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From global rights to local relationships: Exploring disconnects in Respectful Maternity Care in Malawi.

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Abstract

Widespread reports of ‘disrespect and abuse’ in maternity wards in low and middle income countries have triggered the development of rights-based respectful maternity care (RMC) standards and initiatives. To explore how international standards translate into local realities, we conducted a team-ethnography, involving observations in labor wards in government facilities in central Malawi, and interviews and focus groups with midwives, women and guardians. We identified a dual disconnect between, first, universal RMC principles and local notions of good care, and second, between midwives, women and guardians. The latter disconnect pertains to fraught relationships, reproduced by and manifested in mechanistic care, mutual responsabilization for trouble, misunderstandings and distrust. RMC initiatives should be tailored to local contexts and midwife-client relationships. In a hierarchical, resource-strapped context like Malawi, promoting mutual love, understanding, and collaboration may be a more productive way to stimulate ‘respectful’ care than the current emphasis on formal rights and respect.

1. Introduction

The last decade has seen a gradual shift in the field of maternal health from a focus on reducing maternal mortality to fostering respectful maternity care (RMC). Between 1990 and 2015, maternal mortality decreased globally by 44% (WHO, 2015), and skilled birth attendance increased sharply in many low and middle income countries (LMICs; U.N. 2015). However, clinical and interpersonal quality of care has generally lagged behind (Miller et al., 2016). A growing body of literature documents instances of ‘disrespect and abuse’ (D&A) in labour wards, seemingly particularly pronounced in LMICs, attributed to factors like provider attitudes, lack of motivation (Ishola, Owolabi & Filippi, 2017), and, increasingly, systemic causes, including inadequate resources, poor leadership, and gender and class-based inequalities (Bradley et al. 2016; D’Ambruoso et al., 2005; Freedman et al., 2014; Ishola, Owolabi & Filippi, 2017). In response, the White Ribbon Alliance (2011) launched a RMC campaign and published a charter regarding the rights of childbearing women, grounded in universal human rights; the WHO (2014) issued a statement and incorporated respectful care into its maternity care guidelines (WHO 2016, 2018). However, to what extent do ‘universal’ quality standards and respectful care principles fit local realities on the ground?

Answering this question requires reflection on the meaning of ‘quality of care’, increasingly recognized to pertain to the provision *and* experience of care (Hulton et al. 2007; WHO 2016, 2018). Aspects of care considered important for positive childbirth experiences include shared decision-making; information and communication; equity; respect and dignity; and emotional support (Hulton et al. 2007; Shakibazadeh et al., 2018; WHO, 2018). These quality dimensions depend substantially on the interaction between women and midwives. Indeed, studies from high, low and middle income settings underscore that over and above

midwives' technical expertise, positive birth experiences depend on the midwife-woman relationship and labor support (Hunter 2006; Mselle, Moland et al., 2013; O'Donnell et al 2014), whether physical (e.g. therapeutic touch, massage) or emotional (continuous presence, reassurance and praise) (Bohren et al. 2017).

This focus on midwife-client relationships and labor support reflects the influence of the woman-centered care paradigm, which evolved from the 1960s western feminist movement (Leap, 2009). It promotes emotional closeness and a focus on *women's* (social, emotional, physical, psychological, spiritual and cultural) needs and expectations rather than those of institutions or professionals (*op cit.*).

A second paradigm shaping current thinking about quality of care is the human rights paradigm. Rights-based approaches to health, grounded in 'universal' UN Declarations and treaties (e.g. The Universal Declaration of Human rights; Convention on the Elimination of All Forms of Discrimination against Women), gained prominence in the 1990s (Nyamu-Musembi and Cornwall, 2004). In maternal health, the initial focus on women's right to life and access to care (Freedman 2001), recently expanded to include women's right to be treated with dignity and respect, as formulated in the White Ribbon Alliance's (2011) Charter.

The articulation of this new set of childbirth-related rights coincided with the development of 'disrespect and abuse' typologies (D&A); categories of behaviors which violate women's rights (Bowser & Hill, 2010; Bohren et al., 2015; Shakibazadeh, et al., 2018). The first (Bowser & Hill 2010, p.9), included seven categories: physical abuse; non-consented care; non-confidential care; non-dignified care; discrimination based on specific patient attributes; abandonment of care; and detention in facilities. These typologies are increasingly used to document instances of D&A (Bradley et al., 2016; Ishola, et al., 2017; Kruk, et al., 2014; Lambert, et al., 2018), and, more recently, assess its prevalence (Bohren et al., 2018; Sando et al., 2016).

However, Freedman et al. (2014) problematized the use of standardized categories to assess D&A, arguing that both universal standards *and* local perceptions matter. Indeed, despite the ‘universal’ pre-fix, the human rights paradigm is arguably a predominantly ‘western’ and individualistic ideology (Ishay, 2008; Wilson 1997). Similarly, women-centeredness and associated values like emotional closeness are not necessarily universal (Brown, 2010). By extension, certain behaviors may be considered as rights violation and abuse by some (e.g. women; advocates from high income settings), but not others (e.g. providers). Ethnographic studies (Brown, 2010; de Kok, 2019) have problematized the application of generic labels (e.g. ‘verbal abuse’) and universal rights principles (e.g. ‘freedom from harm’) to judge health professionals’ behaviors (e.g. shouting). This may obscure important contextual and situational details which may reframe acts as (intended) care rather than abuse (de Kok, 2019). For instance, shouting at a woman whose labor is prolonged to galvanize her into action when no ambulance or theatre is available, can be seen as act of care for the life of the mother and baby (op cit.).

Hence, we need to examine what women and midwives, in specific contexts and situations, consider ‘good’ or ‘bad’ care, and how these perceptions relate to the recently articulated ‘universal’ rights of childbearing women and standardized categories of disrespect and abuse. Some previous LMIC studies found that providers’ and women’s descriptions of good maternity care echo global principles of women-centered, respectful care and human rights. Adolphson and colleagues (2016, p.99) reported that some midwives in Mozambique described good care as resulting from a “deep engagement with the mothers”. Women in Tanzania described it as ‘being treated well and equal’ (Solnes Miltenburg, Lambermon et al. 2016, p.6). In Malawi, where our study took place, Kumbani et al. (2012, p.6) found that women considered care good when ‘reception was good, they were respected, their privacy and confidentiality were maintained’.

However, differences were identified too. Brown (2010) discusses how in her Kenyan site, midwives did not seem to consider displaying sympathy and closeness elements of good care; this would relax women too much, risking inhibiting labor. Sometimes, providers' and clients' perceptions differ. Lambert et al. (2018) found that in South Africa, midwives felt that speaking firmly is part of good care; while women wanted to be spoken to gently. O'Donnell et al (2014) found that in Malawi, women emphasized the value of positive provider-client relationships; providers emphasized the availability of resources.

Differences between global principles and local conceptualizations, and between midwives' and women's views, may make RMC interventions less effective. Hence, our study, embedded in a rights-based RMC intervention implemented in central Malawi, sought to illuminate conceptualizations of 'good', 'respectful' and 'bad' care, how these play out in care practices, and shape the effects of RMC initiatives. Offering a uniquely detailed analysis, we add to earlier studies, first, by using ethnographic observations to illuminate care practices where previous RMC studies have predominantly relied on surveys and interviews. Second, we include guardians: usually relatives or neighbours who accompany women to the hospital. They perform basic care tasks such as providing food or washing clothes and if the facility allows access to the labor ward, they may assist during labor (e.g. by massaging women's back). Whilst rarely included in RMC studies, guardians' accounts of birth and how they care for women are insightful, partly because they may include events which women 'missed' during labor (Ishola, Owolabi & Filippi 2017). Third, we go beyond describing perceptions of 'bad', 'good' or 'respectful' care; we illuminate *why* certain aspects are deemed important and use this as a lens to elucidate midwife-women relationships, deemed so central to quality of care. We argue that understanding and addressing these relationships will be key to the success of RMC interventions.

2. Study context: Malawi

Malawi is a poor country: half of its population lives below the poverty line and a quarter in extreme poverty (International Monetary Fund African Dept, 2017). It has a low rank (173 out of 188 countries) on the Human Development Index (HDI), measuring three basic development dimensions: a long and healthy life, access to knowledge and a decent standard of living (United Nations Development Programme, 2015). Approximately 85% of the population lives in rural areas (National Statistical Office-Government of Malawi, 2015).

Malawi's most recent estimated maternal mortality ratio (MMR) is 439 per 100,000 live births (NSO Malawi & ICF, 2017); below the WHO (2015) estimate for the sub-Saharan African region of 546. Its proportion of institutional deliveries has increased sharply from 55% in 1992 to 90% in 2015-16 (NSO Malawi & ICF 2017). Malawi provides free maternity care, but quality of care appears suboptimal (Leslie et al, 2016; Ministry of Health Malawi & ICF International, 2014). Health-centers offer basic emergency obstetric and new-born care (EmONC); a limited number of referral hospitals offers comprehensive EMOC services. Malawi's health system is affected by severe lack of physical, financial and human resources (Chimwaza et al., 2014), and high dependency on donor funds (Kanyuka et al., 2016), which means adopting donors' targets, including those concerning respectful maternity care.

3. Methodology

We used a team ethnography approach (Erickson & Stull, 1998), involving semi-structured interviews and focus groups with women, guardians and midwives concerning perceptions and experiences of care, and four weeks of ethnographic observations conducted in five (anonymized) facilities in central Malawi in 2017: two urban referral hospitals, one rural hospital, one peri-urban health center and one rural health center.

Five researchers collected data, including two Malawians, one of whom was a midwife. Three additional researchers, including one midwife, contributed to the organization and analysis of the study. As Barry et al. (1999) described, team analysis can enhance creative thinking and intellectual rigor. In our case, involvement of Malawian researchers and midwives, as well as social scientists was crucial for achieving an in-depth, balanced and contextualized understanding of interview accounts and observations.

Participants

We interviewed 13 women, ranging in age from 21 to 40 who had given birth at a health facility between one week to seven months ago; and 23 midwives, aged 26 to 46, with varying levels of experience, from a few months to 12 years. Two were students. In addition, we held eight focus groups with in total 61 guardians.

Sampling, recruitment and data collection

Participants were sampled purposively, to achieve a range of participants in terms of age, gender (midwives) and site of work/birth (rural and urban; referral hospitals and health centers). We also used convenience sampling according to researcher and participant availability. Women were mostly recruited at under-five clinics, and in one case, after we observed her delivery. We recruited guardians at guardian shelters and midwives during shifts in facilities where we conducted observations.

Interviews with women and focus groups with guardians were conducted in Chichewa, whilst interviews with midwives were conducted in English, mostly in the health facilities; three interviews (one guardian, two women) were conducted at participants' home in a nearby village. Interviews and focus groups were audio-recorded, transcribed verbatim and translated into English, with extracts used for final analysis and write up double checked by a translator.

Ethnographic observations of pre-natal and intra-partum maternity care were recorded in field notes and transcribed in full within 24 hours.

Data analysis

We analyzed the data using thematic analysis (Braun & Clarke, 2006), facilitated by Dedoose, online qualitative data analysis software. Following a preliminary analysis round, the team met to construct a coding tree, with codes derived deductively from the literature, and inductively, based on themes identified in the data. Team-members subsequently each coded a number of transcripts, elaborating on meanings of codes and defining more specific codes where necessary. A number of transcripts were co-analyzed by another team member, if needed followed by discussion to reach consensus regarding interpretations. Each team member then further analyzed a cluster of related themes and sub-themes (e.g. ‘respectful care’; ‘RMC training’). In a final analysis workshop we produced an initial synthesis of findings by selecting key themes, and conducting axial coding across these themes, identifying relationships between them.

Ethical considerations

The National Health Sciences Research Committee in Malawi and Napier University’s Ethics Committee approved the study. We obtained oral (women, guardians) and written (professionals) informed consent and all participants received an explanation of the research aims, were told that data would be anonymized and treated as confidential, and that participation was voluntary and declining to participate would have no impact (e.g. on receipt of future services). Women aged under 16 years and those who had experienced negative birth outcomes were excluded from the study as they were particularly vulnerable. Regarding the observations, we sought permission from both providers and, as much as possible, women for our presence in

the labor ward during delivery, and positioned ourselves in such a way to maximize women's privacy and avoid interference with clinical care.

4. Findings

We found that women, guardians and nurse-midwives value several of the key RMC principles promoted globally. We discuss this overlap in section 4.1, detailing what behaviors participants evaluated positively or negatively, and how evaluations of care appear entwined with its impact on nurse-client relationships. We also identified differences between global RMC principles and local priorities; a first disconnect, discussed in section 4.2. A second disconnect pertains to the fraught relationships between nurse-midwives, and women and their guardians (4.3). Finally, in section 4.4, we explain how these disconnects, a concept central to this paper, may limit RMC interventions' effectiveness, or worse, make them counter-productive.

4.1 Common ground: The importance of attention and talking lovingly

Several women and guardians spoke positively about the care they received, and we have seen several positive instances in which nurse-midwives displayed empathy and were 'with woman', which is the origin of the word midwifery. Yet, complaints were also common. These often matched D&A categories from global RMC typologies, like neglect (Bohren et al., 2015). Conversely, (swift) medical attention often featured in accounts of good care and positive experiences. For instance, explaining why she had been 'welcomed well', a woman referred to the swift attention she had received in a rural hospital:

Yes but they welcomed me well because they didn't make wait for a long time no, they told me sit here for a little while and then was called to go on a bed, that's all, I delivered. That shows that you have been welcomed, but if they look at you, that's all, and then they go out to have some food, that means they are refusing you.

Medical attention was valued not just because of its medical benefits. A guardian explained:

We can say that the main care is the doctor because if one gets sick at night and the nurse is present right there, the pain is less because the nurse is there, but when the nurse is not around and in pain, it's hard, so I feel the presence of the doctor is much care.

Indicating that a health professional's presence can alleviate pain and increase the ability to cope with it, the guardian implies that attention can be both clinical *and* emotional care. The emotional value of a caring presence was highlighted too when guardians explained how they show 'love' (*chikondi*) for their 'clients' by 'being close', 'not going out', and 'being dependable' (*kudalirana*). Providing practical care was another way to show love. As one guardian described: '*It's a matter of taking care of the person, cooking, providing water for bathing, washing her clothes, and loving her frequently so that she should not throw away heart [despair]*'.

We observed that nurse-midwives provide basic care (e.g. draping a cloth over shivering woman) too, but only rarely, and this was subject of critique:

The real care is not there in this hospital. When one delivers in the labor ward, instead of cleaning you and help you to dress up since you don't have enough energy, they leave you to do it yourself and that is not care. (Guardian, FGD).

Resource constraints limit what nurse-midwives can do, but one midwife, working in a peri-urban health-center, noted that she *was* able to engage in such mundane care acts. She too, outlined their emotional *and* relational function:

R They [women] do listen because when I am telling them this, I have to be there. I don't leave them alone. So, they think oh, this one is with me. Then I should listen to her. But if you leave them, then they become uncontrollable. Jah, but you have to be with them. You have to caress them, you have to (..) You have to caress them, you have to rub the back.(..) Jah. So they say that 'okay, this one is nice'. She will help me.

I Ah okay. Yes. So you make them trust you?

R If they say 'I want water', you take water and give them. 'you be near me', you have to do it.

The midwife articulates providing basic, practical care (giving water; rubbing the back), and a continuous presence, as a form of 'being with' which makes women feel cared for, and builds relationships ('okay this one is nice') and trust ('she will help me'). This has practical and clinical benefits, like making women listen to the midwife.

A second category from D&A typologies commonly included in complaints was verbal abuse, whilst 'talking well' was interpreted as another sign of love, and thus, good care:

With that nurse, we were able to talk well to each other and in a loving way {laugh} Isn't it, what is needed is love, right? But not that you should be shown words, may be some bad words it becomes a painful thing. (Woman, peri-urban health center)

The guardian's description of 'talking well' as a sign of love, indicates that communication can bolster relationships, which may have practical benefits, as a midwife explained:

I am such, such, such, such, I am a nurse. That one makes her feels like, okay, she can really tell you, tell you each and every problem that she is having. But if you don't greet, if you shout, your attitude is bad. The patient also feels like, she doesn't open.

She can't say anything. So it is difficult for me to come up with a diagnosis if the patient is not open to me.

Simple communicative acts, like introducing oneself, can improve the nurse-client relationship and enable women to open up. They also facilitate diagnosis and the provision of the right clinical care. Thus, again, we see that emotional, relational and clinical benefits are entwined.

However, although nurse-midwives frequently mentioned communication ('talking well', 'respectfully' or 'politely') in their descriptions of respectful care, several did not define respectful communication other than in terms of 'no shouting' (although some, like the midwife above, mentioned e.g. greeting, addressing people by their name). More generally, nurse-midwives' descriptions of respectful care often appeared quite formulaic, as if listing aspects taught in training, rather than necessarily personally subscribing to, and implementing, these principles, as our observations confirmed (see 4.3).

In conclusion, D&A typologies and women's, guardians' and nurse-midwives' perceptions of poor care overlap, with neglect and verbal abuse common objects of complaints. Rather than neglect, women want regular medical attention, which, like practical care and 'loving' communication (provision of explanations, reassurances, personal introductions) can help establish a caring presence, a form of 'being with', which builds relationships and a conducive care environment, with clinical benefits.

4.2 The first disconnect: Love versus respect, survival versus sympathy.

In addition to commonalities, we identified differences, and thus a disconnect, between global and local conceptualizations of good or respectful care. As seen in previous extracts, women and guardians regularly spoke about good care in terms of 'chikondi', love, rather than respect.

Nurse-midwives also spoke of love, though less frequently so. For instance, when asked ‘what sort of care do you think is respectful care?’ a midwife responded:

Care that preserves the dignity of the woman and her family.(.)Uhm, it ensures privacy, confidentiality, and, at the end of the day the woman feels loved and cared for and is not exposed or exploited.

The start of the midwife’s response has the aforementioned formulaic character, as if repeating lessons from RMC training. When she says ‘at the end of the day the woman feels loved’ the midwife seems to paraphrase respectful care in her own words. Nurse-midwives too, may associate care more readily with love rather than respect

When respondents did mention respect, interpretations sometimes diverted from global RMC principles. Asked what ‘respectful child birth’ (kuchila kwa ulemu) meant to her, a guardian in one of the rural focus groups explained:

To say my sister had respectful child birth, when she goes to the labor ward right? It’s better that she listens to the doctors, the one who is speaking to her, and should agree on one thing and soon things will work out, and I can think that here my sister has respectfully given birth.

For the guardian, respectful care is listening to, and agreeing with the doctors. Like some other respondents, she casts following doctors’ instructions as a patient’s duty, and important for good birth outcomes. ‘Respect’ is about acknowledging doctors’ expertise and higher status. Similarly, when a woman in a rural health-center was asked what she considered respectful care, she described how a fellow client was told to wash herself in the staff bathroom, and commented: ‘*we admired her, that was very respectful*’. She attributed her special treatment to her status: being a secondary school teacher’s wife, she was ‘staff’, like the nurse-midwives. Again, respect is linked to acknowledging (socio-economic) status, re-

flecting the highly honorific and hierarchical nature of society in Malawi. Here, the egalitarian RMC ideals (e.g. freedom from discrimination) may be hard to accept by women and nurse-midwives alike.

Another, relative, difference was that whilst RMC guidelines emphasize the importance of experiences of care, respect and dignity, our respondents foregrounded concrete clinical care and health outcomes (survival of mother and baby). For instance, one woman told us *'They received me very well and they stopped attending to other things and received me who came from far. They gave me four injections, and a bottle of blood, that's it, then the baby was born'*. Another, asked why she felt she had been attended well responded: *'The reception was good and they even gave tablets'*.

The importance of good health outcomes came through in nurse-midwives' accounts of positive experiences: *'Actually I feel very good to see the women coming with their labor pains, assisting them, caring for them, and then, when they have delivered their babies. The baby is okay, the mother is okay. I feel good'*. Similarly, a guardian explained that *'When a person is helped properly, they don't go back to the hospital because they were helped fully, both mother and child become well'*.

This does not mean that women do not care about disrespectful care, but happiness about survival in this high mortality and morbidity context may override unpleasant experiences, as suggested by a guardian in a focus group:

I What if perhaps you have come to labor ward? So the doctor beats her or shouts at her but that person delivers well well, has been discharged, has gone home. How do you see it, or what do you think how will her thoughts be?

R Aaaa it will end there, finding what? She has cured/delivered.

The Chichewa term for delivering is 'kuchira', literally, to heal or cure. Several women explained that they felt they had received good care because they had 'cured' well, and the baby was doing well. Others mentioned how, during delivery, they worried about whether they or the baby would 'cure' well. Two women reminded us that when delivering, one is 'between life and death', and thus good care and attention is required. These accounts remind us that survival can at least be as important for women, guardians, and nurse-midwives, as being treated with respect. This is important, given potential tensions between good clinical care and its experience: sound clinical procedures may be unpleasant (see also Goodwin, Mesman, Verkerk et al., 2018). As a midwife explained: *'Sometimes we maybe shout, may sound harsh because we want them to do what we tell them to do, so the mother and the baby will be ok. If we say "ah..." (speaking in gentle soft tone), they don't do it'*. Earlier studies also noted that behaviors which appear harsh from certain (western) perspectives (e.g. slapping a disobeying woman in second stage of labor), can also be seen as care for the life of the mother and baby, albeit not for the subjective birth experience (Brown, 2010; de Kok, 2019; Soltes-Milenburg et al. 2016).

Nevertheless, clinically sound behaviors could be unnecessarily abusive. One of our respondents complained that the nurse-midwife in the peri-urban health center 'did not talk well'. Whilst in labor, the nurse-midwife told her *"go have a bath, you women do unhygienic things" (...)* *Go and have a bath, other people deliver without washing their private parts "*. Despite explaining that she could not go outside to bath, since her guardian had returned home and she felt she could deliver any time, she was pressed to bath.

Here, the nurse-midwife adhered to the clinical rationale of infection control, but contravenes women-centered care principles, failing to acknowledge the woman's needs and treat her as a 'whole person', or as a partner (WHO 2018). The nurse-midwife does not explain the rationale for bathing, makes a denigrating remark ('you women do unhygienic things'), and

does not enquire after, nor acknowledge, the woman's situation: she was alone, without support of a guardian, and about to give birth.

In conclusion, diverting from the global RMC discourse, women and guardians emphasize love rather than respect, which is associated with acknowledging status differences, and clinical treatment and health outcomes rather than positive experiences. Survival may be deemed more important than respectful treatment. Generally, our respondents appeared focused less on formal rights (e.g. respect for autonomy, equity), and more on details of interpersonal *and* clinical care which make women feel welcomed, loved, and at ease.

4.3 The second disconnect: Nurse-midwives versus women/guardians.

We identified a second disconnect; a 'rift' between nurse-midwives and women and guardians.

4.3.1 Mechanistic care reflects and maintains a rift

Care was generally mechanistic, rather than focused on the 'whole' person, as promoted by women-centered care principles. Consider the field notes extract below:

A woman entered the labor ward of the referral hospital, a plastic sheet and health passport book in her hand. She said she was sent into the room by a midwife, because she had contractions. No one responded to her. She went straight to the empty bed. She placed the plastic bag on the bed and undressed herself, climbed onto the bed, lay on her side, facing the wall and covered herself with the piece of cloth. No one paid attention; all staff continued their work. After about 20 minutes, a student asked her how she was feeling. She said she had severe lower back pain. The student told her to lie on her back, and uncover herself so that she can examine her. She took a fetal scope and

placed it on the woman's belly. She listened to the heart beat for a minute. The woman started screaming with pain. Without saying anything, the student went to get examination gloves, put them on, returned to the woman and asked her to raise and open her legs. She then inserted her fingers inside the vagina. The woman kept screaming, the student midwife took her time inside. After writing down what she thought she found, she told the woman to come down the bed and go back to the antenatal ward. The woman, seemingly reluctant to go, stood still. Then, she took her things and left.

Not acknowledging the woman upon entry, proceeding with examination without responding to her signals of pain - all behaviors observed in other instances too- make the midwife's care seem mechanistic. Generally, nurse-midwives were focused on actions and bodies, especially the lower part of the body, rather than the woman's face. This may reflect lack of experience or skill in being able to do two things simultaneously, but also suggests that nurse-midwives see their job as being about clinical care and achieving good clinical outcomes (see 4.1.2), rather than caring for women's emotional needs. Mechanistic care fails to establish a collaborative relationship with the woman. Carson (2002) describes how the hyphen in the provider-client relationship is key to understanding this relationship. It highlights that the provider-client relationship is simultaneously characterized by separation and synergy; distance and bridge. And, it points to the need for joint venture and collaboration, to achieve 'what neither can accomplish alone'. In encounters between nurse-midwives and women in Malawian labor wards, rather than a 'hyphenated space' (Carson 2002), we tend to see a disconnect (see also Vesterling, 2019).

A mechanistic care approach also came through in nurse-midwives' use of the 1cm per hour dilation standard to assess labor progress. Women mentioned regularly how they were told by nurse-midwives that it was not yet their time to deliver, which clashed with their

own sense that birth was imminent. One respondent reported that she had seen a stillbirth due to nurse-midwives 'working by the clock' (Uny, de Kok & Fustukian, 2019, p.5). This (experienced) dismissal of women's intuitive bodily knowledge (Davis-Floyd and David, 1997) is another form of disconnect, albeit induced by decades of training midwives to use the 1cm per hour standard.

Communication patterns enhanced the mechanistic flavor of care. Deliveries were commonly conducted without exchange of words. Explanations, reassurances, feedback regarding assessments, or even the baby's gender or health condition, were rare. *If* nurse-midwives provided explanations, they usually did so whilst already undertaking a particular activity (e.g. vaginal exam), making it an act of informing rather than seeking informed consent. Non-communication may be a strategic form of care: one midwife told us how they might not inform women of a stillbirth to ensure they stay calm during delivery. Nevertheless, limited or non-communication enacts an unequal provider-client relationship, with women treated as passive, waiting to be told, rather than partners in care. Lack of partnership also came through in women's and guardians' fear of asking questions and requesting for assistance, as expressed by one guardian:

We met other doctors, they shout at you so everyone just get scared and feels like if I talk to them, what will be the response? If I ask this one to look at my patient, will he/she not talk to me the same way that one did? There, one becomes frightened to voice up your concerns even to ask how your child will be assisted. So it happens that one is talking and they respond like: "If you want you may go back to the hospital that you came from". So if they sent me here, can I go back there? That's where people like me just break and stop talking, just listening. Where they can decide to talk to me, they can do so and will agree with whatever they tell me I will agree with it. But for one to

put out my voice and talk to them like chatting with those doctors, here it doesn't happen.

The guardian voices her fears of verbal abuse or denial of care ('you may go back to the hospital that you came from'). When such fears lead women and guardians to not share their worries or express their needs, care becomes uni-directional; we see a disconnect rather than collaborative partnership.

4.3.2 'Don't give us problems': Personalizing trouble, and mutual responsabilization.

Several nurse-midwives labelled women's behaviors, like screaming, or not following instructions, as troublesome. Whilst some expressed understanding, for instance attributing lack of cooperation to women's anxiety or pain, others appeared to hold women responsible for 'trouble' and retaliated. For instance, a guardian described how staff shouted at her daughter who arrived whilst already having contractions:

"So, you were just staying at home when your friends come and wait here but you were just staying there waiting to come here and give us problems. And you also come at the time when I want to go and have some food. Now I'm going to have my food at home".

Similarly, another woman described how, in a rural health-center, a fellow client went to the toilet against nurse-midwives' advice. When she delivered there, the midwife told her "you have done according to your wishes, just go ahead because we don't feel that we can help".

The nurse-midwives framed both women as responsible for deviating from health advice (waiting at the facility; not going to the toilet): they were just acting according to their

‘wishes’, rather than being compelled by circumstances (see also de Kok, 2019). Furthermore, the first nurse-midwife personalizes the troublesome behaviour. ‘Waiting to come here and give us problems’ suggests that the client deliberately intended to create trouble *for these midwives*. Her subsequent withdrawal of care thus appears a form of personal punishment and retaliation.

At the same time, women and guardians also personalized nurse-midwives’ problematic behaviour, and framed them as responsible for it. Several implied that poor quality care was deliberately targeted at them as punishment for disobedience, or through cruel intents. One woman, interviewed at a rural health center told us for instance:

I will talk about what happened at health center [name], it happens that the patient is calling a nurse, she tells you that it is not yet time, she does not want to examine you, she just leaves you to deliver alone, hence the baby is born dead. It is very painful for us mothers keeping the pregnancy from one month to nine months then you meet the nurse and they neglect you like that, is very cruel. This happens mostly in the healthcenters, they do not take care of their job.

The woman responsabilizes the midwife for her neglect by attributing it to lack of motivation and care (‘she does not *want* to examine’; ‘they do not take care of their job’). Furthermore, the label ‘cruel’ (nkhanza), used by several respondents to describe some nurse-midwives, implies that it springs from negative intention. Finally, the woman suggests that abandonment leads to the death of a baby, thus making the nurse-midwife also responsible for the outcomes of problematic behaviors too. In other cases, *women’s* behaviors were linked to poor birth outcomes by nurse-midwives, and sometimes guardians and women, as other studies found (de Kok 2019; Solnes-Miltenburg et al., 2016).

Accounts may or may not reflect actual events; we cannot be certain that nurse-midwives abandoned women or that their or women's behaviors caused a baby to die. Regardless, they point to a negative public imagery of nurse-midwives as potentially cruel actors, with a propensity to punish women, and of women as potentially troublesome, uncooperative and risky. Importantly, the mutual personalization of and responsabilization for 'trouble', reflects mutual distrust and a disconnect between nurse-midwives and women.

4.3.2 Misunderstandings and distrust.

We found that misunderstandings abound between women, guardians and nurse-midwives. These, we argue, both reflect and reproduce distrust. To begin with, rather than resulting from cruelty or unwillingness, nurse-midwives' neglect may well be the result of structural constraints, compelling them to deal with more urgent cases first (Morales, Chaves & Delgado, 2018). As one nurse-midwife in a referral hospital noted, women may not appreciate these constraints and triage procedures:

So imagine you are the patient, you have reported in labor ward at 9 am, and didn't attended to and am with some patient when you will spend one hour without attended to, you feel that, that nurse is neglecting me while professionally am not. But because there are no enough midwives in Malawi, I can't do any otherwise but to save the one who is bleeding.

Women's (perceived) limited understanding of clinical and organizational rationales could lead them to perceive life-saving care (of the other) as neglect (of the self). Another example of how clinically informed care could be perceived as neglect, concerns advice to

ambulate, which could be interpreted as nurse-midwives sending women away. As one midwife explained: *'[primigravida] may think we make their life hard. We tell them to walk, they think we don't care for them, that we are not respectful'*.

Another midwife argued that lack of knowledge could make women uncooperative.

I believe the great challenge is that women in Malawi they don't know what is labor and delivery. (...) They don't know the steps. They don't know anything. Now they come here, with empty heads. They don't know anything. So whenever you try to explain anything to them, they do the opposite because they don't know. Now even if you explain because the mother is in pain, it is hard for that mother to take what you are saying. She would do what she feels. Now, when she is doing what she feels, you are annoyed.

Not following instructions was a common complaint; if it makes nurse-midwives feel annoyed it can affect quality of care. Rather than lack of knowledge, lack of trust in nurse-midwives is at least as likely to make women 'uncooperative'. Women's distrust showed itself in their guarded and hesitant body language, and was conveyed by one of the nurse-midwives:

R: They see us, the midwives as maybe cruel or always shouting always angry at them, so they have a bad attitude towards us.

I: Do you think they all think you are shouting and cruel?

R: Jah I think they have generalized because most of the midwives are not bad, so they just run away. They fear us. They fail to express their concerns because we are always shouting at them. We are always, we don't show smiling faces at them.

If distrust and fear make women run away and not express concerns, the hyphen in the midwife-woman relationship (Carson, 2002) is, again, broken; a disconnect emerges.

In conclusion, relationships between nurse-midwives, women and guardians appear fraught. Care is generally mechanistic rather than women-centered and collaborative. Women

and nurse-midwives blame each other for behaviors which are perceived to be problematic, and for poor birth outcomes. There is a mutual lack of trust and appreciation for each other's abilities and intentions. A vicious cycle ensues: women's fear and distrust make them less cooperative, which frustrates and demotivates nurse-midwives. Moreover, when nurse-midwives sense women's distrust, this likely aggravates their own distrust of women, further problematizing care interactions and reducing quality of care. All of this both reflects and reproduces a rift between nurse-midwives, women and guardians, and makes the notion of collaborative partnerships a futuristic ideal.

4.4 Rights-based RMC campaigns: Increasing the disconnect?

RMC initiatives, including the one in which this study was embedded, often include community sensitization regarding childbirth related rights, such as women's right to complain. To understand their effects, we need to place them in the context of the aforementioned disconnect between nurse-midwives and women.

Human rights initiatives can be powerful tools to redress power imbalances (George, 2003), seemingly pertinent to midwife-client-guardian interactions in Malawi, given for instance women's accounts of nurse-midwives retaliating or their fears of asking questions. Yet, it is exactly because of this backdrop of fraught and imbalanced relationships, that rights-based initiatives may have unintended, negative consequences. Nurse-midwives suggested that community sensitization regarding rights had led to women making unrealistic demands, and 'misusing' their rights, partly due to women's aforementioned limited insight into clinical realities and work circumstances. As one midwife in a peri-urban health center described:

They are saying they have their rights, so they have, they feel they have right to say anything. To health workers. (...) They can come and, they can, they can find you very busy but they want you to help them at the right time. I, I can't say at the right time, but the time

they have reached the hospital, they want the treatment. They have, they have their wishes. But because of the workload, you can't do their wishes at the time they want. So they do insults.

When claiming rights turns into insults, this may (further) frustrate nurse-midwives and worsen provider-client relationships. Nurse-midwives' frustration was also heightened by the emphasis on women's rather than nurse-midwives' rights, and non-acknowledgement of resource-constraints or other systemic causes of alleged 'abuse'. A midwife expressed this strongly:

Respectful maternity care I can say it most of time deals with the rights of the client, but then as health workers we also deserve some rights, we have got our rights, human rights, or we need to work in a conducive environment all those things, but then in respectful maternity care it's like empowering the client to verbalize whatever concerns but then whatever, but then we don't go back to the need of the nurse or to the midwife to find out what went wrong. We just listen to the client. Whatever the client will say then we are saying no, this midwife was wrong, how did he, she treat this woman this way.

Nurse-midwives felt that their needs and concerns were not heard and that they were missing an 'enabling environment', which they saw as required to provide good care or 'love'. As one keenly put it: "we need to be loved to love others." At the same time, RMC initiatives' call for increased accountability led to fears for legal repercussions. One midwife stated:

We work like slaves. And we don't have peace of mind. We have had the same time we have a fear to be, to be, to go, to be, to To go and ehheh and you know that at the same time you be legally, legally...'

Given the perceived injustices, frustrations and fears, it is not surprising that women's or guardians' questioning of nurse-midwives' behaviors could result in a backlash (see also 4.3.1). A guardian at the rural hospital told us:

So one day I said "Nurse, we don't do that, tell the person kindly to prevent complications in there, in that way the person will understand you. But the person is in pain and instead of you encouraging her, you are cruel to her, so how is it going on here?" "So who are you talking over there? Come in here and I will go out."

When the guardian stands up for her client, unlike most others in her social position, she is put firmly in place ('who are you talking over there'), and threatened with abandonment. In the context of a stratified society, fraught midwife-client relationships and a health system subjecting women and nurse-midwives to structural violence, women and guardians face risks when claiming their rights.

In conclusion, nurse-midwives' frustration regarding women's abuse of rights, the neglect of their needs and structural constraints, and their fears of lawsuits, indicate that RMC campaigns may increase the rift between women and nurse-midwives. In the context of already fraught relationships, rights sensitization campaigns and accountability measures may enhance nurse-midwives' distrust, promote antagonistic rather than collaborative relationships, and, ironically, worsen care.

5. Discussion

Our respondents aligned with several ‘global’ RMC principles, underscoring the importance of attention rather than neglect, and positive, loving communication rather than verbal abuse. Yet, we also saw disconnects between, first, ‘universal’ respectful care principles and local notions of good care, and second, between nurse-midwives, women and guardians. Our respondents appeared to attribute greater importance to survival and treatment than the RMC discourse generally does. Another study in Malawi also reported that some women articulated good care as being about delivering ‘normally’ and ‘well’, and receiving medicine (Kumbani et al., 2012). In high mortality contexts, where women’s sense of entitlement is generally limited (op cit.), survival may have priority over absence of disrespect and abuse. This does not mean that women do not value respectful care. However, there may be tensions between striving for survival and aiming for respect (see also Goodwin et al. 2018). In order to ensure that women and babies survive, ‘respect’, at least as defined in the global RMC agenda, may sometimes need to be compromised. If shouting is used to help a woman survive, is this necessarily ‘abuse’? What counts as abuse, for whom, and when? Whilst we must prioritize women’s birth experiences, these questions require greater reflection (de Kok, 2019), especially given increased calls for standardized assessment of D&A prevalence (Bohren et al., 2018).

Analysis of what our respondents valued (attention; love; (loving) communication), and why, points to the emotional and clinical importance of a caring presence and dependable relationships. Our respondents frequently spoke of good care in terms of love, rather than respect and formal rights (e.g. regarding privacy and autonomy), as did Malawian trainee doctors in Wendland’s (2010) ethnography and, further afield, women in Egypt (El-Nemer et al., 2006). When respondents did mention respect, some interpreted it as being about honoring status and nurse-midwives’ instructions. Asking nurse-midwives to respect women and essentially see them as equals may be a tall order, given the marked socio-economic and educational differences between women and nurse-midwives. Hence, whilst previous studies have noted that

class hierarchies may fuel abusive care (Jewkes, Abrahams & Mvo, 1998; D’Ambruoso, Abbey & Hussein, 2008), they may also limit rights-based RMC campaigns’ effectiveness.

The disconnect we identified between nurse-midwives, women and guardians was reproduced through the provision of mechanistic, rather than women-centered, collaborative care. Nurse-midwives adopted a regimented, time-bound mode of practice. They appeared to treat medical knowledge as the only legitimate, ‘authoritative knowledge’ (Jordan, 1997), and devalued women’s own bodily knowledge (Bradley et al., 2006), and at times even their ability to judge whether they needed help, when neglecting women’s calls for assistance. However, rather than chastising nurse-midwives for these shortcomings, we should acknowledge their structural drivers: practical constraints (lack of human resources and time; women’s low education levels), nursing training, and societal and health system hierarchies (Morales, Chaves, Delgado et al., 2018), heightened by colonial and missionary endeavors (Bradley et al., 2006; Jewkes, Abrahams & Mvo, 1998). Even in high-income settings, resource shortages have been linked to health professionals’ ‘production line’ mentality and depletion of their capacity for compassion (Crawford et al., 2013).

We also saw a disconnect between nurse-midwives, women and guardians in the many misunderstandings, the sense of distrust and the mutual blaming for, and personalization of, problematic behaviors. We noted a lack of appreciation for each other’s knowledge, efforts and intentions, for instance when women interpreted evidence-based care (e.g. advice to ambulate) as neglect. Distrust meant that women and guardians worried about speaking out to nurse-midwives or even asking questions, fearing retaliation, as other studies conducted in sub-Saharan Africa found (e.g. Solnes Miltenburg & Meguid 2016).

Earlier studies also observed a lack of trust and collaboration in maternity care (Lambert et al., 2018; Maputle & Hiss, 2010). This is problematic since trust and the quality of provider-client relationships more generally appear to affect the quality of care experienced,

and even health outcomes (Chadwick, Cooper and Harries 2014; Mselle, Moland, Mvungi, Evjen-Olsen, & Kohi, 2013; Gilson et al., 2013; Sripad et al. 2017). Trust seems crucial especially for intrapartum care, since labor can be characterized as a ‘state of dependence’, marked by urgency, unpredictability, and vulnerability (Pellegrino, 1991 in Sripad et al. 2018; Morales et al., 2018), especially in low resource, high mortality settings where means of intervention and referral are few. Indeed, in Malawi, one local term for pregnancy is ‘mpakati’, meaning ‘between life and death’. Morales et al. (2018) note how in Colombia, a middle income, but still resource-poor setting, fear featured strongly in women’s birth narratives; fear of labor, medical procedures and their own or their baby’s death.

Meeting Sripad et al.’s (2018) call for in-depth analysis of the role of trust in maternity care, we offer important new insights into how distrust may shape maternity care. Whilst earlier studies noted the importance of *women’s* (dis)trust, we found that distrust affected *nurse-midwives* too. We identified a vicious circle, or ‘looping effect’, through which distrustful relationships develop. Women’s limited trust in providers, and associated suboptimal cooperation, heightens nurse-midwives’ frustration with and distrust of women. Importantly, RMC initiatives may further increase their frustration, if they feel subjected to unreasonable rights claims and accountability measures, whilst their own rights and needs are neglected. Nurse-midwives may take their frustration out on women rather than on the system, thus further reducing women’s trust, collaboration, and quality of care.

Communication appeared key to the proliferation of distrust and fraught relationships (Sripad et al., 2018). Although in interviews, nurse-midwives listed communication as part of respectful care, we observed various communication problems, noted also in other African studies (Oosthuizen et al. 2017; Maputle 2018), including lack of information, denigrating comments and failure to greet, and thus, start a relationship. Few nurse-midwives engaged in

dialogue with women. Rather than using communication as a bridging tool, which fosters relationships and collaboration, nurse-midwives' communication often appeared to enact a relationship of authority, used to pursue compliance and frame women as responsible for 'trouble', including negative birth outcomes.

How to overcome the disconnects and build bridges?

Improving quality of care and birth experiences will require building bridges, trust and relationships. Rather than woman-centered, care should be relationship-centered, focused on the 'whole person' and needs of the woman *and* the midwife. Guardians too, have needs which should be addressed for them to be able to care appropriately for their daughters, sisters, neighbours. Educating nurse-midwives and women about *women's* rights and *nurse-midwives'* need to respect them, may appear 'foreign' and risks increasing the rift. Promoting loving communication and attention, including through small, 'mundane' acts of practical care (e.g. covering up a shivering woman) could be a more contextually relevant and effective way to improve relationships and care. However, Bohren et al.'s (2017) systematic review found that labor support provided by non-staff was more beneficial. When resources are short, and midwife-women relationships are fraught, guardians may be better placed to provide practical and emotional support. We have however noted risks and limits to their advocacy, and guardians too, may engage in abusive care, as de Kok (2019) found in her ethnographic study in Malawi. Thus, how labor support is best provided in low income settings, and by whom, requires further investigation (Bohren et al. 2017).

Enhancing mutual understanding, including of the circumstances in which women labor and nurse-midwives work, will be key to improving trust. Since communication can improve both understanding and trust (Sripad et al., 2018), it seems essential for closing the 'gap' between women and nurse-midwives. Carson (2002, p. 178), citing Charles Taylor, notes how

speaking constitutes relationships, and “creates the kinds of footing we can be on with each other”. Our findings confirm that nurse-midwives require communication training in aspects underscored by the RMC agenda and the WHO (2016, 2018) maternity care guidelines, like abstaining from verbal abuse, providing clear explanations, addressing patient concerns and preferences. In addition, nurse-midwives could be trained to acknowledge and elicit women’s bodily knowledge by being with, monitoring and listening to them. Women too, could be trained for instance in voicing concerns (Sripad et al. 2017). The lack of specificity in nurse-midwives’ accounts of respectful communication underscores its ephemeral quality. High quality communication training is required, including concrete exercises and ongoing supportive supervision by qualified staff. Such training requires serious investment and thought and should be paired with other interventions geared towards improving midwife-client-guardian relationships. The RMC intervention project in which this study was embedded used citizen hearings to bring providers and clients together, but it is unknown whether these indeed improve relationships. There is evidence that maternity open days can successfully build provider-client relationships at low cost (Warren et al., 2017). Yet, effects of interventions seeking to build trust will be modest and slow: trust is shaped by the broader social context, marked in settings like Malawi by a generalized distrust in public institutions and pervasive class and gender-based power differentials (Sripad et al., 2017).

Any intervention should avoid treating substandard care as a problem of individual nurse-midwives’ attitudes or behaviors; this likely increases their frustration and the rift between women and nurse-midwives. Rather, campaigns and interventions should address structural drivers and show appreciation for nurse-midwives. As Hunter (2006) argued in the UK context, mechanistic care might be a self-protective strategy in emotionally difficult situations. Hence, behaviour change training is bound to fail unless nurse-midwives’ emotional, financial

and practical needs are also addressed. New women- and rights-centered paradigms and policies have changed expectations regarding midwife-client relationships, now supposed to be partnerships (see also Hunter 2006). This requires emotional labor from nurse-midwives, expected to invest in exhibiting appropriate emotions (Hochschild, 1983), and smile and greet, despite difficult work circumstances. By increasing demands, paradigm shifts likely enhance frustration, reducing job satisfaction, and, ironically, quality of care. We cannot ask more of nurse-midwives without ensuring that they work in a more enabling environment in terms of physical, financial and human resources, including social aspects (positive team dynamics, fair systems of accountability, supportive supervision).

Strengths, limitations and further research

Virtually all interviews and FGDs were conducted at health facilities. This was necessary given limited time and resources, but may have constrained participants' perceived ability to decline participation and their openness. Participants volunteered plenty of critical accounts of care, but more so in the guardians' focus groups than in individual interviews with women. The two interviews conducted at a respondents' home were particularly in-depth and critical. For future studies, we recommend conducting more interviews off-site, long term engagement to build rapport, and use of a greater range of participatory methods, such as diaries or photovoice to obtain more varied and in-depth insights.

Although challenging to coordinate schedules to complete the analysis across locations and countries, team-ethnography enabled us to collect a rich and varied data set in a relatively short time. Observations and multi-disciplinary team-analysis led to more holistic and in-depth insights into the way RMC is conceptualized and practiced in facilities in central Malawi. Due to the value-laden nature of the research topic (respectful care), socially desirable responses were likely, making assessment of what people do as well as say pertinent. Of course, nurse-

midwives also adapted their behaviors to observers, but they could not continuously do this, and our Malawian midwife team-member could identify practices seemingly unrepresentative. Furthermore, whilst the midwifery team-members could identify clinical rationales and midwifery paradigms underpinning practices, the social scientists prevented an overly narrow focus on clinical adequacy. Nevertheless, we could have achieved greater depth still if we had more time to build rapport, engage in joint team reflections and focus interview questions and observations on themes identified in preliminary analysis.

Conclusion

In this article, we explored how nurse-midwives, women and guardians conceptualize good, respectful and disrespectful care, and how they enact these care ideals. We identified two disconnects, between the global RMC agenda and local priorities, and between nurse-midwives and women and their guardians. RMC and other quality improvement initiatives, usually donor funded and conceptualized in ‘Northern’ settings, should employ language and concepts aligned with local realities. They also need to close the gap between nurse-midwives and women. Rather than blaming nurse-midwives for not upholding women’s right to respectful care, we should frame disrespectful care as a problem of fraught relationships and mutual distrust produced by a hierarchical context and disabling environment. It seems unlikely that RMC initiatives promoting *women’s* rights and *nurse-midwives’* accountability lead to more positive, trusting and collaborative relationships. Women *and* nurse-midwives require care and attention. Emphasis should shift from women-centered to collaborative care, and from promoting women’s rights to fostering relationships and addressing the rights and needs of all actors involved.

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