical incident. Respondents frequently describe a number of smaller, critical 'happenings' within the event, so researchers often count these as the unit of analysis instead (e.g. Bradbury-Jones and Tranter, 2008). This is the approach I employed.

In-depth interviews (IDI) with key informants

IDIs are a standard tool in the qualitative researcher's armoury and were used in this study to collect data from a range of relevant stakeholders to provide an overview of the policy, legislative, organisational and systems contexts in which midwives were operating. A broad set of overarching questions were developed that most participants were asked, supplemented with more specific topics of interest that differed according to the individual stakeholder's areas of responsibility and expertise, or in response to emerging themes.

Focus group discussions (FGD) with midwives

FGDs can be useful for the exploration of attitudes and experience, and for gaining several perspectives about the same topic. They allow participants to identify and articulate their own concerns and priorities, to generate possible solutions and to take the research into new areas and directions (Kitzinger, 1996). Indeed, the experience of taking part in the group *"may clarify, elaborate and even change participants' views." (*Green and Thorogood, 2004: 117). Further, group interaction and discussion among participants can make visible frames of reference, meanings and normative influences (Finch and Lewis, 2003). However, I was aware that the FGD methodology would not be appropriate for generating in-depth or personal narratives (Liamputtong, 2011) and that there would be inherent challenges in using them. For example, within the hierarchical and gendered context of Malawian health

systems, status issues can inhibit participants, making the use of homogenous groups based on gender or cadre important. More saliently, the acute and absolute shortages or staff make FGDs logistically and ethically challenging to schedule. However, during the piloting phase of my study I had carried out an FGD with a group of NMTs which allowed me to establish the broad parameters of the research topic, identify some of the types of RMC/D&A that were prevalent in local health facilities, and gauge the ease with which this topic could be addressed with participants. In consultation with my Malawian colleagues, I planned to overcome the challenges of scheduling FGDs by 'piggybacking' on local in-service training events, where midwives were already meeting. Unfortunately, delays in receiving the permissions necessary from the College of Medicine's Research Ethics Committee meant I missed the few opportunities available to conduct FGDs during my main fieldwork period, so they did not form part of my data collection.

Informal observation

Formal, ethnographic observation of midwife-woman interactions in the labour ward would have been entirely consistent with my methodology and research aims, but I did not plan to use this method. The challenges inherent in language and social relationships were too complex to overcome within the constraints of a short fieldwork period. Although English is Malawi's official language and most midwives spoke it fluently, the *lingua franca* is Chichewa, so it would be impossible for a non-Chichewa speaker to understand the verbal exchanges occurring between women and midwives, or among midwives themselves. As a white, British woman in a post-colonial context, I was an outsider, who lacked sufficient awareness of the cultural expectations of Malawian midwifery practice to make judgments about what I observed, despite being very familiar with the Malawian context. Nor was I qualified to judge poor professional practice, although I could comment on more overtly disrespectful practices (and have done so in later parts of this thesis).

During data collection, however, unanticipated opportunities for informal observations arose and I found myself embracing many aspects of an ethnographic approach. I incorporated a reflexive analysis of my role and fieldwork relationships in order to understand how these were likely to have affected the kinds of stories participants told me; used reflexive diary entries as part of the analysis; and made use of the considerable amount of time spent on labour wards during data collection to gain an understanding of the context in which participants worked. I captured key moments and thoughts in a notebook or used the voice memo function on my phone (when it was appropriate to do so). Every day I recorded my observations, thoughts and emotional responses as a journal, which eventually ran to 75,000 words. These outlined my journey and growing understanding of the context, providing texture and nuance to the data I collected and a forum to capture and interrogate emerging analytical insights as the data collection unfolded. Although these data were not used for quotes, they provided valuable insights that informed my understanding and interpretations. To manage and synthesise these, I imported my journal into NVivo and carried out an inductive thematic analysis.

4.2 Study population

My study population of interest were practising midwives currently working in the labour ward. In Malawi, these were state registered nurse-midwives (SRNM) or nurse-midwives at technician (NMT) and enrolled (ENM) grades. A convenience sample was used, with all midwives in selected facilities who met the inclusion criteria and were available on the days that I visited invited to take part. Eligible staff had performed at least one of the emergency obstetric care (EmOC) signal functions[21] in the previous month and had worked on the labour ward at least four times during that time (Table 4.1). To ascertain eligibility, interested midwifery staff were shown a laminated list of eligibility criteria. They were asked to tell me which of the EmOC signal functions they had performed in the previous month and the number of shifts they had done on the labour ward across the one-month timeframe. Only one midwife I approached failed to meet the inclusion criteria, as he had only done two locum shifts in labour ward that month. Staff who satisfied all the criteria and who were willing to participate were given a verbal reminder of the nature and requirements of the project and invited to ask any questions they had. Once I was satisfied they fully understood and that they were both willing and eligible to continue, they were asked to provide written consent by signing two copies of the consent form (Appendix E) – one for my records and the other for the participant's own records.

Only two midwives refused to take part, despite some participants expressing concerns about possible repercussions. One of those who decided not to be interviewed was a senior ENM who was unsettled by the consent process, saying she did not have her glasses, but I suspect her literacy was poor. I read the information leaflet and consent form to her and chatted about the project, but she did not want to risk being recorded as she was only a few months away from retirement. The other refusal was a midwife who had only just taken up her post and felt too inexperienced to meaningfully participate.

Within the confines of a PhD study, it was not possible to explore all the contexts within which these midwives operated, nor to study all representatives of one cadre. I decided to use an identified case (rather than a case study *per se*) to allow a delineated boundary for inquiry, where "…*contextual knowledge can be uncovered using multiple methods within a defined ontological and epistemological position, employing congruent data collection methods within a temporal and geographically defined, or bounded, context.*" (Luck, Jackson and Usher, 2006: 103). For the purposes of this study 'the case' was the context, not the process (Stake, 1995) and was employed as a data collection strategy to explore the research question. The case was 'instrumental' in that it was used as an example or archetype from which inferences about the wider situation in Malawi could be drawn.

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[21] Basic EmOC is comprised of seven signal functions: 1. Administer parenteral antibiotics; 2. Administer uterotonic drugs; 3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia; 4. Manual removal of placenta; 5. Removal of retained products of conception; 6. Assisted vaginal delivery; 7. Neonatal resuscitation. An additional two signal functions indicate comprehensive EmOC: 8. Perform surgery (e.g. caesarean section); 9. Perform blood transfusion.

Table 4.1 Sample inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Holder of an accredited midwifery qualification (i.e. SRNM, NMT or ENM)	Does not hold an accredited midwifery qualification
Performed at least one of the emergency obstetric care signal functions in the previous month	Non-performance of any of the emergency obstetric care signal functions in the previous month
Worked at least 4 shifts in the labour/delivery ward in the previous month	Has not worked at least 4 shifts in the labour/delivery ward in the previous month
Over 18 years of age	Under 18 years of age
Willing and able to participate in English	Unable or unwilling to participate in English
Provided informed, written consent	Unable or unwilling to provide informed, written consent

The case was a single district in Malawi, which was selected in consultation with key in-country stakeholders during an initial site visit in August 2015[22]. Midwives were sampled from a central hospital (run by the MOH) but the extant literature suggested that the challenges may be more keenly felt in rural areas (Van Lerberghe et al., 2002; Jewkes and Penn-Kekana, 2015), so data were also collected in rural hospitals and health facilities (both MOH and CHAM) providing obstetric care. I anticipated that a comparison across the hospitals and health facilities, and between CHAM and MOH institutions, would allow a more textured understanding of the barriers and facilitators of RMC across differing contexts.

4.3 Data collection

In this section I describe the data collection process, outlining the sampling procedures, data collection timings and how data were collected. An overview of the data collection is provided in Table 4.2.

All interviews were conducted in English as Malawi is an Anglophone country. English is a compulsory pass subject to obtain a Malawi Secondary Certificate of Education and all tertiary level education is in English (Matiki, 2001). This eliminated the dilemma of using interpreters and translation, which would have complicated my research and removed me from the data. However, although every midwife was educated in English, for many it was a difficult second (or even third) language. I knew there would be concepts that did not easily translate between English and indigenous languages and which needed to be borne in mind.

4.3.1 Sampling

Midwives

Three MOH and three CHAM health facilities were purposively sampled in consultation with colleagues in the study district. The number of sites was constrained by the cost and logistics of moving around the district, but I returned to most facilities multiple times to obtain

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[22] The chosen district has not been identified to protect participant confidentiality.

as many interviews as possible. In addition, I was also able to interview two midwives from two remote CHAM health centres who were visiting one of the CHAM hospitals in my sample.

Within facilities, a convenience sample of midwives available on the day was used. My plan was to randomly select the interview type (CIT or narrative) for the first interview in each facility, then balance the number of each type by alternating them for subsequent interviews. I also tried to maximise the sample of SRNMs as these staff were available in much smaller numbers and to ensure that I secured at least one narrative and one CIT from this cadre. This strategy worked in the first two MOH facilities, and the CHAM facilities, but in the last MOH facility, a rural hospital, staff were under more time pressure and so less inclined to take part. Although I tried to obtain equal numbers of narratives, I was forced to make a pragmatic decision to use the shorter CIT instrument rather than risk not getting any data at all. On two other occasions I had to change a narrative to a CIT interview in response to the midwife's time availability.

Key informants

During the pilot phase I had undertaken a range of informal interviews with 10 key stakeholders, where I outlined my research and objectives, discussed how these connected to their areas of expertise/authority, and consulted on targeting the main actors who would form the sample for the key informant interviews. This exercise served to flesh out a broad understanding of the current context and key areas of interest, and to follow up on leads and suggestions on the most appropriate people to interview to address the research objectives. I also discussed possibilities with numerous colleagues in the College of Medicine.

A purposive sample of the key informants I had identified during piloting provided the main bulk of participants. However, in order to remain flexible enough to respond to unexpected findings or new perspectives arising from the data, I also used a form of theoretical sampling, where emerging ideas from the analysis drove decisions about further data that needed to be collected and from whom, in order to develop the evolving theory (Ritchie, Lewis and Elam, 2013). This allowed me to follow a line of inquiry, with decisions about the sample shifting in response to new areas of interest or information that needed to be understood. Examples of key informant interview guides can be seen in Appendix D. These were handwritten in my notebook and recorded using photographs, as access to printing facilities in the field was highly problematic.

4.3.2 Data collection timings

Due to my extensive consultation with stakeholders in the pilot study (as well as my previous experience in Malawi) I had a good background knowledge of many of the key macro- and meso-level challenges facing midwives. However, I had not heard from the midwives themselves. I decided to start my data collection with them, so carried out the narrative and CIT interviews simultaneously across an eleven-week period in Mar-May 2016. During this time, I took advantage of the geographical proximity of key informants located in or close to the district and carried out nine interviews. These were with a range of district-level midwifery

managers as well as representatives from nurse-midwife training institutions, including tutors and principles. The majority of national level KIs were located in the capital, Lilongwe, so I spent a month there in June 2016 and gathered data consecutively from another 17 key informants.

Table 4.2 Overview of data collection

Data collection method	Status	Sample	Timings
Narrative interviews Critical incident technique	• Planned and piloted. • Used in main data collection	• Purposive sample of MOH and CHAM facilities • Convenience sample of all midwives meeting the inclusion criteria in selected facilities.	• Simultaneously, Mar - May 2016 Narrative (n=21) CIT (n=23)
Key informant interviews	• Planned and piloted. • Used in main data collection	• Purposive sample of core KIs identified during pilot. • Theoretical sample of additional KIs to explore emerging themes	• Simultaneously Mar - May 2016 (n=9, district) • Consecutively, Jun 2016 (n=17, national)
Focus group discussions	• Planned and piloted • Not used in main data collection	N/A	N/A
Informal observation	• Not planned or piloted. • Emerged during main data collection • Noted in reflexive journal	Ad hoc	Mar - Jun 2016

Carrying out the data collection in this order was beneficial in that I was able to listen to midwives' micro-level concerns, using novel insights arising from the data as the basis for some of the questions I subsequently asked key informants about the broader context. For example, many midwives complained to me about the 'wrong' people being stationed in the labour ward, leading me to ask more fine-grained questions of representatives from training institutions about recruitment procedures and from social scientists about broader attitudes to the public sector. It also allowed me to more effectively interrogate differences between midwives' perceptions and those of key informants, many of whom were involved in policy, practice and regulation. In this way I was able to triangulate between the micro-level concerns of the midwife and the meso- and macro-level context described by key informants.

4.3.3 Interviews with midwives

For both the critical incident technique and narrative interviews, I had planned to carry out enough interviews to generate abundant data and until redundancy and saturation were reached. However, I was very focused on the scarcity of labour ward midwives present in the

chosen district, the time limited nature of my data collection visit, and the significant challenges in organising and funding a potential return visit to collect extra data. This meant that, in reality, I interviewed everyone who was eligible and available in each health facility on the day I visited. I secured 44 face-to-face interviews with midwives from 8 different facilities. Of these, 23 were CITs and the remaining 21 were narrative interviews. All interviews took place in a private room in the health facility, usually an empty office or a private ward if one was available. If anyone knocked on the door or the interview was interrupted in other ways (e.g. participant answering the phone), both interviewing and recording were paused and we did not resume until the interruption had ended.

The duration of interviews was variable, often driven by the midwife's availability or awareness that they could be called back to the ward. CITs ranged from 11-41 minutes with an average of 26 minutes, while narratives tended to be slightly longer with a range of 14-52 minutes and an average of 27 minutes. Where midwives were not under time pressure, I was able to ask if they had anything else they wanted to tell me or that they thought I needed to know. This generated additional data which added to my understanding of the context and midwives' perceptions.

Both types of interviews were designed to encourage midwives to talk about a delivery where they felt good interpersonal care had been provided and one where the interpersonal care had been poor. I judged that asking for descriptions of the good examples first would allow participants to relax into the interview and make them more likely to talk freely when we came to the poor examples. I had been advised that midwives might be more comfortable talking about poor care in the third person, so I offered the option to discuss either something they had done themselves or that they had seen a colleague do. Before starting each interview, I reminded participants that the study interest was in RMC, not just technical care. I couched this in language that should have been familiar to them from their curriculum or which I had heard midwives using themselves, such as *the therapeutic relationship*[23]*, respect and dignity, emotional and psychological support.*

Critical incident technique
The CIT data were used to inform an understanding of midwives' perceptions of the ideal model of care in Malawi, using their descriptions of poor and good incidents to identify the aspects that they thought were important. Despite the focus on RMC, many of the 22 good incidents described by NMTs had a strong technical focus. Some participants had to be prompted to consider the interpersonal aspects, while only a small subset spoke about the full package of care. Much of this could be ascribed to participant's satisfaction in using their skills and knowledge for a good outcome, but it is plausible that this also reflected the focus of their pre-registration curriculum.

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[23] During data collection, it became apparent that midwives used the language of the 'therapeutic relationship' to describe interactions with women that they felt constituted RMC. But see comments in Chapter 6 about the importation of a British curriculum and language, and the difficulty of assuming shared understandings of what constructs mean across cultural and linguistic boundaries.

A total of 36 poor care incidents were described, of which almost half were blamed on the woman. The majority concerned the woman's behaviour during labour, a topic which will be explored in Chapter 9 'Relationships with women'. Fourteen incidents described the behaviour of 'other' midwives. However, some midwives were remarkably candid about their own behaviour, describing events when they felt they had behaved unprofessionally.

Narrative interviews

Much of the construction/expectation around the narrative format in methods discourse is informed by a Western sensibility of the primacy of the individual in modernity and the cult of 'the self', alongside expectations of a forward movement through the story (Reissman, 2008). This is reflected in expectations that a narrative will be constructed in the first person, as 'I' rather than 'we', and will be temporally ordered, but also that it will involve an interesting story (of interest to whom?), centred around a topic (rather than episodic or spatially organised) and dealing with specifics (e.g. what happened, when, who was involved and why?). The story is usually expected to have an emotional component or point (Reissman, 2008). Prior to my field visit, I had some concerns that this might not accord with Malawian understandings or cultural expectations of story-telling in this context (such as protocols, temporal ordering). My previous experience of interviewing Malawian health workers meant I expected them to talk quite freely. Once the 'getting in, getting on' element of access was established (Buchanan, Boddy and McCalman, 2014) previous research had generated good stories about specific events that happened to the interviewee. However, I had not used a narrative approach before so was also mindful that it might be conceptualised as occupying a different space to an 'interview', and therefore not be seen as appropriate for the interview setting.

As data collection progressed I could not help but feel that the narratives, although generating stories that were relevant and interesting, were sometimes more formal than I had hoped. I ascribed some of this to the constraints on midwives' time and availability that meant they sometimes were unable to get into a real flow with their stories, while others seemed unsure how much detail to provide. However, shortly before I left the study district and a few days after all my narrative data were collected, I had an opportunity to see an unfettered version of Malawian storytelling which made me question my judgement that the narratives had worked reasonably well. The house in which I had lived for ten weeks was subject to a number of break-ins during that time. I came home one day to find that another attempt had taken place a few hours earlier but had been interrupted and the thief apprehended. The two women involved, who knew me very well, proceeded to tell their story (to me and a small audience of neighbours) in a highly detailed and emotionally charged manner. Their story was full of dramatic gestures and they acted out key highlights. While I was in no way expecting this level of engagement in an interview context with midwives, it did make it clear that only a few of my interviewees had been relaxed enough with me to feel free to relate their stories to me with such animation. Clearly, audience and context were significant factors in the recounting of the thief story, but I wondered if the 'interview' concept

and expectations of telling a 'story' may have caused dissonance for midwives and intersected with my perceived status in this post-colonial context to make participants express themselves in a more formal style. Nonetheless, many of the transcripts show the animation of some midwives when telling their stories and how they were reliving the experience in the telling, putting on voices or visibly pleased or disappointed. Interestingly, some of the most senior key informants told very well acted and dramatic stories, leading to some conjecture on my part that perceptions of status played a role here.

The interview schedule's broad questions allowed midwives to decide which aspects of their stories to focus on and to prioritise **their** understandings of RMC in this context. Of equal interest was how they presented themselves in the narrative. Many were couched in terms of the 'victim' or the 'hero'. The 'good incident' narratives often described overcoming obstacles and triumphing in adversity to save the woman and baby (e.g. alone on duty, the ambulance didn't arrive). These dramatised versions may be employed by midwives who lack status, to move the focus to how well they are coping and to perhaps make them feel that their job **is** worthwhile in a context that does not value or support them. For the SRNMs, who have higher status, these narratives often reflected the intrinsic satisfaction of performing well in difficult circumstances. When telling stories of 'poor incidents' there were often factors at play that caused the incident, with only a few participants admitting that it was their fault or negligence that caused or exacerbated the outcome. Others referred to the incident as 'a team thing' and spoke in terms of 'we', not 'I'.

4.3.4 Key informant interviews

Key informant interviews were scheduled in advance and most took place in the participants place of work. A total of 26[24] interviews were conducted.

To protect participant confidentiality, I decided to group key informants into categories (Table 4.3) based on the participants' areas of responsibility or expertise. Malawi is a small country and it would be easy to identify individuals from their organisational affiliation or job role, so in some cases these have been omitted. However, I retained the individual identifier to allow readers to judge the spread of data across participants. Of the 26 participants, 23 were qualified nurse-midwives; 12 of whom specifically self-identified as midwives, so midwives' voices were strongly represented.

4.3.5 Midwife participant demographics

Forty-four midwives in the study district were interviewed (Table 4.4). Participants ranged in age from 23-60 years, with 45% aged under 30 and 39% aged 30-39. I asked them how long

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[24] A 27th interview with a 'critical friend' was later excluded as it became a discussion of our own interpretations of what was going on. While not included in the formal data, this content was valuable and instrumental in clarifying and shaping some of my understanding of the context and dynamics at work. Emerging from the field of education, a 'critical friend' is a trusted person who constructively critiques your work by asking provocative questions, helps you to articulate and clarify ideas, and advocates for the success of your work (Costa and Kallick, 1993).

they had been qualified at their current grade and answers ranged from 3 months for an SRNM who had just been appointed as labour ward in-charge, to 39 years for one of the ENMs. Nearly 30% of the sampled midwives had been qualified at the current grade for three years or less, but 45% had more than 5 years of experience.

Table 4.3 Key informant groupings

KI grouping	Organisational affiliation	Roles/ *Responsibilities*
'Training institutions (SRNM) or (NMT)' (n=7)	• Kamuzu College of Nursing • Malawi College of Health Sciences • Christian Health Association of Malawi	Deputy Principle, Deputy Head of Dept, tutors and lecturers *Organisational direction, planning and oversight; curriculum content and examination; clinical teaching, placement and supervision; academic teaching (professionalism, ethics)*
'Midwifery managers' (n=6)	• Central Hospitals • District Health Offices • Rural CHAM hospitals	Chief Nursing Officers, District Nursing Officers, Matrons *Oversight of maternity provision, management and supervision at hospital or district levels*
'Midwives' representatives' (n=4)	• Nurses and Midwives Council of Malawi • Association of Malawian Midwives • National Organisation of Nurses and Midwives of Malawi	Executive level participants from regulatory and professional bodies *Registration and regulation of education and practice; representing or supporting midwives; lobbying, advocacy and union representation*
'MOH' (n=3)	• Dept. of Nursing and Midwifery Services • Dept. of Human Resource Management and Development • District Human Resource Officer	Director/Deputy Director personnel at the national level; district level HRO *Strategic oversight of: direction and implementation of national midwifery services; or countrywide HRM. District level HR and liaison with the Ministry*
'Senior advisors' (n=2)	• Affiliated to INGOs or as advisors to MOH depending on the nature of their work	Senior nurse/midwives *Significant experience of the policy, practice, regulatory and political context, working in consultancy and advisory roles*
'NGOs' (n=2)	• White Ribbon Alliance Malawi • ICAP	National/country level representatives *Active in RMC, training, nurse education and advocacy*
'Academics' (n=2)	• University of Malawi	• Senior researchers *Expertise in the social, ethical and cultural context*

Table 4.4 Midwife participant demographics

Instrument	Participants					
	MOH			CHAM		
Critical incident technique **n = 23**	Cadre	Gender		Cadre	Gender	
		Female	Male		Female	Male
	ENM	2	0	ENM	0	0
	NMT	5	3	NMT	4	4
	SRNM	3	1	SRNM	1	0
	Total	**10**	**4**	**Total**	**5**	**4**
Narrative interviews **n = 21**	ENM	0	0	ENM	0	0
	NMT	10	0	NMT	5	1
	SRNM	2	1	SRNM	2	0
	Total	**12**	**1**	**Total**	**7**	**1**

4.3.6 Documentary analysis

My intention was to obtain a range of materials, including: training curricula; guidelines and regulations for registered, technician and enrolled grade midwives; the Nurses and Midwives Council of Malawi ethical and professional guidelines; Ministry of Health (MOH) reports and policies; and literature from professional associations. This proved to be far more difficult than anticipated. My previous experience in Malawi had shown how few documents were available even in hard copy, but that was nearly a decade earlier and I had expected that technological advances and upgrades would have improved this situation. While it was still the case that many documents were theoretically within the public domain, they were not often available even to the key informants who ought to have had them. For example, at the national level, one of my key informants who had a role in human resource management had to physically go to the MOH offices to find out how many midwives there were in the study district. Challenges in printing or circulation of documents accounted for some of these gaps. However, many senior people were not sure if they were allowed to give me copies of documents. Layers of bureaucracy, unease about decision making and fear of responsibility for the wrong decision may be a legacy of authoritarian rule, leaving some participants unsure or protective. However, some were happy to let me make a photocopy (where that was possible), take photos of relevant pages, or make notes.

A further challenge was the lack of data integrity. Health Management Information Systems (HMIS) were weak and where data were available there were long delays in compiling and sharing them. In the study district I tried, on at least 10 separate occasions, to track down the clerk responsible for collating the labour ward statistics but was brushed off each time. Instead, one of the NMTs suggested that we calculated figures for the last month using the birth register. However, this proved to be impossible as the register was poorly completed and totals did not match the numbers of entries. The NMT immediately blamed this on the students, but when she tried to show me the details of a macerated still birth she had attended a few days earlier she realised she had forgotten to log it herself. At the district

level, I asked the Safe Motherhood Coordinator for statistics on the average number of deliveries in each of the health facilities in my sample. She took my notebook and wrote down the figures from memory.

4.4 Data management

All information was anonymised from the start of the study using a unique identity code for each participant. This was used on all stored data records. The identity key was securely stored and remained separate from the main data. All interviews were digitally recorded (with participant's permission) and recordings were labelled with the participant's unique code only. Any computerised data/information was encrypted and stored on password-protected computers or USB devices. These were only accessible to authorised members of the research team. During travel between Malawi and England, I kept the data securely with me. One copy of the data was kept on a password protected USB which remained in a zipped compartment in a handbag. A second copy was stored in a password protected folder on my laptop and travelled with me in my hand luggage. Hardcopy records, such as consent forms, were stored securely in locked filing cabinets, to which only designated members of the research team had access. All data will be stored securely for 10 years by City, University of London. De-identified data will be archived and any personal data will be destroyed.

My Malawian colleagues recommended trusted transcription services in Malawi who transcribed the majority of the interviews into Microsoft Word. Local protocols for confidentiality and professionalism and strict procedures for transfer of password-protected audio and transcriptions were agreed and adhered to, with all transcribers signing a confidentiality agreement[25]. This aimed to ensure professional practice in maintaining confidentiality, storage and subsequent deletion of all materials related to the research data.

4.5 Data analysis

4.5.1 Analysis

The transcription of interviews took place contemporaneously in Malawi. As transcripts were completed I checked them for accuracy, ensuring that all identifying information had been removed from the raw data and correcting errors where the transcriber was unfamiliar with obstetric terms or midwifery jargon. Listening to the recordings and using my field diary, I noted the context of the interview and captured details of body language or tone of voice. I was mindful that the transcript is only a representation of the interview, so tried to capture any extra information that had allowed me to fill in gaps (e.g. the ease with which topics were addressed, participants looking embarrassed). All transcripts were then imported into an NVivo11[26] database for analysis. The use of NVivo allowed a systematic and transparent analysis process, as well as providing an efficient mechanism to keep track of the large body of data collected.

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[25] See Appendix F. for a *pro forma* of the transcriber confidentiality agreement.
[26] NVivo qualitative data analysis Software; QSR International Pty Ltd. Version 11, 2015.

The analysis method differed according to the tools used. Coding for all the CITs was completed first, followed by the key informant interviews and finally the narratives.

Critical incident technique interviews: The CIT interviews were subjected to framework analysis (Ritchie and Spencer, 1993). Existing frameworks of disrespect and abuse (Bowser and Hill, 2010; Bohren et al., 2015) were descriptive, rather than theoretically informed, and also failed to address the larger circulating discourses on how and why different actors may, or may not, abuse women. The conceptual framework I had developed as part of this thesis (described in Chapter 3) was cognisant of the postcolonial legacy and its continuing impacts on the prevailing dynamics in Malawian labour wards. Although it initially related to drivers of D&A, the framework could also accommodate references to RMC. For example, the meso-level theme of 'Work environment and resources' could capture the impact of staff shortages in disrespectful care, however it could also house midwives' perspectives that an adequate staff:woman ratio facilitated RMC. As well as being coherent with the study's epistemological stance, this framework also provided a tool to unpack the most salient factors affecting the behaviour and perceptions of midwives in the postcolonial Malawian context, making it an appropriate choice for the analysis.
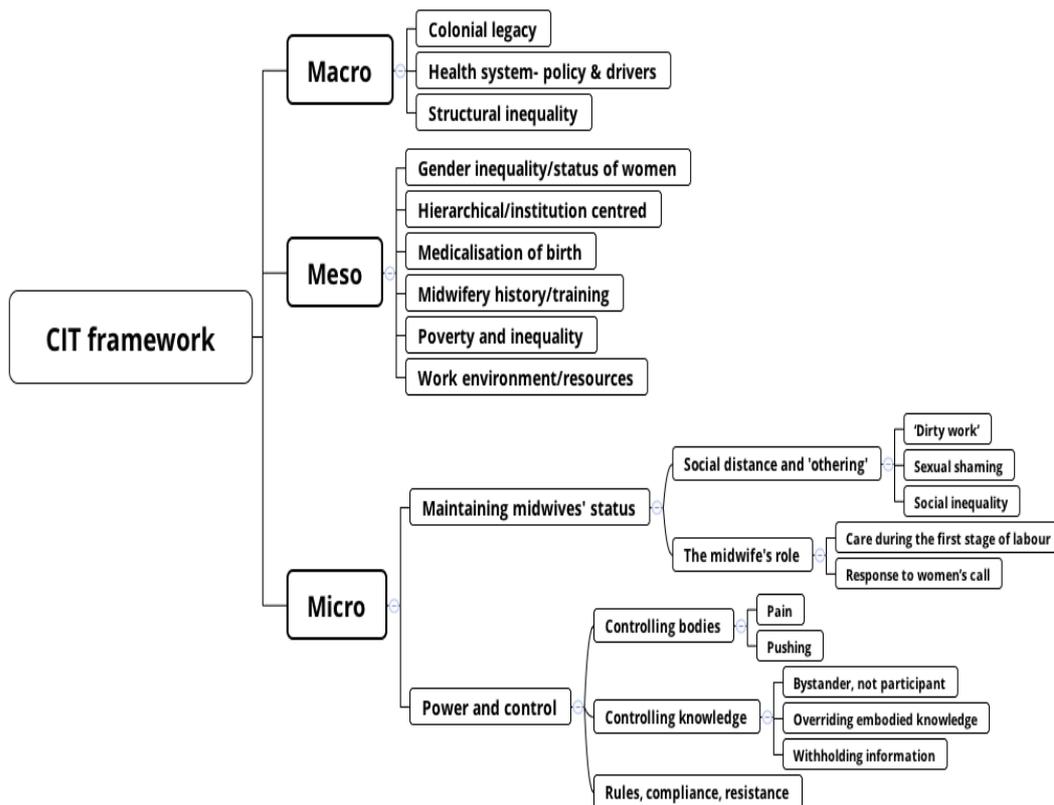
Figure 4.1 CIT coding framework

Coding of the CIT interviews was an iterative, not rigid, process, largely following the classic steps of familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation (Pope, Ziebland and Mays, 2000). The broad analytical themes of the

conceptual framework formed the basic coding structure (see Figure 4.1) into which the raw data were coded. Most of the data mapped well onto this structure, with the majority of data occupying themes at the micro-level. Extra categories, such as 'professionalism' and 'women's behaviour', were added to reflect new ideas arising inductively from the data. Charts were used to rearrange data and summarise it according to thematic content, to outline midwives' understandings of good and poor interpersonal care in the Malawi context.

Key informant interviews were analysed using the same analytical framework. Their data were more focused at the macro- and meso-levels where inductively derived codes populated the top-level analytical themes. This facilitated a more granular understanding of these themes. For example, all data which mapped on to the meso-level analytical theme of 'Midwifery history and training' were inductively coded into a range of new nodes to reflect the specific concerns in Malawi (see Figure 4.2).
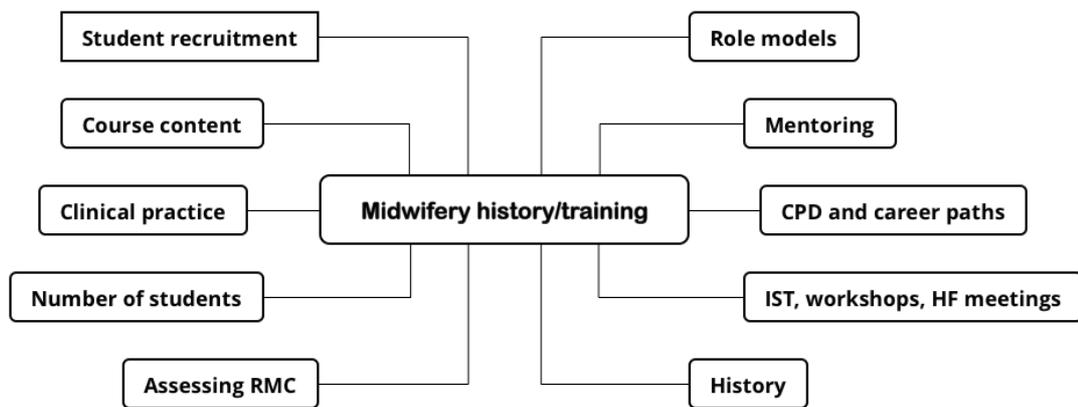
Figure 4.2 Analytical themes and inductively derived codes

Narrative interviews: The original plan had been to use a combination of thematic coding and narrative analysis (Riessman, 2008) for the narrative interviews. However, the narrative participants articulated many of the same concerns that had arisen in the CIT data. I decided to use an adapted framework analysis because the evolving framework had proven comprehensive but flexible enough to effectively capture the concerns of midwives, as well as the macro- and meso- level factors affecting them. New nodes were inductively developed, with mind maps used to make clear any added contributions from the narrative instrument.

A second layer of narrative analysis focused on individual cases, paying attention to the nuance of language, the intended audience and any circulating discourses impacting on the narrative that was generated. An explicit element of the analysis was the interrogation of not only which stories the participant chose to recount, but also their intention in doing so. Further, I explored the meaning being communicated and the background cultural resources, frames of reference or taken-for-granted assumptions used, identifying gaps or inconsistencies. Riessman (2008) quotes Charon (2006) who likens this in some ways to

literary scholarship, in that there is an explicit and critical interrogation of the text in the context of colonialism, politics, gender etc. This was a key element of the theoretical approach to this research, making narrative analysis an appropriate choice.

4.5.2 Rigour and reliability

I coded all the interviews and other reviewers independently coded three randomly selected interviews for each of the research instruments (9/70 interviews). We compared coding for each instrument and met regularly to discuss our emerging understandings and ideas. Given the different purposes of the tools and the types of analysis used, coding was not just about coding data, but involved constant reflexive sorting and iteration. I documented the evolving iterations using mind mapping software, colour coded to identify the original conceptual framework and new nodes generated for each of the instruments. This generated an audit trail of our decision processes, but also allowed members of the team to visualise the data and informed our detailed conversations about the analysis process. The mind maps were particularly useful for identifying data which did not appear to fit into our theoretical structure, enhancing understanding and delineating new areas of insight.

Denzen and Lincoln (2011:5) describe *"The combination of multiple methodological practices, empirical materials, perspectives, and observers in a single study is best understood then, as a strategy that adds rigor, breadth, complexity, richness, and depth to any inquiry."* This study used multiple research tools, differing vantage points (key informants and midwives), diverse contexts (CHAM/MOH; hospital/health centre) and a range of analysis methods and multiple researchers to enhance credibility and facilitate identification of converging and contradictory perspectives (Denzin and Lincoln, 2011; Flick, 2014). Conscious of my outsider status, I sought out opportunities to discuss my emergent findings with my Malawian colleagues or to clarify/check my understanding of the cultural and social context for behaviours and dynamics that I was hearing about in interviews or had witnessed. Midway through data collection, the COM's Research Support Centre invited me to give a seminar on 'Respectful and Dignified Midwifery Care', an open forum which attracted 38 people, including 8 midwives, 2 Chief Nursing Officers and clinical staff from a central hospital's Obstetrics and Gynaecology department. I used this as an opportunity to present my preliminary findings, which generated a lively and engaged debate. The midwives present were positive about my fledgling interpretation of the factors that were driving disrespect in Malawi, but also flagged up some extra issues they felt were important to consider. These feedback opportunities gave me increased confidence in my interpretation of the data.

The analysis was underpinned by my reflexivity and awareness of my positionality in the research process (which form the basis of the next chapter).

5. Methodology and methods – the reality

Introduction

The purpose of this chapter is twofold. Firstly, I want to describe some of the realities of the data collection process, including the unexpected ethnographic turn taken during data collection. Secondly, I want to make visible my reflexivity and awareness of the power dynamics inherent in my field work and the ways in which these impacted on me, on the research process, and on my interpretation of the data. This will include consideration of ethical dilemmas in the field, representation and voice, and some thoughts on cultural/moral relativism.

5.1 Access and field work relationships

5.1.1 National permissions

During my time as a researcher, I had become very familiar with Malawi and spent a considerable amount of time in-country. I had long-standing and reciprocal relationships with colleagues in the College of Medicine's Centre for Reproductive Health (CRH), with whom I had worked for many years. Together we had carried out a range of activities, including local capacity building and team qualitative data analysis with NVivo software; training local data collection teams; overseeing the piloting of research instruments; and co-authoring publications. My previous work had involved conducting key informant interviews with a large range of actors at national, district and facility level, so I knew my way around the Ministry of Health (MOH) and had contacts with Malawi's Kamuzu College of Nursing (KCN), the Centre for Social Research, and Nkhoma Hospital (a rural hospital with an associated college that trains nurse-midwife technicians).

Research undertaken in Malawi must be formally housed under the umbrella of an appropriate Malawian research organisation. My colleagues in the CRH shared my interest in quality of care and were keen to collaborate, offering to provide vital logistical and organisational support. As a non-Malawian researcher, the most straightforward way for to satisfy the complex and bureaucratic requirements was to enrol as a Visiting Research Student in the College of Medicine. My CRH colleagues then liaised with MOH officials to help me identify the key stakeholders whose permissions were needed to ensure ethical approval and access to research sites. To facilitate these formalities I undertook a preliminary, 7-week field visit in August/September 2015. A large part of this time was spent obtaining permissions, including the handover of hardcopies of letters of support from key stakeholders. The project was signed off at the national level by the Secretary for Health in the MOH; at the district level by the District Health Officer (DHO); and by the Director of the central hospital which was one my key sites. During this visit I set up relationships, liaised with or informally interviewed other stakeholders, finalised my ethical approval with the College of Medicine Research Ethics Committee (COMREC) and piloted my research instruments in a different central hospital. Initially, I had planned to only carry out data

collection in MOH facilities, but once out in the district it rapidly became apparent that the absolute numbers of midwives were so small that I would need to increase my sample and include Christian Health Association of Malawi (CHAM) facilities too. Permission to access CHAM facilities was granted by the Executive Director in December 2015.

5.1.2 Local access

Making contact with the relevant gatekeepers at district level during my initial field visit was extremely beneficial. When I returned to start the main data collection (March-June 2016) in the central hospital they knew who I was, were familiar with the aims and objectives of the project and so were happy to allow me to start straight away. However, I fell between the areas of responsibility of the clinical and nursing directors, neither of whom felt able to decide which areas of the hospital I was allowed to be in (I was later told, unofficially, that this reflected a split that was replicated all the way up to the MOH). Instead, one of the matrons offered me the use of her office to conduct my interviews as she was going to be away on a training course. I went into labour ward and handed out my Participant Information Sheets (Appendix G), then went back a couple of days later to start interviewing. Here I remained for almost three weeks, until I had managed to interview all eligible staff. I quickly fell into a pattern of an early morning catch up with the midwives I knew, introductions to those I had not yet met, followed by hours of waiting for someone to come in to talk to me, interspersed with me popping out to check how busy the labour ward was and to remind them that I was still there. As the days progressed and people became used to my presence these boundaries started to relax. The turning point came after about a week, when I went in to the labour ward on a public holiday. It was much more relaxed and informal as there were no clinics or surgeries, many staff were on holiday, and there were only two midwives on duty. They invited me to sit and have lunch with them at the midwives' station where they gently quizzed me about why I was interested in Malawi, my family and my history. Sitting with the midwives became an accepted habit that persisted throughout my time in the hospital, unless the ward was very busy, and gave me an unanticipated opportunity to see midwives in action, albeit from the 'other' side of the curtains. On a few occasions, I was allowed to sit in on the 'morning report', where the head of Ob&Gyn discussed current cases and quizzed worried looking staff about patient care options and protocols.

Access was slightly different for the other health facilities I visited. I usually phoned the matron or labour ward in-charge[27] in advance to introduce the project, asked for permission to visit, then arranged a convenient time to arrive (e.g. avoiding clinic days).

In each facility that I visited, I gave Participant Information Sheets to the managers and labour ward midwives. The labour ward in-charges were happy to accommodate repeat visits, providing me with the staff rota for the month so that I could coordinate my timings to try and reach everyone. They also helped to identify health workers with midwifery skills,

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[27] The labour ward 'in-charge' role is usually undertaken by a SRNM and involves overseeing the practice and behaviour of other midwives on duty. It can be conceptualised as in some ways as similar to the role of a UK labour ward coordinator.

including those who had been temporarily assigned to another unit (as is customary where the majority of staff are nurse-midwives). Most midwives had at least 48 hours to reflect on the requirements of the project and their potential involvement. However, if staff wanted to be interviewed sooner than this to avoid being excluded (for example if they were not going to be on duty for a few days or were keen to take advantage of a lull in the labour ward), I proceeded with the interview.

Access to key informants was relatively straightforward. My status as part of the College of Medicine gave me credibility, while the circle of senior health systems staff in a small country like Malawi meant that almost everyone I needed to talk to was either someone I had met in my previous research role or was a friend/colleague/class mate of somebody I already knew. The only challenges I faced were the logistics of finding mutually convenient timings with busy people, or key contacts being out of the country while I was in Malawi.

5.1.3 Positioning myself in the research encounter

I mentioned earlier that one of the key drivers for my research was the impact of the negative gaze on the midwife. From the outset, I deliberately sought to use a positive frame, couching the research in terms of RMC, not of D&A. This perspective was clear in the content of the Participant Information Sheets and I reiterated it in person when soliciting participation from midwives. Despite this, I was somewhat surprised at how easily the health facility management allowed me to interview their staff and how supportive many were of the research topic.

Some of the ease with which I was accepted was undoubtedly due to who I was perceived to be and my awareness of the importance of managing my 'personal front'[28] (Goffman, 1959). To a degree I also used 'impression management' to optimise the chances of engagement from *"…different categories of participants, and different social contexts, which demand the construction of different selves."* (Hammersley and Atkinson, 1995: 68). Some of this was in recognition of the considerable historical and cultural power dynamics of being a white researcher from a British university, with its attendant baggage of privilege, dominance, expertise and status. Dressed smartly, grey haired, with a City university backpack and laptop, I was frequently assumed to be a doctor, a senior medical visitor, or from an NGO. Although I could have modified my 'appearance' this was not appropriate as Malawian dress code expectations are quite formal and in any case, I wanted to be, and to be seen as, a professional researcher involved in a credible research enterprise. I think I could have walked through the wards with little likelihood anyone would have stopped me. This was a source of constant discomfort for me as I have Irish heritage and we have had our own relationship with oppression. These assumptions occurred in almost every situation I encountered - from the automatic 'one of us' acceptance of other ex-patriates to the 'front of the queue' encounters with officialdom.

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[28] Goffman describes 'appearance' as referring to stimuli that indicate for example whether a performer is engaged in a formal activity, such as work, while 'manner' is how the role is carried out.

On the spur of the moment I decided to amble round to [training college] *to make an appointment to see the Principal. The smiling man I asked for directions is one of the tutors there. He took me to find the Principal's secretary, but we bumped into the Principle herself and she ushered me into her office, despite my protestations. I explicitly told her I wanted to make an appointment, that I did not want to be another European thinking they could just turn up unannounced and be seen, but she just laughed and made me sit down.* (Field notes, 21 Mar 2016)

On a small number of occasions, I experienced (and wryly appreciated) what I recognised as a form of resistance, where the power dynamic was reversed and key informants seemed to make me wait, or cancelled a scheduled meeting at the last minute.

Clearly, I could not change **who** I was, but I did have control of **how** I was. With everybody, I was as transparent as possible about my intentions and activities, offering elements of self-disclosure to reduce the one-way nature of the interview interaction (Oakley, 1981). With midwives, I was open and gentle, making it clear that I didn't want to get in their way but was really interested in their stories. The fact that my daughter is a midwife in London was a great ice-breaker, allowing midwives to turn the tables and question me. Any reservations midwives may have felt about my purpose and motives were usually dispelled quickly. I told them about my previous work in Malawi, my awareness of the challenges of labour ward and my genuine desire to hear directly from midwives. My familiarity with midwifery practice and terminology was very useful, but I needed to learn the specific jargon of the Malawian labour ward. I occupied the space that Atkinson refers to as a 'well-informed citizen' (Atkinson, 1984: 179), which enabled midwives to focus on their narratives without the need to censor technical terms or explain things to me, but where my lack of understanding of the specific workings in this context allowed plenty of latitude to question taken-for-granted knowledge. Another strategy I employed was to deliberately reinforce the idea that they were the expert (as, indeed, they were!) and I would happily wait for them to be free or ready to talk to me, rather than the usual expectation of them dropping everything to accommodate the European visitor.

The in-charge, who has been quite serious with me, said she would come in for an interview. We started a CIT but about 5 mins in there was an interruption as she was needed in the ward. I was quick and soft about recognizing where her priorities should be - with me at the bottom - which seems to have shifted something in her attitude to me. When she came back she was delightful and really friendly. (Field notes, 23 Mar 2016)

5.2 An ethnographic turn

During the four-months of field work I had numerous, unanticipated opportunities to gather informal 'data'. The most relevant of these *ad hoc* opportunities occurred within the health facility setting, particularly in the hospital where I spent the most time. Sitting at the midwives' station provided a vantage point from which I could see and hear the whole ward.

This informal acceptance of my presence in the labour ward, rather than hidden away in an office, allowed me to observe a small slice of the actual behaviour of some of the midwives who I subsequently interviewed. It quickly became apparent that some were presenting an 'ideal' version of themselves in the interview situations. Nonetheless, this dissonance demonstrated their awareness of the required standards of a 'good' midwife and the impact of RMC, even if they were not always able to model this in practice.

A second source of informal data occurred as a consequence of living and socialising with health professionals (both Malawian and expatriate) in the different locations I visited. Coffee table conversations and dinner table discussions provided insights into various aspects of the background to the health system, including standards of practice, corruption, politics and conflict. They also gave me glimpses into intimate family and cultural dynamics, such as religious/witchcraft beliefs, status of women, treatment of staff, and views on sexual and reproductive health issues. Other interesting opinions and scraps of information were revealed in the wind-down when I switched off the recorder after the formal interviews. It would have been a challenge to make sense of it all without the support of a small group of 'critical friends' in Malawi. One acted as a cultural guide, helping me to understand the complexities of the norms and expectations of Malawian society. A second was familiar with the research topic and worked in a labour ward, so was able to engage me in reflective discussion, puncture some of my underlying assumptions, and make me clearly articulate where I stood on some of the more emotional and challenging aspects I encountered. A third was an academic who provided positive feedback, asked provocative questions and supported me in networking and advocacy.

The observations I gathered throughout my stay, while not 'data' in the formal sense, were integral in shaping how I viewed and responded to D&A in this context, as well as informing my understanding of key dimensions of the research questions. However, they also generated a number of ethical dilemmas with which I had to grapple, which I will discuss more fully in the following section.

5.3 Ethical considerations

This section outlines the ethical considerations that needed to be addressed when carrying out the research project. I draw on the work of Guillemin and Gillam (2004) to divide this into two dimensions. 'Procedural ethics' is the domain of research ethics committees, whose mandate is to protect human research subjects. 'Ethics in practice' is the messy stuff that arises day-to-day in the field, when researchers face moments that demand personal moral and ethical consideration.

Critiques of unreflective ethical practice cite the conflation of institutional review board approval with ethical practice (e.g. Rossman and Rallis, 2010).

> *There is no direct or necessary relationship between ethics committee approval of a research project and what actually happens when the research is undertaken. The committee does not have direct control over what the researcher actually does.*

Ultimately, responsibility falls back to the researchers themselves—they are the ones on whom the conduct of ethical research depends. Arguably, procedural ethics has little or no impact on the actual ethical conduct of research. (Guillemin and Gillam, 2004: 269)

Yet it is arguable that ethical and moral dimensions pervade every aspect and every decision made in the research process, necessitating ongoing reflection and action (Goodwin et al., 2003; Rossman and Rallis, 2010). Ethically reflexive praxis can be useful in morally navigating the ethical tensions that arise in the field (Guillemin and Gillam, 2004; Rossman and Rallis, 2010).

5.3.1 Procedural ethics

This study received ethical approval from the School of Health Sciences Research Ethics Committee (SHSREC), City, University of London (Ref: PhD/15-16/02[29]) and from the College of Medicine Research and Ethics Committee (COMREC) in Malawi (Ref: P.05/15/1737)[30]. In addition, I have successfully completed the National Institute of Health's (NIH) "Protecting Human Research Participants" course (2010, #441322).

By its very nature, this study invited midwives to retrospectively describe and reflect upon instances of poor care. Some accounts described behaviours that were legal or normalised within Malawian midwifery care, but would be considered objectionable or even illegal in the UK context. The SHSREC initially suggested a 'restriction of confidentiality' clause if a midwife revealed that someone was currently at risk of harm. However, there were legal and conceptual differences in how harm in this context was defined across the two jurisdictions and such a restriction would have deterred midwives from participating. Further, midwives were describing events that had already occurred, making it extremely unlikely that imminent risk of harm to any individual was going to be disclosed. It was agreed that if a specific case needed to be disclosed, the in-country protocol should be followed. This advised reporting any concerns informally and anonymously to the facility-in-charge, who would then take action according to the agreed protocols and policies as outlined in their standard practice documents (each facility had its own mechanisms).

Obtaining ethical approval from COMREC was very time-consuming and involved significant levels of paperwork and bureaucracy, which were compounded by my status as a non-Malawian researcher. Further, I needed to make revisions to the protocol in the light of findings on the ground. Capacity constraints in COMREC meant that revision applications were not necessarily assessed by board members who had given the initial approval. When I applied to include CHAM facilities due to the shortages of midwives in the district, the new reviewer initially denied my amendment as they required more detailed information on other aspects of the basic protocol which had already been approved. I also requested permission

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[29] See Appendix H. for ethical approval from the School of Health Sciences Research Ethics Committee, City, University of London.
[30] See Appendix I. for ethical approval from the College of Medicine Research and Ethics Committee.

to carry out a focus group discussion in a different district and the reviewer insisted I change the title of the project from 'Malawi' to the name of the district. Despite this being a clear error, I was obliged to wait so long for this to be sorted out that the opportunity was lost.

Standard aspects of institutional ethical approval were followed. Given the sensitive nature of the topic area, it was important to safeguard participants' rights to informed consent, privacy and confidentiality and to stress their right to refuse to answer or to withdraw from the research at any time - all clearly outlined in detailed Participant Information Sheets and informed consent documents. I had anticipated that some themes being discussed could prove challenging or emotionally difficult for participants to talk about. However, the nature of the interview schedules left participants free to choose what they did and did not want to discuss, so this discomfort was avoided. No participants showed any signs of experiencing distress as a result of the study, although some did describe situations that had been difficult for them. When this happened, I expressed empathy and acknowledged their challenges, but no occasions arose where I needed to refer them to the health worker support services at the district level that had been identified by my colleagues at the College of Medicine.

One of my concerns with securing top-down access in a hierarchical system, rather than directly from those I wanted to interview, was that more powerful gatekeepers might give staff the impression that they were **obliged** to take part in my research. Some ward in-charges spoke of 'sending' midwives to talk to me, raising ethical concerns that participants might feel unable to refuse to be involved (Mulhall, 2003). I made it clear that I was only interested in talking to midwives who **wanted** to be interviewed, but could not be sure that this was respected by the in-charges. To obviate this, I was careful to check the willingness of all midwives who I had not directly recruited myself. If anyone seemed uncomfortable, I suggested that we just sit and chat for a while, so it would appear that they had been interviewed. However, no midwife took me up on this offer, but I suspect that providing the option **not** to participate shifted the dynamic of the interview and made them more inclined to take part.

5.3.2. Ethics in practice

I have nearly a decade's experience of carrying out research in sub-Saharan Africa, so was very familiar with the institutional standards of ethical behaviour and principles expected of me. I was also very aware of more explicitly paying attention to respect and mutual courtesy across the postcolonial and cultural divide. However, I have never been immersed to such an extent as on the field work for this project. I operated almost completely alone for four months, gaining access to private worlds and informal observations in a way I had not predicted or prepared for. After all, I am not an ethnographer and observations were not part of my pre-departure data collection toolkit. My contingency plans had focused on procedural ethical challenges, such as how to collect data without impinging on women's care.

Out in the field I found myself privy to interesting, relevant information that I could neither un-see nor un-hear: friendly discussions with participants when the recorder was turned off;

glimpses of labour ward life afforded by my privileged position as someone who was tacitly allowed to be there; gossip and debates across kitchen tables where I was allowed 'backstage' (Goffman, 1959) as a guest in people's homes. Anything relevant to my study was logged in my field diary, a researcher without an 'off' switch. I struggled with the blurring of boundaries in what I conceptualised as a 'hierarchy of confidentiality', doing my best to navigate these different knowledges and to keep track of where I had gathered information and which bits I could, or should, use, and how.

> *It is the ethnographer's responsibility not only to think a bit first, but to make conscious decisions on what to report and what to decline to report based on careful consideration of the ethical dimensions of the impact of the information on those who provide it, and the goals of the research.* (Musante (DeWalt), 2015: 279)

Some elements of decision-making were straightforward. The formal knowledge from the interviews was clearly bounded, covered by professional ethics and standards, while private information gleaned from non-participants was clearly off limits unless it referred to 'common knowledge' (things most Malawians or health workers already knew) or behaviours that occurred openly in health facilities[31]. However, sometimes the boundaries overlapped. During an extended key informant interview with someone I knew well, relaxed in our web of shared connections, she started to disclose information to me **personally**, not to 'the researcher' (Goodwin et al., 2003). She had forgotten that there was a recorder running in the background. From a procedural perspective she had given consent, but it would have been unethical of me to continue recording or to use the information.

My largest ethical challenge, however, was with the unofficial labour ward observations (Long, Hunter and van der Geest, 2008). Midwives knew my role and area of interest. They grew accustomed to me being around, but they had nowhere to be off duty (the midwives' station was an open desk in the ward), leaving staff rather exposed. Yet the dissonance/correspondence between what people said in interviews and how they behaved in practice was extremely informative and relevant to my analysis. Where I have reported this or other incidents, I have taken care to do so without breaching confidentiality or exploiting anyone.

5.3.3 Cultural relativism

Much of the interest on how women are treated during childbirth is rooted in a Western notion of universal human rights. Human rights advocates assert the existence of these and their universal nature; cultural relativists reject universal moral standards because justifications for their existence are culturally based (Renteln, 2013). Donnelly (1984: 402) suggested that in the modern world the international consensus on the Universal Declaration of Human Rights is viewed ...*" as* prima facie *universal, but recognises culture as a limited source of exceptions and principles of interpretation."*

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[31] In making these judgements I was guided by the Association of Social Anthropologists of the UK and the Commonwealth (2011) Ethical Guidelines for good research practice.

During this research, I have tried to be mindful that there is a distinction between midwives' behaviour that feels disrespectful to me but not to Malawians, and 'universal' violations of human rights or abuse. This is of relevance, as my expectations of (dis)respectful care are based on a Western, feminist perspective on women's rights. I have tried to relate my understanding of cultural differences and the contextualised nature of midwives practising in a constrained environment with a universal rights agenda. Some of the work by Freedman et al. is useful in trying to define where that line falls, using a model which defines D&A as *"…those interactions or conditions that are experienced as or intended to be humiliating or undignified."* (2014: 916) Research from Malawi shows that women do experience care as disrespectful (Kumbani et al., 2012; 2013; Kambala et al., 2017) and their judgements should form the bar below which we do not fall.

Navigating this terrain was challenging, complicated by my emotional responses, and changing over time. On my first visit to one hospital, I saw midwives sitting around chatting, while women behind the curtains were alone, whimpering or howling with pain. I had an immediate and visceral emotional response. I found it very difficult to not **do** something, to resist the urge to go and offer some words of encouragement or support. How was it acceptable to ignore another woman in such obvious distress, to do nothing to ease that for her? The labour ward was not even busy - only three women and two midwives - so I could see no mitigating circumstances. My judgement was fast and furious. How awful they were! I had been hoodwinked! However, as the weeks passed my understanding grew, until I could see and feel what it must be like for them. How easy it was to give up under the convergence of the shortage of hands, lack of material resources, lack of status, casual disrespect from (some) clinical staff, no one listening and feeling abandoned, not being able to do your job properly no matter how hard you tried. Then on my very last day in the district, I experienced an event that made me seriously question how much I really understood. An excited midwife called me and took me to one of the curtained beds.

> *"You know my fear of a stuck head?" She threw back the curtain and exclaimed, "Here it is!!" A naked woman was lying on the bed with a face-down breechling hanging from her vagina. I was horrified - for the woman's dignity and predicament, for the callousness with which the NMT had exposed her, as though she were an object, and for the baby. I immediately backed away, apologising, mortified. There were two women sitting on chairs between the admitting desk and the bed, looking very worried. One was older, holding a small baby; the other was younger. It seemed a bit odd as guardians[32] don't usually stay in the labour ward, but I was distracted by my concern about whether they would save the baby or not. Each time someone went in (with syringes, swabs, a razor blade) the curtains wafted open and I could see the SRNM working calmly and slowly - ever so slowly. I was very anxious that so much time had*

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[32] A guardian is usually a family member who accompanies a woman to the health facility and stays to provide basic care, such as bringing food (Hoffman, 2012), but in this facility they would not normally be allowed to stay in the labour ward.

elapsed and that there seemed to be no panic or urgency to the way she and the
student were moving. It was only later that I was told the baby was already dead when
they arrived - she was a second twin, born in a health centre (which is probably 90
mins by ambulance, plus waiting time) and the mother had been transferred with the
dead baby dangling. The older woman was her mother, holding the first twin and I
presume the second lady was a sister or friend. It took about 20 mins to disengage the
head and deliver the body, which was then just put on a trolley next to the bed, not
covered, just left as she has been put down. It was heart-breaking, and I feel upset
again typing this. (Field notes, 21 May 2016)

My own personal circumstances undoubtedly influenced some of my emotional response to this. A different roll of the dice and the woman on the bed could have been me - my first daughter (ironically, the one who became a midwife) was a large, frank breech[33] who eventually was delivered by caesarean section. Despite this, it would be difficult to persuade me that there was any excuse or justification for what was done. None of the factors that cause midwives distress or make their jobs so challenging could account for treating this woman like an object, an item of curiosity for the visiting researcher. Her undignified and humiliating treatment clearly qualified as D&A (Freedman et al., 2014). As an outsider, I tried hard not to judge, but it would be dishonest to say I did not judge at all. Later, I tried to consider the many layers and different dynamics influencing both the midwife's apparent callousness and my own response, to weigh up the balance between universalism and cultural relativism. In the final analysis, however, I think there are basic rights that transcend culture and, on this day, they were not afforded to the woman on the bed.

5.3.4 Representation and voice

Before moving on to the results I want to address the issues of representation and voice, particularly in relation to the challenges of balancing a feminist perspective with a critical realist philosophy (Parr, 2014). My research drew on feminist principles to ground my research in ethically responsible behaviour and contribute to feminism's broader political aims of social change and power for women. Central to this was carrying out research that aimed to *'capture women's lived experiences in a respectful manner that legitimates women's voices as sources of knowledge'* (Campbell and Wasco, 2000, p. 783 in Liamputtong, 2006: 10). However, my epistemological position implies that some understandings of the 'real' may hold more explanatory power than others, by offering more convincing insights into the generative mechanisms that manifest in specific empirical events, such as disrespectful care of labouring women. If this is the case, these insights should be brought to the fore, with pragmatic decisions made about presenting the findings that best answer the research questions. Yet, this must be balanced against my stated feminist aim of 'giving voice' to the midwife who is often excluded from the discourse on RMC. The midwives seemed pleased that someone was interested in what they had to say. *"We midwives, we don't voice out. So*

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[33] A baby in a frank breech position has her buttocks aimed at the birth canal and her legs up in front of her body with her feet near her head.

I just want to thank you for your concern about the midwife." (NMT03) This speaks to a perceived lack of voice that will be reflected in the results chapters, particularly Chapter 10. 'Caring for the carers'.

An unavoidable issue here is the intersection of power with academic knowledge (Rose, 1997). As a researcher from a rich Northern country I had access to material and intellectual resources that allowed me to undertake the production of knowledge:

> *I have access to more narratives of experience and more interpretative tools than my respondents and I have also been 'given' more time to think and particularly to theorise about these issues than many of the people I spoke and wrote to. My presentation is filtered through my understandings, but at the same time I have made a self-conscious attempt to understand my respondents' understandings in their own terms.* (Letherby, 2002: 5.3)

Further, the knowledge generated was contextual and personal, where *"...both the scholar and the respondent construct a particular version of themselves in interviews which is then re-interpreted and re-presented in different ways in future publications."* (McDowell, 1992: 214). Indeed, the narrative approach complicated this further as narrative, by its very nature, is multi-layered and does not just occur at the level of the participant's story. The researcher's interpretation of this and of any field work done is also a form of narrative, which is subject to further construction during the process of reading as the audience develops their own account (Riessman, 2008).

It would be unconscionable to investigate women's experiences in the Global South without addressing the critique of Western researchers who fail to consider the impact of the colonial legacy, power and social inequalities in the woman-midwife relationship (e.g. Kumar, 2013). As a non-Malawian researcher, I was alive to the possibility of the misrepresentation of other women's voices, where *"the subaltern cannot speak"* (Spivak, 1994: 104). However, my aim was for the subaltern (midwife's) voice to be heard and I have attempted to minimise the possibility of participants' voices being drowned out by my own. In practical terms, I have adopted the strategy of using extensive quotes to foreground their voices, with the aim of providing a transparent and clear trail to support my own interpretations, while remaining *"fair and true to the speaker"* (Sandelowski, 2006: 481). At the same time, I am aware of the power and privilege inherent in this position. I retained control, identifying salient points, deciding whose voice to include to best make or illustrate those points. Where necessary I slightly edited quotations to improve flow and readability, but without distorting or misrepresenting the participant's meaning, intent or emphasis. In my defence, the epistemological underpinning of this research mirrored my positionality as a feminist, critical realist. Built into the analysis was the understanding that social reality is historically and culturally constructed and situated. I have used transparency and reflexivity to demonstrate my awareness that findings distilled from this research represent a reality that is partial, positional and fragile (Reid et al., 2009).

6. The setting - Malawi

6.1 Country context

6.1.1 Geo-political background

Malawi is a small, landlocked country in south east Africa. It is divided into three administrative regions (North, Central and South) (Figure 6.1) and twenty-eight districts. The largest city is Blantyre, Malawi's commercial centre and the provincial capital of the South (and home of the College of Medicine), but the capital is Lilongwe in the Central region.
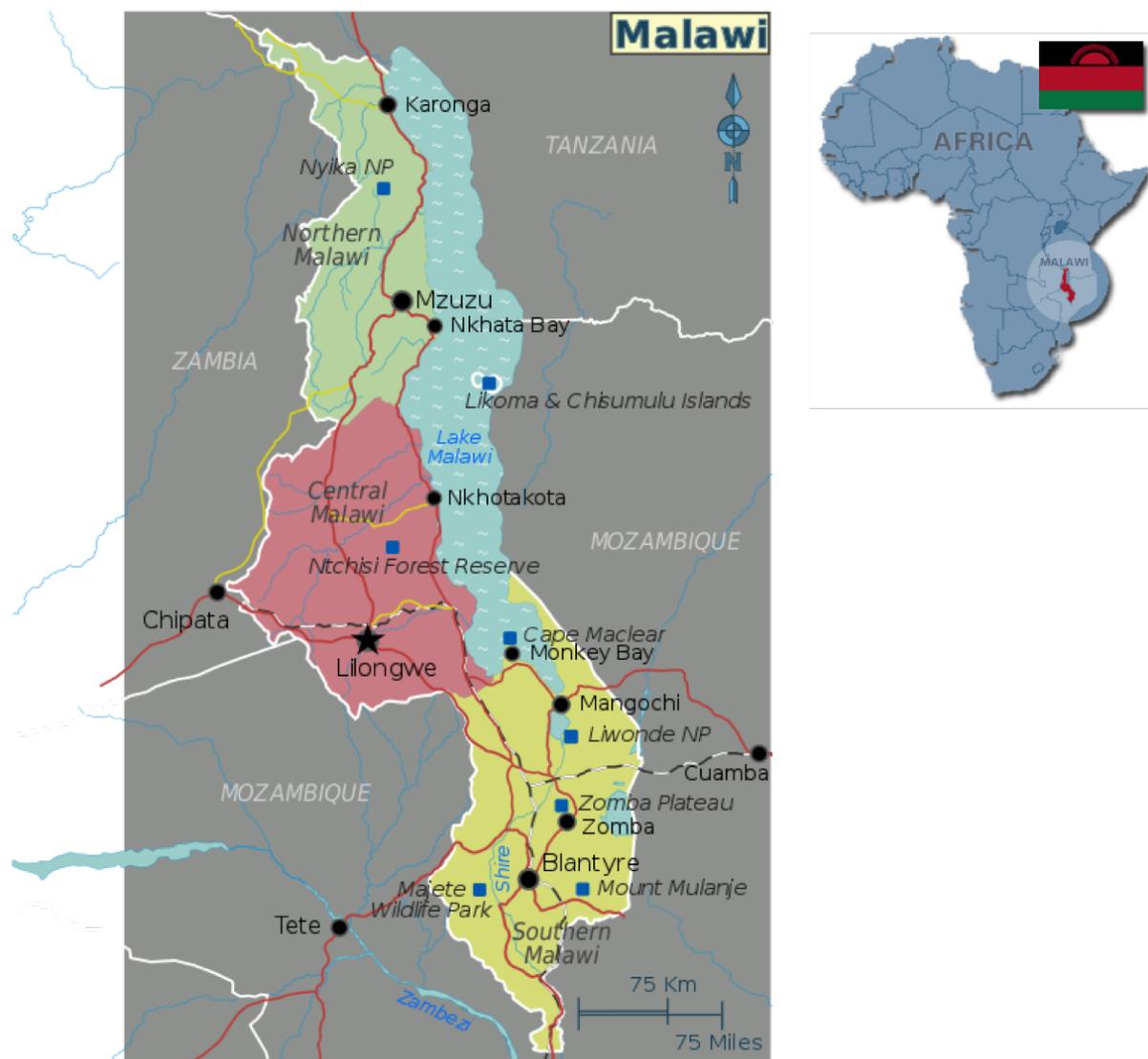
Figure 6.1 Map of Malawi and regions[34]

The country has been buffeted by colonial forces and incursions from different ethnic groups for hundreds of years, the impacts of which still reverberate to this day. The population is

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[34] With thanks to Shaundd, https://commons.wikimedia.org/wiki/File:Malawi_regions.svg

ethnically diverse. The Chewa constitute over one-third, with significant numbers of Lomwe, Yao, Ngoni and Tumbuka tribes and smaller numbers of other groups. The population is largely Christian (87%), with a sizeable Muslim population (12.5%) (Central Intelligence Agency, 2017). European influence started in the 16th century, culminating in a period of British rule with the formation of the British protectorate of Nyasaland in 1907. Independence from Britain in 1964 offered freedom, but of a limited nature, as the country endured three decades of autocratic, one-party rule under the leadership of President Hastings Kamuzu Banda. Banda maintained the country's inherited British systems, such as the legislature and the judiciary, and perpetuated British influence by imposing an Anglophone metropolitan governance structure (Lim, Anderson and McGrath, 2012). English remains an official language (along with Chichewa), used in secondary and tertiary education, including training of all health workers. It dominates in administration, commerce and the mass media. For many Malawians, economic success depends on the ability to speak, read and write English, maintaining the language's social significance as a marker of the educated elite (Matiki, 2001).

In 1994, increasing domestic unrest and pressure from Malawian churches and the international community led to the election of Bakili Muluzi in multiparty elections. Muluzi was succeeded by Bingu wa Mutharika in 2004. Mutharika's rule became increasingly autocratic, causing disquiet in the international donor and aid communities. His sudden death in 2012 handed the presidency over to the vice-president, Joyce Banda. However, in 2013, under her leadership, one of Malawi's worst financial scandals emerged (Mussa and Masanjala, 2015). Dubbed 'Cashgate', it involved large-scale looting, theft and corruption at Capital Hill (the seat of the Government of Malawi), where government officials and civil servants stole billions of Malawian Kwacha from the public purse. Cashgate had extremely negative implications for attitudes to public service. Elections in 2014 saw Peter Mutharika elected as president, but problems of systemic corruption and patronage-based politics persist.

6.1.2 Socio-economic status and health

Malawi continues to be one of the poorest countries in the world. In 2016, it was ranked 170/188 countries/territories in the Human Development Index (United Nations Development Programme, 2016), with approximately 54% of the population living in multi-dimensional poverty[35] (Oxford Poverty and Human Development Initiative, 2017). Selected socioeconomic and health indicators can be seen in Table 6.1. The country relies heavily on agricultural exports which are dominated by tobacco, tea, cotton, coffee and sugar, while 80% of the population are smallholder farmers. This leaves both state and people vulnerable to financial shocks and climatic changes, such as the prolonged, El Niño-induced drought in

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[35] The Multidimensional Poverty Index (MPI) identifies both the share of people in poverty and the degree to which they are deprived. It uses ten indicators across three dimensions - health, education and living standard.

2016 which left over 6.7 million people in urgent need of assistance[36]. Even before this, there were high levels of poor nutrition; the 2015-2016 Demographic Health Survey (DHS) revealed that 37% of children under 5 were stunted[37] (National Statistical Office, 2016).

Table 6.1 Selected socioeconomic and health indicators

Indicator		Year
Population (million)	17.75	2016
Rural population (%)	83.7	2015
Adult literacy (>15 years, female/male %)	55/70	2015
Secondary education (net attendance, female/male %)	34/32	2014
Life expectancy at birth (female/male years)	60/57	2015
Maternal mortality ration (per 100,000 live births)	634	2015
Facility delivery (% of live births)	91	2015/16
Skilled attendant at birth (% of live births)	90	2016
Total fertility rate (births per woman)	4.4	2015/16
Adolescent childbearing (% of 15-19 year olds)	29	2015/16
Unmet contraceptive need (% currently married women)	19	2015/16
HIV prevalence (15-49 years, female/male %)	10.8/6.4	2015/16

Sources: Malawi Demographic Health Survey, 2015-16; UNdata[38], UNESCO, UNICEF, WHO.

Unsurprisingly, Malawi is heavily reliant on external donor support (Danielsen, 2017) and the social sector faces considerable financial challenges. In 2016, the value of the Malawian Kwacha fell by 35%, its overall international debt burden was 40% of GDP, and debt repayments were more than 18% of government revenues (Jubilee Debt Campaign, 2017). As a heavily indebted country, it did not escape the fallout of the 1970s oil crisis and subsequent international economic recession in the 1980s. It was subject to Structural Adjustment Policies and other austerity measures meted out by the international financial powers, which were critiqued for their enduring and damaging impacts on health and other

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[36] In June 2016 when I was collecting data, food aid organisations were starting to mobilise and the final figures of those affected were confirmed by the World Food Programme.
https://www.wfp.org/countries/malawi [Accessed 18 December 2016]
[37] Stunting is a measure of growth retardation, defined by UNICEF as below minus two standard deviations from median height for age of reference population.
[38] UNdata, available from http://data.un.org/CountryProfile.aspx?crName=malawi, [Accessed 18 August 2016]

social services (Breman and Shelton, 2001; Soucat, Schleffier and Ghebreyesus, 2013). More recently, the political upheaval and rising concerns over economic management, governance and failure to uphold human rights led to donor action. In 2011, this resulted in a freeze in donor financing and suspension of all General Budget Support[39] (Department for International Development, 2012). The resulting limited fiscal space had significant negative impacts on critical services such as health, where only 9% of the 2015/16 budget was allocated to the sector (Mwanakatwe and Bhatia, 2016). This falls well short of the Abuja target set by African Union heads of state to allocate at least 15% of their annual budget to improve the health sector. These shortfalls manifest in acute and complex shortages of health workers e.g. vacancy rates for nurse-midwives around 65% (Muula, 2016)[40], severe shortages of even basic resources or drugs, and inadequate infrastructure. These have significant implications for both women and midwives.

6.1.3 Gender

The majority of women, particularly in rural areas, are controlled by sharply defined social roles and norms. Childcare and domestic chores are considered women's work, and are made more difficult by the hardships of basic life in rural areas due to poor infrastructure. For example, it takes more than 30 mins for 47% of rural households to obtain their drinking water; only 4% have electricity and 98% use firewood or charcoal for cooking (National Statistical Office, 2017). Acceptance of male authority over women is a core component of the traditional hierarchy, while gender inequities in access to employment and education, restricted land rights, and gendered expectations of women's role are socially disempowering (Booth et al., 2006; MacIntyre et al., 2013). Some women are politically active and influential. For example, 16.6% of MPs are women and Joyce Banda was Malawi's first female president, but access is bounded by class, education and social expectations, so is restricted to a very narrow socioeconomic group (O'Neil et al., 2016).

Socioeconomic and gender variations in health status are also considerable. Women living in remote parts of the country, as well as those from poorer households or who have lower education, face constraints in accessing services. These are compounded by the degree of women's control over family income and the locus of decision-making on their health care. The latest Malawi Demographic Health Survey reports that for nearly one-third of women decisions about their health care are made by their husband, with only 18.6% making their own decisions. In other areas, a trend for rising involvement of women is almost exclusively due to joint, not exclusive, decision-making (National Statistical Office, 2017).

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[39] General Budget Support is the allocation of funds that are not earmarked for particular sectors or activities, but are allocated at the discretion of recipient countries according to sector needs. They are usually agreed in line with poverty reduction strategies and are expected to have longer-term impacts, particularly on better governance. See http://www.who.int/health_financing/documents/pb_e_08_2-budget_support.pdf

[40] Muula did not cite a reference for his figures, but both MOH and CHAM officials I spoke to during data collection, and again in August 2017, consistently cited a vacancy rate of 65%.

6.2 Malawi's Health System

6.2.1 Overview and structure

In common with other countries in sub-Saharan African, the impact of colonialism can be seen in the structure of the health system (Blaise and Kegels, 2004). This was set up to satisfy the needs and health concerns of the largely urban-based colonisers and the local elite, rather than the majority rurally-based Malawians. The system has retained its hierarchical, centralised, bureaucratic nature and operates to the medical model of maternity care that was becoming predominant in Britain at the time of Malawian independence in 1964.

The Ministry of Health (MOH) has overall responsibility for health care provision in Malawi and is the main provider, accounting for 60% of formal health services. Unlike other sub-Saharan Africa countries, Malawi did not introduce user fees in the 1990s as part of Bamako Initiative[41], so public health care has been free since independence. The Christian Health Association of Malawi (CHAM), a multi-denominational, non-profit organisation, accounts for a further 37% of service delivery, as well as being a major provider of pre-service training[42]. CHAM charges user fees, but operates under a Memorandum of Understanding with the MOH so specific maternal and child services can be provided free. It focuses approximately 85% of its health service activity on the rural areas, where the majority of the population lives.

The health system is divided into 5 zones, and further sub-divided into 28 districts. While some decentralisation has taken place, this is not yet fully operational and most staffing and resources decision-making remains with the centre. In addition, there is weak coordination between the MOH (who are responsible for the district health facilities) and the Ministry of Local Government (who are in charge of decentralization). The governance structures at the district level are set out in Figure 6.2.

Administration of the system occurs at three levels. Nationally, the MOH has a regulatory role, while zonal health offices support groups of districts by providing technical, management and administrative support, including supervision. Each district has a District Health Management Team (DHMT) who deal directly with health facilities and the community. The DHMT holds responsibility for clinical and nursing services in primary and secondary level facilities, including external supervision visits. Since responsibility for human resource management (HRM) and planning is still held at the central level, districts have little autonomy to implement changes, such as employing and deploying staff, or career progression. This can make processes, such as hiring new staff, unnecessarily complex and time-consuming. It is also at odds with the Government's own decentralization process that has devolved responsibility to the districts, with District Health Officers as the focal point in the implementation of programmes at the grassroots level. However, there is poor human

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[41] The Bamako Initiative was adopted by African ministers of health in 1987. Its aim was to increase access to primary health care, providing a basic package of integrated services through revitalized health centres that employ user fees and community co-management of funds.
[42] Further information about CHAM can be found at http://www.cham.org.mw/

resource planning capacity at the district level, with many districts relying on junior grade human resources staff. This makes it difficult for them to implement changes, as they do not have the necessary authority. Further, the lack of capacity for adequate HRM at the district level is a major concern as HRM is a crucial factor in retention and motivation of staff (Willis-Shattuck et al., 2008; Bradley and McAuliffe, 2009; McAuliffe et al., 2009), yet has received very little attention in attempts to address the human resources crisis.
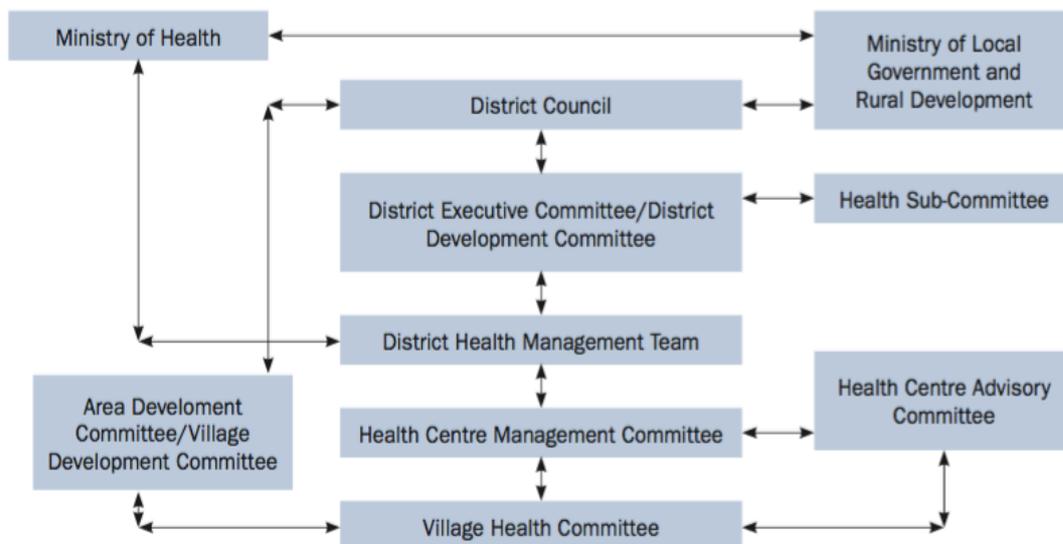
(Ministry of Health Malawi, 2012)

Figure 6.2 Governance structure for the health sector - district level

6.2.2 Policy action for maternal health

Malawi has one of the most acute human resources for health (HRH) problems in sub-Saharan Africa. An MOH report in April 2004 described the HRH situation as *"critical, dangerously close to collapse"* and the health sector as *"facing a major, persistent and deepening crisis with respect to human resources."* (Ministry of Health Malawi, 2004) Efforts to improve staffing numbers included a Malawi-led initiative, the Emergency Human Resource Programme (EHRP) (Palmer, 2006), which was launched in 2004 and targeted 11 priority cadres (including nurse-midwives) who were needed to deliver an Essential Health Package (EHP) - a group of evidence-based and cost-effective interventions that would be provided free of charge at district level. The EHP focused on medical conditions and service gaps that disproportionately affected the rural poor, and gave high priority to maternal health and the needs of children under-5. Also in 2004, the MOH launched the Health Sector-wide Approach (SWAp) Joint Programme of Work which was seen as the health sector's contribution to the achievement of the goals and objectives of the Malawi Growth and Development Strategy and the Millennium Development Goals (Carlson et al., 2008).

At about the same time, Malawi was one of the earlier countries to respond to the African Union call for member states to accelerate the attainment of the MDGs. It did this by carrying out a national assessment of emergency obstetric care (EmOC) to determine the health system's capacity to act. The needs assessment revealed poor access and utilisation of EmOC, with only 2% of the recommended number of basic EmOC facilities and cited the high case fatality rates as evidence of poor quality care (Leigh et al., 2008). The assessment informed the development of the 'Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi' (Ministry of Health Malawi, 2005). The road map's objectives were:

- To increase the availability, accessibility, utilisation and quality of skilled obstetric care during pregnancy, childbirth and postnatal period at all levels of the health care delivery system

- To strengthen the capacity of individuals, families, communities, Civil Society Organisations and Government to improve maternal and newborn health

The Road Map built upon the SWAp programme of work and the EHRP, and was further supported by the Health Sector Strategic Plan (2011-2016) whose successor was still under development at the time of data collection.

These plans and programmes have clearly articulated aims and outcomes, but have been subject to changes in the wider international policy arena. One of the most relevant challenges for this study has been Malawi's position, caught betwixt and between[43] medical and social models of care. It has been buffeted between the international community's oscillating policy positions on the (dis)utility of traditional birth attendants (TBAs), variously recommending training or sidelining them, and the globalisation and normalisation of technical birth regarded as modern and superior (Sarelin, 2014). Despite the MOH's best efforts to encourage facility-based birth, Malawian women continued to use TBAs and figures for facility-based births plateaued at around 50-55% for most of the 2000s. Therefore, in 2007 the government decided to ban TBAs, using traditional leaders to enact customary laws and sanctions to shape women's behaviour and effectively coerce them into a model of a birth that does not address their psychosocial and cultural needs (Danielsen, 2017). Further, women are caught between two types of authority - that of the medical expert mediating the purely biophysical matter of birth and the TBA who has traditional, cultural and spiritual authority to safely navigate the birth process (Sarelin, 2014). It is not only rural or marginalised women who are affected by the denigration of indigenous ways of knowing and the intersection of medicalisation with notions of modernity and development. In the wake of the TBA ban, facility-based birth rates have risen dramatically to 91% (National Statistical Office, 2017). However, staffing levels have not increased correspondingly, leaving far too few midwives for the huge demand that has been generated.

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[43] The Oxford English Dictionary (2017) defines 'betwixt and between' as: "in an intermediate or middling position; neither one thing nor the other."

Malawi's efforts to address maternal health are heavily reliant on nurse-midwives to provide key services, but despite significant efforts and increased output from training institutions, there are enduring and significant shortages of the key cadres involved - state registered nurse-midwives (SRNM) at degree or diploma levels, and nurse-midwife technicians (NMT). A 2010 assessment of nursing cadres found vacancy rates of 64% (MOH) and 71% (CHAM) for SRNMs and 72% (MOH) and 58% (CHAM) for NMTs (Ministry of Health Malawi, 2011b). Training and retention of nurse-midwives are therefore crucial priorities.

6.2.3 Midwifery training and progression

All Malawian midwives are initially trained as nurses, then follow a compulsory additional midwifery programme to qualify as a nurse-midwife[44]. Although for many years the United Kingdom has increasingly moved towards training people directly as midwives, without nurse training, this dual model has persisted in post-colonial Malawi as a deliberate policy option to address the serious human resources for health shortages. In addition, it continues to be taught in English with a curriculum that includes diseases and references to materials that are not readily available, nor common, in this context. Importing a curriculum from a high-income context and across cultural (UK to Malawi) and linguistic (English to Chichewa) boundaries is fraught with problems, not least the assumptions of shared meaning and understanding of some of the attitudinal constructs of respect and dignity. Further, the available training privileges technical skill in a context where local constraints may make this unachievable.

Another strategy to address human resource shortages has been the use of mid-level cadres. In the early 1990s, the Nurses and Midwives Council of Malawi (NMCM) advocated for policy to focus on degree-level nurses, forcing the closure of an enrolled nursing auxiliary programme. However, this plan did not serve Malawi well as the higher entry requirements for degree nurses and the cost of lengthier training dissuaded many candidates. This, combined with the international marketability of degree-level nurses, left Malawi with an acute shortage of nurses, as 79% of all registered nurse-midwives trained between 1993 and 2002 emigrated (Gerein, Green and Pearson, 2006). In response to the crisis in nursing numbers, the enrolled nurse course was reintroduced in 2003, then later upgraded to an NMT diploma programme.

The NMCM organizes midwives in Malawi into two levels. Level I is made up of professional, registered and advanced nurses-midwives. Professional midwives are degree-level SRNMs who play managerial and decision-making roles at secondary and tertiary levels of care. These staff are concentrated in urban areas and represent about 9% of the nurse-midwife workforce. Registered midwives are diploma-level SRNMs who are not considered 'professional' but act as ward in-charges where degree-level SRNMs are not available, usually at the secondary level of care or in larger health centres. Advanced midwives have Masters or PhD qualifications. Level II is made up of the nurse-midwife technician (NMT)

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[44] As a reminder, all the staff I spoke to worked in the labour ward, so I have referred to them as midwives throughout the Results and Discussion chapters.

cadres, diploma-level staff who are considered a 'technical' grade and not categorised as professionals. Level 11 also includes enrolled nurse-midwives, a cadre who have been phased out. Diploma-level midwives make up 69% of the workforce. They carry out many of the tasks which would usually fall within a SRNM's scope of practice, an example of task-shifting in the absence of the higher-grade cadre. Mid-level cadres, such as NMTs, are considered a pragmatic and cost-effective solution due to their shorter training time, lower salary costs and willingness to remain in the rural areas (Dovlo, 2004). However, they may not have sufficient skills and diagnostic abilities, leaving rural facilities underserved and with less qualified staff (MOH, 2007). The NMT cadre also need supportive supervision and responsive human resource management, which is a significant challenge is this context (Bradley et al., 2013). There are also a significant minority of midwives, mostly older, who were trained to certificate level.

More recently a new cadre of Community Midwifery Assistant (CMA) has been introduced (Bell et al., 2014). The aim is for the CMA to take over the role of the TBA, but there are significant concerns about the lack of enabling support structures and supervision for them in the community. Deskilling of the health workforce is also seen in the number of health surveillance assistants (HSA), who now represent 30% of all health workers. HSAs are a type of community health worker who undergo a 12-week training and carry out health promotion and prevention for a population of about 1,000 (Ministry of Health, 2009). The same caveats about inadequate supervision also pertain to these cadres.

Standards and competencies for nurse-midwife education are overseen and accredited by the NMCM. However, training institutions are free to shape their own curricula. Training of NMTs is carried out by CHAM or Malawi College of Health Sciences (MCHS). CHAM is an important partner in nurse education, training 77% of all Malawi's nurses at 12 training institutions across the country, mostly in rural mission hospitals. MCHS is run by the government and its campuses are located in the main cities of Lilongwe, Blantyre and Zomba. MCHS also offers a diploma SRNM course. Degree-level nurse-midwives attend Kamuzu College of Nursing (KCN) or Mzuzu University, which are both constituent colleges of the University of Malawi. In 2016, KCN offered the first direct-entry bachelor's programme in midwifery, with an intake of 20 candidates. Only one CHAM institution offers a degree level nursing course, with a curriculum that is roughly similar to that of KCN (Training institutions-NMT, personal communication, August 2016). The type and duration of courses on offer can be seen in Table 6.2.[45] Midwives holding a BSc qualification are eligible to apply to progress to Masters in *Nursing* and Doctorate in *Nursing*.

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[45] Information on the courses available was obtained from relevant organisational websites.

6.2.4 Professional associations and representation

Once midwives are qualified, there are three key organisations[46] involved in their care and welfare. The regulatory body is the NMCM, a statutory organisation established in 1966, responsible for registration and re-registration of nurses and midwives. The mission statement on the NMCM website highlights its other roles, stating, *"Nurses and Midwives Council of Malawi exists to regulate nursing and midwifery education, training and practice in order **to protect the public."*** (my emphasis). Protecting the public involves investigating complaints against staff. Since 2010, the NMCM has also been involved in the provision of mandatory continuing professional development, in line with the requirements of the Nurses and Midwives Act of 1995 (Chilomo, Mondiwa and Wasili, 2014).

Table 6.2 SRNM and NMT qualifications offered, by organisation, 2016

Qualification	Organisation/course duration (years)			
	KCN	Mzuzu	CHAM	MCHS
BSc Midwifery	4	x	x	x
BSc Nursing and Midwifery	4	4	4[a]	x
Diploma in Registered Nursing and Certificate in Midwifery	x	x	x	4
Diploma Nursing and Midwifery Technician	x	x	3	3
Upgrading to Diploma in Nursing and Midwifery	x	x	2[b]	4[c]
Upgrading to BSc in Nursing and Midwifery[c]	2[d]	x	x	x

[a] Currently only offered in Daeyang Luke and Nkhoma training institutions
[b] CHAM has plans to offer a 2-year 'fast track'
[c] Eligible applicants must have at least 4 years' experience of nursing and midwifery as an NMT
[d] Eligible applicants must hold a diploma as SRNM and have at least 2 years' experience in either nursing or midwifery

The Association of Malawian Midwives (AMAMI), established in 1997, is a registered NGO and member of the International Confederation of Midwives (ICM), who exist *"…to **advance the welfare of midwives** (my emphasis) and promote their significant role in improving healthy outcomes for child-bearing women, newborns, and families."* AMAMI is engaged in lobbying and advocacy, including working with the White Ribbon Alliance to address RMC, but also lobbying the government to improve the working conditions and welfare of midwives. It is also a core member of a key stakeholder task force *"…to develop a Midwifery Strategy for Malawi. Working with NMCM in development of direct entry into midwifery aligning the syllabus to global standards for midwifery education and including essential competencies for*

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[46] All quotes are from the websites for these organisations, which can be found as follows: the NMCM at http://www.nmcm.org.mw/; AMAMI at https://malawianmidwives.wordpress.com/ and NONM at http://www.nonmmw.org/. [All accessed 18 August 2016]

basic midwifery practice." Their capacity building efforts include in-service trainings and educational activities at all levels of the health system and periodic publishing of newsletters and pamphlets.

Finally, the National Organisation of Nurses and Midwives of Malawi (NONM) is a trade union, which describes itself as *"an independent, non-partisan, non-governmental and professional organization representing nurses and midwives of Malawi. Its goals are to safeguard nurses/midwives' professional, organizational union and social economic interests; and to influence nursing education and nursing practice, thereby serving the population of Malawi."* It works to improve retention and conditions of service; runs continuing professional development activities; and provides legal representation and advice for nurse-midwives who are being investigated by the NMCM.

Summary

The Malawi context is challenging for both women and midwives. The country is heavily reliant on donors which limits agency and has left the health system severely constrained. The impacts of poverty, low levels of education and a high burden of disease are exacerbated by the status of women and are significant factors in accessing care. Despite policy action for maternal health, the country still has an unacceptably high maternal mortality ratio. This has not been helped by introducing a traditional birth attendant ban without first ensuring there were sufficient midwives to cope. The acute shortage of midwives, a dual nurse-midwife qualification and the reliance on unsupervised and unsupported lower-level midwifery cadres can lead to low quality of care. Malawian midwives have been left struggling to meet the demand for facility-based birth, often without the necessary resources to do so, while women are forced to forgo a traditional, social model of birth.

The consequences of these dynamics will form the basis of the following chapters.

7. Betwixt and between - the broader postcolonial context

Introduction

In this short chapter I discuss participant data which suggest that Malawi's colonial history has generated a series of 'betwixt and betweens', states of being 'caught in the middle', that hinder the realisation of women's rights to RMC during labour and delivery. Applying a postcolonial lens, key informant perspectives were captured to identify macro-level cultural, organisational and professional barriers to RMC in this low-income context. The chapter content is based on the analysis of 26 interviews with midwifery leaders and other experts in Malawi and its purpose is to situate and clarify a number of key contextual drivers impacting on the provision of RMC. Considering the context is important because it provides a backdrop that informs the subsequent results chapters.

I also want to flag up two other 'betwixt and betweens' which were relevant but have not been included here because they will be addressed in the next chapter. One was key informant perceptions of the inherited British model of the dual nurse-midwife role in Malawi (Section 8.1), where there were questions about the utility of this model for Malawi in terms of midwifery skills and attitudes, but also concerns that the country was not ready for change. The second was the linked exploration of the pressures from external actors in the agenda to professionalise midwifery (Section 8.4) as a way to improve RMC and quality of care more broadly.

This chapter contains, *inter alia*, the concept of *uMunthu* mentioned in Section 1.6.1 where I discussed postcolonialism as a theoretical frame. The *uMunthu* theme here is also informed by academic and professional work at the College of Medicine (COM) focused on ethics, morality and social capital (Mfutso-Bengo and Masiye, 2011). This work resonated with some of the insights emerging from the key informant interviews and heightened my awareness of the relevance of *uMunthu* as a philosophical and analytical frame that could be employed to better understand participants' comments. It also justified the weight I have given to this communal worldview, even though it was frequently implicit, rather than explicitly stated in the data. However, I believe it provides a realistic reflection of current, pervasive concerns in Malawi, which will be illuminated below in Section 7.1.

Permeating the chapter is a sense of Malawi caught between traditional values of *uMunthu* and democracy, between tradition and modernity, rights and responsibilities - creating uncertainty, ambiguity and conflicting influences. My informal data bear witness to this. Everywhere I went people wanted to talk about politics and the state of the nation - a retired civil servant on the bus between Blantyre and Lilongwe; a high court judge at a dinner party; the families whose homes I stayed in; my COM colleagues and other academics; but also an articulate and ambitious bicycle-taxi driver who had achieved good results in his school exams but had no hopes of an office job as he lacked the necessary connections or financial inducements. There was a notable sadness and frustration among older Malawians that the promise of independence and the sense of freedom when they moved to multi-party

democracy had not translated into tangible benefits for the people. They described behaviours and disregard for their nation state that many considered immoral and against Malawi's interests and integrity, but felt powerless to stop. Many worried about what they saw as the falling standards in public life and the impact this has had on the potential for transformation, suggesting that this has evaporated and the system is failing. One, who was more senior in the public sector, described coming under significant pressure to be involved in bribes and corruption, and the personal danger in speaking out or refusing to cooperate. Lack of leadership, accountability and ethical behaviour were key concerns. However, it must be noted that the informal interactions I had were almost exclusively with educated Malawians who spoke English, so may not reflect the concerns of the wider populace.

I must also acknowledge that some of the key informants were well known to me from my previous research work in Malawi, or were good friends of my colleagues at the COM, which perhaps fostered a more heightened degree of candour than would have been the case with a stranger. However, many of the concerns they raised were also articulated to me by people I had never met before. Some issues were clearly difficult for them to discuss, particularly criticism of the Ministry or the inter-agency rivalry among some of the midwifery leadership, but some participants very much wanted to speak despite fear of repercussions, although others were afraid to do so on the record. Further, the interview quotes cannot capture the body language and tone that filled in some of the gaps and enhanced my confidence in my interpretations - raised eyebrows, knowing looks, hands thrown up in exasperation, the range of emotions captured in facial expressions (e.g. sadness, disgust or anger).

7.1. The colonial legacy and the impact of democracy

This first section addresses the colonial legacy and the emerging macro-level picture of a country caught betwixt and between traditional '*uMunthu*' values and the recently-won but, according to participants, '*misinterpreted*' concept of democracy. It covers participant perceptions that the advent of multiparty democracy in 1994 caused a cultural shift where the emphasis moved from the colonial legacy of Victorian moral ethics, via a three-decade autocracy post-independence under Kamuzu Banda, towards personal rights and freedoms but without the responsibilities that support the realisation of everyone else's rights too. This has been in part a linguistic issue, where insufficient importance was accorded to the need for consensus on translating abstract ideas across cultures, but translation has also been problematised as *"…a cultural and political process, its own situational characteristics obscured by human rights activists' commitment to abstraction and universalism."* (Englund, 2006) Englund's critique also suggests that the *mis*translation of rights as individual freedoms serves to shore up the elite and has obscured and silenced the corresponding rights to entitlements and social and economic rights, particularly among the poor.

The most notable of the 'betwixt and betweens', mentioned by nearly two-thirds of key informants, was the impact of democracy. This was widely blamed for the general erosion of

responsibility and accountability in the public sector, with many participants feeling that this was due to Malawians' misinterpretation of what democracy entailed. There was a strong feeling that not enough attention had been paid to the responsibilities that are necessary to underpin democracy's freedoms.

> *Since 1994 people have used '**my** democracy' as an excuse to do things that are wrong. And very often that is the statement that you hear from people, 'Oh, it's my right to do this, it's my right to do that'…then the people who are supposed to be managers or leaders just listen to that, and don't take it up and tell people 'you know **your** rights are just as far as your hand goes'. Beyond that you are encroaching on somebody else's right. And the patient has also got rights and you have got an **obligation** to make sure her rights or the family's rights are respected…We have really misunderstood the word democracy, to mean that I can do anything without the responsibility part of it.* (KI27, Senior advisor)

Many informants suggested that this had resulted in a lack of respect for, and obedience to, authority and generated poor attitudes to the civil service, permeating all levels (including the health sector, which warrants separate consideration and will be covered in the following section). Some key informants felt this had fostered a mindset that the public sector belonged to no one, rather than belonging to everyone, and had allowed public money and goods to be misappropriated with impunity. Those who discussed this issue described the governance system using words such as '*decay*', '*rotten*' and '*corrupt*', and characterised by egregious behaviours from top to bottom. *"People are not interested in being transparent when they are doing things. And even though we have rules and regulations in place, on how different professionals should work, I mean that is not the way our government works these days. Things have changed."* (KI07, Academic) Manifestations included the much-publicised Cashgate Scandal,[47] where billions of Kwacha were stolen from the public purse. Another was what was described as the widespread practice of civil servants taking salaries for work they had not done. Interestingly, only two key informants addressed this, yet numerous informal discussions demonstrated that it was common practice for many senior health staff to carry out full-time private practice or work for NGOs during their MOH-paid working time. *"…this doctor, this nurse, is going to the private sector **within** the period she was required to work. And this is more common **here** in urban areas, central hospitals. For example, at* [name of hospital] *according to our records we find that let us say 78 doctors, but when you go there you hardly find them."* (KI23, MOH) The impact of this dual payment and other waste of resources was blamed for causing considerable challenges in paying adequate salaries or equipping the health system.

> *Most people feel that, and I do as well, that the resources out there might be adequate to run the health system, but there is a lot of misuse of government resources…*

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[47] See for example Mussa and Masanjala (2015: 22) who described Cashgate as *"the biggest financial scandal in Malawi's history. Government officials allegedly exploited a loophole in a computer-based information storage system to divert up to $250 million (225 million euros) from government coffers."*

There's all this money that is being taken out of government, which means that government has the capacity to pay people well, but they are not being paid. (KI07, Academic)

Another participant captured this state of being caught 'betwixt and between':

…where we are neither modern...looking at modernity in the sense of looking at aspirations of modernity, human rights, transparency, good governance...Or traditional, where we are based on our traditional values, moral values, and that was what was controlling us, the internal controls of moral values, taboos and all that. (KI24, Academic)

Some respondents found it hard to reconcile the individualistic behaviour and lack of responsibility they saw in people's public life. *"That is what also disturbs me, as to why are people disconnecting their behaviour in their own settings and their behaviour in the facility?"* (KI21, Midwives' representative) This was felt to be in stark contrast with their behaviour in everyday, private life where Malawi's cultural norms of respect, dignity and the importance of community and connection were upheld – all key aspects of *uMunthu*. Many spoke of the need to return to and reinforce proper values and attitudes, particularly in the workplace, with a focus on professionalism and moral behaviour.

That's [uMunthu] *in our culture, but we have started losing it...That's why if we are training people, we should also look at not only what is **appropriate** knowledge, but we should also look what are appropriate skills, and then we need to look and say what are appropriate **virtues**...because it is the **character** which translates knowledge and skills to become the best practice.* (KI24, Academic)

However, more positive perspectives on democracy were also voiced. These included the growing human rights discourse addressing the gaps between women's rights on the one hand and midwives' responsibilities on the other. These were reflected in a growing awareness among midwives of women's rights to respectful care, which will be discussed further in Chapter 9. 'Relationships with women'. However, they argued that it remains the case that many rural women do not know their rights. *"If you don't know what you should be getting, what care should be provided, then you are easily abused."* (KI25, Training institution-SRNM) In the early 2000s, a Charter of Patients and Health Workers' Rights and Responsibilities[48] was produced. The aim was to display the Charter clearly in all wards, but I did not see these in any of the labour wards I visited. One key informant's rationale for their absence revealed the parlous state of health finances. *"They* [Charters] *were there, but they were papers like this* [showing standard photocopy paper]…*It's because we don't have enough resources! If we don't have drugs in the department, can we laminate this paper?…Look at us!"* (KI12, Training institution-NMT)

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[48] Available from http://medicalcouncilmw.org/patient_charter.html

The impact of advocacy and development work, combined with revelations about corruption and misuse of the public purse, was thought to have caused an internal shift where the population were becoming increasingly aware of their rights, both as citizens and as consumers of services. *"…many people, even the rural areas, they have discovered that if somebody is stealing medicine, it's **our** medicine…They have realised that 'OK if money is being stolen, the price of bread is going up'…But now people are coming to know that these* [health workers and other civil servants] *are our servants."* (KI24, Academic) Conversely, health workers in the public sector were reported to not be aware of this. *"They don't want to connect that the person sitting in front of them, much as they have come to a free public service, they are a tax payer…and their taxes is what has given them employment."* (KI21, Midwives' representative)

Some key informants clearly articulated their unease that the '*misinterpretation*' of democracy allowed women's rights to be seen as subordinate to those of midwives. Respondents talked about a range of measures that were directly targeting the issue of actively realising people's rights. At the national level, the right of a person seeking health care to be treated with dignity had been embedded in the constitution. Various actors (e.g. the WRA Malawi, ICAP[49]) were partnering with the Association of Malawian Midwives or were working with the NMCM to embed RMC into teaching curricula, codes of ethics and scopes of practice. These efforts had been bolstered by increasing voice and complaints from communities themselves, who were starting to demand better care via health advisory committees or direct to the NMCM. Participants also outlined a range of activities at facility level, such as orientation days, customer care training and community score cards, as well as the role of civil society organisations and NGOs (e.g. World Vision's Citizen Voice and Action project[50]) in increasing awareness and trying to bridge the gap between health workers and the community. As we shall see later (Section 10.3), in some facilities committed champions were leading by example and trying to foster organisational cultures that promote the well-being of women and midwives. A further positive aspect cited as an impact of democracy was the articulation of midwives' rights as professionals, citizens and employees. These factors will be covered in detail in Chapter 10. 'Caring for the carers'.

A final positive outcome of the struggle that informants described with democracy and corruption was their recognition that things could not remain as they were and an articulation of the need for change. Discussing the transition to a new order, moving from the Victorian moral ethics that underpinned the colonial era and which were later encapsulated under

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[49] ICAP is a global health project of Columbia University's Mailman School of Public Health in New York. In Malawi, ICAP has partnered with the Government of Malawi since 2011 to strengthen health education by building the capacity of health training institutions, enhancing teaching and learning in the classroom and clinical settings, and using innovative curricula to reduce time to accreditation, as well as supporting the development and implementation of higher degree programs to support the scale-up of the healthcare workforce. http://icap.columbia.edu/where-we-work/malawi

[50] Citizens Voice and Action mobilises and equips citizens to monitor government-provided services, using an advocacy methodology to effect improvement when these services are inadequate.

Banda's autocratic rule as four cornerstones of Unity, Loyalty, Obedience and Discipline, one key informant continued:

> *And after the 1994, when we become democratic, they* [Banda's four cornerstones]
> *were abolished, so they said we don't need. To only now, the new government has*
> *said, 'No, let's go back and have new pillars of ethics for our development'. And as*
> *foundation pillars, they are now three pillars, called patriotism, integrity and hard*
> *work...At the moment in Malawi, because of the Cashgate and its implications, people*
> *see that bad leadership affects them. This is a right time now, a right moment for*
> *Malawi actually to change…There are some people who are emerging and who want*
> *to take advantage of this. For example, there is National Reform Agenda, which is*
> *from government. It's faced a lot of resistance, but people now they feel that there is*
> *no choice…even in the villages, every person, normal people are saying 'we need to*
> *change'…we can say even the Chief Technical Advisor, the Chief Medical Officer, Dr*
> *Charles Mwansambo, is a person who is trying to do his best. The new Minister of*
> *Health is doing well, trying to reform, to fight corruption…So things are moving, things*
> *are moving.* (KI24, Academic)

7.2 Attitudes to the health sector and authority

In this section I briefly draw out some of the manifestations of poor attitudes to the public sector that were raised in the interviews through the lens of maternity care. This theme is a thread woven through the following chapters, reflecting a range of concerns from participants about the impact on, *inter alia,* who gets to be a midwife, organisational culture and challenges in establishing a therapeutic relationship with women. I show how poor attitudes have been exacerbated by the absence of strong, authoritative leadership at the national level and look at the implications of having managerial responsibility without power. This section ends on a more optimistic note with the proposed rollout of decentralised powers to the district level, offering some hope of improvement.

7.2.1 Leadership at the national level

Participants voiced widespread dismay at what they experienced as the absence of strong leadership within the health service, assigning blame for the poor attitudes in maternity care (and health care more widely) to a midwifery leadership that many saw as ineffective. Malawi's links with the UK, coupled with the practice of continuing secondary and tertiary education in English, had facilitated a well-documented 'brain-drain' of highly skilled health care professionals (Muula, 2005) to English speaking countries, although this has slowed of late. As Buchan noted, *"…if you are an English-speaking nurse with an internationally recognized qualification, the world is your oyster…"* (2006, p. 17S). One consequence of this, mentioned in scathing terms by a key informant, was the impact on leadership.

> *Currently I would say we have a problem in leadership roles. I don't think we have the*
> *right people who are holding the key positions. We have had this brain drain, which*
> *left most of the weak nurses in our public hospitals. I am sorry to say it. The strong*

nurses, they went abroad because they could survive. The weak nurses remained behind. And if I am saying weak, you know what it means. (KI22, Training institution-SRNM)

Others characterised their leaders as lacking skills or having a laissez-faire approach, or felt they seemed to be waiting for someone else to fix things.

*...when I look into the profession I surely see that it is like people don't know what they are supposed to be doing. You know even at leadership I see a lot of gaps. The things that they need to be **fighting** for, **advocating** for, ensuring that things are going to be done. It's like they are spectators or something.* (KI17, Senior advisor)

There were oblique references to disempowerment, and one participant felt that donors have been complicit in corruption as they have not wielded their power for the good, particularly in the area of accountability. *"So the donor community is also part of the game, because they would have been instruments of change…"* (KI24, Academic)

A further challenge, reported by a subset of five participants, concerned inter-agency tensions among the midwifery leadership that centred on relationships with NONM, the nursing and midwifery union. The union themselves were well aware that some viewed them as trouble makers, who wanted to shame the government, but felt these opinions were due to misunderstandings about their role. However, there were robust criticisms of the trade union organisation from two senior midwifery leaders, with one commenting, *"…it has destroyed nursing and midwifery in this country because of this same misunderstanding of what democracy means, what rights mean."* (KI27, Senior advisor) Whilst a Chief Nursing Officer also thought the union had caused some challenges, there were clearly other factors at play in this disunity which spread wider than NONM, with *"…each entity doing its own thing…not communicating or relating to the others, maybe because of the attitudes that were there…so it was all blaming each other."* (KI20, Midwives' representative) A more detailed explanation of the prevailing dynamics, which illuminates the relationships between the leaders, bears presenting in full.

*Malawi being a small country…even those who are leading these unions and associations, whatever, they have been **colleagues** with most of us…So I know this one, we were together in college, or maybe she was ahead of me, or whatever. So definitely it shouldn't be difficult to talk to each other because we are in the same circles. But definitely these issues, this pulling up and down, even those members who are in the Ministry headquarters, some of them can even be a colleague to some of these people who are leading these issues. Even some of them were below them, under them. Even some of them were their lecturers before. So that mentality is the mentality that has made, to me, has made even these characters and some of the attitudes to go a bit wild.* (KI26, Midwifery manager)

Participants were aware that the absence of strong leadership was destructive for the development of the profession and voiced an appetite to *"…focus on the leadership to guide*

the whole profession, that we need to reform to go to the world-level midwifery and nursing…not only by talking, but also by doing." (KI18) There were references to the need to listen *"Because **nothing** is changing!"* (KI20, Midwives' representative) The NMCM had set up a Nurse-Leaders Technical Working Group[51] the previous year, but when I asked about this people seemed vague about its progress and I was told, *"I know we had an action plan. But I don't think we have carried it through…because this leadership forum is an annual event, so I think we will have to get back together, and see why we haven't done what we said we would do."* (KI21, Midwives' representative)

However, indications of a more cohesive and united front were emerging. A positive impact of democracy on the health sector was the increased awareness among nurse-midwives of their rights, who were now finding their voices had an impact.

…if the heads are fighting, the ones that feel the effects, the bad impact, are the younger ones on the ground…it's all impacting negatively on the members. And one of our evaluation…was it 2014, the members highlighted the issue that they wanted to see a change in our relationship with the Nurses and Midwives Council…So they demanded that…The nurses have been seeing what is happening there, so we need to change for the better. (Midwives' representative[52])

In addition, a number of participants reported that the current Director of Nursing and Midwifery Services and the new Registrar of the NMCM had previously been members of the union, generating growing optimism among some key informants that these agencies would now start to work together. These three leaders plus a senior midwifery tutor from Kamuzu College of Nursing currently form 'the QUAD'[53] which will bring them together in a further platform for collaborative working.

7.2.2 Accountability and sanctions

Absence of strong leadership intersected with perceptions that systems or structures to ensure accountability were inadequate. Most participants felt that poor performers or those who did not do their jobs faced no sanctions for their actions, resulting in normalisation of poor practice. The quote below gives a snapshot of the impact this had on attitudes to care of patients, professionalism and work ethics.

*It has become normalised that you can say whatever you want to the patient, you can **leave** the patient. Even reporting, I mean people going off duty without reporting how they have left the patient. People going to lunch and staying for three hours, leaving the patient and nobody says anything. People coming on duty at 9 o'clock instead of half past seven, and nobody says something. So, it has become '**normal'** in quotation*

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[51] Interestingly, midwives are not named but simply subsumed under 'nurse'.
[52] Individual identifier removed to preserve confidentiality.
[53] One of 11 country teams of nursing and midwifery leaders in the African Health Profession Regulatory Collaborative for Nurses and Midwives (ARC), a President's Emergency Plan for AIDS Relief initiative. This targeted national issues affecting the health workforce, promoted south-to-south learning and provided funding and technical assistance for country-driven small grant projects.

marks [sic] *for people to misbehave, because they know that nobody is going to do anything.* (KI27, Senior advisor)

These views were mirrored at the district and organisational levels where, despite roles being clearly defined, managers (such as Human Resources Officers (HRO) or matrons) had positions of responsibility without authority and lacked support from line managers. Some reported upward bullying or vertical violence, which made them fear holding others to account. *"Managers can be threatened, 'You do this to me, we will fight'. So managers will fear to discipline that person. Managers can be told 'If you do this, don't be surprised if something happens to you'. So they will not even be able to act."* (KI07, Academic) Indeed, two HROs I spoke to corroborated this. Both were afraid to talk to me on the record. One had been personally threatened with killing or beating for following the existing labour laws and the organisation's disciplinary protocols, and was so burnt out and frustrated that they were considering moving on to a less stressful post. Another, in a different organisation, feared reprisals if the management knew they had talked to me, describing discipline and sanctions as hot political issues. Anyone instigating some form of sanction faced physical or political threats, while shielding of poor performers with good connections was reported to be widespread. HROs then found themselves responsible but lacking authority to take action, facing pressure from matrons who wanted them to resolve problems with troublesome staff, but having to wait for decisions from seniors in the MOH which might never materialise. From the MOH perspective, however, managers were expected to address many issues at the district level. *"…people **fear** each other. They don't want to wear the **bad** name that they have cautioned somebody. So, in most of the cases, they refer to headquarters, but now that has to go because we are going towards decentralisation."* (KI23, MOH) Key informants felt that nepotism and favouritism had an extremely negative impact on efforts to hold health workers to account. One manager reported her own efforts to remove a midwife who had not presented to work for many weeks and refused to take any phone calls to explain her absence. *"I instructed the HR to block her salary. So that month she didn't receive her salary. It's when she came out!"* However, the errant midwife was a friend of the respondent's supervisor. *"So she connived with my supervisor, so the supervisor was shouting at me, 'Why did you do this to this nurse?'…and by the end of the day the supervisor wrote a letter to the bank…So, she got back her salary!…and she continued staying at home."* (KI03, Midwifery manager)

Further, this type of behaviour was reported to be clearly implicated in poor performance. Examples included confusing people's moral compass when *"…somebody is getting promotion and yet he didn't do well, because he is being favoured…"* (KI24, Academic) or a report of a District Nursing Officer (DNO) who sent midwives she did not like to the worst facilities. *"In the survey we did, there was this midwife who said, 'I've never been to a health centre with electricity…if you are in bad books with her* [the DNO]*, she will be moving you in those hard to reach, very poor infrastructure health centres'. So this midwife who is moving*

in very bad health centres, do you expect her to do the right things? No, she won't." (KI13, NGO)

Participants described the overall impact of the ubiquitous lack of sanctions, which was to normalise poor attitudes to public service and reduce standards of care. *"So some people will copy that behaviour. 'If this one is doing that, but is going unpunished, why can't I do the same?'"* (KI04, Midwifery manager)

7.2.3 Hiring and firing

A frequent refrain when leaders tried to discipline staff was, *"Don't tell me what to do. I work for the Ministry, I don't work for you!"* Many key informants were sure that a change to health systems policy that gave districts the authority to 'hire and fire' staff would make a profound difference to their ability to raise standards. A common theme among key informants was that a midwife behaving badly in a public health institution would act differently if the context was changed, such as moving to a private hospital or an NGO, because poor behaviour would not be tolerated. Many cited the organisational structure in CHAM facilities, where firmer leadership and closer supervision, a shorter and clearer chain of command, and the authority to dismiss staff if necessary, were viewed as important influences in maintaining positive staff behaviours. A positive initiative in the reform agenda (mentioned in the previous section) was the move, after more than 20 years of rhetoric on decentralisation, to roll out power to the districts. At the time of data collection an initial pilot project was being planned that would give control to five district assemblies. This left a number of participants cautiously optimistic that things might change and that, *"…when that autonomy comes, I think we will have some power over them* [health workers]*."* (KI04, Midwifery manager) Another felt that it would get the employer-employee relationship off to a good start.

> *If I hire you, it means am creating a relationship with you…we should be able to hire people they have confidence in, not getting people from wherever, they don't know what kind of people they are, just imposed on them. And because of that system, it is very difficult for these managers to discipline this person. After all, she was not employed by you…* (KI05, Training institution-NMT)

In addition, decentralisation offered the opportunity to stop the process whereby newly qualified staff were in such short supply that they were deployed without being interviewed. A human resources representative felt that this had caused problems, not only in facilitating 'ghost workers'[54], but also reduced levels of performance and integrity as there was no competition for posts. *"Because when you are interviewed you are asked all sorts of questions, and when you pass the interview, you **know** that you have fought for the post in which you are."* (KI23, MOH)

Taken together, these distortions of leadership and accountability reinforced the lack of respect for authority in general, which was articulated in the previous section. At the same

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[54] Staff who are on the payroll, but not working.

time, the use of a generic label of 'the leadership' revealed confusion about specific levels of authority and responsibility, with participants sometimes struggling to articulate who was in charge or where responsibility lay.

Summary

This chapter sets out the context in which the dynamics reported in the subsequent results chapters are played out. Participants' responses suggested that in postcolonial Malawi, the advent of multi-party democracy led to a collision between traditional *uMunthu* values and democracy, tradition and modernity, rights and responsibilities. This had a range of negative consequences for the health sector, reflected in falling standards and poor attitudes to public service. These were compounded by lack of strong and visible leadership at all levels, while continuing patronage reduced the capacity to hold poor performers to account, leaving managers with little power to enforce standards. This permeated all levels and allowed poor behaviours to become normalised. However, decentralisation and a growing discourse of rights and responsibilities were giving cause for cautious optimism.

8. Becoming and being a midwife

Introduction

This chapter addresses the research objective to:

- Describe constraints and enablers of professional practice and RMC in this context.

It explores some of the meso-level and health systems factors that affect midwives' efforts to provide RMC in the labour ward. The chapter is split into four sections. Firstly, I consider Malawi's inherited dual-qualification model of midwifery provision, covering key informant perspectives on its continuing utility and impact on professional identity, ethos and practice. Secondly, I focus in on two aspects of the hierarchical nature of the health system: broader perspectives from key informants that question the suitability of existing student recruitment processes; and voices from across the dataset that highlight the status of the NMT cadre. The third section covers the challenges in pre-registration training which impact on provision of RMC, seen in the context of Malawi's human and material shortages and reflecting attitudinal manifestations of the broader changes described in Chapter 7. Finally, I present key informant views on an external agenda to professionalise midwifery and national perspectives on the future direction of midwifery services, ending with the potential of senior role models as enablers of RMC and quality of care.

8.1. The inherited dual-qualification model

The current dual qualification nurse-midwife model was inherited from the British and represents a further example of the 'betwixt and betweens' mentioned in Chapter 7, where professionals were caught between the different identities of the two roles. This section explores the perceived utility of the dual model and perceptions of its impact on a midwife's professional identity, practice and ethos.

8.1.1. The perceived utility of having an 'all-rounder'

The generalist nurse-midwife in Malawi is an 'all-rounder' who is able to deploy both nursing and midwifery skill sets. Previous attempts to boost the number of nurses by removing the compulsory midwifery requirement, in order to reduce training time, were unsuccessful. *"It was like a crash program…these were just nurses. Women were still dying, without what? Midwifery care. They cannot do anything in midwifery, so they had to come back for the trainings."* (KI05, Training institution-NMT)

Key informants were evenly split between those who favoured the dual-qualification as the right model for Malawi and those who thought change was needed. However, many of those who initially said they supported the dual model then went on to discuss its limitations. Those in favour focused most often on the absolute shortages of nurse-midwives, particularly at the primary level of care. The dual qualification allowed these few workers to cover both nursing and midwifery services. It was also viewed positively by managers in larger health facilities. *"…when they are both a nurse and midwife it's also good for us as managers because we*

know we can allocate them anywhere." (KI06) However, others were not persuaded that the current model was effective and thought training for a qualification that might not be fully used was wasteful. *"I had the two qualifications, but I've only worked with one qualification, as a midwife. So, I'm one of the people who have not been convinced that somebody should have two professions in order to be more effective."* (KI18, NGO)

A particular area of contention was the practice of staff rotations. This involved rostering staff to different departments within the hospital at regular intervals. Proponents of the dual qualification felt rotations kept skills sharp, avoided boredom by stopping work from becoming routine, or offered a respite from the demands of maternity and thus helping to avoid burnout. Critics, however, thought it had a negative impact on performance and questioned the utility of moving experienced staff to other wards. *"You learn a new thing here in maternity; after two months you are moved, you are going to male ward. Are you going to utilise the knowledge which you have learnt?"* (KI12, Training institution-NMT) Further challenges included staff actively not wanting to work in the department for which they had been rostered, with obvious implications for both staff and patients. *"…they didn't even want to come and work in that area* [labour ward]*. They have just been deployed because they have that qualification of a midwife…and these are the people that bring in such type of negative attitudes that we are seeing."* (KI26, Midwifery manager) Labour ward was perceived to be the most challenging ward to staff; many found the working conditions and workload too stressful, while others had no interest in midwifery. Various tactics to avoid working in the labour ward were reported.

> KI03: *Ooh! they give you headache…Or sometimes they misbehave* **deliberately** *because they want to be...*
>
> Susan: *So you will be forced to move them?*
>
> KI03: *Yes! 'No, you are not behaving* [in maternity]*, can you go and work in medical wards.'* (Midwifery manager)

Conversely, those who identified as midwives wanted to remain in the labour ward when the new rotations were posted as they would be unhappy in non-maternity work or felt *"all my skills are better expressed there."* (SRNM02) Many spoke of the potential benefits of introducing choice and allowing staff to follow their interests, rather than forcing them to work in areas that did not match their skills or aspirations. Respondents at all levels felt this would make a significant difference to the quality of midwifery care, both technical and interpersonal, with some managers already trying to allow committed staff to stay in labour ward. However, others reported that human resource constraints often made this impossible, particularly at lower levels of the health system; a situation they felt would not change in the short term. One ward in-charge described the impact on staff and provision of RMC.

> *I think sometimes the nurses don't provide respectful care because they are like stretched. They have to provide different care to different conditions and different patients at the same time. They work under pressure…So some of them end up just*

concentrating to the technical part of the work and leaving this other part of respect, dignity and what have you. (SRNM04)

8.1.2. Professional identity, ethos and practice

Most midwifery respondents were happy to have had the nursing training and some felt they would have been incomplete or limited without both elements. However, this must be viewed in a context where midwifery care by a generalist nurse-midwife, rather than a midwife, was normalised. Many considered the nursing qualification as the core foundation upon which midwifery skills were overlaid, with some unaware that direct-entry midwifery courses also covered basic clinical skills. For others, who just wanted to be nurses, it was a challenge to have to add in a second, unwanted qualification in midwifery and the impact on quality of care was obvious to key informants.

> *These are the times maybe when we have cases, maybe women complaining about the type of care they are receiving…the passion to really treat a woman in labour, I think it's not there in them, because it's only they have the qualification, but their heart is not there to do midwifery…they are not interested in midwifery. So, the quality of care is not that what we expect from them.* (KI26, Midwifery manager)

A final cohort of respondents, including a number of senior midwifery leaders, described themselves as midwives, not nurses, and would have opted for direct-entry midwifery had it been available to them, but it was not introduced as an option until early 2016. The blurring of the midwifery role, where even very senior midwives were called 'nurse', and a lack of formal progression in midwifery had significant implications for these midwives' sense of professional identity. One key informant captured this eloquently, saying, *"I'm proud to be called a midwife and not even a nurse. But the position which I'm holding is a Chief **Nursing** Officer, so we are still having that nursing issues. But then, I'm a **midwife in me!**"* (Midwifery manager[55]) There is no position of Chief Midwifery Officer in Malawi.

Perceptions of differences in practice and ethos between the nursing and midwifery sides of the role emerged from the data. Midwifery should be an autonomous profession, but some key informants felt the nursing foundation shaped expectations of a scope of practice with dependent functions[56]. Some described negative implications for a midwife's confidence and ability in independent decision-making, expressing concerns about a growing trend of new midwives not being assertive or competent enough, so waiting for a clinician to tell them what to do, *'like a nurse',* even when the necessary action fell within their scope of practice.

> *I will be **thinking** in the way as a nurse has to behave. But…I'm a midwife. So I* [should] *think as a midwife, because I'm looking at midwifery as more independent…while in nursing we have got a **lot** of…**dependent** functions, as opposed to independent functions. And definitely that's also a thing that makes your*

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[55] I have removed the identifier here to protect the participant's anonymity.
[56] Dependent functions are those that require authorisation; independent functions are carried out on the midwife's own initiative and responsibility.

thinking as well to say, 'then I have to wait for a doctor to tell me what to do'…So the **name** *may even also influence the way that you are thinking.* (KI26, Midwifery manager)

A subset of senior midwives explicitly addressed an underlying difference between the nursing model and the midwifery ethos of care, suggesting nurses, who are used to caring for people during illness, may view labouring women as 'patients' who need to be told what to do. Midwives were thought to be more likely to view them as healthy women going through a normal physiological process. This difference in mindset was manifest in the data, where a strong discourse of the 'uncooperative' woman, who would not do as she was told, emerged as a major trigger of midwives' disrespect and abuse. This theme will be covered in detail in Chapter 9. This psychological split was thought to be even more challenging when staff were obliged to frequently swap between wards or cover both nursing and midwifery duties at the same time, such as in smaller health facilities.

Because where nurses are getting confused is 'OK, this one is not sick'. She is walking in, but she needs **help***. And the situation becomes even more compounded with nurses rotating out from general ward to labour ward. So, orientation-wise, if there were to be midwives alone, I think it would make a difference. Because today she is in the labour ward, tomorrow she in is the general ward, she meets different kind of situations. I think that, psychologically, it's not a healthy business.* (KI05, Training institution-NMT)

Another concern was that the dual role diluted midwifery skill levels, as it meant the focus was on knowing 'everything', rather than specialising in just midwifery. Tutors from the SRNM programme voiced their unease about the challenges of trying to address both components fully within the confines of the current pre-registration training timeframe. Even participants at the tertiary level of care reported that their midwifery complements included labour ward staff who felt they did not have the necessary interest or skills to deal with complicated or high-risk cases, or who did not want to be there.

Because, you know, midwifery is also like a specialised area on its own. Then to put it in the four years [with nursing] *we found that it was not working well…it was overloaded, and we felt like we were not doing* **justice** *to the midwifery aspect…you know there are new things that come in and are added into the curriculum, for both nursing and midwifery aspects. And because of that it was like you had too much content. Then you also need the clinical hours…the minimum hours that you have to meet to be registered. It was just* **barely** *minimum.* (KI25, Training institution-SRNM)

A CHAM tutor echoed this concern, which intersected with the way in which the dual qualification removed professional choice and forced staff into practice areas which did not

match their interests or skills. *"…people are failing midwifery.[57] Why? They are not interested! And there are so many people out there who doesn't [sic] have midwifery certificate, they only have Bachelors in nursing…So had it been that we gave them an option in first day, that would have been better."* (KI12, Training institution-NMT) Some participants considered this an ineffective use of limited resources, while others stationed on the labour ward were very aware of the gap in their skills and knowledge, particularly NMTs. *"…but only that my worry is that I didn't do much of midwifery…my knowledge in midwifery, it leaves a lot to be desired."* (NMT06) The same respondent felt the lack of sufficient knowledge was exacerbated by the rotation system. *"People that come here from other wards…It's like they know nothing."*

This clash between the midwifery and nursing models was a source of dissonance for many midwives I spoke to, who struggled with the ideal versus the reality of how they were expected to provide care for labouring women. This will be covered in more depth in Chapter 9. 'Relationships with women'.

8.2 Midwives in a hierarchical system

This section explores the reasons that participants in the narrative interviews chose a career as a midwife. I report key informant perspectives on the processes used to select candidates, foregrounding the impact of the continued use of English in tertiary education and the primacy of academic results. I also explore the plight of the 'technical' grade NMTs and their position in a system that does not view them as professionals.

8.2.1 Becoming a midwife

An altruistic imperative

The narrative interviews asked respondents to tell the story of how they became a midwife. The most commonly cited motivator was the influence of a family member or role model in the nursing/midwifery profession whom they wished to emulate, usually an aunt or mother. Some also described their desire to become a professional as "*a call",* spoke in terms of "*passion"* or said, *"I wanted to serve my fellow Malawians, especially women, because I read in the newspaper that there were so many maternal deaths, so I wanted to be of help to my country."* (SRNM10) Others were driven by an awareness of the human resource constraints and the plight of rural women. Previous experiences of the health care sector, both good and bad, propelled some participants into a nursing or midwifery career. A well-regarded ward in-charge was motivated after an unpleasant experience on the other side of the nurse-patient interaction. *"…when we approached the nurse, she shouted as if we have done something wrong…So, it pained me. I was hurt and I said, 'Wow! At one time, I need to join nursing so that I can become a weapon of change.'"* (SRNM01) This incident seems to have had a profound impact on this midwife's own practice. I had many opportunities to

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[57] The national press in Malawi reported pass rates of only 42% for the NMT cohort who sat their NMCM exams in October 2016. http://www.maravipost.com/shame-75-cham-students-fail-nurse-midwifery-examinations-many-unable-speak-write-english/

observe her in action and was struck by her professionalism and the consistency of her attitude and tone with women, while her colleagues described her as an outstanding midwife, calm, gentle and respectful.

Just over a quarter of those who discussed why they chose midwifery spoke explicitly of their aim to be a *midwife,* rather than a generic nurse, but others had not even realised midwifery would be part of the package when they started their pre-registration training. *"I just discovered when I went to school that I will become a nurse, at the same time a midwife."* (NMT30)

Selecting the 'right' candidates?

A widely-held opinion among senior key informants was that there had been a fall in the standard of midwifery care. For example, one senior midwife leader said:

> *…if you talk to people they will tell you that there's a great difference between the 'Banda midwives'[58]…and the ones that are here now. The **best** midwives are the Banda midwives…Because we were taught to be committed to our work. Our patient was our **primary** concern and we grew up with that kind of mentality, that my patient **must** get the best out of me. That's how we were trained and that was entrenched in us.* (KI27, Senior advisor)

Falling standards were attributed not just to the 'betwixt and between' challenges of interpreting democracy and poor attitudes to public service covered in Chapter 7, but were also blamed on a shift in the type of candidate being admitted to the training institutions. Over half the key informants discussed this in terms of people obtaining a nurse-midwife qualification purely to get a job in a difficult labour market, rather than being interested in, or called to, the profession. It is also worth noting that becoming a midwife means joining the civil service, a coveted position in Malawian society as it accrues security and benefits (Anders, 2001). When this issue was mentioned, I asked participants if they could estimate how many midwives fell into the 'just a job' category. Figures ranged from 60% (Matron), over 50% (District Nursing Officer), 50:50 (HR manager) and 30% (Chief Nursing Officer). At the facility level, a labour ward in-charge suggested only 5/12 labour ward midwives really had the passion for their work, while her matron was even more pessimistic and could only name three really committed midwives[59].

A further aspect of this reported dynamic of unsuitable candidates applying for midwifery qualifications was the perception that it offered good opportunities to access further education - a significant marker of status in the Malawian context (Matiki, 2001). *"…let's say you do a diploma level, you can easily go and you do Bachelors, you do Masters. So for you to progress professionally, it's really something which is promising in the nursing and*

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[58] These were midwives who trained during the period of autocratic rule under Dr Kamuzu Banda, where the civil service was tightly held to account. Banda's rule lasted from independence in 1964 until multi-party elections in 1994, but the training of SRNMs in Kamuzu College of Nursing did not start until 1979.

[59] Individual identifications have been removed to preserve anonymity.

midwifery…" (KI03, Midwifery manager) This was seen as a good investment, with key informants suggesting some recruits were just using their midwifery qualification as a stepping stone. *"…it's a critical issue…I can say one-third of people are trying to look at how do they change to another field."* (KI16, Midwives' representative)

Previous government efforts to boost health worker numbers (described in Chapter 6) had provided financial support for students and guaranteed them a job when they qualified, using a bonding system to ensure they would work within the health sector for a specified amount of time. Despite continuing high vacancy rates, this incentive had been withdrawn and training institutions were accepting paying students who had achieved sufficient credits in the Malawi School Certificate of Education (MSCE) examinations. An unintended consequence of this was that those who had paid for their education were not bonded and felt entitled to dictate where they would work.

> *Now, when they finish, because they paid by themselves, when they are sent to a* ***rural*** *institution they usually refuse, saying, 'No. I cannot go there. I paid my own fees, why should I suffer in the village or in the rural, in the bush, where there is no electricity?' So many will just say, 'OK I will not go there, I will look for in town, in a private institution'. Now, because government did not use its money, they cannot pin them down.* (KI20, Midwives' representative)

A major concern raised by many key informants, which underpinned the challenges in the type of candidate who was accepted into midwifery training, was the insufficiencies they perceived in the student recruitment process. Prior to 2003, Kamuzu College of Nursing (KCN) used to interview potential candidates. In 2016, applications were made centrally to the University of Malawi[60], with candidates indicating a choice of up to six courses in any of the university faculties, ranked in order of preference. Those who missed the grade requirements for their first-choice subjects were offered the next course on their list for which they had sufficient credits. This meant many students ended up studying nursing and midwifery instead of following their true interest. *"My first choice was irrigation…So I was chosen to go into nursing, I didn't have any choice…But when I went into midwifery I* ***loved*** *it more than the general nursing."* (KI04, Midwifery manager) While the end result for this matron was good, many others ended up in a job for which they did not have the interest or enthusiasm, with women bearing the brunt of their apathy or frustration (which will be discussed in Section 9.2).

NMT-level hopefuls made a direct application to either Malawi College of Health Sciences (MCHS) or one of the twelve CHAM training institutes. Both institutions used a written entrance exam to filter prospective candidates, but this was not considered adequate, so CHAM training colleges also included oral interviews. At the national level, their system was viewed positively. *"Someone can pass written interviews but can fail oral interviews.*

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[60] KCN and Mzuzu (which also offers BSc nursing-midwifery courses) are both constituent colleges of the University of Malawi.

Professionalism is assessed on the base of the interviews." (KI12, Training institution-NMT) This reflected the opinion among a diverse range of stakeholders who felt interviews should be brought back, because without them, *"…people who would have been sieved out during the interviews are taken on board, and that is the problem we are facing."* (KI11, Training institution-SRNM) However, at the grassroots level of the training institute, it was evident from key informants' comments that this was not as clear cut as it seemed and significant numbers of students were successfully playing the system, with one CHAM principal suggesting about one-third of students were just doing the training because it offered a guaranteed job. *"But because of the unemployment rate out there, yeah, everyone will pretend to be what she or he is not…Because they want to be admitted into the program."* (KI05, Training institution-NMT)

Permeating the results at all levels was the perception that too many people who did not have the passion and vocation to be midwives were finding their way onto Malawi's labour wards, with respondents describing the negative impact they thought this had on women and the type of care they received. *"…we really need to recruit nurses who really wants to join this profession. That's why we have problems when it comes to care of patients, because they are not interested in patient care."* (KI01, Training institution-NMT)

8.2.2 The status of midwives

As we saw in Chapter 6, the NMCM only categorised the degree-level SRNMs as professionals. Despite their high status within midwifery, SRNMs were subject to what was seen as a gendered policy of only assigning leadership and facility manager posts to the male-dominated clinical officer or medical assistant cadres, rather than the female-dominated midwifery cadres (Muula and Maseko, 2006). In larger health facilities, this resulted in a leadership hierarchy where degree-level midwives were expected to answer to diploma-level clinical officers, while in smaller health facilities the facility in-charge role would be allocated to a certificate-level medical assistant rather than a more highly qualified, diploma-level NMT. One HRO found this an incomprehensible problem that could easily be changed. *"We have that problem in most of the facilities…Why can't we say the one with higher qualification being the in-charge of the facilities?"* (KI10, MOH) However, SRNMs suffered less from status issues than the NMT cadres. NMTs provided the bulk of hands-on care, carrying out many of the signal functions that were also part of the SRNM scope of practice, but were not considered professional midwives (WRA Malawi, 2016). Their benefits were that they provided a cheaper option because of shorter training, lower salaries and increased retention in rural areas (Dovlo, 2004). Considerable inter-cadre tensions were expressed, as NMTs felt aggrieved to be paid significantly less than the SRNMs for whom they were effectively substituting.[61]

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[61] A Human Resources Officer informed me that monthly salaries for SRNMs were almost twice those of NMTs (approximately MK190,000 versus MK100,00).

… we [NMTs] *are the one doing the job, touching the patient. So, you feel not motivated…most of the time they* [SRNMs] *delegate all the jobs, they give to the nurse-midwife technicians. They say that they already sweated at the university…But I am the nurse-midwife technician managing all these people. But everything that is good, they are going to the registered nurses* [SRNMs]. *The technician, you get low wages, low salaries, you don't go to workshops.* (NMT13)

It was clear midwifery services, particularly in rural areas, relied on NMTs, with one HRO convinced, *"…we should have been training those cadres at lowest level, because when we focus to train at diploma, degree level, those people, they cannot go into the health centres. They will always want to be in town."* (KI23, MOH) A few participants were worried that Malawi could not manage without NMTs, but were roundly criticised by one senior midwifery leader. *"…we get this entrenched idea that we can't do without them. We can't do without them because we have not invested in training at professional level!"* (KI27, Senior advisor) Others felt that many NMTs provided good care, but that it was vital for them to be properly mentored and supervised.

Critics of the NMT model thought this cadre lacked the technical skills, autonomy or decision-making capabilities to deal with more complex cases, especially in referral hospitals. One SRNM tutor stated, *"I can confidently say this abuse of patients is mostly by nurse-midwife technicians."* (KI11, Training institution-SRNM). As we shall see in Section 9.2.4, NMTs legitimised some abuse of women as necessary to avoid the bad outcomes for which they feared they would be blamed. NMTs' criticisms of SRNMs focused on their lack of availability on the wards. None spoke of abuse committed by SRNMs. However, a theme in SRNMs' descriptions of 'good' incidents was of them intervening to 'save' a woman from the poor care being meted out by their NMT colleagues.

NMTs themselves were described as part of the growing appetite for change. *"They are a frustrated cohort. They seem not to have a future, so they also feel the attitude of being undermined. But when you look at some of them, they did their O-Levels **very** good, but didn't have the opportunity to go to into the RN* [registered nurse] *and professional* [SRNM courses]*."* (KI17, Senior advisor) This mirrors previous findings on the situation of Clinical Officers in Malawi, where very good candidates missed the opportunity to train as doctors due to the small number of places available (Bradley and McAuliffe, 2009). The route from NMT to SRNM at degree level is cumbersome as it has to be done step-wise via a second diploma, adding another four years of education on top of the initial three years for the NMT qualification. Many senior midwives thought was too long with one suggesting a more realistic timeframe. *"They don't need 4 years. I mean, 4 years is already what you would do if you were coming from secondary school* [to do a BSc]! *So, what I would think is that maybe 18 months for nursing and maybe 6 months for midwifery, and they have it."* (KI27, Senior advisor) It was clear from participants that the position on upgrading NMTs had been politically driven and subject to inter-organisational disagreements. Participants reported that supporting agencies, such as ICAP, had funds to run a bridging programme to shorten this

time frame, but were thought to have been blocked because *"…people were so embroiled in interpersonal things that they didn't see **far**. They were saying, 'Oh, NONM* [the union] *is pursuing this'…"* (KI18 NGO) The union's NMT members were reported to be *"abandoning the nursing profession"* because they wanted a programme that would take them straight from diploma to degree. However, the change in personnel at the Directorate of Nursing and Midwifery and the NMCM (mentioned in Section 7.2.1) was expected to bring about a more united stance on this issue. *"Now these senses are coming. We are hoping that we will work on that, and **everybody** agrees that indeed it's wasteful. So, when you come again you will hear different stories!"* (KI20, Midwives' representative) However, key senior midwifery leaders, including within the NMCM, wanted to see the NMT cadre phased out altogether, suggesting that despite training greater numbers of NMTs *"…we still think we haven't improved much in maternal mortality. What we are looking for is to have nurses trained at a higher level and being put in all the health centres, those who have done direct-midwifery **or** those who have trained as registered nurse-midwife."* (KI19, Midwives' representative) A representative from CHAM, the key provider of NMT training in Malawi, also favoured higher-level skills and wanted to support the move towards standalone midwives.

While for some participants professionalisation involved moving away from the lower-level cadre, a recent decision was made to introduce an even lower level, the Community Midwifery Assistant (CMA). CMAs undertake an 18-month training programme in normal births, obstetric and neonatal complications, under-fives surveillance and family planning, and were designed to replace TBAs (Bell et al., 2014). Two very senior midwifery leaders were agreed there was a need for community midwives, but at the professional (i.e. degree) level. *"When we say, 'community midwife' I don't mean somebody educated with a certificate!"* (KI16) In the discussions about degree-level midwives, one of the fears mentioned by participants was that they would be difficult to place at the health facility level. A different perspective on this was raised when discussing the CMAs. *"Why can't we have Community Midwives, but at professional level? Because if you have them at professional level then you have less need for referral…because this person would be so **grounded** in midwifery skills that they would be managing most of the women that come to that health facility."* (KI27, Senior advisor) The same senior midwifery leader captured the strategy of using lower-level cadres, such as the CMA, thus: "*When you have a dress that has a problem, you patch today here, and put another patch there tomorrow, and put another there* [pointing to one spot, then another]. *You are wasting money. What you need is to buy a new dress."*

The staff list I was shown for the study district showed 12% of midwives in its health facilities were CMAs. I had the opportunity to meet one who had been posted to a hard-to-reach health centre covering a population of approximately 4,000 people. My field notes captured the reality of the CMA's working life and the demands put upon her by the local constraints.

> *It's difficult reading the literature to really understand what it means to be the lone*
> *provider in a remote or hard to reach area - you need to see it. The health centre is*

about as remote as you can get in Malawi. It is staffed by a 21-year old, newly qualified CMA, supported by three HSAs [health surveillance assistants] *and a patient attendant, but the CMA is effectively on-call 24/7. She is on a 3-month placement and eagerly awaiting a permanent posting somewhere else. When we asked about her workload she talked about delivering a few babies a week - four this week, sometimes none. The bulk of her work is OPD* [out patients department]. *Her record book bears testament to the sheer volume of work and needs of the locals. This week she has seen about 300 patients. Yesterday she saw 49 people, 5 of whom woke her during the night for urgent attention. One of these was a man with a lacerated scalp. I asked her what she had done. Why, she sutured it, of course! Sounds simple, but it was a massive wound that needed 16 stitches in a context of no analgesia, other than 2 panadol to take once she had finished. I wondered how she knew what to do, given that her role is midwifery and she replied that they do some fundamentals of nursing as part of the course, so she uses that and just hopes she is doing the right thing. She also has the option of calling some friends who are Clinical Officers if she is really out of her depth, but the MOH don't provide a handset or any airtime, so she has to fund that backup service herself.*

It was interesting to see how upbeat she was about it, although I suspect some of that positive vibe may have been generated by how astonished and impressed we were at how she copes. She can manage normal deliveries, but has to refer women in difficulties to hospital - an unimaginable journey of 3.5 kms by walking ambulance to the village, waiting for the motorised ambulance boat, a 10-minute transfer across the lake, followed by at least 90 mins by car - and that is assuming anyone has the money to pay for it all or the woman survives that long. (Field notes, 02 Apr 2016)

8.3 Pre-registration training

This section focuses on how students are moulded into the midwives they will become. It outlines the content and expectations of RMC, which was frequently couched by participants in the language of the 'therapeutic relationship', and identifies barriers and enablers caused by human and material resource shortages and lack of mentors.

8.3.1 Content and expectations of RMC

Teaching of the professional and ethical aspects of care that facilitate RMC were supposed to be cross-curricular and frequently revisited as part of other modules in the curriculum. However, tutors voiced concerns that the time and effort spent on these aspects of care were heavily dependent on the attitude and importance attached to them by individual tutors, particularly in the NMT curriculum where one tutor suggested: *"...our curriculums in the training institutions, they should include this component* [RMC] *as another course, not just being tackled just in passing, as we are doing about woman-friendly care."* (KI02, Training institution-NMT)

When asked how the facets of RMC were assessed, participants reported the use of guidelines and checklists to steer student NMTs' behaviour during practical assessments, such as during pre-arranged OSCE (Objective Structured Clinical Examination) sessions. *"So things like respectful tone, low tones* [speaking quietly]*…they are all embedded in the check list."* (KI05, Training institution-NMT) CHAM students who did not display the correct behaviours would fail, but the prearranged, rather than surprise, nature of the assessment was felt to be insufficient. *"They know when you are coming! They will memorise all the right things and they will do that because they want to pass the assessment. But not to do that **every** day."* (KI13, NGO) Another tutor suggested that staff put in a lot of effort to make sure students understood the conduct required of them by the profession, with frequent assessment of this component. *"…there's also an assessment which is done on daily basis during supervision, during clinical teaching and all those other…hours that we have in contact with the students. So the emphasis is both done at college level and even in the clinical area."* (KI02, Training institution-NMT)

For SRNM students, ethics and professionalism were explicit elements of the curriculum, with students' professional conduct assessed through an evaluation at every placement. This covered communication with patients, colleagues and seniors, as well as looking more deeply at issues of respecting a patient's values and dignity. *"If one fails the aspect of professionalism, they fail the clinical placement!"* (KI11, Training institution-SRNM) In addition, midwives confirmed that evaluation was not pre-arranged. *"…they just come at random time, without telling you that they are coming…they will just come…and watch and see what you are doing."* (SRNM01) However, there were still concerns about the impact of who taught these aspects and how frequently they were revisited, with tutors suggesting the need for more awareness in their own teaching practice, *"…to actually focus that 'this content that I am teaching, I have to make sure I talk about the knowledge, skills **and** the attitudes'. I think I would say we still need to strengthen the attitude bit."* (KI25, Training institution-SRNM) The same respondent blamed some of the shortfall on the content load of the dual qualification syllabus. *"…when you have less time, then maybe you focus more on the knowledge and the skills, and pay less attention to the attitudes."*

During the data collection period, a number of actors were engaged in bringing more attention to the importance and practice of RMC. The most visible effort was the work of the Association of Malawian Midwives (AMAMI) to develop a discrete module on RMC, in collaboration with key stakeholders, by identifying relevant, existing elements of the curriculum that could be used to develop a standalone module. *"The teachers were able to say, 'OK we have a little bit of information in foundations, we have a little bit of information in ethics, we have a little bit of information in sociology, we have a little bit of information on communication'. So we took all these things and we put them together."* (KI21, Midwives' representative) It was anticipated the module would be useful for both pre-registration training and continuing professional development, but respondents had questions about how it would be assessed. Lecturers from both CHAM and MOH institutions showed me

checklists focused on easier to measure, obvious elements of respectful care, such as greetings, communication and privacy, but there was less awareness of how to capture the more intangible values and attitudes that underpin RMC.

> *…we agreed that during clinical assessment, how would you assess for respect? And we were not able to pin point. Everybody was saying, 'Oho no, we assess' and we were saying, 'tell me **exactly** what you assess'…So we were not able to do that. So one of the things we are agreed was also that we needed to have some **clinical** things or **attitudinal** things that we can look at, which we can interpret as respect.* (KI21, Midwives' representative)

8.3.2 Clinical practice challenges

Too many students, too few tutors

A significant bottle neck in the teaching of clinical skills was the *'huge'* and *'unmanageable"* rise in student numbers in the wake of efforts to address the human resource crisis. *"Previously…they were no more than 30. Nowadays, you go to a training college, like the CHAM training colleges, the minimum you get in a class is 120."* (KI13, NGO) Representatives from all the different training organisations (CHAM, MCHS and KCN) described situations where students from different institutions were out on placement together, in the same clinical area, vying for the same patients. *"Do you think that these students can learn? 50 students against 10 patients? They can't. They cannot learn."* (KI01, Training institution-NMT) One MOH respondent reported that the situation was so severe they had been forced to reduce the competence stipulations for clinical procedures. The lived consequences of not receiving the necessary hands-on practice during pre-registration training were described to me by an NMT who narrated the story of a birth where she felt she had done a really good job. Alone, in the middle of a night shift, she had carried out her first manual removal of placenta. *"It's like when you are a student you miss some of the procedures...Aah, of course I have seen, but I've never done it while I was a student."* (NMT03) Although this young midwife found it exciting because the outcome was good, this is a clinical competence that is supposed to be practiced and assessed as a requirement for qualification. A thought must be spared for the poor woman who underwent this invasive procedure. *"…it was done perfectly…except we did not give the patient medication to eliminate the pain…we just do it."*

At the ministry level, there was clear acknowledgement of the efforts to produce quality staff, but concerns about how possible this was in the current context. *"They* [training institutions] *would want to mould. The spirit is there, the commitment is there, but the numbers are too huge to mould. So in the process, yes, some would really come out as competent and with the necessary values for the profession. But others, because attention was not brought to them, they would not **be** as what the tutors would want them to be."* (KI14, MOH) More than one key informant referred to '*half-baked*' midwives, who might be able to pass the theory elements of the course but lacked the clinical skills and struggled to practice autonomously

when they graduated. The implications for the quality of newly qualified midwives being produced was captured best by an ex-tutor.

> *…they will memorize the notes, they write an exam, they pass. Not that they know what they are doing, but they have just memorised, because they want to pass the exam…And you send 20 students to the clinical area…and there is one tutor to go and supervise all these students…So we are not teaching them what they are supposed to teach them…They are going out* [as newly qualified staff]*, just knowing the theory, not the skills, the hands-on. And even the theory, it's just rote learning. They memorize, not understanding things. So when they go to the ward, she will be sent to a facility where she will be alone on duty…She has no one to mentor her.[62]*

The large number of students was exacerbated by a shortage of clinical tutors, with training institutions struggling to fill posts, an issue the last Health Sector Strategic Plan (2011-2016) had aimed to address (Ministry of Health Malawi, 2011). However, key informant interviews clearly showed these concerns were still very live and affected both NMT and SRNM students. Participants from both SRNM and NMT training colleges considered many tutors insufficiently skilled to deliver both the theory **and** practice elements of the curriculum, which most felt was then compounded by them not spending enough time supervising students in the clinical area. The situation appeared to be worse for those tutors overseeing NMT students, perhaps because of their larger numbers. Sympathy for the NMT tutors' situation was tempered by regret at the impact this was having on the quality of staff being produced.

Teaching is not part of my role

In the absence of sufficient clinical tutors available in the clinical area, there was an expectation that skills teaching could be delegated to qualified staff instead. However, key informants reported many midwives considered teaching as an extra role, rather than part of their professional responsibilities, despite clarity from the NMCM that, *"…every qualified state registered nurse, or any nurse, is a teacher and must assist students."[63]* (KI11, Training institution-SRNM)

Given the human resource challenges, qualified midwives often failed to assist students because they were too busy. However, hierarchy and status differentials between NMTs and SRNMs were reported as a factor, with some key informants inferring NMTs had an inferiority complex and were uncomfortable instructing the higher-level SRNMs. However, there were dissonant voices who felt this was not necessarily the case. *"I think it has been also fuelled by both sides…it was repeatedly said 'that's not your role, that's not your role' by the registered nurses. So, it's not really something we can say they are feeling inferior. I think the other side needs to take responsibility that they also contributed to this scenario."* (KI18, NGO) A further complication was the unintended consequences of a previous initiative, where qualified staff were paid an extra allowance for acting as a mentor or preceptor. The

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[62] Participant's individual identity number has been removed in the interests of confidentiality.
[63] The NMCM were finalising revised job descriptions, code of ethics and scopes of practice when data collection took place. These will include mentorship, preceptorship, teaching, and supervision.

legacy of this had been widespread reinforcement of the false idea that teaching was, in fact, an extra duty. This expectation of financial gain for teaching, rather than it being part of the professional role, intersected with a strong *per diem* [64] culture in Malawi, where NGOs and donors provided financial incentives for any training days off-site. This has been critiqued as having a perverse effect on outcomes, such as frequent reports of staff who did not attend a training opportunity refusing to adopt new practices or ways of working because they have not been 'motivated[65] (Vian et al., 2013). During my initial field visit, an RMC training project had been underway. Feedback about its impact was positive from midwives who had done the training but had not spread to other staff. *"But for our friends, they are saying, 'we didn't go for the training so don't tell us about that. You are the ones who went to that training, you can go ahead to do it.'"* (KI13, NGO)

The end result of the lack of mentorship or allocated clinical teachers was that students were frequently left to work completely unsupervised. There were obvious consequences of this, usually for the women, but also for students, as one midwife's story of her worst delivery demonstrates. *"…due to insufficient skills…I never supported the perineum so well…I thought with a supervision from whoever was there, I wouldn't have ended up into a woman having a second degree tear…Aah, I felt bad for the woman."* (SRNM10)

Despite these challenges, participants reported positive steps were being taken to try and address the issue of qualified staff shying away from the teaching role. Actors such as ICAP were running SRNM training and NMT orientations on how to act as preceptors for students. This was a pragmatic initiative to maximise the utility of available staff and operate within country constraints, despite the preference for the more highly qualified staff to act as preceptors. *"Whether we like it or not, the student is bound to learn or to copy what the nurse-technician is doing. So, because of that **gap** we thought we should orient also the nurse-technicians so that they at least have the knowledge and the skills on how to assist students."[66]*

Improvisation, short cuts and an extra pair of hands

A widespread complaint from participants, at every level of service, was the intractable problem of acute shortages of even basic resources (which will be covered in Chapter 10) that significantly impacted on quality of care and left staff and students with no choice but to improvise as best they could. However, midwives' challenges were not just limited to lack of material resources. Often, the most pressing resource missing when students were trying to learn was time. Despite the government's efforts, there were still significant vacancy rates for midwives, yet facility-based deliveries were rising, driven by the continuing ban on TBAs. Students who tried to put classroom theory into practice faced irritation from busy staff.

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[64] *Per diems* are a commonly used incentive in sub-Saharan Africa, originally intended as a daily allowance to cover expenses related to travel, training etc. as part of one's job. They have morphed into an expected payment for any activities seen as 'extra' to the job role.
[65] 'Motivation' is usually used to describe an incentive or financial reward in Malawi.
[66] Identity removed to protect anonymity.

…the students also complain that, 'if we try to do everything you teach us at school, the qualified staff will shout at us, saying, 'You are delaying us. We have a lot of patients to take care of. If you do all that, we will take more time on one patient.' So they go for the short cuts and that short cut using, they will internalise that. So, when they go out to work, they've gone out with the short cuts, not what they learnt in class, because they don't have time to practice what they learnt in class. (KI13, NGO)

Intersecting with the reluctance of some midwives to supervise students, was the issue of students sometimes being seen as *"an extra hand"*, a dynamic said to be largely driven by the shortages of staff, which were outside everyone's control. *"…there are times when students work on their own and even the midwives available, they are too busy.'* (KI05, Training institution-NMT) The reality is likely to be more nuanced than this. My own informal observations were of students largely left to carry out care without supervision. Sometimes this was clearly due to staffing constraints, but I regularly witnessed this happening when the qualified staff were not busy and could have been available to them.

Encountering poor behaviour and attitudes

The challenging context for student learning was compounded in some instances by the negative impact of the unprofessional behaviours they were exposed to when out in clinical practice. Key informants described significant temptation for students to copy the behaviour and norms of qualified staff, as part of fitting in and being accepted in the workplace. This dynamic was evident even among highly motivated students. *"…some nurses, they come from school with that passion, but when they join the civil service they find that there are some senior nurses who are just very lazy, who do not respect. And then they just copy that."* (KI09, Midwifery manager) Instances of poor attitude or unprofessionalism were also described as impacting on the credibility of qualified personnel, as they could not reprimand students or hold them accountable for behaviour they were guilty of themselves.

Students often had to learn in a context where they, as well as women, were being disrespected. *"…the **attitude** of the qualified staff as they talk to these students, sometimes it is not good. And also when they are speaking to patients, it's not respectful."* (KI11, Training institution-SRNM) Students and recently qualified midwives faced cultural norms and power dynamics that inhibited their ability to voice concerns about poor behaviour as this would be seen as disrespectful of more senior staff. *"…there is a challenge when you are just a new beginner…So to us, we just see and we keep quiet. But it's a challenge, because...about the age, communication, sometimes it will be like an insulting. It will be like you are telling somebody that she doesn't know how to work."* (NMT16)

A sobering thought about the long-term impact of the combination of taking in students who are not dedicated and the challenges in imbuing them with the necessary skills and attitudes during clinical practice was offered by a senior midwifery manager.

*But people are not really willing to...do a lot for the patients…So you see that that type of **attitude**…is really rooted in their behaviour. By the end of the day, they come out*

*really not full-baked, they are half-baked…people can do well when they are not really that good in their skills. So by the end of the day, these type of midwives are the ones who are graduating! And when they graduate they will become supervisors. **They** are the ones even to supervise their fellow students. So, imagine this type of student. She has graduated, she is in the ward, another student is coming. Can she be a good supervisor?…So it's garbage in, garbage out.* (KI03, Midwifery manager)

8.4 The agenda to professionalise midwifery

A key mechanism identified in the international agenda to address disrespectful care is to professionalise midwifery. This was under serious consideration in Malawi, which is one of six White Ribbon Alliance (WRA) national alliances in sub-Saharan Africa. *"Each National Alliance determines – based on the specific local/national/regional safe motherhood issues – its own unique priority areas of focus, structure and decision-making processes that are inclusive, participatory, transparent and consistent with the White Ribbon Alliance mission, vision, and values."*[67] The WRA Malawi has driven calls for separate budget lines and planning for midwifery; institutionalisation of the direct-entry midwifery programme; and increased respect for midwives by providing conditions that allow them to perform, including a clear career path (WRA Malawi, 2014). As we saw in Chapter 6, AMAMI[68], is a key player in the RMC agenda and supports professionalising midwifery as a central component of translating RMC into practice. Many of these actors are working together to embed respectful care into teaching curricula, codes of ethics and scopes of practice. However, at the time of data collection it was not yet clear whether the professionalising project's focus was on making midwifery an autonomous profession outside of nursing or if it would just focus on improving the professional behaviour and skills of midwifery staff.

8.4.1 Direct-entry BSc Midwifery

In early 2016, KCN enrolled its first cohort of students onto a new, direct-entry midwifery degree programme, a key step in response to the professionalising agenda. However, this initiative had been met with ambivalence within Malawi. Some key informants strongly disagreed with this course of action, suggesting the country's human resources and financial challenges meant it was not yet ready for such a step. *"My personal opinion is it's too early for Malawi…So, to introduce the direct-entry, to me it's a luxury…It should have been a **post-basic course.** [Very strongly emphasising this point]…We haven't reached that stage, we are still on the crawling stage..."* (KI11, Training institution-SRNM) Participants' reservations tended to focus on the challenge of deploying specialist midwives to rural facilities, rather than suggesting these more highly skilled staff might be best placed at tertiary and secondary levels of care. Others felt professionalisation was an externally mandated process into which they were being pushed. *"We need a dual role...But what can we do if the regulatory, like the International Council [sic] of Midwives, they want us separate? We just go that way."* (KI20,

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[67] http://whiteribbonalliance.org/about-us/national-alliances/
[68] https://malawianmidwives.wordpress.com/what-we-do/

Midwives' representative) However, other, senior midwives perceived the international community to be supporting Malawi's own passionate midwives who wanted to have professional autonomy and recognition, and to make midwifery a chosen, rather than imposed, career. A significant majority expressed positive views about the professionalisation agenda, including representatives from the MOH, NMCM, CHAM, KCN and AMAMI, as well as practicing senior midwives. Some hoped specialisation would allow midwifery to become a separate, autonomous profession. One of the most frequently mentioned benefits was that allowing staff to specialise in midwifery would improve quality of care, as this would improve not only knowledge and skills, but **attitudes** towards women. This links back to the ideas of an *uMunthu*-based way of learning, discussed in Chapter 7, articulated by one of the key informants. *"…according to this umunthology of Malawian culture, the right attitude is a combination of appropriate virtues for a particular institution or particular context. So, if you are a nurse you need certain virtues appropriate for that particular job…that's what we need to look at."* (KI24, Academic)

Another felt the direct-entry midwives would engender a more woman-focused dynamic to care.

> *I can just deduce from those who did a Bachelor's in Midwifery,[69] and they have also done their Master's in Midwifery, they are very much inclined to be on the bedside, to look after this woman…You would see that their attitude is very different…that curriculum that was there, yes, the issue of looking after a woman and a mother was very evident.* (KI17, Senior advisor)

Many participants discussed the impact direct-entry midwifery would have on recognition and status of midwives, making visible their contribution to maternal health in Malawi. *"I want midwives to be recognised that it's a profession that people should look at it **higher**, highly. Not to think that because there was a traditional birth attendant that was doing it, no! They should know that even at PhD, as an expert, I can be in the community and be a midwife."* (KI16, Midwives' representative) Some hoped the direct-entry programme would remind midwives of the value of their superior experience and skills, particularly in relation to clinical officers who tended to override midwives' assessments in the labour ward. *"It's like the expert is the clinician, though they are supposed also to consult the midwife on duty. But then, sometimes it's maybe the midwives that won't contribute…some of them, they don't go together with the clinicians…they always think, 'Ooh clinicians! They feel they are bosses' because they always think their decision is final."* (KI06, Midwifery manager)

Aside from the future of the direct-entry midwifery programme, the other significant factor in Malawi's deliberations about the issue of professional midwives was the need to develop midwifery-specific career paths for these staff.

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[69] In 2003, a one-off course for 10 diploma-level registered nurses was run to upgrade them to BSc Midwife.

8.4.2 Career paths for midwives[70]

A strong theme in the professionalisation discourse was harnessing the motivation and heart for midwifery by recruiting people who actively wanted to be midwives, supporting them to perform at the top of their skill level, and ensuring there was a dedicated career ladder for midwives. *"As an association, we are lobbying heavily, that it is high time that we have **only** positions that are midwifery, then as a midwife I would know where I am going. And…people would know that a midwife is an independent practitioner."* (Midwives' representative)

Advocacy efforts (e.g. from the WRA) to professionalise and recognise midwifery have had some success in that the title of the Directorate of Nursing and names of some training colleges (including those under the CHAM umbrella) have recently changed to add '…and Midwifery'. This was a welcome move for many of the midwives I interviewed, as they felt it raised their visibility. However, formal career progression in midwifery had yet to be introduced. The impact of this lack of options on both SRNM and NMT cadres was reported by key informants, who suggested that many leave the profession altogether, rerouting to areas with a clearer career path. However, a range of recently introduced opportunities at Masters and Doctoral levels may have opened up a route forward, although these higher qualifications did not seem to be rewarded. *"…to keep them motivated they have to be recognised, even by the ministry, in terms of remunerations…As of now, you graduate the Masters in Midwifery, not even a promotion, nothing…I think it's not recognised at the ministry level…We will practice at that advanced level, and we really contribute a lot* [more] *than when you graduate just as a midwife."* (Midwifery manager)

A long-standing concern was the normalisation of a higher qualification or promotion meaning a move away from clinical care and into administration and office-based activity. There were clear and cogent reasons expressed for why it was high time to stop this practice, with some participants noticing promising signs of a new attitude. *"…some people, when they get their education they move away from patients, but I can see the trend is changing…the **currently** qualified matrons who are working in the hospital, with Masters, they are on the bedside. I just had my PhD. I'm always with the patients in the ward, **all** the time.* (Training institution-SRNM)

A representative from the NMCM confirmed this shift in thinking and the impact it could make.

> *From my perspective, I feel that we need to work on that issue **very** aggressively…we have to look at it differently, that the higher we go, the closer we go to the patient. So, the way our fellow medical personnel are doing…I think it will change the morale. People will be happy, because they **know** that a labour ward will be manned by the in-charge with her **advanced** midwifery.* (Midwives' representative)

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[70] In this section I have removed key informants' identifiers to maintain confidentiality but have left the category identifier to allow the reader to see the type of informant quoted.

Participants were clear about the benefits of keeping these senior Masters and PhD midwives in the ward to act as role models and mentors, acting as standard bearers for the profession. The potential impact of role models forms the basis of the next section.

8.4.3 Midwifery role models as enablers of RMC and quality care

A key concern cited by participants, which underpinned the pre-registration moulding and socialisation processes, and which endured as a significant post-training influence, was felt to be a damaging lack of midwifery role models.

> *You need role models. Now if you are a senior person, you must behave in a manner or your performance must be consistent with your qualifications and your position to act as a role model to the junior ones…and that is why you see people sitting and the woman is calling. They don't attend because the matron is just sitting. If they need to be assisted, nobody comes. So, what happens? You follow the leader!* (KI11, Training institution-SRNM)

Key informants were clear that it was vital to have senior role models in the clinical area if there was to be an improvement in the calibre of staff coming out of the training institutions and to maintain the integrity of the profession. The nascent trend of keeping highly skilled and highly qualified staff in the clinical area offered hope that senior staff would become increasingly present and visible to act as exemplars of both skill and professional comportment. Where these role models were already in place, participants were definite about their value in providing a template of 'the good midwife', displaying the hallmark qualities of the profession, such as excellent skills, working hard, responsiveness, and respecting patients and colleagues. Some key informants felt this would help with shaping students whose attitudes were less than ideal and supporting those who behaved well. *"The more people are qualified, the more people they are on that bedside and the more they are mentoring others, modelling others, the better in terms of our profession."* (KI14, MOH) However, the dominant opinion was that in most facilities the higher-level staff, such as matrons, were in such short supply that they tended to focus on managerial work, rather than supervision or clinical practice, despite these being reported as an integral part of their job description. There were serious concerns about the behaviour of many matrons, with robust criticism coming from regulatory bodies, senior midwifery leaders and midwives. The key problems articulated were weak leadership and accountability, too much time sitting in offices, not enough presence in the wards, and lack of supervision or support. These combined to present an overall impression that many matrons did not do much work.

CHAM facilities faced different challenges in that they only had one matron per facility. *"Even in the district hospitals, there is only one matron and the rest are in-charges, maybe with one year's experience, two years' experience. So that's nuts! It won't work. We want somebody who is wiser, who can assist someone."* (KI12, Training institution-NMT) In some of the CHAM facilities I visited, the in-charge was a young SRNM with very little experience, yet both age and experience are critical factors in maintaining authority and credibility in Malawi's

hierarchical health system. Many smaller MOH facilities relied on external supervision and support from visiting matrons (such as from the District Health Office). The challenges these senior staff faced in regularly visiting health facilities has been well-documented[71], so in their absence, these in-charges may be the only personnel setting the tone and expectations. SRNM ward in-charges in this study reported their efforts to be role models themselves, leading by example and hoping their good performance and professional attitude would encourage their colleagues to behave in the same fashion. This was considered to be an effective strategy because it contrasted with the current practice of many SRNMs. *"…in a Malawian setting, most of the registered nurses, they don't want to work that much. They are going to surveys, they are coordinators, they stay in the offices, they go to workshops…in a week they work only maybe two days…They don't work night shifts, they don't want to work weekends."* (SRNM06) The same respondent felt being more hands-on and demonstrating professionalism *"…can set a tone...yeah. Because if the registered nurses are working hard, they* [NMTs*] can say, 'If the registered nurse are working like that, so how about us who are lower? Let's work harder than them.' So, it will be like there will be more motivation and the tasks should be shared…"* In another facility, the matron agreed that the presence of a dedicated and active ward in-charge had produced a significant and visible impact on labour ward performance.

One final perspective on midwifery role models bears reporting in full as it concerns the dual-qualification nurse-midwife covered in Section 8.1. and provides an insight into why many key informants supported efforts to professionalise Malawi's midwifery workforce.

> *We have got very few midwives available, and among the very few midwives there are even few*[er] *who are fully passionate to be a midwife…most of the students when they are coming in, they will interact much of their time with midwives who don't have the interest to be a midwife…So you wonder, how they will be modelled? How can I be modelled by somebody who don't want to be what they want **me** to become?…whoever is moulding somebody, should be himself or herself that particular person that you want them to be…So whether you would have done it at Masters level, PhD level or even at BSc, as long as that is what is in **you**, and you want to really to be like that, I think that's what is more important, being modelled by somebody who is **that**."* (KI26, Midwifery manager)

However, it must be borne in mind that the absolute numbers of these highly qualified midwives were still extremely small and there were concerns that the leadership lacked a united stance on promoting this as a policy. *"I can count them in one hand, like five or less who have got Masters and are at the bedside."* (KI27, Senior advisor)

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[71] See for example Bradley et al. (2013) for a discussion about perceptions and challenges of supervision in Malawi.

Summary

This chapter demonstrated a growing shift in perceptions about the need to re-evaluate the current state of midwifery in Malawi, partly as a response to the RMC and professionalising discourse from actors such as the White Ribbon Alliance. There was strong evidence that the current challenges in student recruitment, pre-registration training and socialisation need to be addressed if competent midwives are to be produced. The pernicious impact of the 'just a job' dynamic, lack of senior role models and midwives' perceptions of professional invisibility have led respondents to question the dual qualification model and the pathways forward for midwives. Concerns were also voiced about midwives' low status within a hierarchical system, where 'technical' NMTs felt overlooked and demotivated, particularly when substituting for 'professional' SRNMs, and controversy surrounded the future of this cadre, with competing opinions on whether to phase them out altogether or upgrade them to SRNM status. The focus on RMC has provided a catalyst to look more deeply at the midwife and her role, and how the differences in the professional identity, ethos and practice of midwives might impact on care encounters and the relationships with women that are the subject of the next chapter.

9. Relationships with women

Introduction

In this chapter I explore midwives' relationships with women, drawing mainly on the data from the Critical Incident interviews (CIT), supplemented with relevant insights from the narrative interviews and, where relevant, input from key informants to provide national level perspectives. My aim is to shine a light on the largely unexplored perspectives of Malawian midwives to address three of the study's main research objectives, which, as stated in section 1.5, were to:

- Explore how 'good' midwifery was defined and conceptualised in the Malawian context.

- Describe midwives' practice of RMC during labour and delivery.

- Explore midwives' perceptions of the value and impact of RMC for midwives, women and the health facility.

The chapter is split into four sections. Firstly, I outline perceptions of 'good' midwifery, captured as an ideal model of RMC, using examples from the CIT data. The second section explores the micro-level factors and dynamics identified as challenges to the provision of RMC, which arose from the negative incidents that CIT participants related. Midwives' descriptions of 'triggering' behaviours segue into the legitimisation of D&A, where the excuses and rationalising that justify D&A are reported. The third section reports on midwives' perceptions of the impact of RMC, for themselves and for women. Finally, I explore the issue of midwives' relationships with the community, noting the emotional and professional importance of recognition and respect to midwives; the interactions between midwives and the community; and the implications of this for providing RMC.

9.1 An ideal model of RMC

9.1.1 The 'good' midwife

A subset of midwives were asked if there was somebody they had met over the course of their career who they thought was an example of a really good midwife. In most cases, someone immediately sprang to mind and many were happy to identify colleagues who they would recommend. One NMT fondly remembered a really good in-charge. *"…she was a team leader, a team builder…we were always looking to her…we should follow her there, how she do things…The way she was speaking to the clients…So she was a motivator to us and it was good to work with her." (*NMT22) Others had been inspired by the enthusiasm and passion their tutors had shown for midwifery. *"She loves her job so much…she' so passionate, I tell you! That one! It's as if she is still fresh from college."* (NMT32) Another was reported to have *"attended to the patients with all her heart."* (SRNM10) Being hardworking also stood out as an admirable quality, which may be more noticeable given the significant reporting of poor attitudes to public service. Other midwives were admired for their

attitude, particularly being calm or humble in their interactions with clients. *"She holds her temper. She communicate nicely to patients."* (NMT31)

9.1.2 Empathy and relationship

Many midwives were clear about the ideal model of care that facilitated the establishment of the good interpersonal and therapeutic relationships necessary for RMC. The underlying attitudes needed for this were broadly conceptualised in two, interlinked ways; firstly, in religious, particularly Christian, terms of *"…do to others as you wish them to do for you"* (NMT02); and secondly, by midwives consciously trying to think of how they would feel if the labouring woman needing care was one of their relatives. *"…the first thing that comes in my mind is my sisters, my mother…If they are pregnant how would I wish somebody to help them? So that is the bottom line of myself."* (NMT23) These two ideas reflected the importance of religion and community in the Malawian context and intersected with a subset of views, mainly from CHAM facilities, on not being judgmental or discriminating. *"…without saying she is coming from a well-to-do family and this* [woman] *is coming from poor family. No! Without doing that. We treat them equally. Equal treatment for equals."* (NMT30)

Some of the personal qualities that midwives felt embodied good midwifery care included being *"calm", "humble", "passionate", "low-tempered",* and *"empathetic"* which one midwife defined as *"…being in the shoes of the patient."* (NMT30) Other attributes, closely linked to ideas of behaving as a professional, were *"patient-oriented", "hard-working"* and having *"good communication skills".* When asked what RMC meant to them, two midwives explicitly extended respect beyond the micro-level interaction with the woman, to include respect for colleagues too, and seemed to be describing a way of **being** in the labour ward, rather than a discrete activity. One NMT said, *"To me this respect means I need to give respect to my clients, because they are not patients, they are not sick, and even to my colleague"* (NMT32) while a SRNM echoed this, saying, *"…maternity care is about team work. You can't do it on your own. You have to be respectful to the mother, respectful to your fellow midwives, the juniors, so everybody."* (SRNM02)

Alongside the attitudinal components, midwives described tangible behaviours that they thought demonstrated RMC, particularly making women feel entitled to be in the labour ward. One of the most important factors mentioned was the way women were welcomed (or not) by midwives. Many participants alluded to Malawi's cultural expectations of showing other people respect and that this was manifest when midwives greeted women in a warm and friendly way, asked their name and introduced themselves to the woman in return. This was seen to let the woman know *"you are welcome here"* (NMT19) and was a crucial moment that set up the relationship. *"When you miss at that time then you cannot cope later."* (NMT19) Another NMT concurred, saying:

> *Just that welcome, the woman can predict what type of care she's going to have…That is very important, because that's the beginning of everything…So if we welcome the mother well, we introduce ourselves, who we are, and then we ask some questions,*

we ask the name, where she comes from, she feels greatly welcomed and she is free to express. (NMT16)

Although the midwife introducing herself was considered basic behaviour, expected of all staff and explicitly assessed in pre-service training, as we saw in the previous chapter good practices were not always internalised or normalised when the prevailing organisational ethos did not either model or reinforce them. My informal observations were that midwives did not wear name badges. Sometimes this was because they had not been provided with them. A matron in a CHAM facility reported *"Currently we don't have. Of course, we are in the process of making the badges."* (KI06, Midwifery manager) However, another key informant thought midwives were resistant to having their names known. *"They don't want to wear them because they don't want to be identified. If they have done something wrong, somebody will know them."* (KI19, Midwives' representative) This meant that if they chose to, midwives could avoid giving their name to women and effectively remain anonymous.

9.1.3 Communication and support

Good communication skills were another of the more important aspects of the ideal model of good midwifery that participants described, with emphasis placed on how women were spoken to, such as not shouting or using *"low tone"* (i.e. speaking softly). An NMT thought that the use of appropriate language, tailored to the woman's educational level was also important because *"Sometimes other women they are illiterate. They don't even know their age. So even the language we can use will determine the rapport we created."* (NMT16) One enthusiastic, newly-qualified SRNM encouraged women with non-verbal cues. *"So you're supposed to smile* [demonstrates big smile]*. Smiling alone will tell the patient that, 'Oh the nurse is happy to attend to me.'"* (SRNM10) Midwives felt another benefit of communicating well with women was the ability to set expectations. *"…we had very good relationship…we were able to share what I expect from her and as well what is expected of me, and* [she] *was able to understand."* (NMT26) Other midwives obviously enjoyed the occasions when they had enough time to develop relationships and spoke warmly of times when they had been able to chat to women and help to distract them from labour pains.

Midwives' views on the importance of having time to establish a relationship intersected with their perceptions that presence was a vital part of the psychological (as well as technical) component of care but, as we shall see in Chapter 10, the working environment often made this impossible to achieve. A small group of midwives clearly felt that their role was to be on hand to support the woman and respond to her calls, and their stories of a good incident were occasions when this had been possible.

Every time she called I would come…She didn't even have a complaints [sic]*, but she just wanted me around. So that time, because I was not busy, when she called I would go to her…I think when she came for postnatal check-up she said, 'No, my husband gave me this, so much amount of money, that I should share with you'. I said, 'No…It was my job, you are not supposed to pay me for that. That's what I am supposed to*

do. Only that maybe sometimes we are busy...we don't offer you our best, but that was what it's supposed to be.' (NMT32)

Other aspects of the ideal model described by midwives were related to the way in which women were treated, such as reassuring those who were fearful or anxious and having empathy for women's pain. *"There are some times that as a woman feels pain, even you yourself feel pain!"* (NMT32) However, an element of RMC that was mentioned less frequently was the need for privacy, with many midwives feeling that the provision of curtains was adequate. However, in one of the CHAM facilities the beds were organised so that women's feet pointed towards the wall, in contrast to all the other facilities I visited where women's feet pointed towards the open ward. This was a simple, thoughtful change that gave women added privacy when the curtains were opened. Closely linked to this were discussions about the possibility of including a companion for the woman as part of RMC, but not being able to do so as there was insufficient privacy. Labour companions were still relatively uncommon in Malawi (Banda et al., 2010; Kumbani et al., 2013), but staff in one CHAM facility could easily facilitate companionship for private patients as they had their own separate room. Some MOH midwives allowed a companion to be present if there was only one woman in their 3-bed labour ward because of the good impact it had. *"I thought involving the guardian might help to reduce stress in the patient."* (SRNM04) They were forced to stop if another woman arrived. However, not all midwives were in favour, with one SRNM reporting resistance to allowing companions. *"…but midwives, they don't want guardians to be available…mostly what they say is when guardian is there, the woman will be difficult."* (SRNM09)

Providing women with information was another key element of being a good midwife and RMC that was mentioned. Some midwives put an emphasis on explaining, listening to women and generating the conditions where they would feel free to volunteer clinically relevant information that they might otherwise have kept to themselves, such as grand-parity or previous caesarean sections. "*Now if you have conducted yourself badly to the woman and she has chosen not to tell you that she has gone* [for] *caesarean section two times...you can end up having a ruptured uterus to this woman because you were in the bad relationship at the first time*." (NMT07)

For many NMTs, forging a good relationship impacted heavily on their ability to manage labour as it made it easier to inform women of what would happen. Others were pleased that they were able to give feedback and useful tips. *"After every observation, I was telling her my findings…And you need to be doing this and that, like you need to be ambulating so that you won't take long. It should promote the descent."* (NMT24)

9.1.4 Participant, not bystander

Closely linked to giving women information were a small number of incidents where midwives felt good because they had involved the woman in the birth, asking her what she wanted, although this choice was often couched in terms of 'permission' rather than 'entitlement'.

…it's like we give them all the freedom. When they are in labour ward, if they want their partner to come, if there's only that client, we say, 'OK, you can bring your partner, or you can bring your guardian here.' Or if they want, they say, 'No, I want to go out[side] *or I want to do this', we allow them. Because of the rights, we don't limit them.* (NMT12)

An SRNM also described giving a woman the option to have a companion present, saying, "*I think it was good care just because she was like asked…because her ideas or her decision was respected.*" (SRNM04) Others felt that a good relationship allowed dialogue that involved the woman. One NMT working with his colleague said, "*…she was also asking questions. 'What should I do now? I'm feeling more pain' and my friend was talking to her that she should be using deep breathing mechanics.*" (NMT19) In another CHAM facility, an NMT described his best delivery as with a private patient whose husband was present, a model of birth that was rarely available to most women (Kululanga et al., 2012). His perspective was not typical of the majority of midwives in this study. Talking about the benefits of establishing a good relationship he said, "*…it also helps the women to be the part and parcel of planning for her own care…and again, for us to give good care it means that we also need to involve the mother, the woman, and even her companions, about her care and what to expect.*" (NMT22) Another CHAM NMT stressed the importance of having passion for the work if midwives were to provide RMC. "*…so give the women passion. If you give them, they will also give you back that, and work as a team with her and you.*" (NMT24)

Although views about women's agency were not often expressed by midwives, it was sometimes clear from the manner in which participants spoke that some were uncomfortable with the *status quo.* I asked a ward in-charge about whether women had a choice about the position in which they delivered. "*…during labour they can move around, they can be in any position. But when they come to second stage, we encourage them to be in a supine position because it…it's easier for the midwife. Yes.* [looking and sounding a bit embarrassed]*"* (SRNM05) At the national level, key informants were more vocal about the need for change, demonstrating the nascent move towards a more woman-friendly approach.

*I think at the end of the day what we need is a change in mind set. Where **women** are looked at as partners, yeah? The value that we as health workers **give** to the women, we have to change. It should no longer be like 'OK, I'm doing this for you', but rather it should be 'we are doing it **together**'. Because if am saying 'I'm doing this **for** you', it's like it's an object, I can do things on this object and go away with it. But if we are together and I attached certain values, I think things are gonna change. So, trainings, we are doing them. Respectful care trainings are being done, but what we need is translation on the ground.* (KI05, Training institution-NMT)

9.2 Challenges in providing RMC

9.2.1 Negative attitudes and lack of time

Midwives were aware that health facilities were sometimes not very welcoming and that women were reluctant to attend because of disrespectful attitudes from some staff. They felt that these manifested in women not being greeted or properly attended to when they arrived in labour ward, and sometimes poor care incidents resulted in women delivering alone. For example, an NMT reported a colleague *"who just say, 'Just go and find a bed.' I hoped she was going to attend the mother. She didn't go, even to know if really she was in labour. So, after some time, the mother just cry* [puts on high pitched voice] *'Oh the nurse, it's a baby.'"* (NMT16) Although midwives described their own instances of poor care, they were unlikely to comment on any negative attitudes they might have themselves, instead focusing on the poor attitudes of 'other' midwives. A key concern was the impact on facility-based delivery. *"About attitude...not all of us, eh? But others…It can be difficult for the women maybe to come here. Others, they decide to deliver at the TBAs because of the attitude."* (NMT08) Alternatively, given the existing ban on TBAs, midwives suggested women resisted by delaying their arrival at the health facility. *"…the attitude of the midwives…that's putting them off from coming to the hospital…so they make the decision very late."* (SRNM08)

A significant number of participants, at all levels, explicitly linked midwives' negative attitudes towards women to the issue of midwifery being 'just a job' (as we saw in Chapter 8), which they felt intersected with the broader cultural shifts in attitudes to public service and the lack of accountability that were discussed in Chapter 7. There was a widespread perception that attitudes needed to change and that some midwives were using the prevailing circumstances as an excuse. *"…they know how to do the right things. Most of them know to do the psychological care. We learn them, and we know them. But they are just blaming on other things, political things, economical environment, the social environment, they bring it to work."* (SRNM06) However, this sat in opposition to another commonly held idea that *"the attitude they* [other midwives] *have is just inborn".* (NMT13) Efforts to improve attitudes, such as via continuing professional development and in-service training, were welcomed, but some midwives did not think they would make much difference. *"Because you can learn not to, but if it's inside you, that's when you hear some other midwives maybe slapping or pinching…"* (NMT01)

Participants felt that many of the challenges of establishing a therapeutic relationship and providing RMC stemmed from the lack of time they had with women. In some cases, midwives believed this was due to women arriving late in the labour ward (as we saw above) which meant they did not have the opportunity to talk to women before labour became well established. Others attributed it to the sheer weight of patient numbers or having to deal with emergencies which resulted in some women having to cope on their own.

> *I was all alone and I had four or five patients in the labour ward…So it was like a matter of just taking care of a patient, see her deliver, I'm done with her, go to another*

patient. So, it was like I haven't had enough time with the mothers…when you are in labour, you feel you need the nurse's time more than ever before…Because of the pain, at least you want someone around…and with our culture most of the time we don't allow the husbands in the ward. The one trusted there is the nurse. So as a nurse I felt I have failed somewhere, because I couldn't give much of my time to the patient. (NMT32)

Midwives worried about managing many competing responsibilities and the potential to make mistakes. An NMT who made a serious error and gave a baby to the wrong guardian said it was because, *"I was rushing…they were two other patients, near to second stage. So I was rushing, to take the baby to nursery, come back and conduct a delivery, because I knew if I delay I will find the patient delivered on her own."* (NMT07)

9.2.2 Social distance and 'othering'

The midwife's status

Midwives did not allude to their own status when talking about disrespectful care, instead referring to women's lack of education and low literacy levels as drivers of disrespect. *"…they are illiterate, so they don't know their rights. So, some people, they mistreat them, because they know that these people they don't know their rights."* (SRNM09) However, key informants were more likely to raise the issues of power and status. Being a midwife was regarded as *"a high-status job…you have a status in your society, people respect you."* (KI22, Training institution-SRNM) Further, the midwife's education also created a sense of entitlement to mistreat women.

> *…you know most of our women in Malawi are not that educated, so for us midwives we feel we are educated so we can talk **anyhow**, she can't say anything. So, there are a lot of verbal abuse to the women…and we wouldn't want that woman to talk back to us. If they do, we deny them the care they are supposed to get. So the woman will keep quiet, will just suffer inside.* (KI13, NGO)

A number of participants were clear that this dynamic was more prevalent in rural areas where midwives would usually have higher status than local women. A Chief Nursing Officer described how this impacted on what midwives thought they could get away with and the differences between urban and rural facilities.

> *…nurses feel those ones* [rural women] *they don't have a lot of **say** or they can't retaliate in any way. But here* [in a city hospital]*, the midwives they are sensitive because they are in an urban area…Here, they* [women] *would complain. But in the villages, in the rural areas, most of them* [women] *would just say, 'I will not go again' but here they would come back and use those other means to complain that I was not treated properly, and the midwives also know that.* (KI15, Midwifery manager)

Some key informants explicitly addressed the power differential between midwives and women, which varied not only according to geographic location but also by socio-economic status. *"Probably the health care provider seems to view themselves as a little bit* [more]

powerful than the people they are taking care of…Because I am looking at why, I'm looking at the power imbalance. You don't hear much of these complaints from the private facilities." (KI21, Midwives' representative)

It was during data collection in one of the rural MOH facilities that I first observed the phenomenon of women kneeling to show respect and humility. This was a cultural practice that I had heard about, which I knew was expected when giving food to guests or talking to senior relatives. I was also informed that senior female project staff would be expected to kneel when talking to a chief, and later was extremely uncomfortable to be on the receiving end of this behaviour when staying with a Malawian family. One of my sample MOH facilities was in an area where the SRNMs reported difficult relationships with the community. After an interview with one of the NMTs I wrote:

> *Just before we started the interview a woman was sent in to the office by another member of staff to ask for a prescription to be written. The woman came in and knelt in front of the midwife and stayed kneeling the entire time she was talking to her. She was not invited to stand and the NMT didn't make much eye contact with her, just waved her off when she was finished. Yet off tape the midwife was openly critical about how the treatment women receive often depends on what health workers know they can get away with. Her view is that care is much better in urban areas as women know their rights, tend to be more educated and of higher status, but are also more aware of the constraints under which midwives operate, so there is less tension in the relationship. In rural areas she suggests that women are treated badly because they are seen as uneducated and of lower status (see the kneeling!), while their ignorance of their rights means they don't expect more or complain if their treatment is poor.*
> (Field notes, 15 Apr 2016)

Social inequality

Midwives also described circumstances where some women were more welcome than others, contrasting sharply with the aspirations espoused in the ideal model of all women being treated equally. An NMT was eloquent about the differential treatment he saw in a CHAM facility.

> *I think it's high time that all midwives in Malawi, they should learn to treat each patient as equal…looking at maybe religious affiliation, the financial status, or maybe the closeness of the patient. I have seen people maybe trying to overwork because it is a relative of their friend…You see a private patient comes in, you see lots of people panicking trying to offer the best care. And you see somebody from the village, coming in…you see that this lady is being helped, but not as compared to a private patient…We cannot run away from that, we have to say the truth. That is happening not only in this institution, but I have gone lots of places to visit friends…I could really see that this person came here, has been treated in such a way; this person is coming has been treated this way…* (NMT23)

One of the poor care incidents described a woman actively being treated badly because of her social status. She had been deemed 'uncooperative' during the birth and was subsequently mocked by the midwives.

> *…she was using an old blanket as a pad after the delivery. Yah. They were shouting about the pad, and when she was trying to bend down they said 'don't bend down near us because you are going to fart near us'…things like those which were embarrassing, eh? 'Heh, look at your clothes'. 'Look at...you didn't even prepare for this delivery. Look at the clothes you have for the baby, they are not even new. Look at the basin you are using.'* (SRNM06)

9.2.3 Power and control

The uncooperative woman

A significant trigger for disrespectful care, cited in half the poor care incidents, was the 'uncooperative' behaviour of the woman. This reflected midwives' efforts to control women's bodies and was frequently framed by respondents in terms of women deliberately misbehaving and needing to be disciplined. The key focal points reported were how women dealt with pain and the 'effort' they made to push during birth. Particular irritation was expressed about primagravidas, who were considered the most troublesome group to deal with. *"Those that was the worse is primagravida"* (NMT11)

In the poor care incidents, women were often frightened - of the health facility, the midwife or the birth process itself - and this was exacerbated by not being able to manage their pain. In Malawi, drug resources were in short supply and pharmacological pain relief was not usually used for labour pains. For example, participants reported that even in the central hospital pethidine was not kept in the labour ward and invasive procedures, such as manual removal of placenta, were carried out without any analgesia. Midwives had non-pharmacological methods to help women which were considered to be part of psychological support and encouragement. *"If the pain is more, you do back rubbing and encouraging to have deep breathing technique. And chatting with her, some stories which can make her forgot* [sic] *the pain."* (NMT27) However, within the health system's constraints, midwives felt this could only be done *"If you have enough time and if you have few patients."* (NMT05) One SRNM's strategy for this was *"…you just encourage those things that are possible, like panting, walking around, pelvic rocking. I always teach them. Then you see the client has stopped* [crying].*"* (RNM01) Although midwives were taught that massage was an effective and expected element of care, this strategy was not often applied. *"When we are at school we are taught to provide pain management, one of which is massaging. So those things we normally tend to forget when we qualify."* (NMT06) Midwives expressed their distress when they were unable to offer non-pharmacological methods of pain relief, for example due to the number of patients or women presenting too late in labour to be able to listen and respond to the relevant tips. *"It was even distressing to the midwife to see the woman crying for more than 5 hours, 6 hours, crying throughout."* (SRNM05)

The other trigger point for disrespectful care, which appeared under the 'uncooperative woman' theme in the data, was pushing. Women were chastised for 'poor maternal effort' or for pushing too soon or when the midwife was not ready. 'Poor maternal effort' was described by an NMT as *"when somebody is not able to push with strength, so that we can take the baby out, despite all the mechanisms that you are adding. You may put some IV line, push some dextrose, the contractions are there, encourage the woman to push, change the positions."* (NMT11) She went on to list the possible reasons as *" they are not **sure** of what they are doing…they are afraid of the pain…they don't know what to do…maybe this person doesn't want the baby."* When women would not push midwives reported resorting to shouting, calling the guardians, or threatening to abandon the woman. One SRNM recounted a story where her colleague had two women in late second stage together, but the one she was attending was not bearing down as instructed. *"She said, 'No, I'm feeling so much pain, so I can't do that.' So, this midwife was like, 'You lady, I have another client to attend to at the same time, so just do it fast so that I should help you and I should help your colleague!'"* The second woman started calling for help. *"So, the midwife thought of leaving this one who was not willing to bear down and rushed to somebody who was asking for help as she was also about to deliver."* By the time she had changed her gloves *"…the client delivered on her own, so she went and just found the baby already delivered on the bed…"* When she had finished helping the baby she switched her attention back to the first woman. *"So that client who was refusing to bear down delivered also **alone**."* (SRNM04) Other midwives spoke of the challenges of a commonly used herbal uterotonic (known colloquially as local pitocin), which young girls were advised to use by older women in the village to speed up labour. This could cause overwhelming contractions and a premature urge to push. *"Then the woman becomes distressed, she can not maybe cooperate on the labour ward…the woman starts pushing while she is 4cms…it seems as if you are **harsh** because you are telling the woman **not** to do."* (NMT08)

Many midwives spoke of 'uncooperative' women who were out of control, throwing themselves around in the labour ward and moving from bed to floor in a way that contravened the expected rules of behaviour. A frequent refrain was that women *"…are not doing what they are being told to do."* (NMT01) A woman's refusal to obey the midwife's orders, rather than the 'orders' of her body, such as wanting to move around or not wanting to ambulate when instructed, or refusing to allow vaginal examinations, made it *"…very hard to give quality care"* (NMT24) and risked *"…you end up in having complications."* (NMT24) In some cases midwives felt obliged to call in guardians/family members to help 'persuade' the woman to cooperate. *"We even involve the guardians eh? to come close so that they can talk to her, so that we repair the perineum."* (NMT17) Others described how they struggled to keep calm when faced with behaviour they felt was endangering the mother and baby. *"If the woman is not responding you can get angry…As a midwife you just do your best to tell the woman, to make the woman understand. If she is not understanding, then you can get assistance from your fellow worker or the guardian, at least to communicate with the patient."*

(NMT07) However, in some cases the guardians were brought in to join forces with the midwife to bully the woman into cooperating.

> *And sometimes there's also a trend that when the midwife shouts at the woman and she is not delivering, they also call the guardians to shout at her. So there can be sometimes the parents, sometimes the aunts, sometimes even from the in-laws, they also sometimes come, so they even also shout at the woman. They make it stressful because, especially the in-law, they feel like she is going to kill their baby.* (SRNM06)

Rules, compliance and resistance

Linked to the cooperative discourse were midwives' descriptions of women being punished for transgressing rules and expectations, or for simply not doing what they had been told. This most often took the form of shouting or threats to withdraw care. Many of those relating these incidents spoke about 'other' midwives' behaviour. Incidents included an NMT who *"was not impressed"* when describing an incident where a college slapped a woman in pain who *"…after being told to keep quiet, she was just shouting…"* (NMT21) Another told of stepping in to help a woman who sustained a second-degree tear during a home delivery, but was punished by two midwives who refused to treat her because she had delivered at home, with one saying, *"I will not suture you so that you can take a lesson."* (NMT13) However, midwives were also aware that women were not always in a position to make the decisions about the actions for which they were subsequently punished. For example, a woman who delivered at home was reported to have done so because *'My relatives said that I should wait so that I cannot stay long at the hospital. I have to wait because it's the first pregnancy, so I didn't have the mandate to just start off the journey without my relatives.'* (NMT13) Another example was a women who was referred to the central hospital by the health centre. An SRNM had to intervene because her colleagues scolded, then ignored the woman because the health centre had referred her inappropriately. When the SRNM put on her gloves to assist she *"…found the baby already head out on the bed."* (SRNM01)

A small number of midwives were comfortable enough in the interview to tell me about their own poor behaviour. One particular story I was told bears telling in depth. Although it was an outlier in the data, in many ways it encapsulates the issues of power, control, cooperation and 'woman as bystander' that underpin less extreme manifestations of the micro-level interactions that remove women's agency and choice in Malawian labour wards. An older, male midwife (NMT26) described his involvement in an escalating incident with a 16-year old primagravida who was throwing herself off the bed as she was unable to cope with the labour pains. He was concerned because she was *"…falling on the floor and against the abdomen, which may affect the life of the newborn"* and grew increasingly irritated because *"We could not eh ah* [pause] *we are not able, in a position, to do work well, because she was doing what she wanted…"* He decided to consult the girl's mother, subtly threatening to move the daughter to a higher level of care - something which causes alarm and fear for rural women - if the girl would not behave, and raised the spectre of the baby dying before delivery. The mother's response was to give him a free hand, saying *"If you feel like you can assist us here*

[in the health centre]*, then I want to leave you with the patient. Do **anything** with the patient…I will be on your side."* When the mother left the ward he told the girl, *"…'you should expect pain to have your fruit out. So, I don't need to give you another painful…it's not good. So, if you want it, it's up to you. Now your mother has left everything in me. I will do anything, but before I do anything, I would like to ask you to take your heart.' So, she had a fear of unknown, what am I going to do."* He continued to tell her about the risks of a dead baby, then threatened her with an episiotomy, saying, *"…the shortcuts that will be used will be painful to you. Because I would like you to have a baby born very fast, so that will cause you pain."* While he was recounting his story to me he was miming holding the girl down and cutting. When I asked him why this was an example of poor interpersonal care he said:

> *I think she was not understanding, because I **explained**, but because I put on words that were…that seemed to be **harsh**, that I would be harsh, because she would not...she did not want to be treated in that way, then, she chose to be quiet. So, I was not happy because it's like forcing her to do what she don't want…it's forcing her to do good when she did not want to do good. Mmm, yes. It ended well, yes, but eeh it's not in my wish that she should think of, had it been I didn't listen, he would have done that* [hurt her deliberately]. (NMT26)

Although an extreme case, this story demonstrated how lack of cooperation was not permitted and that a relative's permission would override a woman's wishes, making her a bystander in the process. At the same time, the midwife felt he lacked other options and described feeling compromised by what he had done. The justifications midwives offer for this sort of behaviour are the subject of the next section.

9.2.4 Midwives' justifications and legitimisation of D&A

The story of the threatened episiotomy above was an extreme example of an underlying and strong rationalisation by midwives in the CIT data that the ends of 'live baby, live mother' justified the means. Some midwives expressed confidence that once the pain was over women would quickly forget any harsh treatment or shortcuts they had endured, even if *"...the care she received is not the care she was supposed to be given…if the baby is just born and crying, nothing went wrong, she won't complain a lot."* (NMT03) However, underlying many of the incidents that were recounted was a pervading sense of fear of something going wrong and the midwife being held to blame. Many worried that the NMCM could take away their licence, or the guardians or community would react badly. *"If there are any poor outcomes then eeh! It's* [pause] *it's dangerous, because the community then, they shout at us if we do that."* (ENM02) Midwives' concerns sometimes manifested in the exclusion of the more interpersonal elements of care, particularly when complications arose, and this was strongest among the two ENMs and many of the NMTs. *"I think we were just only focusing on the technical aspect of it. I think the person, that was a bit neglected. Because maybe we were trying like to assist so she could deliver faster…but maybe telling her what to expect, I think that aspect was missing."* (NMT22) Midwives reported their anxiety about prolonged labour or women crying too much and the impact this would have on

foetal outcomes. Crying and screaming were often considered part of uncooperative behaviour and may have been driven by a common belief that *"…when you are crying you are depriving your baby from oxygen, because when the uterus is contracting it's depriving the baby from oxygen. And you are crying again, you are depriving even more."* (SRNM01) One NMT had been told *"If you don't shout* [at women]*, you will have more asphyxiated babies",* but did not think this was true. *"You need just to explain to a woman politely about the process of labour, until that woman understands."* (NMT15) However, the choices that midwives felt they faced were described to me in stark terms by one key informant.

> *…treating women with respect…they say if 'I don't shout to this woman she will not push when I tell her to push. She will deliver a flat baby.[72] When there is NND* [neonatal death] *or SB* [stillbirth]*, all the blame will come to me as a midwife. I didn't help this woman.' …They* [the NMCM] *will come and say, 'write a report' and the relatives of the woman will say, 'she has delivered a flat baby. The midwife didn't support them well, we are going to court.'…So, this midwife's licence is at stake.*
> (KI13, NGO)

For some midwives, the perception of poor maternal effort caused very negative emotions, which one NMT was brave enough to share with me.

> NMT21*: She tells you that she is tired, mm? And you, you are just seeing the baby there* [on the vulva]*…Sometimes you just feel like, 'aah but this one, mm? she is not serious'. And you feel that thing, mm? that anger thing, coming, and you just like shout at her and threaten her. 'You! If you are not serious with that, that baby will die there, and it will not come out.' So, it's like you speak such words and you find that the person is just pushing and the baby is out. Yeah. So, it's like, sometimes such words, we* **use** *them because we want the action to be done there and then, the baby to be out, and then you are relieved…because you feel that if that baby delays there, at the end of it all the baby will not be well. So, I can say maybe fear, fear also is there…*
>
> Susan: *…then afterwards how do you feel?*
>
> NMT21*: I feel relieved, mm? You laugh. Yeah. And then I now can go to her now, to say, 'You see, what you were doing? You see a very healthy baby and you were almost killing it?'*

While the fear of poor outcomes was used to justify some of the ways in which women were treated, women themselves were held responsible by some midwives for much of the disrespectful care they received. One NMT captured a common justification for the treatment of the uncooperative woman when she said, *"…the way the woman is behaving, is what makes a midwife to respond."* (NMT15) As well as blaming women for the way they behaved, some midwives also used women's responses after the birth to minimise what they

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[72] When midwives refer to a 'flat' baby they mean one who has been delivered in very poor condition e.g. no respiratory effort, little or no response to stimulation, poor colour.

had done. I asked the male midwife (above), who had bullied and threatened a young girl with an unnecessary episiotomy, how he thought she had felt. His response was, *"At least on her part she felt good, because I saw that she was thinking that she would not make it and at last she did it. So she was very happy."* (NMT26) In other cases the harshness meted out to women was vindicated in midwives' eyes when women apologised for their behaviour. One NMT told a story of a really uncooperative woman, who he was forced to attend when she birthed on the floor. *"Sometimes when they are stable, after delivery, others may come to apologise, 'Ooh I'm very sorry, I did this and this'. But then you feel happy…Because she came, she knows what she did was wrong…"* (NMT17) However, women were thought to not feel able to protest. *"Most of the times Malawian women...they don't talk...maybe they had something to say, but they didn't say it."* (SRNM04) Further, this sort of disrespect and abuse was perceived to be normal by both the woman and the community. *"Because if you ask a woman, she will say 'No the midwife just wanted to assist me. That's why she slapped me, that's why she talked to me harshly, because she wanted me to do what she wanted for me to have a live baby'."* (KI13, NGO) However, for some midwives this dynamic was not welcome, eliciting feelings of guilt and undermining their sense of professionalism.

> *I felt guilty after that experience because I knew that she was young. And even what made me feel bad also was that she even apologised to me…'I am sorry for that. I didn't know what you were doing to me.' And I also said, 'Aah, I am sorry, because I was tired, but I was on a night shift and me also, I was tired.' So lucky enough we both reconciled before she went home, but I even regret it up to now, the way I shouted to her. I was very unprofessional and unhuman-like, because she was very, very uncooperative.* (SRNM06)

9.3 The value and impact of RMC

The CIT participants were specifically asked about the impact of RMC, for themselves and for women. However, some of the midwives who took part in narrative interviews also spoke about this, so their views have been included here. Their responses allowed me to explore midwives' perceptions of the value and impact of RMC. The final section discusses the growing discourse on women's rights and includes perspectives from key informants.

9.3.1 Benefits for midwives

Many midwives were positive about the benefits for their own practice when they invested time in establishing good relationships with women. Both NMTs and SRNMs commented on how it fostered cooperation, which made their working lives easier. *"…it has a positive impact to our job, because if we welcome the patients warmly, that means the patient will be cooperative…that means everything will go smooth."* (NMT13) Another NMT also described multiple ways in which RMC, particularly good interpersonal care, made his working life easier. *"It's good because you are able to gain cooperation and trust from the patient. And it's also good because…it's easier to get, to give feedback to her. And also if you want something, then to get consent it becomes at least a bit easier."* (NMT22) Another said,

"…when the woman is happy, that makes the work easy, because you talk to her, she will respond and the delivery will be easy." (NMT07) Conversely, participants felt that poor relationships exacerbated already challenging working conditions and had a negative impact on women's cooperation. Other benefits reported by midwives were felt to be due to the sense of growing professionalism and learning in the wake of a good delivery. An example of this was related by an SRNM who had watched another health professional's management of pain and been inspired to change the way she practiced herself.

> SRNM09: *At first…I just thought when the woman is in pain, mostly you just ignore her, or you just tell her* [puts on scolding voice] *'Yes, pains comes! You just have to bear it.' But ever since that time, I realised that much as maybe we cannot give the pethidine, but the psychological care itself is very much important to the woman. I can assure her, 'I know you are feeling pain, I know you are in pain, but don't worry, I'm here to support you.'*
>
> Susan: *So that changed as a result of seeing…?*
>
> SRNM09: *Someone do it!*

Midwives described how providing good care to women also enhanced their own feelings of satisfaction and professionalism. One SRNM felt, *"…it helps building my professional conduct…and people can easily point to say, 'we have a midwife'. Yah, for somebody to say, 'we have a midwife', it means you have shown an outstanding character on your clients, so I feel happy when I have done something that pleases my client."* (SRNM01)

9.3.2 Benefits for women

A small number of midwives articulated benefits to RMC that were not confined to the discourse of cooperation. Two male NMTs, both of whom were described by their colleagues as outstanding midwives, described the positive psychological impact on women. One suggested that with comprehensive management (which included interpersonal care) *"'…there are a lot of benefits to the woman…So when we give comprehensive management we reduce those stress, the anxieties."* (NMT16) The other NMT said:

> *I've seen there is a lot of disrespect to the patient...that will frustrate the patient and when you want to do any procedure the patient also won't respond in a good manner, and at the end, you find maybe that the delivery will have complications because you didn't have the cordial relationship at the first time. So respecting patients…is very important as far as the good midwifery care is concerned because the outcome will always be good when you have developed a good relationship.* (NMT07)

In addition, three SRNMs described physiological benefits when care was respectful, because shouting at or scolding women slowed down labour. One was very aware that women were afraid when they came into the labour ward and that RMC was one way to manage this.

…when you shout at a woman and psychologically she is disturbed, it also affects the labour progress because it may take longer for the woman to deliver…when they come to the hospital it's a new setting and they see the instruments, they see us putting on uniforms, masks, and some of them might be scared…I feel that it's important to explain to them so that they can they can adapt to the new environment…I believe it helps to progress the labour and reduce other complications which might come when a woman is in labour, is scared. (SRNM06)

9.3.3 A growing discourse of women's rights

There was a growing awareness among midwives, expressed much more strongly in CHAM facilities, that women have the right to quality care and to be treated respectfully. NMTs in CHAM said, *"I should know the patient's rights"* (NMT23) and spoke of the *"…need to respect her views"* (NMT31), while a CHAM SRNM was clear that women should make their own decisions. *"You know that they have to make the decision themselves, you cannot force them after all, you have to respect that."* (SRNM08) Others spoke of mechanisms for the community's voice to be heard, such as hospital advisory committees or community score cards,[73] while some mentioned the impact of NGOs in raising awareness.

SRNM10: *…when I joined the profession I noted that there are some who are a bit rude, but then due to the sensitisation…people were told that if someone does this to you, you're supposed to report. Things are changing, so it means it's improving. Yah. Midwives are now being respectful to the mothers.*

Susan: *And is that because the mothers know their rights or is it because the midwives know their responsibilities?*

SRNM10: *Either ways!* [Laughing]

These sentiments were also very visible at the national level but, until recently, women were considered to be unaware of their entitlements, as one key informant involved in training degree-level midwives noted. *"Disrespect of women, I think it's an issue. But maybe most people don't even know, you know? If you don't know what you should be getting, what care should be provided, then you are easily abused."* (KI25, Training institution-SRNM) Informants felt that in the past women had little recourse in the aftermath of poor care. *"Another thing that is changing more and more, which undermined our health care, is that there was almost no litigation. But now, they are coming, and people are realising their rights, health rights, and people* [health workers] *are now taking notice."* (KI24, Academic) However, other key informants worried that women were not empowered to speak out, that *"…it's not a lot of people who can have that courage."* (KI09, Midwifery manager) A Chief Nursing Officer agreed that there was a large social distance between women and health

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[73] Community score cards have been used by CARE in Malawi since 2002. They are a social accountability approach that uses a negotiated process to develop and score indicators and develop/implement action plans. Progress is regularly checked by the community, health workers and power-holders. See Creanga et al. (2017) for an example of its use in perinatal service utilisation and patient satisfaction.

workers that made it difficult. *"…to see a patient coming, fearing 'how do I express myself to the doctor or to the nurse'? So you are looking at somebody **sick**, they want **care**, but they are even afraid to express themselves about their issues."* (KI26, Midwifery manager) This gap did not just affect marginalised women. One senior nursing officer said, *"Even me, when I'm not in uniform, to approach a nurse who doesn't know me, you think twice. How do I approach that nurse? Because of the...I think the attitude that a lot of nurses have."* (KI09, Midwifery manager). Another very confident, senior midwife described the poor care she observed when she attended the labour ward with her daughter and the dynamics at play when she felt forced to complain.

> *My daughter was not treated very well…No observations were made. And I said, 'Oh! I don't want to lose my daughter'…I just reported myself to the doctor, that there was no progress. So, in the end I just revealed that* [assumes soft, apologetic voice and meek body language] *'I have to apologise, I'm a midwife. According to this situation of my daughter, there is high blood pressure, 180 over 130, and **definitely** this is severe pre-eclampsia. Sorry, I am not forcing you, but I'm just giving in suggestions. If you can take this daughter of mine to theatre, provided you save the life of my daughter and the neonate, I will be very happy.'* (KI01, Training institution-NMT)

If women were unhappy with the treatment they had received there were mechanisms for complaint. For example, the local District Health Office required complaints to be made in writing (KI10, MOH). The NMCM had until very recently stipulated that all complaints be made in person to the headquarters in Lilongwe, but realised that this made it very difficult for people from the northern and southern regions. When the data for this study were collected (May 2016) the Council had started to set up regional offices in Mzuzu and Blantyre. In the interim, they had opened a toll-free phone line to make it easier for people to report their complaints, but *"…we were advised by our legal advisor, to say if they call on the toll-free line, they should write even an e-mail or a letter, because that would be much* [better] *evidence."* (KI19, Midwives' representative)

9.4 Relationships with the community

9.4.1 Recognition and respect

It was clear from many of the narratives that a primary reason that midwives remembered their good incident so vividly was because a happy woman and/or her guardians had taken the time to thank them after the birth. It was poignant that for many midwives this was clearly an unusual event. Some were smiling broadly as they recounted times when women wanted to name the baby after them as a thank you, or *"…sometimes even when we are going in the streets, when you see a mother showing you a baby, 'Here's your baby, she is growing', you feel, 'Ooh!' So they do appreciate what I did.'* (SRNM05) Women sometimes asked for a midwife's details and some ended up becoming friends. *"I felt that, 'OK, if I did this and someone had to request for my contact, now she is a friend', I was really motivated. I did a good job! I have to continue."* (SRNM09) Other midwives spoke about how a positive birth

experience, where they were able to provide RMC, encouraged them to continue. *"I think it's nice when someone appreciates your work…you feel motivated…I felt like 'No, maybe I should do more and improve on this one.'…Seeing those mothers trusting me. So it was like I have done my best!"* (NMT32) Opportunities to treat women well were extremely satisfying for some midwives, while others felt the urge to improve as a consequence of women's responses to their care and noted the impact on their sense of professionalism.

> *…as a professional, that encouraged me to also be telling the others that...if you assist the patient good, you won't be in conflict with the patient. In fact, you will also be appreciated by the patient and as a profession it means…we are up, we will get there where we are loo-...we want a good standard of care. So, we can get there because you have that passion to work since you are being appreciated by the patient.* (NMT07)

One SRNM's poor incidents centred on intervening to help women who had been subject to disrespectful care from her colleagues, and the pride she felt when women left the facility having been treated with kindness and compassion. The respect of the community was an important consideration, with many midwives concerned to maintain their reputation and acutely aware that poor behaviour in the labour ward did not just have an impact on the woman concerned, but rippled out into the wider community and shaped the way in which women viewed facility-based delivery. The disrespectful actions of colleagues were described as having harmful impacts, where *"…my fellow friend is destroying the name of midwife."* (NMT15) Key informants agreed. *"There are some who are very dedicated and committed. But if there is **one** who has got poor attitude, even if they do well, the whole labour ward, the whole maternity, it looks to be bad."* (KI19, Midwives' representative) Others took steps to stop their colleagues. *"I just told her that 'aah, am not impressed with how you have performed there, because at the end of the day it's not **you** whom people will be talking about, it will be **us**.'"* (NMT21) At an individual level midwives were aware that their poor behaviour would be discussed in the village and that other women coming to the facility would know about them. *"…when you mistreated them, you meet them, they say, 'This is the bad nurse, she shouts at you.' And when people came here, saw you, they discuss outside about you…and the other one came and saw you here in the labour ward."* (NMT02)

Conversely, good midwives could improve the facility's reputation. *"Even at the community they tell to each other 'at that hospital they do receive us well'. So you can contribute a lot in this as midwives."* (NMT18) In two facilities, participants were pleased to be able to demonstrate how well their facility was regarded after efforts to improve. In an MOH facility, an NMT reported:

> *…we have 5 if not 6* [health facilities] *around us, but women are coming from those areas, coming to deliver in* [name of health centre]. *They are saying that 'nurses…welcome us well, and they are caring us very well.' So that is the sign that*

you know we have improved. Yeah. A big number, they are coming from far away.
(NMT10)

In one of the CHAM facilities, an SRNM was proud about the improvements they had made to their reputation.

SRNM08: *People now come from* [name of another area]*! Do you know* [name of area]*?*

Susan*: No, no…but I can see from your gestures that it's a long way away!*

SRNM08: *And other **nurses** come to this hospital to deliver. So that one also can tell you a story. We can be bad, but at least we are trying. Because there are also other hospitals there, why can't they go there? And they choose to walk out of* [name] *town to come to this rural area.*

Individual midwives who were respectful and competent acquired a word of mouth reputation, with women asking for them when they arrived at a facility. A male NMT in an MOH facility, who was described as an outstanding midwife by his ward in-charge, told me about the impact of his way of working on the local community.

Sometimes the clients in their villages, they know whom to contact and they prefer a certain midwife to the other, just because they have got experience from other woman who got delivered there. So, the way she got cared, the moment she came into the labour ward, she reports those messages into the village. So other women, whenever they came here, they also prefer, they just have that mind-set, 'If I see that midwife, I think am going to be given total or even comprehensive care, and am going to be handled properly.' (NMT16)

9.4.2 Negative attitudes towards midwives and facility-based delivery

Midwives reported that some women arrived at the health facility with negative attitudes towards them, influenced by either women's own previous bad experiences or by reports from their friends. *"Other clients have bad information from the community. 'When you go to the hospital you will find nurses, they are very furious and very angry'…And with that mentality, they come here with their minds not good."* (NMT17) There was awareness among some midwives that the women *"…are afraid of us, our behaviour"* (ENM02) and that some expected midwives to treat them badly. *"…they have that in mind, that when they come here they are not assisted well."* (NMT07) Another NMT reported women's perceptions that midwives *"…don't talk good to us, you do like violating our dignity."* (NMT25) Fear of midwives and expectations of being mistreated caused conflict and generated a tension in the relationship from the outset, with some women arriving at the facility ready for confrontation. *"But others, they can come as if they have planned that 'today, that midwife will know who am I!'"* (NMT25) Other women were reported to arrive ready to test the midwives. *"Yah! To see what you are going to do. Are you going to produce bad words to them? Are you going to assist them as you are supposed to assist them?"* (NMT30)

As well as reporting women's negative attitudes towards midwives, some respondents also felt the poor behaviours some women experienced from midwives could push them to birth with TBAs. A subtle thread through the data was the awareness of a small subset of midwives that the care being provided was not what women wanted and that many would prefer to birth in their villages. Midwives believed that harshness, shouting and talking to women as if they were children were reasons that women may opt for *"…**somewhere** where they will be treated with respect."* (NMT21) Another NMT concurred, saying, *"…you disrespect the patient, that one will never come back. She will opt to go to other hospital or else just have the delivery at home because that's where she is being respected by the fellow women there, the TBAs…So that is very important here, respecting them…"* (NMT07) Other women were thought to delay their arrival at the health facility because they felt *"when I go to the hospital, sometimes I cannot be cared for as I need."* (NMT05) At the national level, a senior midwifery leader made the case for a focus on RMC if there were to be meaningful improvements to the quality of midwifery care and to stop women using the TBA's services.

> *I think that's* [RMC] *an area that can maybe help us to really move forward…if somebody thinks that 'if I go to a health facility the midwife will not care, will not take good care of me'. Other women are still choosing not to **come** to our facilities, and they are still going in maybe to have deliveries in the traditional birth attendants, or just to have a home delivery where somebody from within their communities will help them. Much as maybe in the country we have tried to ban TBAs here, but still people, from the experience they are having from the midwives, they will say 'I think it's better I will not come'.* (KI26, Midwifery manager)

9.4.3 Misunderstanding and communication

Some midwives reported how aggrieved they felt to be trying so hard and having their behaviour and intentions misinterpreted and misunderstood. This was partly attributed to women's failure to understand the constraints under which midwives were often forced to work, which meant women did not always get the midwife's full attention. *"So she feel that I'm not welcomed here, the nurse is so rude, the midwife is not working, blah blah blah."* (NMT13) In these circumstances midwives felt that it was easy to misinterpret their urgency as disrespect. *"And at times when you want to stress something, some people do understand it as if you are shouting. But you want to stress something. For instance, you want somebody to **push**, so that you can get the baby as early as possible, and somebody takes it as if you are shouting at her."* (NMT11) A senior SRNM tutor could see both sides of this dynamic.

> *Patients don't wait, you know, they are in labour, they want to be assisted, and you try to **weigh** which ones are priority. 'OK, let me start with this one, because the priority is in second stage. This one can wait'. But you know, labour is labour, everybody feels pain. So the other one feels neglected and starts talking not nice to the nurse and the nurse, because of pressure, they will respond unconsciously, which is maybe in a*

disrespectful way or disrespectful manner, and that is how these things go. (KI11, Training institution-SRNM)

Other women were thought to experience care or procedures as disrespectful because *"Maybe other things were done to them and they did not know what those things **meant**, just because information was not well given."* (KI26, Midwifery manager) For some midwives, it was clear that they needed to communicate better, a topic which was covered by a number of key informants who stressed the need to let women know what was going on.

> *…if I leave mothers…without communicating to them…they don't even know that I am also stressed…Don't think that when you are working in the ward people know what you are doing…stop and say 'yes, I know. I've seen you, but there is this mother convulsing. I will be with you.' They will understand!* (KI16, Midwives' representative)

Midwives agreed that explaining was much more effective. *"Rather than,* [scolding voice] *'Don't you see that we are busy? Don't you see that the ward is just full?'"* (NMT02) This was supported by a CHAM midwife whose practice was to regularly update women when she had too many to work with in the way they expected. *"I have never seen a woman cross with me in labour ward. I have never had such an experience. They do, they do understand."* (NMT32)

However, one of the challenges to effective communication, mentioned across a range of different participants, was the low educational status of many rural women. *"…some of them, literacy level is very **low**, so the level of understanding and autonomy sometimes, I think they don't balance well…Because if they understand the implications of some of the things, then it would work."* (KI22, Training institution-SRNM) Midwives' responses indicated that this lack of education and understanding also meant that women's expectations and those of midwives did not always match, which some midwives suggested could sometimes trigger an adversarial relationship characterised by rudeness, uncooperative behaviour and shouting. In addition, midwives voiced frustration when local beliefs about birth, such as use of local pitocin or delayed presentation at the health facility, caused unnecessary challenges for midwives which women did not understand. A prime example was the clash between women and midwives on when to push, caused by different perceptions of where authoritative knowledge lay.

> *Their mum told them that when you have contractions you have to push…their thinking is focused on **that**. So even if the nurse tells them 'no you are not supposed to push, you have to wait until the cervix is fully dilated', they **don't** listen. What they know is 'my mum told me when it's painful I have to push'. So sometimes it's very, very hard, even if you tell them in such a good way, there are some people who don't understand. They don't. And they wouldn't want. What they do is what they know from their home, that's what their mum told them. So sometimes that's what makes a lot of nurses maybe to shout.* (KI09, Midwifery manager)

9.4.4 Reaching out to the community

Although challenges were articulated in the relationships between women and midwives, there were also pockets of good practice that demonstrated how midwives wanted to work and the efforts many made to maintain the woman at the centre of care. A number of initiatives had been started in response to the challenges described here. At the national level, the campaign for RMC was underway and there were clear ideas about changes that needed to be made. *"…we want this **mutual** relationship. If they all understand each other, then we will not have a problem. But if the community comes to the hospital with **fear** and the midwife does not explain properly to this woman, there will always be this conflict, so we will not achieve what we want in RMC."* (KI13, Training institution-SRNM) At one of the central hospitals, preparation and setting expectations started at the antenatal stage. *"And from the antenatal clinic booking visit, they do visit the maternity wing. Yeah, so that they know 'when you come into labour this is where you will be admitted; when you deliver this is where you are going to be'. So they have a tour of the maternity unit. So the education or the awareness starts right from the antenatal clinics."* (KI05, Training institution-NMT)

At facility level, some midwives voiced their opinion that *"…it's high time we midwives, we should accommodate the views of the community and the views of our clients"* (NMT32) In one MOH facility, the staff had gone out into the community to try and start a dialogue to improve care. An NMT explained that initially *"the women are few in numbers for delivery and they are starting the antenatal at a late stage"*, so they had set up a meeting with the chiefs and community to see if they could improve. They found out that women were scared to come to the facility because of the attitude of the midwives, so the midwives were honest and said, "*OK. We cannot deny it, just because there are many of us, we cannot shout at the patients, but the women know the one who has done that. But we as health workers, we are very sorry. We will try our best and be good to them."* The meetings successfully established positive dialogue:

> *…to explain the problems they face here and us as health workers, the problems we face with what? the patients, so we could find solutions to those problems. So, they were able to voice out their problems, we were able to voice out our problems. So, we were able to reach a conclusion…of how are we going to assist the women, and how the community are going to assist us as health workers, in order to deliver health care to them…After talking, after doing everything, then we went for a follow-up and there were a lot of things that had changed.* (NMT08)

This NMT also felt that the initiative had resulted in more women delivering at the facility, reduced use of local pitocin and fewer asphyxiated babies, as well as more male involvement in maternity care. It demonstrated that positive results can accrue when there is better connection between the community and the facility. However, in order to satisfy women's needs, midwives need to be adequately supported and cared for too - which we will look at in the final results chapter, Caring for the carers.

Summary

The findings in this chapter demonstrated midwives' robust understanding of the ideal model of RMC, even if they might not always have achieved it in practice. However, in contrast with the aspirations of some senior midwifery key informants, their ideal did not extend to viewing women as partners in care. The therapeutic relationships necessary for RMC were hampered by negative attitudes of 'other', 'just a job' midwives and lack of time to establish a connection. However, D&A was normalised and used to achieve good outcomes, with a strong discourse of 'uncooperative' women bringing it upon themselves by their behaviour. This was rationalised as due to women's ignorance and driven by midwives' fear of responsibility in a culture of blame.

The benefits of RMC for midwives were more clearly articulated than those for women, with only a handful of midwives appreciating its psychological and physiological impacts. A growing discourse of women's rights was emerging and intersected with good midwives' yearning for recognition and respect from women and the community, who were felt to sometimes have negative attitudes towards midwives due to previous bad experiences, fear, or expectations of D&A. Many midwives were aware that better communication was needed, with some facilities instigating outreach in an effort to start a dialogue and improve care. Nonetheless, many midwives felt that women did not understand the constraints under which they operated, which led to misunderstandings and poor relationships. These constraints, along with midwives' perceptions of being unvalued and unsupported form the basis of the next chapter.

10. Caring for the carers

Introduction

This chapter outlines the extremely challenging circumstances in which Malawian midwives work. My aim is to foreground some of the meso-level health system factors that make it difficult for them to deliver respectful maternity care. This is not to excuse disrespect and abuse, but to make visible some of the drivers in this context by exploring the midwife's reality and articulating the lack of support and sense of abandonment that many respondents, across all levels, described.

The chapter is divided into three sections. The first is the unconducive work environment, which covers the perfect storm of inadequate human resources (numbers and skills), rising facility-based delivery in the wake of the ban on traditional birth attendants, and lack of basic resources and inferior infrastructure, that combine with inadequate referral systems to compromise the ability of midwives to meet professional standards and expectations. It uses extracts from their narratives to demonstrate the circumstances in which midwives operate and the impact this has on RMC and quality. Insights from key informants are also included.

The second section addresses the perceptions among midwives of a lack of institutional support, reflecting feelings of being unsupported and abandoned, by national and local managers as well as their midwifery representatives, in a hierarchical system that does not value them. The third and final section looks at the importance of organisational culture and its impact on professional behaviour, using the lens of oppressed groups theory.

10.1 The unconducive work environment

10.1.1 An acute shortage of midwives

One of the most pervasive problems, mentioned by 80% of respondents and underpinning many of the poor care incidents, was the acute shortage of midwives. Official figures on the actual number of midwives were challenging to obtain as the NMCM registers count nurse-midwives, without disaggregating by role, although they do disaggregate by level.[74] Further, the figures kept are cumulative and do not take into account those who are no longer in practice or have left the service.

> *By dual qualification, yes, we have a large number. But those who are really doing midwifery I think the numbers are low numbers, and therefore these ones who are just coming in with a direct-entry into midwifery, definitely it will help us even to know the real numbers…So we will know that these are midwives and in **all** their time they work as midwives.* (KI26, Midwifery manager)

A 2016 census by WRA Malawi counted all midwives who were spending at least 75% of their time on midwifery. They enumerated 3,420 bedside midwives serving an estimated population of 17.3 million people and described this as a 'critical shortage' (WRA Malawi,

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[74] The organisation of midwives by level and cadre was described in Section 6.2.3.

2016). It was not unusual to hear utterly astonishing stories about the number of births midwives regularly had to attend. For example, a key informant described the reality in one of the central hospitals.

> *…we are thin on the ground. And the nurse-midwife technician or state registered nurses, they are **overwhelmed** with work load. One nurse can be catering for over twenty women in labour…At one time, when I was still in the labour ward I had assisted women to deliver, within one hour **fifteen**, within **one** hour.* (KI11, Training institution-SRNM)

Many respondents I spoke to told me of significant and regular shortfalls of staff on duty against the expected complement. *"…it's not all the time when we are enough nurses to work. Sometimes we are two instead of five nurses."* (NMT05) Night shifts were considered the most challenging times because that was often when the labour ward was busiest, yet fewer staff were rostered on duty and many found the workload and the 15-hour shift pattern (16:30 - 07:30) exhausting. *"…when you are tired you cannot think properly. You cannot treat someone as the way she was supposed to be treated."* (NMT13) Midwives also found it difficult to provide the appropriate level of care:

> *…so nine beds should be monitored by a single midwife. That's not easy and it's difficult to really have that good trend of monitoring every 30 minutes...foetal heart, auscultation, you can't manage that one…the health workers are not enough to make it at least conducive for a good delivery.* (NMT07)

Others described being forced to leave women alone during first stage. *"Most of the time we just admit the woman in labour. Then we don't examine her thoroughly…just because of shortage of midwives, and then we might come* [back] *when the labour is almost full dilated."* (NMT16)

Another key informant, also speaking about unmanageable numbers of deliveries over a short space of time, described the impact on quality of care and the way women are treated. *"We could deliver about 30 to 40 babies in one shift when you are on night duty and you are 2 midwives. So, sometimes you want to do the best, but you become like a **machine**."* (KI18, NGO) This was a source of considerable distress for some midwives, with participants reporting *"The midwife is under panic…it's very stressful."* (SRNM09) Others felt compromised in their ability to perform according to their personal and professional standards. *"..to have ten women against one midwife, you can't manage your profession since care will not be good."* (NMT15) Other midwives were distressed when the outcomes were not good, despite their best efforts.

> *…you are supposed to give total care to somebody but just because you are alone on that duty, you fail to make it happen. And instead* [of] *the baby coming out alive, sometimes the baby can come out asphyxiated or maybe the baby is dead. So as a midwife you see that, you feel that pain inside that...Where have I gone wrong? What didn't I do? What went wrong? What went wrong? So you have a lot of questions*

without answers. In that case, when bad thing happens, it's difficult for you as a
midwife to continue with the work, your duty. (NMT08)

Despite the ongoing human resources challenges, midwives were not taught how to deal with
the existing circumstances in Malawi's labour wards.

Our content in class doesn't include the fact that you will be alone, or the shortages.
No, it's just like one-on-one. Eeh! 'You assist the patient, [she] *delivers, you refer to*
postnatal'. That's all. That you need to attend to 10 women at once, it doesn't include
that. (KI04, Midwifery manager)

Linking to some of the other data about lack of support from management, midwives also
reported asking for help when circumstances were too much for them to cope, but not being
assisted.

There was broad appreciation from midwifery managers for the hard work and extremely
challenging situation facing midwives in more remote health centres. To put this into
perspective I want to highlight the staffing levels at one remote health centre in my study
district. It was a CHAM facility that, in addition to all its other health care activities, averaged
200 deliveries per month and had seven NMTs on staff. During the day two NMTs were
supposed to be on duty. One covered outpatient department and the second was
responsible for labour, postnatal and antenatal wards. At night, one NMT was rostered to
cover the entire facility. The situation was often worse in MOH health centres, with huge
staffing disparities between facilities even when the catchment population and number of
deliveries were similar. Delivery statistics I was shown for the previous month demonstrated
this. The two busiest facilities carried out approximately 100 births each, but the one that
was close to town (where staff preferred to work) had 13 nurse-midwives on staff, one-third of
whom were SRNMs; the other was in a hard-to-reach area and was staffed by two NMTs.

…and for them to have like a 24-hour coverage of the health centre…it's a
challenge…when they are on duty they basically work abnormal hours. Their working
schedule, it's really very difficult. They just try their best to cover the hospital. You find
some other nurses who are really working **hard***. For example, there's a labouring*
woman who is in the labour ward. They have worked the whole day, that is the **night***,*
they are supposed to rest, but they are not resting. They will stay in the labour ward
until this woman delivers. (KI03, Midwifery manager)

Another key informant captured the perspectives of many respondents when they discussed
the challenges for midwives in the rural areas and how lack of adequate numbers impacted
on disrespectful care of women. *"…these midwives they are really burnt out, they are*
tired…they feel that they are **overwhelmed***. So one of the contributing factors may be that*
the midwife is tired." (KI15, Midwifery manager) In one of the better-staffed health facilities,
an SRNM was clear about how the ratio of women per midwife affected the sort of care that
midwives were able to give. *"...if you give me time to attend to two patients, they will tell you*
a different story. But if you give me 20 patients they will tell you another different story…The

shortage of staff has to be looked into." (SRNM08) At the national level, key informants had their own ideas about suitable ratios if midwives were to be enable to provide professional, respectful care.

> *…if I have three women in labour for that particular day it should be enough for me…for me to offer the care to this woman, I mean just the physical examination and the continuity of care that I need to provide to a woman, there should be more attention to a woman…So the value that the midwife offers, or the care that the midwife offers, it will also depend on how much time you are with the patient.* (KI14, MOH)

10.1.2 Lack of basic resources

Voices at every level, from senior advisors at the national level down to the NMT in a rural health facility, bemoaned the acute shortages of even the most basic materials, such as gloves or delivery packs[75], necessary to carry out midwifery care in Malawi. For some midwives, the consequences of this were catastrophic. One of the enrolled nurse-midwives I interviewed was clearly upset when relating her poor care incident. The labour ward had run out of cord clamps and staff were forced to ask mothers to bring thread from home.

> *I did it, but it didn't help…because the baby was alive, eh?…Then it **bled** from the umbilicus…The baby died…I do worry up to now…I felt bad, I still feel bad, I...I feel I have killed the baby, but it wasn't my **fault**. It was the fault of authorities, not supplying us with sufficient equipments…it's **now** [once the baby died], they now started bringing more equipments. So, I say, Aah! They are waiting for the incident to happen. The equipments **were** there. Why were they not sending us so that we can be doing our jobs perfectly?* (ENM02)

Other midwives told stories of lack of organisation or forward planning that allowed supplies to run out, describing how these hampered provision of care and their sense of professionalism. In such circumstances staff had no choice but to improvise as best they could. One NMT described working in a labour ward that had run out of gloves, which must be considered in the context of national HIV rates of 9.2% (UNAIDS, 2016).

> *I phoned the officer in-charge at* [name of district DHO] *and they say, 'OK, we are trying to bring the gloves. We will try at least by afternoon the gloves will be there' and yet I am having a patient who is at 7cms! Within an **hour** that one was ready to deliver and I wasn't having even a single pair of gloves…Eeh! I felt so bad, to have even not the equipment that I can use to deliver this lady, but with the passion to help. There was nothing I could do. I communicated with the guardians so that they can bring me even the plastic papers. So, I put on the plastic papers and helped this lady to deliver…Eeh, it was a really a very hard time.* (NMT18)

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[75] This is the basic sterile set needed for delivery and includes cord clamp, episiotomy scissors, scissors (or blade) to cut cord, suture material with needle, and needle holder (MOH and ICF International, 2014)

Another NMT reported unnecessary referrals to a central hospital because of shortages of low cost items such as sutures, or having the skills and training to handle postpartum haemorrhage herself but being forced to refer because the health centre did not have any oxytocin. At a personal level, she felt she had failed the woman, with her professionalism undermined, despite her skills and through no fault of her own. At a systems level, she was clear about the waste of resources and expertise in having to make unnecessary referrals.

> *…we overload our friends at the central hospital or district hospital,* [with] *the case that we would have managed at the health centre, because we don't have enough drugs or enough equipments…I feel bad, because I see* [imagine] *myself working at the central hospital, and somebody referring the patient just because there* [in the health centre] *they don't have sutures. Instead of managing other critical issues, you stop and manage that one that she has a tear, rather than managing somebody that has a maybe eclampsia or PPH* [postpartum haemorrhage]. (NMT13)

This unnecessary waste of precious resources, such as ambulance time or using tertiary level care for minor procedures, echoed key informant views in Chapter 7 about the misuse of government resources. Sometimes midwives suggested these issues were compounded by lack of planning or systems-thinking on the most effective protocols for accessing resources or of assigning responsibility for refilling when stocks ran out. In a rural hospital, an NMT said, *"…the deliveries room should have everything needed for emergency. Not running up and down. Eeh! there's no oxytocin. You run to the pharmacy to check for, to take your oxtocin. There's no oxytocin. You come here* [labour ward]*, eish...the patient is bleeding, no IV fluids. What can you do?"* (NMT14) She also noted *"It* [oxytocin] *was out of stock…last month, three weeks in March, we didn't have any."* However, one of the most disturbing elements was that drugs were so tightly rationed that:

> *…as a health centre, we are not given any pain reliefs like the pethidine or even diclofenac injection. We don't have at the health centre. But even when they go to the central hospitals, they have those drugs, but they are in short supply…they are used for post-operative care but not in labour ward.* (SRNM02)

Within a central hospital I was told *"…the protocols of this hospital, they only give pethidine to patients who are in severe pain, but in that severe pain, they exclude labour pain."* (NMT02) Some midwives found the inability to ease pain distressing, while others ignored it completely. As was discussed in Chapter 9, this had profound ramifications for midwives' relationships with women and were a significant driver of disrespectful care, couched in the language of the 'uncooperative' women.

10.1.3 Infrastructure

Infrastructure in many of Malawi's health facilities was very weak. Midwives were aware that the open ward structure impinged upon women's confidentiality and privacy. *"There's need for separate rooms…Not one room with three beds. That's not good."* (NMT19) The ward layout also made it impossible to have a labour companion at a time when *"We are now*

advocating about male involvement and involvement of other support persons…" (KI02, Training institution-NMT) It also intersected with the human resource constraints and left many yearning for private rooms. *"Because you cannot do this on your own, as a midwife, you also need support from the others. So the family can also participate in the care of the woman. So I wish we had such facilities."* (KI03, Midwifery manager)

In terms of their own practice, midwives were concerned about the widespread use of 'floor beds' - mattresses that are put on the floor when all the other beds are fully occupied. In the wake of the ban on TBAs and with a fast-growing population, labour wards regularly exceeded capacity. In one three-bed labour ward an NMT told me, *"Sometimes we have 10 patients in labour ward. Others deliver on the floor, which is uncomfortable to the patient and also the provider of that delivery. On the floor is so difficult."* Further, the beds were static. *"…they are wrong beds…not good for delivery, especially when there's a condition of PPH* [postpartum haemorrhage] *or eclampsia. You can't extend the bed to have that procedure done well."* (NMT15)

Many rural facilities lacked running water or electricity, which was a significant problem for midwives, both in terms of their living conditions (which I will address in the next section under 'Conditions of service') and on their ability to perform as professionals. These infrastructural deficits left midwives in situations where they had to cope as best they could, yet after only a few weeks experiencing erratic electricity and water supply I was exasperated.

> *Getting fed up with this. I can see how people get totally demotivated by having to improvise or do lots of extra and unnecessary work just to get the basics done - I wonder at what point one just stops bothering?* (Field notes, 26 August, 2016)

Midwives, however, were left with little choice. *"…they still have to continue working because they have been designed to work there."* (KI15, Midwifery manager) An NMT described this reality.

> *You find yourself in labour ward during the night and you are having no electricity. We use phones. And even our phones, their light are not strong…so it becomes a major problem. Being in contact with blood, you need a good light. So, we just do what we are supposed to do, because you can't leave the woman that, 'there's no light here so I will not help you'.* (NMT17)

10.1.4 Referral

Referral was another major challenge in Malawi, with lack of ambulances and significant delays in response times. Midwives who discussed this issue often reported feeling that they had failed the woman in her hour of need, usually because they were left waiting far too long for an ambulance to arrive. Some mentioned waits of up to ten hours, particularly at night. Informally, I was told that ambulances were used as unofficial staff transport to ferry health workers to and from the hospital for their shifts, but resource shortages were also a factor. The negative impact on midwives was stark.

*You try best the way you can do. You call the ambulance, but you know it's very far, and the ambulance, maybe because of fuel, it's somewhere at a certain health facility and they tells [sic] you 'We are coming.' You see one hour is going, two hours is going. You try to apply your effort, but in the **long run** you see that everything is in **vain**. So, you get depressed, and you get demotivated.* (NMT16)

Others suggested that relying on referral was not appropriate and that it would be better to have enough resources to be able to care for women within the health facility, particularly when the facility staff were competent in the procedures that needed to be done. An SRNM described her frustration at not being able to act due to the level of facility and having to wait for an ambulance that did not come in time.

*If our hospital was big enough and we have the capacity whereby we can **administer** blood on our **own**, this client could have received blood at such, such a time. And by now we could have been maybe managing this now…Because you know what to do but you don't have the resources to do what you want to do.* (SRNM04)

The reality - a vignette

During one of the narrative interviews I was given an insight into the stark reality of what this commonplace and dismaying combination of resource, referral and infrastructural challenges meant for midwives in rural areas. An NMT had told me a detailed story of a memorable 'good care' incident that involved a woman who *"delivered at the bush at her village"* then started to bleed, so was brought into the health centre where she birthed two more, very small babies.

The ambulance couldn't come, it was midnight…we couldn't transfuse because we didn't do that at that facility. So we resuscitated the mother with the Ringers [lactate]...**only** *the fluids. We didn't have the plasma expander, we were relying on those fluids only. We could see the woman going into shock and I could almost **cry**.* [quietly] *'Aaaa! She should die here, what else can I do?'* So we kept on resuscitating the woman, all night, standing.*

Eventually the ambulance came and the mother was transferred to the central hospital. It was almost as an afterthought, when I asked if there was anything else she thought that she had done really well, that she added:

NMT12: *…the other challenge there…we had no electricity…so you can imagine working in darkness, because there we relied on solar...the power could go off around 9pm. So, from 9pm you relied on phones, maybe candles. So, you can imagine, resuscitating someone, no light, putting an IV line, using the light from a candle…we had no catheters we could use, so we were using the giving sets[76] as a catheter so that maybe we should be draining the urine, so that maybe the uterus should also be*

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[76] Giving sets are used for intravenous fluid administration and consist of the tubing that connects a bag of fluid to a cannula point.

contracting, this woman should not be losing blood. At the same time, we should be resuscitating this woman so that she should not go into shock.

Susan: *And you had three very small babies to look after as well?*

NMT12: *Yah, at the same time we don't have electricity so that we can put them on a heater so that maybe they could feel warm. We could rely only on the linen from the guardian…we don't have clean linen most of the times, because there is no water so that you can wash the linen and have clean, ready for use. So you can think of that situation…it was very terrible.*

Key informants and midwives were acutely aware of the challenges presented by the unconducive environment and the consequences for both women and midwives. A midwife in one of the MOH facilities captured this, saying, *"…even you as a nurse, you are stressed because you don't have enough things to use to work. That furious, that anger can be transferred to your clients…"* (SRNM05) However, many felt that no one was listening and midwives were not being supported. This will be the subject of the next section.

10.2 Lack of institutional support

10.2.1 Lack of voice

When describing the reality of data collection in Chapter 5, I mentioned a subset of midwives had explicitly expressed their pleasure that someone was interested in their concerns and listening to what they had to say. One NMT felt that women's voices were getting attention, but not those of midwives. *"There are very few people who come to a nurse to say, 'I want to interview you…to find out the problems that you do meet as you take care of the patients'. Mostly it's the patient and the interviewers, the researchers, but not the nurses, involved."* (NMT03) Another asked if *"…the outcome* [of the research] *will be given to those who are responsible?"* (NMT07) and one spoke of me *"…as our mouthpiece to the government and to the CHAM."* (NMT16) Part of this was driven by a perception among midwives that, *"We lack people who can come and ask, as you are doing, how are you experiencing working in labour ward? How are your problems? Maybe if they were coming, I think there could be something to be done."* (NMT04) Others felt that even if they managed to speak to leaders, nothing would happen. *"When you voice out your concerns to our bosses, they don't take them seriously."* (NMT01) At the national level there was acknowledgement that midwives' needs were not being met, with an MOH representative saying, *"…you go* [to the health facility]*…they will say, 'We don't have enough nurses'. Then we go again, it is the same problem, we haven't even rectified it."* (KI10, MOH)

In Chapter 6, I outlined the role of the main organisations representing midwives, locally referred to as 'the Council' (NMCM), 'the Union' (NONM) and 'the midwives' association' (AMAMI). Very few labour ward midwives referred directly to these organisations whose role was to support them. Some midwives expressed general concerns that their certificate to practice would be taken away in the event of poor outcomes, but only one SRNM explicitly

spoke about the professional bodies. Her thoughts bear presenting in full as they mirrored many of the views of key informants, some of whom were representatives from these organisations. These included the idea that the Council was interested in "*protecting the practice*" and *"reinforcing standards"*, while the NONM and AMAMI were competing for the same midwives and, as a consequence, were deemed less powerful than they used to be.

> SRNM08: *…we have professional bodies, we don't see them supporting us…So those people, those professional people, have to also take* **care** *of the people that are taking care of the people. But I don't see that. Every little mistake that the nurses does, it's just negative to them. The nurse's voice is not heard. Like in a situation whereby I have made a mistake, yeah? It's rare that you hear that they will pose on my previous experience, how I have handled issues before, how I have taken care of the people before…Because every person can make a mistake…*

> Susan: *What about the union, I thought the union was quite strong about defending nurses and midwives?*

> SRNM08: *Yes, it was quite strong, it defends the nurses and midwives, but…it's just not enough…They take* **long** *to come to the rescue, when you have already passed through hell. Yeah, so, like that support is not there…you need to support the nurses. You need to show them that you love them. Now, they will also take that love to the patients. You need to show them that you* **care** *even if you cannot do* **anything***. They will take the same care and care for the patients. But if you show them a negative part, for them it's so stressing, how are they going to respond to this?*

> Susan: *Yes, there's a lot to be said for the idea that if you don't look after your nurse-midwives, how can they look after the women?*

> SRNM08: *Yes! Because they have to be taken care...they have to be* **heard***, and when they address their complaints they have to be...***solutions** *have to be put in place!*

10.2.2 Conditions of service

The cumulative effects of the un-conducive environment intersected with and exacerbated midwives' perceptions that their conditions of service were not good enough and they were not being valued. Labour ward was perceived as *"one of the busiest wards"* where *"Even if people* [midwives] *are told to come here, they refuse."* (NMT06) Key informants, cognisant of the difficulties of staffing labour wards, also felt that something needed to change to recognise the extra demand on midwives.

> *So, one area we would also like,* **recognise** *that additional load that comes with midwifery. Unfortunately, I think in our country that's not recognised. We treat everybody equally. Whether you are working in outpatient department…and somebody is in antenatal clinic…Usually there, they knock off at 12 when they finish the clinic, so most of the times they go home. And you compare with this lady who is*

in labour ward, midwife, who cannot maybe even go for a cup of tea, because there are lots of women… (KI25, Training institutions-SRNM)

Midwives' responses clearly demonstrated that many did not think they were adequately compensated for the challenges and responsibilities of their role. *"…most midwives here feel like they are not being paid enough…they are working more…working overtime, and the pay they are receiving and the work they are doing does not match."* (SRNM06) There were also tensions due to the large salary differentials between midwifery cadres, where SRNMs earned nearly twice the salary of an NMT (Training Manager-NMT, personal communication, August 2016). In addition, salaries were supposed to be paid on the 27th of the month but were regularly late. An NMT in a CHAM facility reported frequent calls from friends in MOH facilities, complaining. *"You know this is 15th of the other* [next] *month, I haven't received my salary. How do they expect me to work?"* (NMT23) Others had second jobs or worked extra locum shifts to supplement their income, with obvious impacts on midwives themselves, but also on quality of care.

I bumped into the NMT who was doing a locum shift on labour ward yesterday. He finished there at 5pm and went straight onto a night shift in postnatal and Obs/Gyn. He looked wrecked, despite the 4-hour sleep he had had overnight on the ward. I asked him if he thought it had an impact on the quality of care he could deliver, and he said, 'Yah, of course! It's not good.' But apparently it is common practice here and there are no systems to stop it - even if the hospital wanted to. (Field notes, 30 Mar 2016)

A key informant was also worried about the impact of the locum culture. *"At the end of working more shifts they have made themselves more tired, that it's difficult for them even to be there for the woman."* (KI18, NGO) Conversely, midwives who did not want to do locum shifts came under pressure to work on their off days and were penalised if they refused.

…if a midwife says she has worked her days, her hours, and then maybe the authorities ask her to add some more days, and if she says, 'I am tired' they will say, 'Oho, this one is not a good nurse. She is naughty, she is rude…she doesn't take orders'. So, you know they will be deemed to be difficult nurses. But they have done what they are supposed to do…They are saying, 'I need also to rest'. (KI20, Midwives' representative)

The disgruntlement with salary levels and pressures to take on extra work were situated in the context of a poorly performing economy. *"You know with the inflation in Malawi, life is hectic. No salary increment, school fees going up, life, rates, food, up, house allowances, what what, house rents…so that can also put a strain on someone, on anyone!"* (SRNM08) Respondents spoke of midwives being *"stressed up"* and *"…worried about how are they going to cover the whole month. So you have staff…they are preoccupied with their basic needs and you want to move them to another level* [of performance]. *That's really a very, very big challenge."* (KI18, NGO)

The impact on midwives' motivation when the government was perceived to not be helping them to *"work comfortably"* was clearly articulated by a number of midwives. In addition to the workplace challenges already outlined, many midwives were not provided with uniforms, so had to buy these themselves. For others, seemingly trivial issues, such as not providing drinks or sugar for night staff, seemed to cause midwives to feel unvalued, while recent cutbacks to other benefits had serious unintended consequences on the care of women.

> *…they used to actually give us lunch, because they always wanted that the labour ward should be covered, no-body should go out* [for food]*…but now they took that away, they stopped giving us…at least they could feed those actually critical areas, like labour ward...I feel it's not on that we should leave the ward and go out for lunch.*
> (NMT06)

To put this in context, in some of the health facilities I visited it was normal practice for labour ward staff to stop and have lunch at the same time.

One key informant described the gap between how midwives used to be treated and the current situation, which demonstrated a significant fall in status and living conditions.

> *They look at them like they are not being taken care of. I think the issues really have changed…when I was young, we admired the way the nurses were being respected…transport to pick them up…but they would also be given accommodation within the surroundings of the hospital. So right now, what is happening is the doctors are given accommodation, but the nurses are not…From their salary, their small salary, they have to pay for rent, they have to pay for transport from where ever they are coming from. They have to pay for their lunches, for their teas…so there are so many contributing factors.* (KI19, Midwives' representative)

Further, in rural and hard to reach areas midwives were living and working in conditions that lacked many of the basic social amenities that educated professionals required and left them relatively isolated. *"She is alone, working 24 hours and the authorities or the government wouldn't give them all the necessary support. They are in very remote areas, the houses there are not that good, with no electricity, no water…"* (KI15, Midwifery manager) Another key informant agreed, saying, *"We need good roads, we need the houses maybe with the solar energy, we need to have appropriate communication…we should also think, after training do we have adequate resources to provide to this employee?"* (KI23, MOH)

10.2.3 Supporting midwives

Many midwives I spoke to felt unsupported and that they were on their own. A key factor mentioned was the lack of supervision, yet the supervision structure in the district was clear. *"Each and every facility, there is an immediate supervisor or there's an in-charge. And basically, from that in-charge there's a matron. That matron, there's a DNO* [District Nursing Officer]*."* (KI03, Midwifery manager) However, in smaller facilities with only two midwives there might not be an in-charge, so midwives were reliant on visits from external matrons. I spoke to midwives who were rarely, if ever, supervised and this was corroborated by one of

the midwifery organisations. *"Some have worked for **years** without being supervised in the health centres. They just do things on their own."* (KI20, Midwives' representative) Some in-charges were reported to provide good supervision, with one NMT saying, *"…we work hand-in-hand with the registered nurse. He assists us, he conducts delivery."* However, she also complained *"…he don't come for night shifts, he come for day shifts."* (NMT13) This links back to and supports the results in Chapter 8 on the importance of role models and the criticisms of SRNMs not wanting to work unsociable hours, leaving the less skilled NMT cadres to cope on their own. Interestingly, the same in-charge bemoaned his own lack of support from the district matron responsible for the facility. *"…we have got a matron here, but she doesn't come. It has been maybe a year now…she has been assigned to this hospital, but she never comes here."* (SRNM06) Key informants suggested that along with the resources issues, such as budget for fuel, that made it challenging to arrange external visits[77] some supervisors actively avoided visiting midwives.

> *They* [district supervisors] *will tell you: 'We don't have resources to give the midwife. If I go there* [to the health facility]*, she will give me a lot of complaints…and I don't have those things to give the midwife. So why should I go?' They are forgetting that just **seeing** the conditions and appreciating what this midwife is doing is **enough** to put this midwife at ease and to do the right things.* (KI13, NGO)

Other midwifery managers struggled with this dynamic too, feeling that being unable to offer tangible support undermined their credibility and authority.

> *So basically, if a nurse is not performing as expected…she can complain about 'I don't have this, I don't have that…How do you expect me to do this without?'…Currently there's **nothing** that you can do about it…when you tell somebody to deliver, you make sure that you give her or him the necessary...the conducive environment to deliver quality services.* (KI03, Midwifery manager)

In some facilities, the midwives in-charge reported initiatives they had instigated for supervision, such as regular ward meetings and discussing challenges. Others used strategies, particularly for poorer performers, such as *"…when I'm writing the duty roster…I put them like in pair with someone who is very good, so that can at least learn from this other person."* (SRNM09). In another example, a matron in a CHAM facility reported that the new in-charge had instigated weekly meetings for the team and random checks of her colleagues' documentation to keep an eye on their performance, with a focus on supporting them to do better. *"…and if there are any problems, that midwife is called…I think that is helping a lot."* (KI06, Midwifery manager) A matron in a central hospital described her own efforts to keep staff on their toes. *"…when I see that the team which is in labour ward today is not that hard*

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[77] In the Malawi context, the district health management team cite numerous challenges to implementation of regular supervision visits to the facilities for which they are responsible. Resource shortages (money, transport and fuel) have been a long-standing issue, but they also face conflicting responsibilities and multiple demands on their time, too few senior level staff and lack of prioritisation of the supervisory task. (See for example Bradley et al., 2013)

working, I spend the whole day in labour ward. That's pushing them." However, she then admitted, *"But mostly it doesn't happen."* (KI04) An NMT in the same facility revealed that this oversight was not in place, saying, *"There is lack of supervision…I can work for two weeks on day shifts, but I never saw a matron coming and assist, even though you are alone…They see that you are busy…Off they go. So this is discouraging."* (NMT04) The impact of absent or ineffective supervision on staff motivation and performance has been well documented (e.g. McAuliffe et al., 2013; Bailey et al., 2016), while, as identified in Chapter 9, recognition was an important motivator and source of professional satisfaction for midwives in this study. Describing the impact of this dynamic on midwives' attitudes to women, a key informant said:

> *…there are drivers to this. One, this midwife is coming to work frustrated already. There is no recognition. She does well, she does bad, no recognition. So their supervisors, there is no supportive supervision. They just come when there is a problem to reprimand them. They* [midwives] *do a good, there is no one coming to say, 'Oh, Susan you have done very well. Keep it up'. The good things go without being noticed…they should be recognised, they should be supported, so that they are motivated to do the right things.* (KI13, NGO)

A subset of key informants felt the lack of supervision and experienced leadership at all levels of service meant health workers were not held to account.

> *…the leaders just leave things to happen…If the leader does not discipline the nurses, they will do whatever they want. But if you are **strong** and you are able to look at what is happening and be able to point out the wrong things, then they start doing the right things. But if you **fear** the subordinates, they will not respect you. Most of the leaders on the ground are also young, they just come from college and then they are given these positions."* (KI20, Midwives' representative)

One of these young leaders was a highly regarded, passionate in-charge who was becoming increasingly burnt out from trying to maintain standards in the labour ward in the absence of backup from her line manager. Sounding really sad and disheartened, she told me that despite modelling good behaviour to her colleagues and reporting problems to her supervisor, *"Nothing is done, so you are blocked somewhere, to say 'I don't know what to do…Maybe I should move to another department. Maybe **I** am the one who is a failure.'" You think all over like that…it's really bad."* (SRNM01) Responses from line managers demonstrated their awareness of the impact of not supporting frontline staff. *"…they may make a decision on the ground, they come to report and then you are not supporting them. In the end they are frustrated and they just leave."* Yet this manager re-enacted the same dynamic with her own supervisor, echoing the pattern of the unsupported supervisor articulated by SRNM06 above. *"I don't have that power to make decisions...I depend on my DNO as well."* (KI09, Midwifery manager)

A few months after I returned from Malawi I discovered SRNM01 had resigned.

Taken together these challenges of leadership and accountability underpin the expectations and organisational culture these midwives operate in, which will form the basis of the next section.

10.3 Organisational culture and oppressed group behaviours

A key factor in the lived experience of the labour ward midwife was the prevailing organisational culture. Using the lens of oppressed groups theory, participant data and informal observations were used to explore its influence on how midwives behaved, their feelings of professionalism and performance, and how this varied between MOH and CHAM, or in facilities with strong leadership and expectations. The results presented here resonate strongly with the key informant perceptions, outlined in Chapter 7 'Betwixt and between', that there was a significant challenge in leadership and accountability, permeating all levels of the health system.

At the health facility level, it was difficult to explore this topic as so much of the culture of an organisation is tacit and assumed. However, key informants often spoke about the difference between MOH and CHAM facilities, suggesting that the same midwife would change their behaviour if they transferred between these different settings. This was largely attributed to the explicit Christian values of CHAM, their high expectations, and the freedom they had to hold staff accountable and to dismiss people who did not fit their ethos.

> *We serve the poor people and heal. We assist them to be in good health. So, if you are negligent of duties, you are not respecting clients, for **sure** you are not part of our compassion. That's what we **are**! We are there to serve and to **heal**. And if you are not doing that, we dismiss.* (KI12, Training institution-NMT)

Some of my informal observations have relevance here too. During data collection, I spent over three weeks at a central hospital, long enough for many of the midwives to largely forget about my presence and for me to see how they moved about the labour ward and the way in which they worked. Many of my field notes from the early days expressed my emotional responses to seeing behaviour from some midwives that I considered to be disrespectful, not just to women but to their colleagues too. An element of organisational culture that was of relevance here and impacted on the 'caring for the carer' discourse was the emergent theme of horizontal violence, spoken of as 'pull down syndrome' in Malawi and couched in the language of conformity. This was described as very common, *"in the culture"* and characterised by an attitude of *"Who does she think she is?"* (KI17, Senior advisor) Midwives, with a very small number of exceptions, only spoke to me about this 'off the record'. However, some key informants were more forthcoming, suggesting that staff who tried to behave in a professional and responsible manner faced the risk of being targeted by colleagues. This was a dynamic that was reportedly also played out at higher level of the nurse-midwife hierarchy, as we saw in Chapter 7 where this *"pulling up and down"* was described among members of the midwifery leadership.

A number of participants spoke of how difficult it was for midwives to maintain professional behaviour and do their work in the face of negative attitudes from colleagues that went unchallenged by line managers or senior staff.

> *Let's say there are three nurses on duty. One of them is hard working; two, they are just sitting on there, on the nurses' station. So, this one will work, work, work, then she will get tired. They don't even have to tell her 'Who do you want to look like?' No. But because she will get **tired** of 'Why am I the only one working while the others are just sitting there?', so she will join the system.* (KI04, Midwifery manager)

An example of this was an NMT who was motivated to become a midwife after a positive birth experience of her own. *"…when I was giving birth myself, what the midwife did to me, that was great…So one day I also I want to do the same like to the women… she was just massaging me at the back. Yah…and also some encouragement, word of encouragement."* (NMT01) There was marked dissonance between this NMT's aspirations during the interview and her actual behaviour in practice, which seemed to be largely linked to the presence of certain colleagues. One in particular, (NMT02), was widely regarded as a poor midwife and freely admitted that she hated labour ward. I noticed that when NMT02 was on duty, NMT01 frequently ignored women's calls altogether, staying in the midwives' station to chat. However, in the absence of NMT02 or when the in-charge was on duty, NMT01 was more attentive, encouraging and kind with women. Participants agreed that eventually the negative peer pressure would wear down the good midwife until *"they feel that they can't really make a difference."* (KI26, Midwifery manager) In the absence of external controls that demand professional standards, they felt this could lead to good midwives giving up and the normalisation of low quality care and disrespect of women and of colleagues. For example, one NMT in a central hospital thought that massage was a very effective pain management intervention, but had felt judged by his colleagues for doing it. *"I haven't seen many of them qualified people doing that, even these students, they don't do that. But it's very helpful. I have done once in a while…other people look at your doing that…they just think it's not necessary, it's just too much."* (NMT06) I observed this NMT across the course for four or five hours, watching him working non-stop while the only other midwife on duty sat at the midwives' station, ignoring him and the women. Speaking about workload he said of some of his colleagues, *"Others are a just a burden"* and *"the workload is not the same."* In my notes I wrote:

> *He was busy delivering a baby in the nearest cubicle (Oh, I'd like to be able to see!!) and it sounded like he was explaining, instructing the woman and his tone was soft. I heard the noises of delivery, the grunts and slithering of a new life into the world, and a few minutes later he brought out a small girl to be weighed, checked…All the while he was tending to the baby, cleaning up the woman, doing the paperwork and then started attending a second woman, NMT02 stayed in her chair…I found this participant very moving. He is yearning to be better, more than an NMT and to work in a*

professional environment, rather than this current one where he is often left to do all the work and ridiculed for being 'with woman'. (Field notes, 01 Apr 2016)

In addition to leaving some colleagues to do all the work, there was a normalisation of not being punctual for duty, which meant those waiting for handover could not go home. This was particularly problematic for those on a night shift who should be relieved at 07:30. *"…that tendency for reporting for duties late…it has assimilated into the culture…you come at half past eight and you find that you are the first person to reach the ward."* (NMT07) Another practice that seemed normalised was the lack of team work, with some staff mainly operating alone and a lack of helping hands when there was a heavy workload or an emergency. Below is a brief time log I kept one morning, that demonstrates a number of challenges in the organisational culture of a central hospital.

07:40 arrived at labour ward and found NMT02 resuscitating an undiagnosed twin…5 clinical officers, a doctor and 3 x third year midwifery students were milling around, but none of them seemed interested and no one offered to help, despite the fact that the mother had been left immediately the cord was clamped, she was clearly bleeding and NMT02 had her hands full. Further, she has been on night shift, should have been relieved at 07:30 but her day shift colleagues have not arrived. Last night she was alone on the ward too and had to beg for someone else to come and assist…These 2 midwives delivered 15 x SVD [spontaneous vaginal delivery]*, plus dealt with 2 x CS* [caesarean section]*.*

07:45 both babies breathing, so NMT02 went back to finish attending to the mother - throughout the resuscitation no one was with the woman and I didn't see anyone offer her any information or reassurance about the status of her twins. The twins did not receive any checks or attention again until 08:00 when some female relatives came in to look at them. Still no day staff in sight so NMT02 did all the paperwork to transfer them to the nursery.

07:55 a Clinical officer and an NMT arrive for duty

08:00 Another NMT arrives for the day shift, then a third NMT appears, but he has already been involved in a handover and is on his way to theatre to receive a CS baby.

08:45 NMT02 manages to finish her paperwork and goes home. The twins are ready to be moved, but nothing happens.

09:20 It's more than 90 mins since the twins were born. They are still in the resuscitaire and they have not been held by their mother yet. (Field notes, 04 Apr 2016)

Some participants articulated how difficult it was for good performers to maintain their professionalism in the face of negative input from colleagues and the normalisation of unprofessional behaviour. *"…you confuse people, you confuse their moral orientation. Because bad things becomes* [sic] *a standard and good things are ignored…that's why if a*

nurse tries to say, 'No, no, let's do this' people say, 'What do you think you are?'" (KI24, Academic) An NMT I interviewed in one hospital informally confirmed this, as my diary notes show. He had been a little hesitant about the interview, asking a lot of questions about what the research was for, how and where it would be reported.

> *When I turned the recorder off I asked him, jokingly, if it was a bad as he had feared.*
> *To my surprise he said he'd really enjoyed it and that he was very pleased at the*
> *questions I asked and to have the opportunity to say how he really feels, as no one*
> *ever asks and there is no acceptable forum to discuss issues such as disrespect from*
> *colleagues, poor attitudes and care in the ward, or how difficult it is to maintain*
> *professionalism and integrity when others don't care and actively undermine good*
> *performers.* (Field notes, 04 Apr 2016)

These informal observations provide small insights into some overt elements of the organisational culture, particularly as they are supported by corroborating data from the staff. In other facilities, I was not able to gain the same prolonged access, but I built upon my previous observations and experience to roughly gauge the tone of the labour ward from the way that the women behaved and their body language, rather than looking directly at the behaviour of the midwives. In a central hospital, many women hesitated before walking into the wards, almost bracing themselves, and seemed very unhappy to be there. The interview data reflected staff and manager perceptions that many of their colleagues were doing a poor job, and that some should not be in the labour ward. I also noticed a similar dynamic in another MOH facility (Facility 3) where the in-charges spoke to me of difficult relationships between the facility and the local community, of mistreatment and poor attitudes among some of the staff. This is where the incident I described in Chapter 9 took place, where a woman knelt to speak to a midwife I was with, but the midwife did not even look at her. Elsewhere, other women in the wards were quiet and subdued. One of the in-charges described the lack of sanction and how this affected behaviour of his staff. *"…they are not being responsible, they are not being professional…they know what they are doing is not good, but because they do not see any punishment they can be given for that, so they are not careful at all."* (SRNM07) Conversely, in an MOH facility with a strong complement of dynamic and present SRNMs (Facility 2) there was an air of collegiality, and the women appeared more relaxed and likely to make eye contact or chat to the staff. The way the midwives behaved seemed to be reflected in the women's demeanour. I later found out that this facility had started outreach programmes to the community and was actively trying to engage in dialogue with women about the type of care they wanted and the constraints midwives faced. These contrasting examples may illustrate that it is possible to deliver RMC in the context of similar constraints, by focusing on changing the organisational ethos.

I also noticed a much more positive atmosphere at Facility 8 (CHAM), which one of the midwives described as a lovely place to work, with good teamwork and clear expectations of what staff were expected to do and how they were supposed to comport themselves. This has resonance with the key informant views mentioned earlier, that midwives in CHAM are

not allowed to treat women badly, and from CHAM midwives in this facility who described how they explained the situation to women when they were constrained by staffing or resources issues and made sure to keep them informed.

I was struck at how relaxed the women there were. As I walked past one of the wards there were lots of women sitting on beds, laughing and joking with a midwife, looking really entitled to be there. One lively lady called me in to say hello to them, then they asked lots of questions, getting the midwife to translate and howling with laughter at my responses. Lovely atmosphere, and heart-warming at the end of my data collection to see such a positive dynamic at work. (Field notes, 23 May 2016)

The importance of a conducive organisational culture on behavioural norms was prominent in other CHAM facilities where midwives articulated the impact on their own performance. A young NMT who had been qualified for a year contrasted how things had been done during training with the expectations in the rural hospital in which she was now working.

…when we were at school, when we were going at the district, it was that short cut documentation. But here it's full documentation…just because of the way people document it here, you remove that picture in your head and then you start doing what the people are doing here. (NMT20)

An SRNM at a different CHAM hospital was able to relax because even when she was not in the labour ward she knew *"that people are being taken care of. So, those who are bad are slowly learning the culture, how we have to treat people…"* (SRNM08)

Summary

The situation of midwives revealed in this study was extremely challenging. Many perceived that they were not cared for or valued and were only visible when something went wrong. They reported working in conditions that were often impossible, with inadequate resources, supervision or support to carry out their jobs. Many felt their conditions of service did not adequately compensate for the challenges, responsibility and stress of labour ward. One of the key informants summed up the plight of the midwife far more eloquently than I could.

*The midwives are not recognised, they are overworking, the conditions they are working in are **pathetic**…So all those things, they pile up in the midwife. Where can they bring their grievances? They don't have anywhere to bring them, because the supervisors are not coming to supervise them...So where can they speak out? It's to the woman who comes for the care. So, all that pain will be pushed to the woman."* (KI13, NGO)

Organisational cultures and horizontal violence had a deep impact, undermining professionalism and good performance, allowing normalisation of disrespect of women and of colleagues. However, differences between facilities demonstrated that positive cultures, with present and engaged senior staff, could foster professionalism, collegiality and engagement with the community, allowing midwives to deliver RMC.

11. Discussion

Introduction

The overarching aim of this thesis was to explore midwives' perceptions of the practice, impact and challenges of delivering respectful maternity care in the Malawian context. The results presented in the findings Chapters 7-10 add to our understanding of the ways in which RMC is conceptualised, enacted and valued in this low-income, postcolonial context. Using the theoretical lens of postcolonialism facilitated an exploration that was cognisant of the factors, at different levels, which influence the dynamics of care during the intrapartum period in Malawian labour wards. Intersecting with this was the emergent theme of oppressed groups, manifest in this context as 'pull down syndrome', which blocked midwives' ability to provide the quality care, including RMC, that many felt was part of their professional scope of practice.

In this chapter I present a summary of the key findings, demonstrating how the theoretical frames used as an analytical lens provided insight into the deeper drivers and contextualised my interpretation to answer the original research questions posed in Section 1.5. The results explored the research questions by moving from the macro-level, postcolonial 'betwixt and between' of leadership and attitudes to the public sector, through the meso-level aspects that were relevant to the lived reality of becoming and being a midwife in an inherited, hierarchical system, down to the micro-level of relationships with women, before moving back out to focus on the plight of the midwife. The discussion will mirror these levels, addressing aspects of the research questions along the way. Finally, I will address the strengths and limitations of the study.

Before proceeding with the discussion, I want to flag up the passion and commitment of many of the midwives I spoke to, who were very often working in circumstances that were, frankly, untenable. The tendency in much of the literature has been to focus in on the micro-level interaction of the midwife-woman dyad, with an implicit assumption that things would improve if only midwives would be kinder, nicer, more professional. Failing to address the broader context in which midwives' behaviour is embedded sells midwives and their efforts short, effectively constituting disrespect for these professionals and the constraints under which they operate.

11.1 Betwixt and between - the broader postcolonial context

In Chapter 7, I characterised Malawi as 'betwixt and between', drawing on postcolonialism as a theoretical frame to interpret data that suggested a collision between traditional *uMunthu* values and democracy, tradition and modernity, rights and responsibilities. Participants outlined a variety of challenges, most notably the impact of what some characterised as a 'misunderstanding of democracy'. This 'misunderstanding' privileged individual rights over responsibilities, including those of midwives over women, allowing individual behaviour that violated Malawi's social norms of respect, dignity and the importance of community. These

dynamics manifested in corruption and misappropriation of the public purse, poor attitudes to public service and a perception of falling standards.

The concerns articulated by participants often reflected the epistemic clash articulated in postcolonial discourse, where indigenous knowledges and ways of being (captured in *uMunthu*) were overlaid and marginalised by dominant Western ideologies (democracy and individual rights) (Said, 1993; Kayira, 2015). Voices within Malawi suggested that the cultural liberation due to democracy had been at the expense of preserving cultural integrity (Mfutso-Bengo and Masiye, 2011). Sentiments expressed by participants in this study agreed that unprofessional behaviour had become normalised at all levels, which many blamed on the absence of strong leadership and inadequate systems for accountability that left managers responsible, but without authority. Nepotism and favouritism were pervasive. Patronage-based decision-making related to postings or sanctions was common, while those who tried to take action faced upward bullying or feared reprisals. These actions linked back to the 'betwixt and between' of a pre-existing communal system where community obligations and expectations dominated, overlaid with an individualistic interpretation of democracy. They also represented what Cammack et al. (2007) described as *"institutional hybridity"*, where *"Formal (legal-rational) institutions and informal (patrimonial) practices and norms interact in constantly changing ways, creating multiple* de facto *rules and uncertainty for all." (*p.vii) Other commentators suggested the need to refocus on the underlying values of *uMunthu* in order to reap a moral capital dividend, fostering sustainable professionalism and development, nationally and globally (Mfutso-Bengo, 2016).

Leadership was clearly a significant issue in this context, with those who should be taking action described as '*spectators'* or perceived to not know what they were doing. In other cases, participants were unable to clearly articulate who 'the leadership' were, demonstrating a significant lack of clarity on where responsibility lay for leading midwifery services forward. For example, even organisations who had been part of a recent technical working group on nursing and midwifery were unsure about the direction they should be taking or the actions they were supposed to have accomplished to meet the working group's goals. This speaks to a lack of direction and the need for someone who would take ownership and drive this agenda forward, but may also reflect a paternalistic, post-colonial/aid dependent dynamic where, as a poor country, Malawi has become accustomed to doing as the donors bid. However, it also needs to be considered in the context of historical inter-agency tensions. As I left Malawi in July 2016, there had been significant changes in personnel in the main agencies shaping midwives' futures (the Directorate of Nursing and Midwifery Services, the NMCM, and NONM (the union), leading to burgeoning optimism among key informants that things would start to improve. The appetite for change was not restricted to the future direction of midwifery, but also covered a growing human rights discourse, centred on the rights of childbearing women and, to a lesser extent, those of midwives themselves.

The postcolonial context still had a significant impact on the shape of the health system and, by extension, on the profession of midwifery. Austerity measures and economic restraints

have had a sustained, negative impact on the fiscal space available for the health system, resulting in severe resource and human resources for health (HRH) constraints. Peripheral midwifery services were still mostly provided by lower-level NMTs, whose training was technically focused and task driven (Blaise and Kegels, 2004), and who operated to a medical model of care. In 2007, the emergency focus on intractable maternal mortality figures and low skilled attendance at birth culminated in the Malawian government banning traditional birth attendants, an action taken without evidence or consultation. The ban was enforced by local by-laws and penalties that have been described as *"harsh… exacting and non-negotiable"* (Banda, 2013), disproportionately affecting the most vulnerable women. This step effectively coerced Malawian women to undergo a model of birth that they demonstrably did not want, driving them into a weak and under-resourced system that was ill-equipped to deal with the sharply rising numbers.

11.2 Becoming and being a midwife

Chapter 8 explored how and why people became midwives in Malawi, examining relevant meso-level drivers that affected their ability to provide RMC in this context. Many of the key factors that emerged can be traced back to Malawi's colonial history and the postcolonial legacy that continues to exert an influence. These include: the inherited dual-qualification model; changes in the type of candidate entering midwifery in the wake of multi-party democracy; shortages of the human and material resources needed for adequate quality of pre-registration training; and an external agenda to professionalise midwifery. Intersecting with these postcolonial challenges was the emergent theme of oppressed groups theory, where the low status of midwives, particularly the NMT cadre, was a cause of inter-cadre tensions and where NMTs were deemed most likely to be perpetrators of D&A.

11.2.1 A midwife or a nurse?

A significant issue exercising senior midwives in Malawi was the growing debate over the utility of the dual nurse-midwife qualification, a remnant of the system introduced by the British under colonial rule. Key informants were divided over whether Malawi was ready for dedicated midwives. However, they acknowledged that labour ward was difficult to staff, many nurses did not want to be midwives, and it would be better, for women and for midwives, to allow health workers to follow their interests. Tutors at both SRNM and NMT levels admitted training courses had become overloaded, concerned at the waste of resources in obliging students who wanted to be midwives to train as nurses first, and suggesting it would be better to split the roles. The paradigmatic differences between nursing and midwifery models of care and the implications of maternity care being provided by staff whose training was based on pathology and ill health were explicitly addressed. This reflects concerns that specific interpersonal skills are necessary for RMC (Fauveau, Sherratt and de Bernis, 2008) and that: *"Maternity services deal with the culturally and emotionally sensitive area of childbirth. Non-biomedical outcomes may be more important for childbirth than for other areas of health care."* (Pittrof, Campbell and Filippi, 2002) Many of those

interviewed strongly self-identified as midwives, in a context where all midwives are called 'nurse'. The strength of their professional identification had been almost completely neglected, despite cogent concerns that the existing model was eroding the expectation of autonomous practice that is a key element of midwifery (ICM, 2014). However, growing calls for a serious re-examination of the model of care on offer within Malawi were echoing evidence from the international arena on the importance of midwives and the benefits for women and newborns of quality midwifery care (e.g. Sandall et al., 2016; United Nations Population Fund, 2014). Taken together, these factors of work practices, attitudes and expectations left Malawi's nurse-midwives betwixt and between two professional stances that, in other jurisdictions, were seen as significantly different.

11.2.2 Midwives in a hierarchical system

The 'right' candidates?

The narrative interviews asked participants to tell the story of how they came to be midwives. Their responses echoed previous literature from Malawi suggesting a strong element of altruism and public service in their choice of career (e.g. Bradley and McAuliffe, 2009). However, there was a significant theme across the data of the 'wrong' sort of people coming into midwifery, which many felt had its roots in the advent of multi-party democracy. This ushered in increasing freedoms and new choices for women's employment, but were set in a changing environment of deteriorating working conditions and economic decline, which made nursing a less attractive option (Grigulis, 2010). Nonetheless, in an increasingly competitive market, the 2004 Emergency Human Resources Programme[78] was an attractive proposition, as its efforts to boost health worker numbers included paying student tuition fees for midwives (O'Neil et al., 2010) and graduates were virtually guaranteed to be hired. Since then, the focus for many SRNMs had been on obtaining a government-sponsored degree, but the 'guaranteed job' had remained a key motivator for NMTs (Grigulis, 2010). Grigulis also provided evidence that students took up nursing places by default, when they failed to secure their first choice[79] courses. This reflects one of this study's prevailing themes; a significant percentage of staff on the labour ward were considered 'just a job' midwives, who were thought more likely to lack professionalism and to show disrespect of their colleagues and the women in their 'care'. It is possible the 'just a job' discourse could be seen as a way of midwives judging who was worthy to have the midwife's status, to compensate for their own lack of status. However, it struck me that negative comments about 'other' midwives were based not on vocation *per se*, but instead reflected judgements about behaviour that showed a lack of care for women (e.g. letting women cry, shouting at them) and colleagues (e.g. arriving late, not doing their share of the work). As I observed earlier in the Methods

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[78] An emergency HRH programme instigated by the government which I outlined in Section 6.2.2.
[79] KCN changed its entry requirements for the 2017/2018 intake. The application forms now state that all candidates must put nursing as their first choice if they want to be considered. This is not the case for Mzuzu University which also train SRNMs. Available at:
http://www.downloads.cc.ac.mw/doc/NCHE_2017.pdf [Accessed 01 September 2017]

section, it may also have been the case that this was informed by participant's own presentation of self, where they wanted to differentiate themselves from 'bad' midwives.

The difficulties of choosing the 'right' candidates were made more challenging by the postcolonial context. Malawi's pervasive poverty and the near collapse of education services in the wake of externally imposed austerity programmes (Federici and Caffentzis, 2017) caused significant access barriers. Midwifery training in English and a British model of education can be seen as a continuation of the colonial 'civilising' mission, where the use of the coloniser's language and ideologies served to reinforce power and class differentials (Marks, 1994) and to groom health professionals as part of the privileged elite (Coovadia et al., 2009). This excluded less privileged Malawians from participation (Matiki, 2001), reducing access opportunities for good students from poorer backgrounds and leaving many students struggling and insufficiently fluent to pass the certification exams[80] (Grigulis, 2010). However, it also increased the social distance between midwives and women, which was implicated as a driver of D&A in the metasynthesis of women's experiences of facility-based delivery (Bradley et al., 2016), although less strongly articulated by midwives in this study or in the systematic review of midwives' perceptions (also in Chapter 3). Key informants identified the reluctance of midwives who hailed from wealthier backgrounds to work in the rural areas (described in Section 8.2.1) exacerbating the existing maldistribution of health workers (Soucat, Schleffier and Ghebreyesus, 2013). Yet, internationally, there is unanimous consensus on the utility of recruiting rural candidates as a mechanism to improve rural retention (World Health Organization, 2013). This intersects with growing calls for targeted policies to address social equity in admissions, including scholarships for disadvantaged students and supporting communities to select their own candidates and then hire them after graduation (Frenk et al., 2010).

The midwife's status

Midwives' perceptions of their position in the health hierarchy was a newly emerging theme in the meta-synthesis described in Chapter 3. Status was an important consideration in the dynamics of D&A, which was strongly reflected in the Malawian data where the status of 'professional midwife' was reserved for SRNM degree-holders[81] only. Thus, over 80% of Malawian midwives, most of whom are NMTs, were considered non-professionals. The invidious position of the NMT cadre was a key element of the results in Chapter 8 and had implications for the oppressed group behaviours outlined in Chapter 10. NMTs represent a mid-level cadre substituting for the traditionally recognised professions, such as doctors and midwives (Dovlo, 2004). A useful concept here is the indeterminacy: technicality ratio. O'Boyle (2009) draws on Jamous and Peloille's (1970) work, which differentiated between technical activity and indeterminate judgement, characterising the professions as having high

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[80] In March 2017, a number of Malawian newspapers carried reports of very high failure rates in the NMT exams, citing lack of proficiency in English as a key issue.
[81] The designation of professional excludes SRNMs at diploma-level (Personal communication, WRA Malawi Lilongwe, May 2017)

levels of indeterminacy.[82] In this model, technical skills (including touch and caring processes which are not knowledge based) are afforded less status, being seen as instrumental compared to the more cognitive aspects of using experience and creative problem-solving. This was reflected in key informant perceptions that NMTs were a technical cadre who lacked decision-making capacity (i.e. indeterminacy), echoing the parallel predicament of clinical officers (Chilopora et al., 2007) and pharmacy technicians (Lim, Anderson and McGrath, 2012) in Malawi. Linked to this was the inflexibility of the civil service pay structure, where all technician grades (including NMTs) were on the same pay scale[83] regardless of their working conditions or levels of responsibility.

Despite the perceptions of NMTs as technical staff, many of the NMTs I interviewed spoke about their practice in terms of being professional, emphasising skills and expertise, satisfaction, professional growth and learning. Others explicitly wanted to be 'more', but lacked ready alternatives to advance and become more proficient. The importance of career development and access to educational opportunities on health worker performance and motivation are well recognised (e.g. Willis-Shattuck et al., 2008; WHO, 2010) and have received significant attention in international policy debates about maximising the benefits of mid-level health workers, including NMTs (Brown et al., 2011). Key informants recognised this waste of potential, advocating for good NMTs to be upgraded to degree status, yet efforts to support a shorter upgrading route were stymied by inter-organisational tensions in the national-level leadership. Increasingly vocal NMTs had been calling for action, while changes in personnel heading the relevant agencies involved had led to encouraging signs that this issue could be resolved in the near future.[84]

Intra-professional issues of status and hierarchy between SRNM and NMT cadres were significant. NMTs were expected to refer to SRNMs, substituting for them in their absence and carrying out the bulk of delivery care, despite earning salaries that were approximately half those of SRNMs[85]. Yet SRNMs' responsibilities were largely administrative, and the majority were reported to not work unsociable hours (i.e. night shifts and weekends). Further, NMTs had limited opportunities for promotion as senior posts are assigned to SRNMs, a source of considerable demotivation among mid-level cadres more generally (e.g. McAuliffe et al., 2009). In addition, NMTs were often the first port of call in a hospital setting, or the only person with midwifery skills in a health centre, but often lacked sufficient technical skills, autonomy or decision-making capabilities to comfortably fulfil that role. When complications arose, they were expected to cope, regardless of the resource and referral constraints, often without supervision or back-up. Some key informants suggested the bulk of complaints of

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[82] Some scholars couch indeterminacy/technicality in opposition terms of the 'art' and 'science' of health care (see for example Traynor, 2009).
[83] Although there are some top-ups available to select cadres of health worker, introduced as part of the EHRP to boost human resource numbers.
[84] For example, CHAM's website suggests it will 'soon' be offering a 2-year upgrading diploma from NMT to registered (RNM) certification.
[85] This dynamic is now being replicated with the CMA cadre, who are currently backfilling vacancies in health facilities, where they are doing similar work to the NMT but on a lower pay grade.

D&A involved NMTs, which was borne out in the data I collected. NMTs legitimised D&A as necessary to avoid bad outcomes. However, NMTs can be viewed as an oppressed group: they have low status and are not supported or valued as professionals; feel exploited as poorly paid substitutes for SRNMs; lack autonomy, accountability and control (Roberts, 1983); and are working in a context where they are not afforded the rights they are required to offer to women (Kirkham, 1999). Many of these factors are implicated as drivers of D&A (Bowser and Hill, 2010) and played out in the disciplinarian and abusive behaviour that many of the 'poor incident' stories described.

SRNMs were not immune from status issues and faced inter-professional tensions with clinical cadres (clinical officers and medical assistants). In the Malawian health system, facility management roles were only assigned to 'clinicians'[86], not midwives, resulting in a hierarchy where degree-level midwives were expected to answer to diploma-level clinical officers, and medical assistants with a certificate were higher in the hierarchy than NMTs with a diploma (Muula and Maseko, 2006). This was at direct odds with a Malawian norm of education as a significant marker of status but was a historical remnant of the colonial health system, which brought in a gendered view of roles that privileged a male, medical hierarchy over lower status, female caring work (Witz 1992). It caused significant inter-cadre tensions and had negative impacts in the clinical area where midwives reported clinicians with less experience overriding the midwife's professional judgements. Some felt this erosion of midwifery autonomy constituted a professional threat, which was in danger of becoming accepted practice, particularly among newer graduates. The teamwork and inter-professional collaboration necessary for effective obstetric care are casualties of this dynamic (Renfrew et al., 2014). The quest for professionalism was a manifestation of these tensions but also a possible route forward, with key informants suggesting that a specialised, autonomous midwife cadre could ease the tensions between clinical and midwifery cadres. In the Malawian context, these dynamics may be more pronounced for NMTs who faced questions about their competence and professionalism, and were further complicated by a sense of senior midwives trying to regain the status and position in society that they felt had been lost since Banda's time (Grigulis, 2010).

11.2.3 Pre-registration training

Content and expectations of RMC

The core aspects of RMC were mainly taught during modules on ethics and professional behaviour, which were fundamental elements of the midwife's professional identity. These aspects were important and cross-cutting in the curricula for both NMTs and SRNMs, but were considered insufficiently embedded. This could be partially explained by a more technical focus in the NMT curriculum, while tutors suggested the time constraints of the content-heavy, dual-qualification programme tended to privilege knowledge and skills over attitudes. This reflected the concept of the 'hidden curriculum' (Hafferty and O'Donnell,

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[86] In the Malawi context participants usually refer to 'clinicians' to mean Clinical Officers, or medical assistants.

2014), where students learnt a different set of lessons from those taught in the classroom. A further challenge concerned how to capture the more intangible values and attitudes necessary to operationalise RMC in this context. This is a subject of considerable interest in the maternal health arena as a range of actors attempt to create typologies and measures of RMC (Sheferaw, Mengesha and Wase, 2016; Afulani et al., 2017; Ndwiga et al., 2017) and D&A (Bohren et al., 2015; Abuya et al., 2015). Indeed, this study reported that while key stakeholders from training colleges stated they assessed RMC, they were unable to say exactly how they did this. Checklists I was shown tended to capture easy-to-measure manifestations, such as privacy and tone of voice, with significant omission of some of the behaviours enshrined in international consensus statements and advocacy literature. I would question the assumptions of shared meaning and understanding of some of the attitudinal constructs of respect, dignity, choice and consent in this context. It was clear that some of the concepts did not easily translate, with one senior midwifery leader calling for a contextualised understanding of what constituted RMC in Malawi.

Clinical practice challenges

The postcolonial legacy was clearly evident in Malawi's challenges in training midwives. These had intensified in the wake of the Emergency Human Resource Programme where student numbers increased significantly, but training institution capacity (both numbers and skills) did not rise enough to match (O'Neil et al., 2010). Participants suggested professional socialisation processes for knowledge and skills were severely compromised, driven by a legacy of ongoing poverty and lack of fiscal space for provision of even basic public services. Supporting Msiska, Smith and Fawcett's previous findings with Malawian nursing students (2014a), participants reported serious human and physical resource constraints in the clinical practice area, as well as the lack of sufficient tutors, midwives and mentors who were present and willing to teach. Fullerton et al.'s (2011) work with Malawian midwives reported: a lack of tutors with midwifery skills; didactic rather than problem-based learning; and students graduating without the recommended number of clinical experiences[87]. Unsurprisingly, they also reported falling pass rates for midwifery credentialing examinations, which was corroborated by key informants in this study. These findings complement an earlier analysis of pre-registration education challenges in Africa which left the majority of graduates without the skills and experience to do their jobs (Beaglehole, Sanders, and Dal Poz, 2003). Together, these factors speak to a cohort of new midwives who are inadequately prepared for practice.

The hidden curriculum emerged again in clinical practice at the organisational level, where students experienced the enormity of the gap between the theory and practice of professional behaviour. Here, students learnt about power, authority, conformity, and the underlying values and assumptions that circulated in the broader cultural and social context (Hafferty and O'Donnell, 2014). The attitudinal aspects of professional socialisation were undermined

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[87] In Chapter 8, an NMT described conducting her very first manual removal of placenta while alone on a night shift.

by unprofessional behaviour from qualified staff. For example, even when the wards were not busy, staff often did not support students. Some of this can be explained by the previously described attitude where qualified staff did not regard teaching as part of their role, but a previous study in Malawi suggested students were forced to shoulder the workload by nurses who would later sign off their competencies (Msiska, Smith and Fawcett, 2014b). It is also likely some of this behaviour was driven by, and intersected with, the broader cultural shift in attitudes to public service this thesis has identified, as well as the lack of vocation or passion for work that was 'just a job'. A significant consequence of the lack of appropriate senior role models was a failure to model the skills and demeanour of a professional midwife, thus damaging the professionalism expected of new recruits.

The shortages of staff, resource constraints and lack of role models, mentors and supervision, reinforced each other, pushing both students and qualified midwives to tacitly, or even explicitly, adopt and normalise behaviours, such as shortcuts and poor practice. These behaviours were at odds with both the expectations of the training colleges, the guidelines produced by the MOH, and midwives' own professional scopes of practice and ethics. Mistreatment of women was modelled and normalised in practice, mirroring the engrained nature of D&A in health systems in other countries (Moyer et al., 2016; Rominski et al., 2017).

11.2.4 Professionalising midwifery

The international maternal health community is paying considerable attention to improving respectful care of childbearing women and improving the quality and acceptability of midwifery care more broadly. Malawi is under pressure from a range of external actors to take action on RMC; professionalising its midwifery workforce forms part of that agenda. The postcolonial theoretical frame was important in understanding the challenges of navigating this situation in a context where the colonial legacy and heavy reliance on donor support limit the country's agency and autonomy. In Section 1.6.1, I raised the issue of different types of power - financial, epistemic and normative - and how these can be brought to bear on a country like Malawi. The data I gathered showed some ambivalence among stakeholders about the proposed introduction of direct-entry BSc midwives. Some key informants felt pushed into an action the country could not yet afford; others felt their international colleagues were supporting Malawian midwives' efforts to become an autonomous, independent profession. However, there were no dissenting voices when it came to the issues of the importance of career progression and the impact of role models to promote professional behavior, including RMC.

The results presented in Section 8.4 demonstrated that despite some participants' reservations about Malawi's readiness, efforts to professionalise midwifery had begun. The introduction of a direct-entry BSc in Midwifery in 2016 was a constituent part of considerable RMC advocacy efforts by international agencies, such as the WRA Malawi, and was positively viewed by a significant majority of key informants, including representatives of relevant national stakeholders (e.g. MOH, NMCM, AMAMI, CHAM and KCN). Many favoured specialisation as a mechanism for midwifery to become a separate, autonomous

profession,[88] suggesting this would reinvigorate the profession and produce skilled practitioners with the right attitudes to work with women as partners, thus enabling RMC in this context. However, a lack of cohesive leadership and contradictory policy directions left questions about how or whether this would happen. For example, many senior key informants thought the NMT cadre should be phased out, yet the government had recently introduced an even lower level cadre, the Community Midwifery Assistant (CMA), which was designed to replace the TBAs who had been banned since 2007 (Bell et al., 2014). The CMA initiative was a political, rather than strategic, move, which produced staff who *"…fell outside the international and national legislative definition of a midwife."* (WRA Malawi, 2016). The contradictory initiatives of professionalising with a direct-entry midwifery degree on the one hand and deskilling to the CMA level on the other, reflected the lack of a united voice or coherent plan for the future, but was clouded by political decisions.

Midwives in this study felt invisible in the current dual role system, where all midwives were called 'nurse'. This was reflected in the lack of dedicated career options specific to midwives, where even very senior midwives had job titles such as 'Chief Nursing Officer'. Continuing professional development was also generalised and targeted at nurses. The lack of a separate identity had serious implications for midwifery. At one level it, too, was part of the hidden curriculum, sending messages about the value of this profession, which was already under attack from the globalised focus on medicalisation and the erosion of normality. Lack of a career path challenged professional socialisation by undermining the importance of having senior midwifery role models to act as standard bearers for the profession, who would display professionalism in action and inspire others to emulate them. Factors removing role models from the ward were identified as: a mentality of 'the higher the qualification, the further from the patient'; normalisation of expectations that doing less work was a perk of seniority; and posting inexperienced and often unsupported SRNMs to health facilities as the ward in-charges. Recent changes, however, suggested a nascent trend to reverse these dynamics and act as an enabler for professional and respectful care of women. This study identified a growing appetite from senior leaders to halt the practice of moving highly qualified staff out of the labour ward, instead keeping them at the bedside as advanced practitioners. Some key informants reported already putting this into practice in tertiary facilities, providing a new model of the responsibilities and skills of senior professionals. The availability of a small but expanding set of opportunities for midwives to avail of higher education (such as PhD and MSc programmes) may have provided the impetus for this change. However, absolute numbers of staff involved were still very low and it will be some time before any impact is felt.

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[88] Malawi is not alone in advocating for midwifery as a profession independent to nursing. A news item on a 2013 ICM workshop on midwifery education with representatives of 12 African countries, including Malawi, noted: "*A common denominator in the discussions was the need to separate midwifery from nursing and to raise the profile for midwifery as it's* [sic] *very own profession*.' Available at: http://internationalmidwives.org/news/?nid=105 [Accessed 24 September 2017]

Career progression and access to training opportunities are powerful non-financial incentives, with well-documented impacts on job satisfaction and staff retention (Goldberg and Levey, 2012; Fogarty et al., 2014). However, the allocation of opportunities was reported to be influenced by patronage and nepotism in this postcolonial context. Transparent and fair processes must be in place, but the findings of this study mirror those of other research in Malawi which has demonstrated widespread perceptions of managerial unfairness and favouritism in the allocation of upgrading, promotion and education opportunities (Manafa et al., 2009; Bradley and McAuliffe, 2009; Chimwaza et al., 2014, Chipeta et al., 2016). At an organisational level, lack of career progression can also cause a leadership gap and decrease the voice of midwives in policy discussion. For example, a recent global consultation of midwives documented that they: *"…felt that the lack of leadership opportunities for senior midwifery staff disempowered the profession, particularly when midwifery is subsumed within nursing structures."* (WHO, 2016a: 3) In Malawi, it was likely that the lack of dedicated senior midwifery voices in key leadership positions hampered efforts to secure agreement and generate a cohesive plan for the country's midwifery services which continued to be subsumed under nursing.

11.3. Relationships with women

This section covers midwives' practice of RMC during labour and delivery and their perceptions of the value and impact of RMC.

11.3.1 RMC and challenges in providing it

As we saw in Chapter 9, one of the core questions this thesis set out to answer was how 'good' midwifery was conceptualised in the Malawian context. Midwives who described a good midwife spoke of hardworking, passionate, committed individuals; colleagues who were calm or humble in their interactions with women; and those who were team builders, motivators or role models. Their descriptions of good birth incidents revealed an ideal model of RMC focused on providing the type of care they would want to receive themselves, expressed in terms of empathy, relationships, good communication and support. Only a small group of respondents spoke explicitly of including the woman as a participant or partner in care, although this sentiment was espoused by some key informants at the national level. For many of the NMTs, the positive aspects of respectful care were less clearly articulated, with significant omission of many of the behaviours recommended in local[89] and international expectations and guidelines (e.g. WRA, 2011; FIGO, 2015; WHO, 2016b). Their narratives tended to focus more on technical aspects of care, which may be a reflection of their pre-registration training.

The therapeutic relationships that facilitated RMC were hampered by the work environment constraints and the negative attitudes of 'other' midwives for whom midwifery was 'just a job',

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[89] The Malawi National Reproductive Health Service Delivery Guidelines 2014-2019 (MOH, 2017) have a clear section on RMC (p.70-72) and the MOH Participants Manual in Integrated Maternal and Neonatal Care (2015) contains principles of mother-friendly care. However, none of the midwives I interviewed referred to these when discussing interpersonal care.

both of which can be ascribed to the postcolonial context. Despite the hierarchical nature of the Malawian health system and the significant status given to education, social distance and othering did not emerge as strong factors in the midwife data, with only limited references to social inequality in how women were welcomed or treated. However, key informants were more vocal about this dynamic, reporting differences in women's treatment across public/private and rural/urban axes. The behaviours described, and rationales given, demonstrated a widespread perception that women were uneducated and did not know what to do. More positively, there was evidence of a growing discourse among midwives, particularly in CHAM facilities, of women's rights to RMC, which seemed to be trickling down from international debates and actions. An opportunity exists to engage with this more robustly, particularly at the community level.

11.3.2 The 'uncooperative' woman - a justification for D&A

One of the more overt issues in the Malawian context was a dominant discourse of 'the uncooperative woman', which served to allow midwives power and control over women and their bodies, using punishment for non-compliance. This resonates with some of the recently emerging literature on midwives' perspectives of (dis)respectful care (described in the metasynthesis in Chapter 3) where women were considered to be deliberately difficult and actively flouting midwives' authority, thereby justifying the control and discipline that was exerted over them. Midwives reported their deliberate decision-making to neglect or withhold care of women deemed 'uncooperative'. Using their discretionary powers in this way, midwives act as street-level bureaucrats (Lipsky, 1980), attempting to balance women's needs with the demands of the institution and their own overwhelming workloads.

I had expected midwives to be hesitant to discuss D&A, to feel more comfortable describing poor behaviours of 'other' midwives. Although some did do this, the majority were remarkably candid about their own behaviour, mirroring the lack of shame reported elsewhere in sub-Saharan African (e.g. Jewkes, Abrahams and Mvo, 1998; Rominski et al., 2017), and intersecting with the widespread prevalence (Kruk et al., 2014; Abuya et al., 2015) and normalisation of D&A. Almost all the incidents I was told about related to bullying 'uncooperative' women to do what they were told, including shouting, threats to remove care, or bringing in guardians to shout at the woman too. These behaviours are symptomatic of the low status of Malawian women and the widespread use of gender-based violence to control their behaviour (National Statistical Office, 2017). A strong and pervasive rationalisation in the data was that D&A was justified as long as the outcome of 'live baby, live mother' was achieved, supported by midwives' conviction that women did not know what to do, particularly around the time for pushing. Intersecting with this was evidence of overriding embodied knowledge (Jordan, 1997) and assuming authoritative knowledge in

their judgments of maternal effort, timing, and denial of choice of delivery position.[90] Also driving this was midwives' deeply held fear that if something went wrong they would be blamed. This must be viewed in the context of midwives' holding responsibility without supervision, backup or support from line managers (e.g. Bradley et al., 2015; Chipeta et al, 2016), where they felt there was limited attention to, or allowance for, the health systems deficits that made it hard for them to deliver quality care. The discourse of the 'uncooperative' woman appeared to be an attempt to cast the woman as actively subverting the midwife's best efforts and so shift blame for poor outcomes onto the woman. In this way, the woman was made responsible for incurring much of the disrespectful care she experienced. Midwives justified their actions by demonstrating that women often thanked them afterwards and apologised for their behaviour.

A key trigger for behaviour deemed 'uncooperative' in this study was women's inability to deal with pain. It is important to note that this was in a context where no pharmacological pain relief was available in labour wards, even for invasive procedures such as manual removal of placenta, despite MOH protocols stating that it should be part of care (MOH, 2015). Women were reported to be afraid of facility-based birth and worried about mistreatment from midwives. Their concerns were exacerbated by not knowing what to expect or being left alone for extended periods during labour. Extant literature from sub-Saharan Africa suggests midwives have limited empathy for women's pain (Yakubu et al., 2014; Rominski et al., 2017) and this was evident in some accounts in this study. Although midwives were taught that massage was an effective and expected element of care, this strategy was not often applied. In some cases, HRH constraints were cited, but some midwives who thought massage was a useful tool suggested there was organisational resistance to its implementation in practice. However, many midwives did describe efforts to provide non-pharmacological pain relief as they recognised the role of uncontrolled pain in making it difficult for women to follow instructions when the midwife was trying to help them. I argue that in a resource-constrained context, the interpersonal aspects of care become even more important. Indeed, good midwives in this study knew the value of the therapeutic relationship in working with and informing women, who would then cope with pain better and trust the midwife enough to do what was asked of them. Research in high-income countries has shown that when labour pain is perceived as productive and women feel safe, they are better able to manage (Whitburn et al., 2017), yet many midwives reported women who were not adequately supported, who, when they struggled, were often shouted at and threatened with the prospect of a dead baby. These are extremely counterproductive behaviours from midwives which could be reframed to improve the situation for both parties, emphasising the need to re-engage with the biosocial aspects of care during midwifery education. Women were also

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[90] At the same time, however, facility practice often disregarded evidence-based practice, with midwives routinely failing to carry out beneficial practices, such as immediate skin-to-skin contact, despite these being enshrined in national guidelines and taught in pre-registration training. Conversely, they are expected to facilitate choice of delivery position, but are only taught to catch babies in lithotomy, so were afraid of dropping the baby.

blamed for 'poor maternal effort' when they got to second stage and needed to push. Some midwives initially seemed to consider this as wilful or deliberately difficult behaviour. However, upon probing, they described a variety to reasons this might happen, including being too young, terrified of the pain, exhausted, anaemic or malnourished. It appears the understanding they demonstrated when questioned more deeply was not displayed in their interactions with women. This objectification of women was apparent in some of the midwives' narratives, where both the ENMs and some NMTs focused exclusively on themselves, despite being asked explicitly about interpersonal care and the impact on women. They needed to be prompted to remember that the woman had feelings too, and was not just a body on a bed upon which they performed their technical skills.

11.3.3 The value and impact of RMC

The metasynthesis (Chapter 3) revealed a gap in the literature related to midwives' understandings of the impact of (dis)respectful care. This was addressed in one of the thesis aims: to explore midwives' perceptions of the value and impact of RMC to midwives, women and the health facility. It was clear that for many midwives there was significant personal satisfaction and a sense of professionalism in being able to provide RMC. They described tangible impacts on working practice, as RMC facilitated trust, communication and cooperation, which they felt made their work easier. Some spoke explicitly of the psychological benefits for women of reducing stress and anxiety, with only a small number also articulating positive physiological impacts on labour and delivery. Particularly in CHAM facilities, midwives were more likely to talk about a woman's rights to be treated respectfully and receive quality care, mirroring a growing discourse at the national level among key informants on the need for, and entitlement to, RMC.

11.3.4 Relationships with the community

Many of the benefits of RMC cited by midwives centred on their impact on relationships with the community, demonstrating their awareness that their behaviour mattered. Narratives of the 'good incidents' were often couched in terms of how word would travel back to the community, enhancing both the midwife's individual reputation and that of the health facility more generally. Many of those I interviewed were clearly delighted when women thanked them or when they were stopped in the street to admire a baby they had delivered. The findings demonstrated that recognition and respect, including from the community, were important. A review of health worker motivation and retention (Willis-Shattuck et al., 2008) highlighted the role of personal recognition as a key driver; while appreciation by patients is seen as an indicator of staff professionalism (Mathauer and Imhoff, 2006).

Baldé et al. (2017b) distinguished between women's 'lived' or 'shared' experiences of mistreatment, suggesting both direct mistreatment or hearing about mistreatment from friends were powerful drivers of negative perceptions of facility-based delivery. Midwives I spoke to agreed that the actions of one bad midwife would reflect negatively on everyone in the facility and make relationships with the community more difficult. Some reported intervening and speaking to colleagues guilty of D&A to try to encourage them to change. Many tacitly

accepted that the model of care on offer was not what women wanted, articulating their awareness that women feared facility-based delivery, expecting mistreatment and poor attitudes from midwives. In other low-income contexts, D&A erodes trust in the health system and is a key barrier to facility-based delivery (Bohren et al., 2014), leading women to choose a more social model of care with traditional birth attendants (e.g. Bohren et al., 2015). However, the TBA ban in Malawi leaves women with no choice but to birth in a health facility. The combination of enforced facility-based delivery, fear, and expectations of D&A, were reported to generate negative attitudes from women; some demonstrated their resistance by presenting as late as possible in labour or arriving prepared for a fight. These strategies seriously compromised efforts to forge relationships and provide RMC. In addition, midwives' perceptions were that women did not appreciate the constraints under which they operated, leading to situations where necessary urgency or lack of attention were misinterpreted as D&A. Some midwives suggested the need for better communication with the local community. In Facility 2, midwives had instigated their own outreach programme, to build dialogue and start to make changes to benefit women and midwives. However, lessons learned elsewhere in sub-Saharan Africa suggest that success and sustainability rely on supportive management and health workers who are proactive and embrace the need to connect with the community to address RMC (Warren et al., 2017). Proof of concept research from Tanzania suggests that linking norms and standards to quality improvement can enhance mutual respect between providers and women (Kujawski et al., 2017). Reflecting this discourse on the wider international stage is a growing articulation of women's rights in Malawi, although, as yet, there are few mechanisms for recourse. The existing power differentials between women and midwives restrict women's ability to complain. Even when they do feel sufficiently aggrieved to speak out, the mechanisms for complaint seemed to me to exclude many women. For example, both the District Health Office and the NMCM required complaints to be made in writing, which can be a serious obstacle in the context of high levels of illiteracy or limited education.

11.4 Caring for the carers

One of the aims of this thesis was to explore constraints and enablers of RMC in the Malawi context. This was a cross-cutting issue in the results chapters, influenced by a range of upstream factors. At the macro-level, broad relevant concerns included: the impact of a post-colonial context, contributing to poor attitudes to public service; inadequate leadership; and lack of accountability (Chapter 7). Meso-level constraints were: nurses who did not want to be midwives; a focus on technical care; and challenges in professional socialisation, such as the practice-theory gap in clinical training and the lack of role models (Chapter 8). We saw the impact of these factors on the midwife-woman relationship in Chapter 9. However, it is the results from Chapter 10 that provide an insight into what midwives perceived as the most pressing and immediate constraints on their professional practice. Foremost of these was the work environment, which constituted a pervasive limitation that compromised midwives in their ability to provide maternity care (respectful or technical) but also constituted disrespect

of midwives. Secondly, the perceptions that midwifery was not valued or supported, and finally the impact of organisational cultures and oppressed group behaviours that failed to support or enable quality working practices, eroding professionalism by tacitly sanctioning poor attitudes and behaviours that constitute D&A of both women and midwives.

11.4.1 The unconducive work environment

The circumstances in which midwives in this study worked (described in Chapter 10) mirrored similar challenges faced elsewhere in the region, telling a dispiriting story of too few staff, erratic and unreliable provision of consumables and other resources, inadequate infrastructure and poor referral systems. These reflected the reality of the postcolonial legacy of other sub-Saharan African countries suffering ongoing poverty, absolute shortages of health workers and scarcity of the basic resources necessary for maternal health, which compromised not just the ability to provide care, but the quality of that care (Gerein, Green and Pearson, 2006). The challenges in the work environment comprised one of the most immediate barriers to RMC, particularly the aspect of a woman's right to the highest attainable level of health care (WRA, 2011). They also constituted D&A of the midwife.

A significant body of evidence demonstrates the detrimental effects of existing working conditions in many sub-Saharan African countries. One of the most serious challenges voiced by participants was chronic, ongoing human resource shortages. This was implicated in many instances of sub-standard care and clearly articulated by all respondents as a driver of disrespect. A particular source of conflict was the inability of midwives to provide enough attention to women when they had too many others to care for at the same time, leaving women feeling unwelcome and abandoned, and frustrating midwives. A key problem in the HRH discourse has been the use of provider to population ratios as a way of estimating staffing establishments. However, these usually do not take into account context-specific factors, such as poverty, fertility rate or burden of disease. Recent modelling suggests Malawi needs nearly twice the WHO-recommended number of midwives (1.9 instead of 1 per 175 births; ten Hoope-Bender et al., 2017), yet at the time of data collection (mid-2016) vacancy rates stood at 65%. Further effort needs to be made to match staffing establishments to local need, rather than the existing policy of allocating staff according to facility type (Ministry of Health, 2013). Some of the documentary evidence I collected demonstrated wildly different compliments of midwives and skill sets between rural and urban facilities carrying out the same number of births. The data also showed rural facilities relying on less qualified staff, when arguably they need a more comprehensive skill mix available when referral and backup are so limited (McCourt et al., 2012). Working alone or in the absence of supportive supervision affects staff confidence and intersects with expectations of personal blame if a mistake is made or outcomes are poor (Bradley et al., 2015), a dynamic that also affected midwives in this study and which had obvious implications for quality of care. I suggest that this fear may partially account for the findings of non-performance of key obstetric care functions among staff who have been authorised and trained to carry out these procedures (Lobis et al., 2011). Certainly, midwives in one health facility told me they were

expected to carry out manual removal of placenta, but tended to ignore the guidelines and their own training because they feared it might develop into a post-partum haemorrhage that they would not be able to control, so preferred to refer to the central hospital instead. With supportive supervision and back-up, women would not have to endure unnecessary referrals, while their colleagues in the hospital could use their limited human resources for tertiary level care.

A second major constraint was the serious under-resourcing of the health system. Some of this was attributable to the country's poverty, but others blamed corruption and waste in the system, linking to the findings in Chapter 7. An additional frustration was that many of the challenges, such as unnecessary referrals due to stockouts (e.g. of sutures), or delayed referral caused by non-emergency use of ambulances, were avoidable with proper management and planning.

Describing conditions in a maternity ward in Cameroon, Tantchou (2017) suggested there was a significant impact on human interactions in the labour ward when the "materiality of care" (which included, *inter alia*, infrastructure, space and resources) was compromised. Midwives struggled to manage a physical environment that was unconducive to carrying out the professional roles and routines that should allow them to work efficiently and effectively. *"Altercations with users arise from this demanding and continuous process of translation and anticipation as well as the emotional, intellectual, and physical fatigue it causes."* (n.p.) Many staff I interviewed described similar time-consuming, and sometimes futile, efforts to improvise, anticipate and cope, yet were still expected to be compassionate and altruistic, despite their own frustration and dissatisfaction. This highlights the tensions between the physical provision of care and the attitudinal domains of (dis)respectful care, but also emphasises the need to focus on more than just extolling midwives to be nicer to ensure RMC. In this study, midwives were well aware that the physical infrastructure impeded their ability to provide some of the key elements of respectful care for women. For example, the open ward structure made it difficult to provide privacy and confidentiality, or to accommodate labour companions as per the MOH guidelines, yet companions could usefully benefit midwives as well as women in the context of such severe staff shortages. Infrastructure also impacts negatively on staff. In many of the facilities I visited, the midwives' station was in the open labour ward, visible to everyone. Manning (2014) suggests that paediatric nurses in her West African study knew the 'feeling rules'[91] expected of them, but the lack of a private, backstage space (Goffman, 1959) to process difficult emotions (e.g. due to emergencies and death) resulted in increased expressions of anger and frustration towards patients. However, engineering a small or even temporary 'backstage' ameliorated this and facilitated delivery of the professional and compassionate care to which many aspired.

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[91] Feeling rules are the norms governing the type of emotions that are considered appropriate or acceptable to display in different social contexts, including the workplace (Hochschild, 1979).

Some key informants critiqued the lack of preparation during training for the reality once students went into practice. Indeed, some authors (e.g. Yakubu et al., 2014) have suggested that one solution to address D&A would be to train midwives to be able to deal more effectively with the current constraints. I would argue that skills can only provide a degree of buffer in impossible circumstances. For example, it is difficult to imagine how to prepare a lone midwife to deal with multiple babies crowning at the same time - a situation described to me time and again in the health facilities I visited. I am also concerned about pushing responsibility to cope back on the midwife, when the blame for, and challenges of, the deficits of an entire health system already sit on her shoulders. At the same time, I acknowledge that many midwives did not possess a suite of tools to help them cope, often stumbling upon mechanisms to respectfully support women as a result of positive feedback from good experiences.

The impact of the unconducive working environment cannot be understated. It is a key 'push' factor, driving staff out of the public sector. Indeed, some of the 'good' midwives I interviewed have subsequently migrated or moved to less stressful posts. Lack of staff, overcrowding, lack of adequate resources and inadequate referral combine to disempower midwives (Pettersson et al., 2006; Mselle et al., 2013). Research from Malawi shows that shortage of staff causes increased workload and generates a range of negative consequences, including burnout, absenteeism, and reduced morale (McAuliffe et al., 2010). High levels of burnout, particularly emotional exhaustion and reduced personal accomplishment, have been reported among Malawian maternity care providers (Thorsen, Tharp and Meguid, 2011).

11.4.2 Lack of institutional support

Even when midwives reported their concerns about the challenges they faced, they felt ignored by managers. Some suggested their professional bodies were too slow to respond and did not support midwives in the way they needed, leaving midwives feeling unvalued. McAuliffe et al. (2009) reported not being valued and lack of management support as key features of the Malawian health environment, with the latter correlated with dissatisfaction and intention to leave. A systematic review of motivation and retention in low-income contexts (Willis-Shattuck et al., 2008) found consistent evidence of the importance of effective management and leadership on staff motivation. Staff in Malawi describe inadequate human resource management (Manafa et al., 2009; Bradley and McAuliffe, 2009) and poor relationships with managers (Chipeta et al., 2016) as particularly demotivating. Yet there is also evidence from Malawi that efforts to support health workers by addressing their needs for an enabling work environment can have tangible benefits. Perceptions of justice and fair treatment have been positively correlated with job satisfaction (McAuliffe et al., 2009), and formal supervision processes are linked to obstetric care provider's satisfaction and intention to stay in post (McAuliffe et al., 2013).

The challenging working environment was a key factor affecting midwives' ability to provide quality care, but it was compounded by midwives' perceptions that leaders and managers

had effectively abandoned them. Midwives, particularly NMTs, spoke of no one visiting health facilities to see the reality of their situation, or of not being listened to when they tried to voice concerns; key informants agreed, suggesting supervisors were reluctant to visit because their inability to offer solutions or tangible assistance left staff frustrated and undermined the supervisor's credibility and authority. National level professional bodies were characterised as unsupportive, slow to respond, or only likely to become involved when there was a poor outcome. Many midwives feared revocation of their licence if they made a mistake, even if it was due to the constraints of the working environment, rather than unprofessional conduct.

A significant demotivator was related to conditions of service. The labour ward was considered one of the most stressful and demanding places to work, a view articulated by key informants and midwives alike. Midwifery carried more personal responsibility, with autonomous practice and longer hours than other departments, especially in rural health facilities where HRH shortages were more acute. Echoing previous findings from data collected in 2008 in Malawi, there were reports of NMTs being pressured to take extra shifts, even during their off days (Bradley et al., 2015). Although the importance of the health sector is recognised, government policy has long been to have uniform salaries throughout the civil service. The intra-professional salary gap between SRNMs and NMTs that were discussed earlier, also have relevance here. NMTs reported working extra shifts or taking second jobs to supplement incomes that they felt were inadequate. Some of the disgruntlement with conditions of service reflected the perspective that the status of midwives had fallen (echoing Grigulis, 2010), with some senior midwives sadly reminiscing about the days when they were held in high regard, respected and well rewarded for the services they rendered.

11.4.3 Organisational culture and oppressed group behaviours

One of the more pernicious influences on professional practice was the prevailing organisational culture and the impact of oppressed group behaviours, which manifested in episodes of horizonal violence between midwives (described in Section 10.3) but also in the vertical violence against superiors that was outlined in Section 7.2.2).

Organisational norms have a strong influence on behaviours, with deteriorating standards in the health sector ascribed to a pervasive absence of leadership and accountability. In the context of oppressed groups theory, some of the D&A described in this study, and tacitly normalised within the organisational culture, represented midwives' efforts to maintain status. Behaviours such as bullying, shouting at women, justifications of being 'forced' to use D&A to 'prevent' death or because women were ignorant, can be seen as a form of horizontal violence (Fanon, 1968) where midwives take out their frustrations and low self-esteem on women. Indeed, some midwives were quite open about this as a driver of their disrespectful behaviour. However, midwives also faced horizontal violence from their peers, a dynamic which had added dimensions in Malawi's postcolonial context. Traditional values include collectivism, where conformism is expected, allowing mediocrity to be tolerated and individuals who stand out (tall poppies) to be cut down (Booth et al., 2006). In rural

communities, cutting down takes the form of false accusations, gossip and witchcraft.[92] In the workplace, this dynamic manifests as the 'pull down syndrome' mentioned by participants, where those trying to resist poor practice or make change are targeted by peers. It is also seen in 'push down' from those above trying to maintain their own position (Carr et al., 1995). These dynamics were not restricted to the lower levels of the hierarchy in the health facilities, but were also reported by senior midwifery leaders, with suggestions of national level actors deliberately frustrating each other's efforts.

Strong leadership and role models are key determinants of organisational culture. A prevalent viewpoint among key informants was that the same midwife would perform differently in a different context. This reflects perceptions that CHAM facilities had higher expectations, with organisational cultures that did not tolerate the levels of disrespectful care that had become normalised in some MOH facilities. Indeed, Leape et al. suggest disrespect is: *"…learned behavior, and it thrives in a culture that tolerates and supports disrespect. Eliminating disrespectful behavior in an organization thus requires transforming that organization's culture." (*2012: 853) A significant driver of a more positive organisational culture was the autonomy of CHAM facilities to set their own standards and dismiss staff whose behaviours did not match CHAM's ethics. However, differences were also seen in one MOH facility where there were engaged and present SRNMs providing leadership. This influence of leadership has been explored in Tanzania, where Tibandebage et al. (2015) contrasted two resource-poor hospitals with differing management styles. They demonstrated the impact on women's care when participatory management and clear leadership concerning ward culture (including promoting professional behaviour and enforcing sanctions for poor behaviour) were in place.

Conversely, in neighbouring Zambia, a similar cocktail of poor working conditions, low pay, weak mechanisms for accountability and inequitable or inefficient health centre management factors were implicated in reduced workplace trust (Topp and Chipukuma, 2016). Impacts identified included resentment among providers and creation of a normative work culture of blame shifting, helplessness, negative attitudes and abuse of patients. Previous research has shown the negative impacts of poor leadership in Malawi. Leadership styles were characterised as transactional[93] and laissez-faire, where management by exception, open criticism and fault-finding attitudes were commonplace, leaving obstetric care staff feeling unsupported and unfairly treated (Chipeta et al., 2016). Supervision processes were largely focussed on inspection and control (Bradley et al., 2013) and mechanisms, such as maternal

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[92] Belief in witchcraft is strong in Malawi. In 2008, 76% of sampled Malawian households said they knew of witches in their community; 62% knew someone accused of witchcraft; and this belief persists regardless of age, education or social position (National Statistical Office, 2008). A later report (Chilimampunga and Thindwa, 2011) described even higher levels of belief and rising numbers of witchcraft cases, which were attributed to the country's growing inequality.
[93] Transactional leaders believe staff need punishment and contingent rewards to perform. This type of leadership is often contrasted with transformational leaderships styles, characterised by idealized influence, inspirational motivation, intellectual stimulation and individual consideration (Bass, 1985; Avolio, Bass and Jung, 1999).

death audits, which are designed to improve practice, were perceived as looking for someone to blame (Kongnyuy and van den Broek, 2008).

Perceptions of a culture of blame were a clear driver for some of the egregious behaviours described in this study, echoing the perceptions of midwives across other countries in sub-Saharan Africa (e.g. Jewkes, Abrahams and Mvo, 1998; Yakubu et al., 2014; Rominski et al., 2017). A culture of blame left midwives fearful, believing there was often no other option to D&A if they were to secure a positive outcome. This dynamic was also raised by midwives in the metasynthesis presented in Chapter 3, who felt they, too, had *'no choice'* and must do *'whatever it takes'*. However, this justification cannot be viewed in isolation from the low status of midwives, who find themselves at the bottom of the medical hierarchy. When women do not 'cooperate' by doing what they are told it can be seen as undermining or refusing to acknowledge the midwife's higher status (relative to the woman) and ignoring her authoritative knowledge and expertise. Further, midwives face pressure to conform, to show loyalty to the prevailing organisational culture (Kirkham, 1999), even when it clashes with existing ideals of professionalism and RMC. The consequences for midwives whose behaviour does not match that of their peers can be severe. Reports from high-income contexts reflect the punishments described by midwives in Malawi, including verbal abuse, humiliation and exclusion by peers (Parsons and Griffiths, 2007).

Midwifery training in Malawi includes aspects of practice that can be characterised as 'with woman', such as emotional support, kindness, respect and dignity, but the challenging situation in Malawian health facilities makes standardisation of care and a 'with institution' ideology a pragmatic response. In high-income contexts, the resulting ideological conflicts between 'with woman' and 'with institution' create dissonance for midwives and can be a source of emotion work (Hunter, 2004), with negative implications for morale and retention (Ball, Curtis and Kirkham, 2002; Hunter and Warren, 2013). There is a paucity of literature on emotional labour in midwifery in the African context. One exception is Msiska, Smith and Fawcett's work (2014a; 2014b) which indicates that the significant emotional demand caused by severe contextual constraints is exacerbated by negative attitudes from qualified staff. Other authors have highlighted the emotional toll on staff when professional and personal standards cannot be met and the stress and demotivation when avoidable deaths occur (Bradley et al., 2015).

11.5 Strengths and limitations of the research

A strength of this research was the use of different qualitative methods, that harnessed multiple perspectives across diverse stakeholders. These ranged from midwives in the labour ward who were at the sharp end of service delivery, to national level figures at the Ministry of Health and in the professional associations, making policy and regulating the profession. Their views were supplemented by input from middle managers, educators and academics. Together, the various perspectives provided triangulation of views and a more rounded appreciation of the issue of RMC in the Malawi context. In addition, the four-month

data collection period allowed me ample time to not only collect a great deal of data, but also to selectively target key informants in response to emerging analytical themes. I suggest this improved the quality of data collected and also provided sufficient latitude for me to delve more deeply into previously unfamiliar sociological territory, thus strengthening the quality and breadth of my interpretations. Further, the conceptual framework that was developed as part of the literature review and subsequently used in the data analysis had significant utility. It provided a flexible tool to focus attention on the broader circulating discourses at micro-, meso- and macro-levels, so avoiding the temptation towards the descriptive that can occur when the cultural, social and historical contexts are not adequately considered.

An unanticipated addition to the study was the ethnographic turn taken during data collection (outlined in Chapters 4 and 5), which allowed me to include informal observations as part of my methods. This was occasioned by my long immersion in Malawi and tacit acceptance at the midwives' station in one of the labour wards. It provided an excellent opportunity to observe midwives' backstage behaviours (Goffman, 1959), sharply bringing into focus the dissonance between what I was told in interviews and what I saw in practice. It became clear that some had presented themselves as the professional they wanted me to see, or perhaps as the professional they aspired to be. This was illuminating in itself, as it indicated an awareness of how a professional should behave, even if that was not always achieved in practice, and informed elements of the 'ideal model of interpersonal care' that was described in Chapter 9. Further insights offered by key informants were also used to refine my understanding of the gap between what I heard and what I saw. However, it was clear that many of the behaviours I witnessed were so normalised by midwives as to not register as D&A (Freedman et al., 2014).

A limitation to the study was that the facilities I managed to visit were the most accessible ones, yet some of the most challenging circumstances for midwives are found in rural and remote areas. For example, one of the most remote facilities in the district had the largest number of deliveries each month, yet was managed by only two NMTs. As well as my logistical and geographical constraints, there were enormous ethical challenges in including these facilities in the sampling frame. Even if I had been able to organise transport, it would have been nigh on impossible to find a time when I could have interviewed one of the few midwives on duty without compromising patient care. Fortunately, on a visit to one of the larger facilities I met two midwives from remote facilities who were on a training course, and who were eligible to be included in the study, so this perspective has been included. A further limitation, linked to the issue of staff shortages, was my inability to use focus group discussions in the main data collection. My efforts to capitalise on existing staff training opportunities met with limited success, in part due to delays in securing the extra ethical clearance necessary. I suspect this lost opportunity to engage with midwives in a different format would have added extra texture and new ideas to the analysis.

Another limitation was the use of English in my interviews. Although all the staff I interviewed spoke English and it was the medium of education, some were more fluent than others. As

my familiarity with the context and idiom of labour ward increased, I had a growing suspicion that despite NMTs using the words 'respect', 'therapeutic relationship' and 'dignity', and irrespective of these being key attitudinal themes in their pre-service education and professional socialisation, for a minority these were not the clearly delineated constructs that I understood them to be. I would question the wholesale importation of external curricula and guidelines on RMC without a thorough consultative process to establish meaning and linguistic equivalence.[94] I attempted to ameliorate this by explicitly asking NMTs to describe what these ideas meant to them and the types of behaviours that epitomised them. Nonetheless, it was clear that for some (particularly older ENMs and NMTs) these were concepts that had been dutifully learned, but were not necessarily internalised or reflective of the Malawian experience or worldview. This was not the case for SRNMs who spoke clearly and articulately about these constructs.

Throughout this research I have endeavoured to be transparent in my methods, motivations and decision-making, as evidenced by my significant attention to reflexivity and positionality in Chapter 5.

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[94] See also England's (2006) critique of the lack of attention to consensus building on translating abstract ideas related to human rights across cultures (Chapter 7).

12. Conclusion and recommendations

Introduction

The overarching purpose of this study was to explore how respectful maternity care was conceptualised and enacted in the Malawian context, by exploring midwives' perceptions of its impact and identifying the challenges they face in providing it. In this final chapter I offer my conclusions on the overall findings from the study, commenting on the situation in which midwives find themselves. I also highlight my contributions to the literature and to theory.

My personal goal in undertaking the research was the hope that it might identify useful strategies and practices that could be implemented to empower midwives to become what one of the SRNMs referred to as *'weapons of change'*. I propose a number of actions that could be taken at different levels of the health system, many of which can be translated into practice using Malawi's existing resources. Finally, I suggest some potential avenues for further research.

12.1 Conclusions

In this thesis I have characterised Malawi as 'betwixt and between', outlining a range of consequences for the health system and midwifery due to the legacy of Malawi's colonial history and changing social and cultural dynamics in the wake of democracy. My interpretation of the findings is that the impacts of these broader dynamics cascade down through the health system and have left midwives, too, betwixt and between: nurse or midwife; professional or technician; vocation or 'just a job'. Further, midwives are caught between medical and social models of birth, operating in a system that currently lacks leadership and accountability, thus allowing D&A of women and of midwives to continue with impunity. Many of these factors intersect to maintain a set of circumstances that reinforce poor attitudes to women and challenge efforts to provide RMC in this context. Student recruitment practices that privilege academic results have allowed candidates without the interest or passion to care for women to join the profession. The government's understandable focus on boosting midwifery numbers has compromised the quality of training and clinical practice, flooding the workforce with new midwives, many of whom have normalised the low standards of the rest of the civil service. Poor behaviour and attitudes towards women were reported to have become part of the culture and practice.

And yet…there are passionate, committed midwives helping women to birth using compassion and skill, modelling what it means to be a professional and trying to hold the line in circumstances that are often extremely challenging. They are doing this in a 'perfect storm' of converging factors (described in Chapter 10) that conspire to block their efforts. To expect them to continue to do this, shift after shift, without leadership, support or supervision, is unfair and unsustainable. Now is the time for the midwifery leadership to step up and take action. Serious consideration is needed to answer a range of questions. What is the right model of care for Malawi and where does RMC fit into this? What does it mean to be a

professional midwife in this context? How do we support organisational cultures that promote quality? How do we make the necessary changes within the resource constraints we face?

The time for this soul searching is opportune. The midwifery leadership is under pressure to professionalise the midwifery workforce and to implement international standards for RMC; it has taken steps to work on both. While many midwives warmly welcomed the prospect of dedicated midwives, some stakeholders expressed reservations. A key concern was that Malawi needed the dual role and having a separate midwifery profession was an unaffordable luxury. I would argue that it is a more effective use of resources to have skilled midwives, rather than dual-qualification staff who, given the training constraints highlighted in earlier chapters, may not be properly prepared for either role. A second, more pervasive argument was that dedicated professional midwives would be too specialised to deploy to rural communities. In the absence of effective referral or access to medical backup, staff need more expertise so they can manage complicated cases (WHO/ICM/FIGO, 2004). Indeed, some key informants explicitly spoke of the need for professional-level (i.e. degree) community midwives for exactly this reason. Ironically, this study demonstrated that highly-qualified hospital midwives were often **not** practicing, instead carrying out managerial or administrative roles, while rurally based NMTs were managing complex breech and triplet deliveries while waiting for ambulances to arrive. Some of the key informants interviewed for this study were Banda-era midwives who spoke with great nostalgia of postings to rural hospitals, where they had the skills and autonomy to work to the full extent of their training; a source of professional pride and motivation. However, they seem to be battling an ideology of community-based practice as low status compared to hospital-based practice. A very senior midwifery leader at the national level commented that there is still an underlying view that midwifery is not really professional, skilled work, as it used to be done by uneducated women in the village. This leaves midwives in a further 'betwixt and between' where their high status in the community contrasts with their low status in the health system's hierarchy.

Much of the hesitance about the professionalising project centred on the logistics in Malawi's current constrained environment. Concerns about fiscal shortages, training challenges (such as number of student places and tutors) and the extra salary burden of degree-level staff are valid. So, too, are fears that professional midwives will not tolerate the lack of rural infrastructure or modern amenities associated with their educational status and middle-class lifestyle aspirations. However, the current need for dual-purpose nurse-midwives in the rural areas does not preclude the option of dedicated, specialist midwives in the labour wards of central and rural hospitals.

An aspect of the professionalising discourse that has not been adequately considered is the plight of high quality NMTs. These mid-level cadres are woefully neglected. They bear the brunt of the system's failures and are not adequately valued or supported for their contribution to maternal health, yet many of those I spoke to yearn to improve. Growth and learning are key elements of professional satisfaction that should be harnessed. Instilling professionalism is seen as a route forward for quality improvement in sub-Saharan Africa

(Blaise and Kegels, 2004) and a way to empower and motivate health workers (Fonn, Ray and Blaauw, 2011). However, the fate that awaits NMTs is uncertain, with many voices calling for them to be phased out as they are not educated, professional or skilled enough. This has parallels with the rationale for professional closure strategies used by obstetrics to exclude midwives (Witz, 1992). In Malawi, as in many other countries, the same tactics have been used to close out TBAs, yet at the same time midwives in other jurisdictions struggle to hold their turf against the growing dominion of the medical model.

A crucial impediment to the exercise of RMC in the Malawi context was the impact of falling standards and lack of accountability nationally, that were mirrored at health facility level and had become normalised. Professional norms have a role in not only shaping the way in which individual midwives behave, but also the organisational culture in which they operate (Freedman and Schaaf, 2013). This is exacerbated by the tacit agreement of leaders and managers who fail to take action to hold midwives to account on D&A (Jewkes, Abrahams and Mvo, 1998). It is clear that organisational and professional norms need to be addressed, but this is complicated by the pervasive impact and practice of the pull-down syndrome. The drive to professionalise may be a route forward. The findings of this study demonstrated midwives' appetite to behave professionally and the altruistic drive to make a difference to women's experiences. However, some found themselves unable to perform as they wished due to horizontal violence and other manifestations of oppressed group behaviours.

An important issue in the RMC discourse in Malawi is the medical model of care and configuration of services. This study has shown the dominance of technical skills, with services that are set up in ways that preclude the development of relationships between midwives and women. While some midwives may prefer to maintain status by remaining the aloof, technical expert, many of the voices I heard yearned to be more connected. They were aware that women feared them, but the TBA ban meant women had no choice other than to come to the facility despite their unhappiness with the care on offer, setting up tensions in woman-midwife relationships before they even begin. The ideal model of RMC was hampered by the lack of connection between midwives and women. Women's first contact with maternity services is often in ante-natal classes that consist of didactic health education groups with large numbers of women[95]. These frequently repeat the same topic and do not address women's specific needs (Lungu et al., 2011). Other studies in Malawi suggest that although there are opportunities for dialogue, women rarely take advantage of these (Pell et al., 2013). In neighbouring Tanzania, Montgomery et al. (2006) described power differentials between the 'educated' health professional and 'uneducated' women, whose dynamics are reminiscent of the authority of the teacher-pupil relationship and undermine women's own knowledge and agency. It is likely that a similar dynamic exists in

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[95] I have seen groups of 50+ women sitting on benches and being lectured by a health worker, with no visual aids or opportunities to ask questions.

Malawi and is carried into the labour ward. It is difficult to see how RMC and relationship can develop from such roots.

More meaningful, respectful ways to engage with women abound, including examples of group ANC, which has recently been trialled in Malawi (Patil et al., 2013). Midwives in this study reported taking action themselves to reach out into the community to instigate an open dialogue and build trust. This links to midwives wanting the respect of the community and to start relationship-building with women before they arrive in advanced labour. Midwives in other contexts express increased satisfaction when they have continuity of care and meaningful engagement with women, feeding into a sense of professionalism (McCourt and Stevens, 2006). It is unclear from the results how prevalent this attitude is in Malawi, although there were midwives (both NMTs and SRNMs) who clearly articulated the positive benefits of this dynamic and their pleasure when the necessary elements that facilitate RMC (e.g. time, staff, resources) converged to allow it to happen. Continuity of care can make a big difference as it builds reciprocity and allows both sides to see the other as individuals. In a context where the health worker is simply a cog in a wheel and uncared for by the organisation, the women may also see them as just functionaries, rather than understanding the constraints under which they are working. Indeed, midwives described feeling misunderstood and misinterpreted. Research from Mozambique also found that health workers are not motivated to respect women when they are not respected themselves (Fonn et al., 2001), suggesting the need to support and enable staff to behave as professionals and reduce the impetus for them to feel some semblance of control by abusing women in the labour ward setting. The current RMC discourse is vocal about empowering women, but there has been less emphasis on health workers and on identifying resource-constrained contexts where good care does happen, despite the challenges and structure of local health systems.

In these circumstances, midwives sorely need a united midwifery leadership, speaking with one voice and following a strategic vision for Malawi's future midwifery workforce. Instead, they have been rudderless, subject to in-fighting among their representatives that has blocked efforts to professionalise and caused a lack of clarity on the optimal way to proceed. However, as I left Malawi in July 2016 there were positive signs of rapprochement between the three key organisations involved in shaping midwives' futures - the Directorate of Nursing and Midwifery Services, the NMCM and the union (NONM). At the same time, decentralisation of power to the district level was beginning to be rolled out, leading to optimism that local control would enable human resource managers to tighten up standards by hiring and firing at the district level. I am hopeful that the increasing appetite for change will include experimenting with new ideas that may make a tangible impact on service delivery, on RMC, and on the working lives and professional satisfaction of midwives.

12.2 Contribution to the literature

This thesis supports existing literature from sub-Saharan Africa that has explored (dis)respectful maternity care at the micro-level of the mother-midwife dyad. It echoes many of the factors identified by other authors which were outlined in the metasynthesis of midwives' perceptions described in Chapter 3. There was significant convergence in this study with previous data that demonstrate midwives' conceptualisations of birth as a medical event, mediated by their exertion of power and control over women and their bodies, and rationalised as necessary due to women's ignorance and lack of cooperation. It also shows, albeit to a lesser extent, that social inequality affected the care that some women received, particularly in the rural areas.

Some key gaps in the existing literature, identified by the metasynthesis, were addressed in this research. The first was the paucity of evidence on midwives' conceptualisations of good midwifery in this context and their practice of RMC in the intrapartum period. The findings presented here show that many midwives held an ideal model of care, often framed in terms of 'not being disrespectful or abusive', which they frequently struggled to achieve. The study also explored midwives' perceptions of the value and impact of RMC, which has received limited attention in the literature. They were well aware of the fear and unhappiness of women when care was disrespectful but felt powerless to change the dynamic. However, the impacts of RMC and its benefits, particularly for women, were less clearly articulated, indicating an area of professional training that warrants further attention.

A key knowledge gap was the impact of macro- and meso-level drivers as constraints and enablers of RMC and professional practice in this postcolonial context, an area that has received insufficient attention in our efforts to understand and address labour ward dynamics. Many of the factors implicated are already familiar (particularly work environment, resources and referral challenges). However, key new influences were identified that have not been described in the literature. A toxic combination of the wrong sort of student (who is only there for a job and doesn't care about the women), inadequate training (too few tutors, insufficient attention to RMC in practice) and lack of professional moulding (especially a lack of midwifery-specific role models), lead to what one key informant called '*garbage in, garbage out*'. The consequences of this for labour ward dynamics were clearly described and constituted a source of considerable distress for staff who aspired to be professional in their work and to put in place the behaviours that, for them, constituted their professional role.

12.3 Contribution to theory

Efforts to understand respectful maternity care and the factors that enable or inhibit it have tended to be descriptive and largely focused at the micro-level of the labour ward. I used the theoretical frame of postcolonialism to illuminate the broader context in which the prevailing dynamics and behaviours articulated by respondents were embedded. To my knowledge, no other studies have done this. Jewkes, Abrahams and Mvo's work (1998) addressed the reasons nurses abused patients in South Africa, using the structural and historical impact of

apartheid as a backdrop. While there are some overlaps between their analysis and mine in terms of the legacy of a British model of nursing and training, my use of postcolonial theory was intended to provide insights that could have resonance across sub-Saharan Africa and that looked at the broader social and cultural impacts of a colonial history. This perspective provided the tools to use participants' insights to describe a cascade of negative dynamics that directly impacted the practice and performance of care in the labour ward, which would otherwise have been hidden. For example, it revealed how the intersection of pre-existing structures of neopatrimonialism and communal *uMunthu* values on the one hand, and newer manifestations of democracy and rights on the other, combined to damage attitudes to public service, severely compromising leadership and accountability; both had significant impacts on how care was enacted in the labour ward.

This postcolonial perspective was instrumental in contributing to theory. Firstly, it had not been used to interrogate this issue before. Secondly, it underpinned the development of an original conceptual framework on the drivers of disrespectful care during facility-based delivery in sub-Saharan Africa. This adds to the discourse by moving the focus beyond the micro-level interactions of the mother-midwife dyad, encouraging an expanded gaze and consideration of the impact of messier, more complex upstream factors which are often overlooked in the quest for solutions. Further, using this original conceptual framework in the data analysis provided a test case for its utility. I found that the data mapped well onto the constructs, providing a practical tool to unpack the most salient factors in the Malawi context. It also made visible the relationship between macro-, meso and micro-level factors and the labour ward dynamics of D&A and RMC. The broad similarities in the historical and current day experiences of other Anglophone postcolonies in the region suggest this conceptual framework may prove useful in other contexts to aid our understanding of how and why different actors do or do not abuse women in their care.

This thesis uncovered significant horizontal violence ('pull down syndrome') and upward bullying, linking these to the role of organisational culture in normalising and tacitly sanctioning disrespect of colleagues as well as of women. I used the secondary frame of oppressed groups theory to interpret these emergent findings. Oppressed groups theory has been used in high-income contexts as an explicatory mechanism for why staff who consider themselves lower in the pecking order and feel disempowered vent their negative emotions by abusing those below them or being disrespectful or obstructive to their superiors. However, this perspective remains relatively unexplored in low income-contexts and unused in explorations of the drivers of D&A, yet combined with a postcolonial lens it has significant explanatory power. The postcolonial perspective provided a critical edge as it allowed the local nuances to be examined in more depth, positioning them in their macro-level and historical context. This revealed a backdrop of continuing poverty and inequality, imposition of a medicalised model of birth and external agendas to professionalise midwifery. The lens of oppressed groups theory informed a more textured understanding of the impact of these drivers on the midwife, who is trapped at the bottom of the cascade and caught between

medical and social models of care in a context where 80% of midwives were not recognised or treated as the professional group they aspire to be. This has clear consequences for how women are treated during labour and delivery. However, conceptualising midwives as an oppressed group has implications for the new professionalising agenda and its potential to address some of the problems of identity, recognition, status and skills that midwives in Malawi face.

The use of the theoretical frames of postcolonialism and oppressed groups theory, in conjunction with the conceptual framework developed as a result of the metasyntheses, has allowed a more rounded and nuanced appreciation of the factors driving D&A and the possibilities for RMC in Malawian health facilities.

12.4 Recommendations

A key motivation for this research was to use midwives' voices to identify drivers of, and barriers to, respectful maternity care. My hope was to identify appropriate strategies with the potential to improve care, both locally and regionally. However, it is clear that many of the most serious challenges facing Malawi, such as lack of the human and financial resources available for the health sector or the impact of democracy on attitudes to public services, need long-term, structural level attention. Nonetheless, positive action can be taken, within existing resources, that can have a significant impact on the experience of facility-based birth for midwives and for women. The recommendations below will involve shifts in thinking about who becomes a midwife, what it means to be a professional, and serious consideration about the model of care that Malawi wants to provide.

I am also mindful that externally imposed solutions can undermine the development of local agency (Fonn, Ray and Blaauw, 2011). However, the recommendations outlined below were largely synthesised from the input of midwives and key informants and speak to their concerns about, *inter alia,* student recruitment processes; inadequacies in training; supporting and rewarding good midwives; and connecting with the community.

1. Consult midwives:

Midwives are not listened to, yet have clear insights into many of the challenges and are the actors best placed to address them. As the findings show, some midwives had taken things into their own hands and were taking action themselves, to good effect. In other contexts where policy/practice change has been implemented without involving those expected to carry out the work, there has been a negative impact on motivation and morale, which resulted in worsened relationships between providers and patients (Walker and Gilson, 2004). However, there is also evidence that midwives are not sufficiently aware of what women really want (Melberg et al., 2016) so there is space for dialogue.

2. Engage the community:

Midwives' frustrations are often triggered by women not knowing what to do, making it clear that current ANC mechanisms are not adequately preparing women. Midwives in this study had instigated small changes themselves that could be made routine and rolled out to other

health facilities, including maternity open days so that women could meet the midwives and familiarise themselves with the labour ward. Maternity open days have been used successfully in other contexts, including Tanzania (Ratcliffe et al., 2016a; 2016b). Other simple steps can tap into existing cultural norms, such as welcoming guests into your home (or labour ward), which is an important element of Malawian hospitality and has been suggested in other cultures where this is relevant (Warren et al., 2015). Midwives in this study also met with community members to air grievances and establish expectations, forging a two-way dialogue that has the potential to allow women and midwives to identify a model of care that addresses the need for technical quality but also incorporates women's needs for psychological and emotional safety. Connection with the community can allow midwives to harness the motivational and professional satisfaction of being recognised, trusted and competent advocates and guardians of women's births and can provide an entry point for more continuity of care.

3. Improve student recruitment:

Midwives faced significant challenges working with staff for whom midwifery was 'just a job' and key informants blamed inadequate recruitment processes that allowed them to enter the profession. District-level managers estimated this group accounted for 50% of labour ward staff, while many of the remainder did not want to work in the labour ward. It is hard to imagine this does not significantly compromise quality of care. The current selection system favours academic prowess and proficiency in English, excluding rural or less advantaged candidates. It also fails to select for the pro-social and attitudinal traits that spur many candidates to choose a career in the health care professions (Serneels et al., 2007). These flaws in the system could be overcome by setting a minimum educational requirement and introducing instruments, such as multiple mini-interviews (MMI) (Callwood, Allan and Courtenay, 2012), to select the best applicants. Widely used in high-income contexts, MMIs assess the attitudinal suitability of candidates following the style of OSCEs, a format that is familiar in Malawi. Use of MMIs can widen access to students who would otherwise be excluded (Wilson et al., 2012) and the instrument can be locally adapted to select attributes reflecting the desired midwifery philosophy (Roberts, 2008). Added benefits would accrue as pro-social attitudes and selection of rural candidates are both important in addressing acceptability and inequitable distribution of health workers (Serneels et al., 2010; World Health Organization, 2010). At the same time, the profile of midwifery in Malawi needs to be raised to make it an aspirational career choice, so making it only available to the most suitable candidates could be used as a marketing strategy.

4. Focus on training for RMC:

Representatives of both SRNM and NMT training institutions suggested that pre-registration education on the attitudinal aspects of RMC needed to be improved. I would suggest that the curriculum also needs to engage more robustly with the biosocial aspects of birth. Many midwives demonstrated a lack of knowledge about the psychological and physiological benefits of compassion, information, not being alone and controlling pain. Others were afraid

to allow women to birth in non-supine positions as these techniques were not part of their training. This intersects with the lack of evidence-based practice, such as not accommodating birth positions or skin-to-skin contact.

5. Reconfigure some services:

Name badges: All midwives are supposed to wear name badges when they are at work. Enforcing this would change the dynamic of the mother-woman relationship and increase accountability. As one key informant mentioned, when she trained in South Africa if she did not wear a name badge she was not allowed to work so did not get paid.

Allocations: In some health facilities services were provided as tasks to be completed, with minimal evidence of care being delivered holistically. Allocating care of a specific woman to a named midwife for the duration of her shift would have a positive impact on accountability and also allow the most skilled person on duty to be allocated the difficult cases, so would be a motivator.

Labour companions: some midwives try to engineer opportunities to 'allow' labour companions, although the MOH policy is to encourage this. More effort needs to be made to find workable solutions. For example, in one of the hospitals 3/4 height walls have been built around the beds to allow more privacy. Where this is not possible, allowing only female companions could be trialled for community acceptability. In the prevailing HRH circumstances, midwives need all the help they can get, so finding ways for at least some of the social support to be given by the woman's relatives (in a structured and meaningful way) would allow midwives to focus on the technical skills that give them satisfaction.

Teamwork: Promote and enable teamwork as part of professionalism and a lived element of the model of care, moving away from specific tasks, so the team works together with individual women and the team gets rewarded for good results. Rewarding the team, rather than the individual, reduces the 'tall poppies dynamic" that pulls down staff, and allows peers to exert pressure on poor performers to conform. Community score cards have some utility here.

6. Raise the status of midwifery

Choosing to be a midwife: Encourage larger health facilities/hospitals to take first pick of the nurse-midwives who want to do midwifery before the other allocations are made, helping to showcase that midwifery is an active choice, and provides a rewarding role that is valued by the health system.

Direct-entry midwives: An opportunity exists to explicitly cast the direct-entry midwives as a highly skilled, professional group whose practice is based on a more compassionate, woman-focused model of birth, in line with international shifts. These midwives could function as on-the-job role models and leaders, complementing the RMC training efforts that are planned for continuing professional development and in-service training, showcasing a different way to deliver care.

Upgrade good NMTs: Undertake a nationwide campaign to identify good NMTs, using RMC and community feedback as part of the assessment process, and upgrade them to degree-level. This could be combined with existing bonding mechanisms to keep them in the rural areas, ensuring their new skills are used for a specified period of time.

Community midwifery: Address the perception of community midwifery as a low-skilled occupation by recognising the need for higher skills in the rural areas. Make it more attractive/high status to be in the rural areas by rewarding with accelerated training opportunities and market it by emphasising the more complex case load and opportunity for skills development. Follow the lead of countries like Nigeria[96] who reward professional, competent staff who work in rural areas with improved access to training and upgrading

Mentoring: Send senior midwives out to rural areas for regular, short term rotations to act as mentors, provide in-service training, role model skills and professionalism, and motivate rural midwives

Communities of support: These are an underused concept that could be nurtured to connect midwives in remote or rural areas, providing a sense of community, team and professional support. Existing champions could be linked together using mobile technology and mentored by committed midwifery leaders.

12.5 Further research

This thesis addressed some of the knowledge gaps raised by the literature review, replacing them with new questions arising from the emerging findings.

The 'pull down' syndrome of horizontal violence and oppressed group behaviour in the Malawi context bears much closer examination. There is a small body of literature on this phenomenon in South Africa (e.g. Khalil, 2009), but it has received limited attention elsewhere in sub-Saharan Africa. It was an important theme in this study, with significant impacts on the provision of care and the dynamics at play in the labour ward, as well as considerable repercussions at the national level. Further qualitative work could explore the contextual drivers of this phenomenon and elucidate implications for practice, such as impact on teamwork, midwives' performance and professionalism, and emotional well-being.

Intersecting with horizontal violence was the significance of organisational culture. A comparison of ethos and culture between facilities and across providers (i.e. CHAM or MOH) has great potential for tackling D&A. Understanding the underlying factors involved can provide insights and evidence that will be useful in designing effective interventions to harness individual and organisational energy to address disrespect. Committed champions

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[96] Efforts include use of ICT to connect midwives in rural areas to other health workers. In addition to voice and data transmission, midwives can use internet and video conferencing that can work with mobile technology. See https://www.nphcda.org/programmes/midwives-service-scheme/ [Accessed 30 September 2017] The West African College of Surgeons, Faculty of Surgery now includes 6-month mandatory rural postings, that are documented and supervised, before final membership accreditation. See http://www.wacscoac.org/downloads/SURGERY%20CURRICULUM.pdf [Accessed 30 September 2017]

and leaders are already attempting to change workplace cultures and normalise quality and RMC, so the results of this research could be used to support their efforts.

The introduction of the direct-entry midwifery cohort offers a prime opportunity to investigate the impact of specialist midwives. Studies could measure a range of factors, including: comparisons of philosophy of care; attitudes to and practice of RMC; impact on autonomy and decision making. It would also be informative to identify the factors involved in deployment of these new midwives and track the type of role and the locations in which they end up practising.

As this thesis closes, decentralisation is being rolled out across Malawi and steps are being taken to introduce shorter upgrading programmes for suitable NMT candidates. It would be informative to explore what impact the rise to 'professional' status has on ex-NMT's perceptions and performance of professionalism and how this manifests in labour ward dynamics.

This research has revealed that a broader consideration of the prevailing drivers and influences can be more fruitful in generating a textured and nuanced understanding of D&A than simply looking at behaviour at the health facility level. If future research is to serve its purpose and enable us to frame and devise more appropriate interventions, it will necessitate an inter-disciplinary perspective that has, as yet, been lacking in this field.

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Appendix B. Presentations arising from this work

Oral presentation

- Bradley, S., McCourt, C., Rayment, J. and Parmar, D. *Colliding or Blending? Exploring the 'Betwixt and Between' of Midwifery in Malawi Using Respectful Maternity Care as a Case Study.* 18th Annual Researching Africa Day Workshop. "African Studies Beyond the Binary: Critical Encounters at the Intersection." St Antony's College, University of Oxford, UK. 03 Mar 2018

- Bradley, S., McCourt, C., Rayment, J. and Parmar, D. Betwixt and Between: Challenges in Realising Women's Rights to Respectful Maternity Care in Malawi. Postcolonialism in Interdisciplinary Perspective Conference. University of Birmingham, UK. 17 May 2017

- Bradley, S., McCourt, C., Rayment, J. and Parmar, D. *"I hate labour ward...I don't want this." Stakeholder reflections on the challenges and utility of the dual qualification nurse-midwife and efforts to professionalise midwifery in Malawi*. 5th Annual Doctoral Research Conference. School of Health Sciences, City, University of London, UK. 08 June 2017

- Bradley, S., McCourt, C., Rayment, J. and Parmar, D. *Challenges and opportunities in providing humanized care: midwives' views from Malawi*. IV International Conference on Humanization of Childbirth. Brasilia, Brazil. 26- 30 November 2016

- Bradley, S., McCourt, C. and Rayment, J. *Disrespectful maternity care - bad for women, but bad for midwives too*. Oral presentation. Human Rights in Childbirth Africa Summit. Johannesburg, South Africa. 30- 31 July 2015

Poster presentation

- Bradley, S., McCourt, C., Rayment, J. and Parmar, D. *Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and thematic synthesis of women's perceptions and experiences.* IV International Conference on Humanization of Childbirth. Brasilia, Brazil. 26-30 November 2016

Invited talks:

- Bradley, S. *Respectful and Dignified Midwifery Care*. 20th Research Support Centre Research Seminar, College of Medicine, Blantyre, Malawi. 27 April 2016

Appendix C. Metasynthesis methods - midwives' review

Midwives' perceptions of (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa: a metasynthesis

1. Systematic search and screening

A version of the PICO model, modified for qualitative systematic reviews (The Joanna Briggs Institute, 2014), was used to guide the review process. In this context PICo represents the population (P) to be considered, the phenomenon of interest (I) and the context (C).

Population: The review considered studies concerned with midwives or nurse-midwives working in maternity wards or units. Final year midwifery students were also included as their training involves significant clinical practice in the labour ward.

Phenomenon of interest: The focus was on midwives' views, perceptions and experiences of the interpersonal aspects of intrapartum in the health facility, or the impacts of this aspect of care.

Papers that addressed only clinical or technical quality of care, or that described midwives' experiences through the perspective of other actors (e.g. other health workers) were not eligible.

Context: The review was concerned with the quality of interpersonal care during facility-based delivery in sub-Saharan Africa. 'Facility-based delivery' was defined as birth in a health facility at any level of the health system that was designated to provide intrapartum care, including hospitals, health facilities, health centres and health posts. Papers that exclusively addressed home birth, birth with traditional birth attendants, or where the site of birth was unclear, were excluded. The MDG regional grouping for sub-Saharan Africa was used to delineate which countries to include. This grouping covers all countries on the African continent except the countries of north Africa (Algeria, Egypt, Libya, Morocco, Tunisia and Western Sahara) but includes Sudan.[1] A small number of island nations are also considered to be part of sub-Saharan Africa.

The methods closely followed those of an earlier systematic review of women's experiences of (dis)respectful intrapartum care during facility-based delivery in sub-Saharan Africa (Bradley et al., 2016). A scoping search in PubMed was used to identify key words in the title and abstract of relevant articles, which helped to generate a list of text words and subject headings that captured the new elements of the review (i.e. midwives' experiences). The search strategy and full list of terms were piloted in PubMed; then refined and adapted to reflect the idiosyncrasies of each platform/database's specific search terminology and commands. An example of the final search terms can be seen in Table 1.

Searches mirrored the MDG time period and were carried out from 01/01/1990 – 16/02/2017, using CINAHL, PsychINFO, PsychArticles (all EBSCO platform); Embase, Global Health, Maternity and Infant Care (all OVID platform); and PubMed. '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. Saved search alerts were set up and the searches were rerun in July 2017, with one extra paper identified for inclusion. Only texts available in English, French or Portuguese were considered. Published and unpublished primary qualitative studies of any description were considered. These included designs such as phenomenology, grounded theory, ethnography, action research and feminist research. The qualitative element of mixed-methods studies was considered if interpersonal care formed a significant and relevant component of the study. Reviews, opinion pieces and policy documents were not included. The inclusion and exclusion criteria can be seen in Table 2.

All records retrieved during the search process were uploaded into the ProQuest citation management tool, RefWorks, and any duplicates were deleted.   All retrieved items were screened using title and abstract. Initial screening to remove any items that were clearly irrelevant to the review questions was undertaken by one reviewer. Full text was obtained for any abstracts that were assessed as potentially relevant. These records were then assessed

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[1] http://http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Data/REgionalGroupings.htm

by two members of the review team to ensure they met the inclusion criteria. If a clear consensus could not be reached a third reviewer was available for consultation. Only references that satisfied all three reviewers as being relevant to the review questions have been included in this review.

The most common reason for excluding papers was that the main focus of the paper was not on midwives' experience and perceptions of (dis)respectful care (17 papers). A specific aim of the review was to hear directly from midwives and the inclusion criteria (Table 2) reflected this. A particular challenge encountered was that many authors had reported medical and midwifery staff's perceptions together in a generic 'health worker' or 'provider' category, so did not satisfy the requirement for the midwife's voice to be clearly identified, so three papers were excluded at this stage. However, a decision was made to include four papers (from two studies) where a only small amount of data could be ascribed directly to midwives (Bohren *et al.*, 2016; Baldé, Bangoura, *et al.*, 2017; Baldé, Diallo, *et al.*, 2017; Bohren *et al.*, 2017), but their contribution to the synthesis results was limited. Other reasons for excluding papers can be seen in the PRISMA diagram (Figure 1).

Table 1 PubMed search strategy

Filter: From 1990
All terms were searched as Title/Abstract, except MeSH headings

Midwives' experiences	1. 2.	**nurse* OR provider* OR health worker* OR sage*femme* OR "skilled birth" OR "midwifery"[MeSH] OR "nurse midwives"[MeSH]**
	3.	experience* OR perception* OR view* OR opinion* OR attitud* OR perspective* OR belie* OR account* OR narrative* OR story OR stories OR distress OR emotion* OR moral* OR ethic* **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 OR relationship* OR mistreatment OR interpersonal
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**

2. Quality appraisal

Two reviewers independently assessed the methodological rigour of each contributing study using the Critical Appraisal Skills Programme (CASP) tool for qualitative research (Public Health Resource Unit England). Studies were rated high, medium or low quality for each domain and assigned an overall quality score. However, study quality was not used to exclude studies with the potential to answer the review question. Quality ratings were: one low quality; one low/medium; seven medium; and five medium/high quality studies. However, study quality was not used to exclude studies with the potential to answer the review

question. Best practice would be to include only studies of robust design and quality, but this needed to be balanced against the possibility that excluding less well-executed studies could omit new insights or information (Ring et al., 2010). Indeed, there is considerable debate as to whether it is possible or even desirable to assess the quality of qualitative research (e.g. Thomas and Harden, 2008).

Table 2 Inclusion and exclusion criteria

*Collectively referred to as 'midwives'

	Inclusion	Exclusion
Participants	Midwives, nurse-midwives or final-year midwifery students* working in maternity wards/units and carrying out facility-based delivery	Midwives working outside health facilities or where the site of delivery is unclear / Specific focus on perinatal loss, severe maternal morbidity or HIV
Intervention	Midwives' 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 only / Clinical or technical quality of care only / Midwives' experiences described by other actors (e.g. women, community members)
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	Midwives' experience and perceptions of (dis)respectful care either as the main focus of the study or as a substantial element of it.	Main focus is not on midwives' 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	1/1/1990 – 16/02/2017	Pre-1990
Language	Only abstracts available in English, French or Portuguese will be assessed	None
Publication type	Peer reviewed articles, dissertations/theses or research reports	Reviews, opinion pieces, policy documents

3. Search results

Electronic database searches resulted in 2,651 potential papers being imported into RefWorks, where a total of 1,173 duplicates were removed. The remaining 1,478 records were screened using title/abstract and all articles that clearly did not fit the inclusion criteria were excluded, leaving 41 articles for full text screening. Searching through the reference lists of these papers and using 'cited by' and 'related articles' database functions uncovered no further records, but 8 relevant papers known to the review team that had not been found in the original searches were added. The search statistics can be seen in Figure 1.
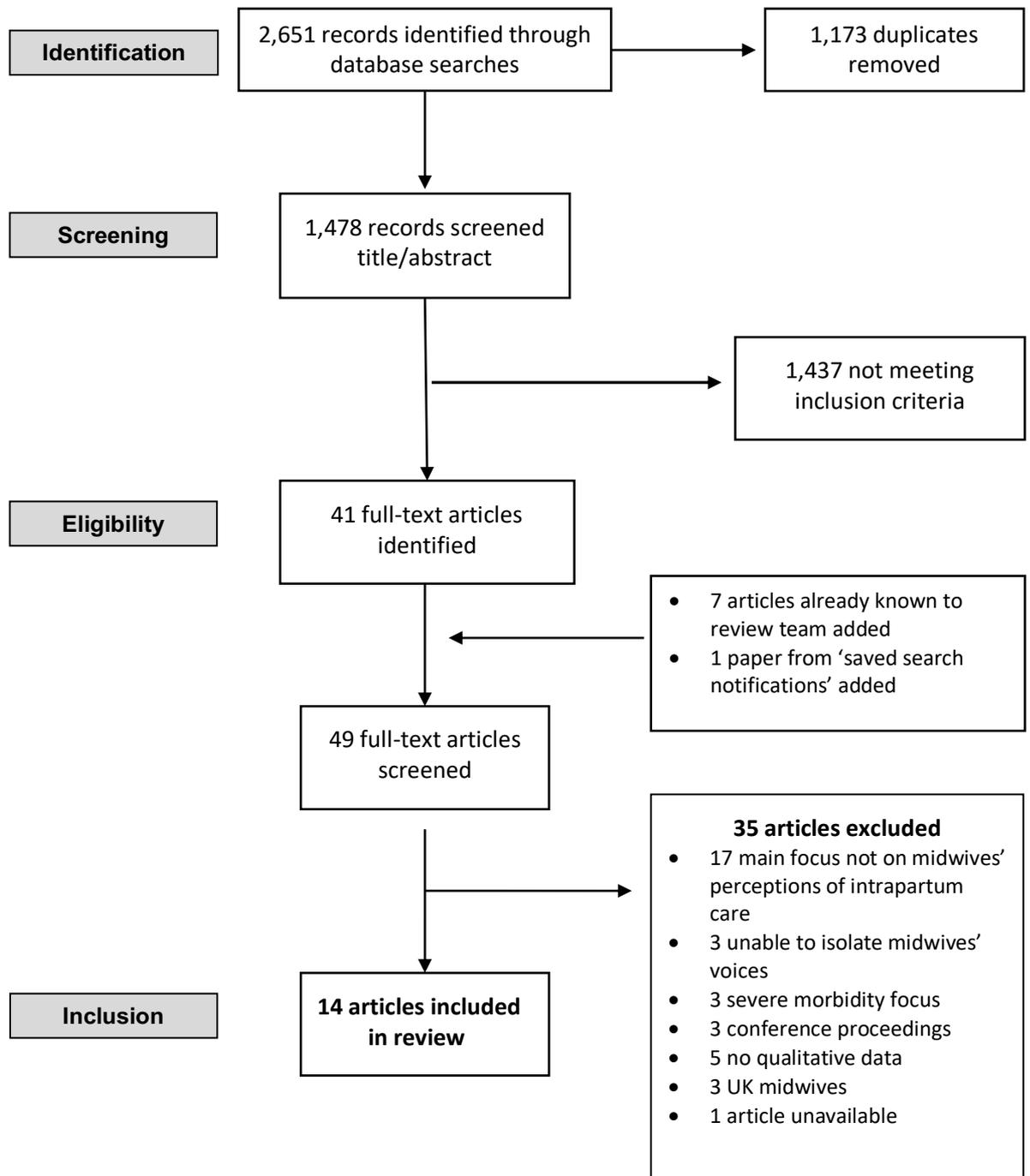
Figure 1 Search statistics

Fourteen 14 articles (11 studies) were eligible for inclusion and their study characteristics can be seen in Table 3. Ten papers had aims that were negatively framed: eight explicitly focused on mistreatment or abuse: (Kruger and Schoombee, 2010; Yakubu et al., 2014; Warren et al., 2015; Bohren et al., 2016; Baldé, Bangoura, et al., 2017; Baldé, Diallo, et al., 2017; Bohren et al., 2017; Rominski et al., 2017); one looked at the psychological stress of caring ; and another reported midwives' perceptions of barriers to quality perinatal care (Pettersson et al., 2006). In contrast, Fujita et al., (2012) reported on the implementation of a humanised care intervention. Only three explored midwives' experiences of intrapartum care from a neutral position (Jeng, 2008; Maputle and Hiss, 2010; Adolphson, Axemo and Hogberg, 2016)

4. Data extraction and synthesis

Our synthesis of the literature on women's experiences of facility-based delivery in sub-Saharan Africa (Bradley et al., 2016) had 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.

These synthesis findings were used to develop a conceptual framework of the drivers of disrespectful care in the sub-Saharan African context (Figure 2). This aimed to describe how micro-level interactions in the labour ward were mediated by meso- and macro-level influences. In the model, the flow of influence is from the outside to the centre, situating disrespectful care within a broader framework of the structural dimensions underpinning disrespect that are often neglected in discussions of the mistreatment of women. It is a useful tool as it provides a starting point to unpack the most salient factors for different contexts, helping to focus our understanding on the larger circulating discourses on how and why different actors may, or may not, abuse women.
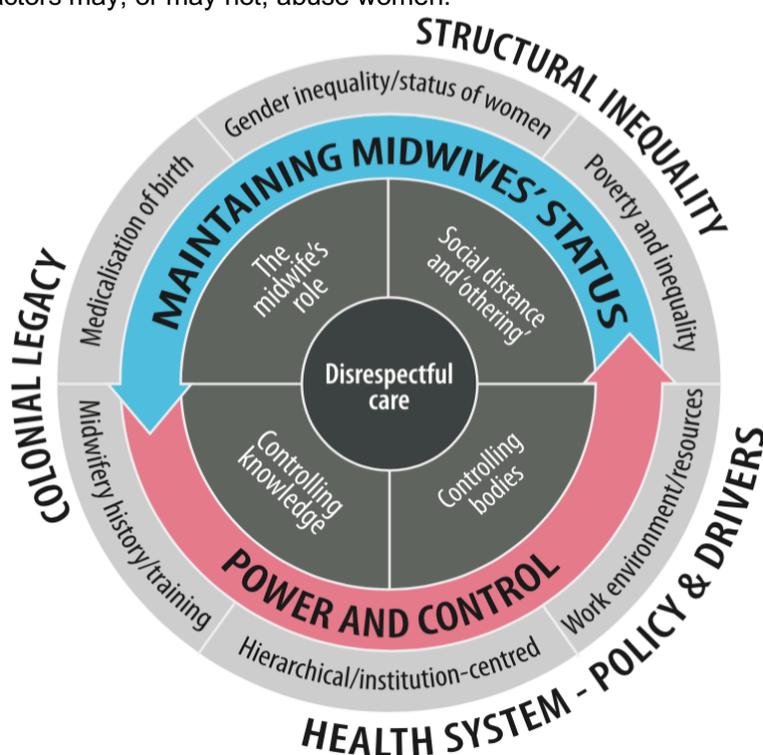
Figure 2 Conceptual framework of the drivers of (dis)respectful care in sub-Saharan context

All study results and findings, including participant quotes, were imported verbatim into NVivo 11 software for data analysis. A coding framework was constructed using the individual domains of the conceptual framework as top-level nodes at the macro-, meso- and micro-levels. Line-by-line coding of each article allowed data relevant to the domains to be captured, while any data that did not fit the framework were inductively free-coded into new nodes. Three papers were independently coded by supervisors to identify themes arising and to assess how well these mapped onto the framework. This facilitated a transparent and flexible process where convergence or divergence between the insights gleaned from women's experiences and those of the midwives could be clearly identified.

5. Methodological considerations

Using CASP to appraise quality of the papers identified for synthesis was challenging. Articles could score well on study findings and value, but lack detail of the methodological techniques employed (Kruger and C. Schoombee, 2010; Fujita *et al.*, 2012; Rominski *et al.*, 2017). Others were very descriptive, lacking the conceptual richness and depth that may be necessary for interpretive synthesis (France et al., 2014). A further limitation was that over half the studies did not demonstrate any attention to reflexivity. While for some authors this may have been due to journal space constraints, it is nonetheless an important issue when discussing sensitive issues such as disrespectful care. For example, in two studies (Fujita *et al.*, 2012; Adolphson, Axemo and Hogberg, 2016) the data were collected by doctors, which raises issues of social desirability bias.

It is also of concern when researchers investigate women's experiences without considering the colonial legacy, power and social inequalities (Kumar, 2013). The majority of studies paid very little attention to this wider context in which (dis)respectful care is embedded and focused only on the midwife-woman dyad. Only four papers alluded to gender based violence (Warren *et al.*, 2015; Bohren *et al.*, 2016; Rominski *et al.*, 2017; Baldé, Bangoura, *et al.*, 2017); Bohren et al. discussed structural gender inequality and the similarities between mistreatment during childbirth and intimate partner violence, while Rominski et al. mentioned the broader social and political dynamics. Kruger and Schoombee (2010) discussed power and control in the context of the medical model of birth and hospital hierarchy.

Table 3. Characteristics of included studies

Only midwifery participants are recorded. Interviews: IDI = in-depth; SSI = semi-structured

Study	First author, year	Country	Study aims	Participants*, setting	Study design, data collection* and analysis	Quality
1.	Adolphson et al., 2016	Mozambique	• Explore midwives' perspectives of working conditions, professional role and attitudes towards women	• 9 midwives (6 x medium, 3 x basic level) • Urban, suburban, village and remote areas in 3 southern provinces	• Qualitative methods • SSI • Content analysis	M
2.	Baldé, et al., 2017a	Guinea	• Understand social norms and acceptability of scenarios of disrespect	• 13 midwives • Maternity ward of an urban regional hospital and a peri-urban district-level hospital	• Qualitative methods • IDI • Thematic analysis	M
	Baldé, et al., 2017b		• Explore midwives' perceptions and experiences of mistreatment during birth			L/M
3.	Bohren et al., 2016	Nigeria	• Explore acceptability of four scenarios of mistreatment during childbirth	• 17 midwives • Maternity ward of one urban and one peri-urban facility	• Qualitative methods • IDI • Thematic analysis	M
	Bohren et al., 2017		• Explore midwives' experiences and perceptions of mistreatment			M
4.	Fujita et al., 2012	Benin	• Determine how the practice of humanised care affects midwives; implementation, understanding and factors influencing change in practice.	• 6 midwives • Tertiary hospital in the capital city, Porto-Novo	• Qualitative, descriptive • IDI • Grounded theory	M
5.	Jeng, 2008	The Gambia	• Assess the practices and quality of delivery care during childbirth	• 5 midwives, 3 x student midwives • Delivery ward, Royal Victoria Teaching Hospital	• Qualitative methods • IDI • Content analysis	L
6.	Kruger & Schoombee, 2010	South Africa	• Explore experiences of being nurses in a maternity ward	• 8 'Coloured', middle-class, Afrikaans speaking females	• Social constructionist grounded theory • SSI	M/H
	Schoombee et al., 2005		• Explore maternity nurses' psychological and emotional experiences	• Maternity ward of the local state hospital		M/H

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Study	First author, year	Country	Study aims	Participants*, setting	Study design, data collection* and analysis	Quality
7.	Maputle & Hiss, 2010	South Africa	• Explore and describe the experiences of midwives managing women during labour • Inform development of a woman-centred care model to be integrated into the Batho-Pele Principles	• 12 midwives • Tertiary care hospital in the Limpopo Province	• Exploratory, descriptive, contextual and inductive • IDI • Open coding (Tesch)	M
8.	Pettersson et al., 2006	Mozambique	• Explore midwives' perception of factors obstructing or facilitating their ability to provide quality perinatal care	• 16 midwives • Labour ward, Maputo Central Hospital	• Qualitative • IDI • Grounded theory	M/H
9.	Rominski et al, 2017	Ghana	• Examine disrespectful and abusive treatment towards labouring women	• 83 final year midwifery students • 15 public midwifery training colleges in all 10 of Ghana's regions	• Not stated • FGD • Thematic analysis	M/H
10.	Yakubu et al., 2014	Ghana	• Explore attitudes, beliefs, and self-reported behaviours of midwives to improve understanding of maltreatment during facility delivery	• 7 midwives • Small rural hospital, Central region	• Cross sectional, qualitative • SSI • Thematic analysis	M
11.	Warren et al., 2015	Mali	• Explore both respectful and disrespectful and abusive behaviours towards women in labour	• 33 auxiliary midwives • Continuing education session at a regional referral hospital • 31 x rural, 2 x urban practice	• Cross sectional mixed methods • SSI • Qualitative description	M/H

Appendix D. Data collection tools

Critical Incident interview

- I'd like to focus on the emotional, psychological and interpersonal components of labour and delivery, so aspects such as respect, dignity, consent and kindness…..
- Can you think of a specific birth you have experienced (either one you did yourself or one that you witnessed) where you felt that the woman received really good/really poor interpersonal care?
- Describe who was involved and what happened.
- Why was this an example of really good/really poor interpersonal care?
- What factors/reasons made really good interpersonal care possible/made it difficult for interpersonal care to be provided?
- How did you feel about this delivery?
- What was the impact of this delivery on you?
- What impact do you think it had for the woman? How do you know?

Narrative interview

- Can you tell me the story of how you decided to become a midwife?
- What are the elements of midwifery practice that you find the most satisfying/rewarding?
- Can you describe a delivery that you feel was really good? For you? For the woman?
- What about a time when you felt it was a challenge and you could not deliver good care?
- If you had the freedom how would you make delivery care different if it was you or your wife/sister/daughter in labour instead of a local woman?

Example key informant interview

Overleaf is an example of a key informant interview. In the absence of access to printers I often had to sketch out my questions in my notebook.

HRMO   stats/info

① Role
   Authority   MOH/CHAM/CH
   Autonomy ⎾ staffing establishment — need   #: pop^
             ⎿   ⎿ workload

             ⎿ Hiring ⎾ process
                (MW) ⎿ timing
                        current embargo?

② Expectations of MW (staff)
        Job descriptions / guidelines
        Professionalism, status

     work ethic ⎾ punctuality
                ⎾ working/just present
                ⎿ attitude ⎾ to ♀
                            ⎿ to peers

   support ⎾ supervision
           ⎾ Ⓣ
           ⎾ teamwork
           ⎿ reward/recognition

③ Accountability
   • Respect for authority ⎾ rights/responsibilities
                           ⎿ "MOH"

   • DHA process ⎾ steps
                 ⎿ sanctions

   • Taking action ⎾ enforcement
                   ⎾ fear
                   ⎿ horizontal violence

④ Attitudes to public service ⎾ changes over time
                              ⎾ ownership
                              ⎾ just a job
                              ⎿ corruption

⑤ Leadership ⎾ nationally
             ⎾ locally
             ⎿ impact of leader behaviour

⑥ Professionalisation of midwifery
        – N/M issue
        – deployment/rotation
        – impact ⊕
                 ⊖

Interview guide - Human Resources Officer

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Appendix E. Consent form

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COLLEGE OF MEDICINE

CONSENT FORM

Title of Study: **Midwives' perspectives on the practice, impact and challenges of delivering respectful obstetric care in Malawi**

Please initial box

1.	I agree to take part in the above City University London/College of Medicine research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.	
	I understand that my participation in the research will involve me: • Being interviewed by the researcher • Allowing the interview to be audiotaped	
2.	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that confidentiality cannot be guaranteed for information which I might disclose in the focus group(s)/group interviews(s). I consent to the use of quotes from the audiotapes in publications.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way. I understand that the research team will tell me if there is any new information which may affect my willingness to continue.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	**I voluntarily agree to take part in the above study**.	

_____   _____ _____
Name of Participant   Signature   Date

_____   _____ _____
Name of Researcher   Signature   Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix F. Transcriber confidentiality agreement

COLLEGE OF MEDICINE

CITY UNIVERSITY LONDON

Midwives' perspectives on the practice, impact and challenges of delivering respectful obstetric care in Malawi
Susan Bradley, Dr Effie Chipeta

As a transcriber of this research, I understand that I will be hearing recordings of confidential interviews. The information on these recordings has been revealed by interviewees who agreed to participate in this research on the condition that their interviews would remain strictly confidential. I understand that I have a responsibility to honour this confidentially agreement.

I agree not to share any information on these recordings, about any party, with anyone except the Researcher named above. Any violation of this and the terms detailed below would constitute a serious breach of ethical standards and I confirm that I will adhere to the agreement in full.

I, _____ agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the content of the interviews in any form or format (e.g. WAV files, CDs, transcripts) with anyone other than the Researcher.
2. Keep all research information in any form or format (e.g. WAV files, CDs, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g. WAV files, CDs, transcripts) to the Researcher when I have completed the transcription tasks.
4. After consulting with the Researcher, erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher (e.g. CDs, information stored on my computer hard drive).

Transcriber:

_____ _____ _____
(print name)   (signature)   (date)

Researcher:

_____ _____ _____
(print name)   (signature)   (date)

This study has been reviewed and ethically approved by City University London SHS Research Ethics Committee (Ref. PhD/15-16/02) and the College of Medicine Research Ethics Committee (Ref. P.05/15/1737)

CITY UNIVERSITY LONDON

Midwives' perspectives on the practice, impact and challenges of delivering respectful obstetric care in Malawi

Information for midwives

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

Further information and contact details

Susan Bradley

Effie Chipeta

Version 1 20.04.15

What if there is a problem?
If you would like to complain about any aspect of the study, the College of Medicine or the City University London have established complaints procedures.

College of Medicine: You need to phone +265 1 871 911/Fax: +265 1 874 700 and ask to speak to the Chairman, College of Medicine Research and Ethics Committee. You could also write to the Chairman, College of Medicine Research and Ethics Committee (COMREC), College of Medicine, Mahatma Ghandi Campus, Private Bag 360, Chichiri, Blantyre 3, Malawi or email: comrec@medcol.mw

City University London: You need to phone +44 20 7040 3040 and ask to speak to the Secretary to Senate Research Ethics Committee. You could also write to the Secretary at: Anna Ramberg, Research Office E214, City University London, Northampton Square, London, EC1V 0HB. Email: Anna.Ramberg.1@city.ac.uk
You need to tell them that the name of the project is Midwives' perspectives on the practice, impact and challenges of delivering respectful obstetric care in Malawi.

Remember to tell them that the name of the project is *Midwives' perspectives on the practice, impact and challenges of delivering respectful obstetric care in Malawi.*

Study approvals
The study has been approved by the College of Medicine Research and Ethics Committee (COMREC) and by the City University School of Health Sciences Ethics Committee.

What is the project about?

Respectful maternity care (RMC) is important to women, but there is not much evidence about midwives' views on the value, practice or challenges of delivering RMC.

In Malawi, midwives work in difficult environments, with inadequate support, overwhelming workloads and lack of resources. These factors are implicated as drivers of disrespectful maternity care. Poor care discourages women from facility-based delivery and undermines efforts to reduce maternal mortality and morbidity.

We want to understand the context in which Malawian midwives are working and explore the barriers and facilitators to providing RMC to Malawian women.

Why have I been invited?

We have asked you to take part because you are a practising midwife. We would like to ask you about your views of what it means to be a professional midwife and your experience and thoughts about RMC during labour and delivery.

To take part you:

- Hold an accredited midwifery qualification (i.e. RM/RNM, NMT or ENM)
- Have performed at least one of the emergency obstetric care signal functions in the last month and have worked at least 4 shifts in the labour/delivery ward in the last month
- Are over 18 years of age
- Are willing and able to participate in English
- Will provide informed, written consent.

Do I have to take part?

No. You don't have to take part in the project if you don't want to. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

If you decide to take part we will ask you to take part in either a focus group discussion or a one-to-one interview with a researcher. We will ask for your permission to audiotape the interviews, and we will ask a few questions about your age, current midwifery qualification, the type of facility you work in and how long you have been a midwife.

Focus group discussions will be with 6-8 other midwives and will last about 90 minutes. Interviews with the researcher will last 30-60 minutes.

What are the possible disadvantages and risks of taking part?

There are no risks to taking part in this study, but some of the issues we discuss might make you feel uncomfortable. Please remember that if you do not wish to answer any questions you do not have to do so and you are free to stop the interview or withdraw at any time, without having to give a reason.

What are the possible benefits of taking part?

There is a lot of international advocacy to improve RMC, but midwives' voices are not always included. We hope this study will be a chance to highlight Malawian midwives' voices and help to find strategies that can improve the obstetric care environment for women **and** midwives.

What will happen when the research study stops?

Your name will not be recorded with the information you give us, so no one will know it is from you. It will be kept, password protected, on a computer for ten years and then deleted.

Will my taking part in the study be kept confidential?

The answers you provide will be used only for the purposes of this study. All answers will be handled confidentially and any information we gather will be stored without using your name. We will not use your name in any reports and your name will not be shared with any other people.

What will happen to results of the research study?

Findings from this study will be used to generate policy briefs and recommendations for MOH/CHAM and to write academic articles. They will also be shared with others interested in RMC at national, regional and international forums.

Please give your contact details to the lead researcher, Susan Bradley, or email her if you would like a summary of the report.

What will happen if I don't want to carry on with the study?

You are free to withdraw from this study at any time, without giving a reason. If you don't want to take part or change your mind, just tell the researcher.

Appendix H. SHSREC ethics approval

CITY UNIVERSITY LONDON

School of Health Sciences

Research Office
Northampton Square
London EC1V 0HB

Tel: +44 (0) 20 7040 5704

www.city.ac.uk

Ref: PhD/15-16/02

2 July 2015

Dear Susan / Chris

Re: Midwives' perspectives on delivering respectful obstetric care in Malawi

Thank you for forwarding amendments and clarifications regarding your project. These have now been reviewed **and approved** by the Chair of the School Research Ethics Committee.

Please find attached, details of the full indemnity cover for your study.

Under the School Research Governance guidelines you are requested to contact myself once the project has been completed, and may be asked to complete a brief progress report six months after registering the project with the School.

If you have any queries please do not hesitate to contact me as below.

Yours sincerely

Alison Welton
Research Governance Officer

Appendix I.   COMREC certificate of ethics approval

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.05/15/1737 – Midwives perspective on practice, impact and challenges of delivery of respectful obstetric care in Malawi by Susan Bradlley

On i9 August 2015

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

Approved by
College of Medicine
1 9 AUG 2015
(COMREC)
Research and Ethics Committee

Dr. C. Dzamalala - Chairperson (COMREC)

19th August, 2015
Date