DISRESPECT AND ABUSE OF WOMEN DURING MATERNITY CARE IN SUB- SAHARAN AFRICA: SYSTEMATIC REVIEW

MASTERS OF SCIENCE (GLOBAL HEALTH IMPLEMENTATION) THESIS

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Disrespect and Abuse of Women During Maternity Care in Sub- Saharan Africa: Systematic Review

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DECLARATION

I declare that this is my original work which l have not submitted to any institution, and that l took into consideration to acknowledge other people's work that has been used in this thesis.

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ABSTRACT

A systematic review of studies seeking to determine the factors that contribute to disrespect and abuse of women and the effects of disrespect and abuse of women during maternity care Published between January 2015 and March 2021 was conducted through the following databases; PubMed, Google scholar, African Journal Online (AJO), Cochrane library. After searches, 8974 studies were retrieved, after the screening of the studies only 16 studies met the inclusion criteria and were used in this review. The studies were from 11 countries. Using the Critical Appraisal Skills Program (CASP) quality analysis tool, 81.25 % (n = 13) of the studies were of high quality, 18.75% (n = 3) were of moderate quality and no studies were graded as low quality. Factors of abusive maternity care were categorized into three main groups for more straightforward explanation and system failure was identified as the driver of most abuse factors. If the system or the organisation is not functioning well, it affects the service provider and the recipient of care. Disrespectful maternity care affects women differently with some opting not to utilize health facilities for either antenatal care or delivery, exposing the health of both the mother and the baby to pregnancy and birth complications. This review has identified system failure as the most contributing factor to disrespectful maternity care, including some fee provider and client-driven factors. Disrespectful maternity care exposes women and their unborn babies to pregnancy and childbirth complications and contributes to increased maternal and neonatal morbidity and mortality. Some strategies to prevent and reduce disrespectful maternity care; were identified and were used in other countries with positive results.

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ABBREVIATIONS

AJOL	African Journal Online
ANC	Antenatal care
CASP	Critical Appraisal Skills Program
COMREC	College of Medicine Research and Ethics Committee
PNC	Postnatal care
WHO	World health Organisation
WRA	White Ribbon Alliance

OPERATIONAL DEFINITIONS

Abuse or obstetric violence - neglect, physical abuse and lack of respect during childbirth

Disrespect - deviation from the right to health presents a dilemma

Maternity service – this is care provided to women, babies and families throughout the whole pregnancy, during labour and birth and after birth for up to six weeks.

Mistreatment – violation of women's rights to information, consented care and confidential care, verbal and physical abuse.

Physical abuse - refers to women being mistreated like pushed, beaten, slapped, pinched, physically restrained or gagged when they are delivered in the health facility

Quality of care – according to World Health Organisation, is the extent of services provided by the health care system to individuals and populations to improve desired health outcomes

Respectful maternity care - care organised and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensuring freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth.

Safe - free from harm

Safe motherhood - ensuring that women have access to the information and services they need to go safely through pregnancy and childbirth

Verbal abuse – refers to scolding, insulting, threatening or talking to women rudely.

CHAPTER ONE: INTRODUCTION AND OBJECTIVES OF THE STUDY

1.1 Background

According to Miller, generally, global women suffer at least some form of disrespect and/or abuse when seeking maternity care services, primarily in the hands of doctors and nurses. Disrespect and abuse of women during maternity services violates women's fundamental human rights and, therefore, should be taken into serious consideration [1].

They suffer different forms of disrespect and abuse from health care providers and therefore there is a need to address the associated factors and effects to come up with effective strategies to address them and alleviate these suffering women endure. According to McMahon et al.[2], some women resort to not protesting to abuse but instead use non-confrontational strategies like returning home or bypassing certain facilities and providers associated with disrespectful maternity care.

A statement by World Health Organisation highlighted that abuse of women is not a new occurrence in sub-Saharan Africa, and there is need to find ways to stop it. Women's health and rights advocates have for a long time complained of poor treatment of women during maternity care, especially for poor and marginalized women. According statement by World Health Organisation, cited in by Sethi "pregnant women have a right to be equal in dignity, to be free to seek, receive and impart information, to be free from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health"[3].

Different studies and observations from experts in maternal health have shown that abuse and disrespect of women in maternity units are traumatizing to women, and it leads to their choice of place of care, some women opting to deliver in the comfort of their home where they are treated with respect and dignity despite being attended to by non-experts [4].

Women are encouraged to seek care and give birth in health facilities with skilled personnel for early detection and prevention of complications of pregnancy and childbirth. Respectful maternity care and a conducive environment make women and their family to be attracted to health facilities and have the confidence to seek care in health facilities. There are many reported and unreported cases of disrespect and abuse of women and their families during maternity care. This has become one of the contributing factors none utilization of maternal health services leading to an increase in pregnancy and childbirth complications and increased maternal morbidity and

mortality. Women need to be empowered so that they can identify disrespectful maternity care as such and gain the confidence to speak out.

1.2 Literature Review

According to Fulani [5], there is need to look into the adverse effects and factors that contribute to disrespect and abuse of women to come up with strategies to promote and improve respectful maternity care. This will help improve utilization of public and private maternal health facilities for maternity care and support in early detection and prevention of avoidable maternal and neonatal complications during pregnancy, labour and puerperium.

Safe motherhood is an essential key during pregnancy and childbirth; therefore, mothers need skilled care and all the respect they deserve. According to a guide on respectful maternity care by White Ribbon Alliance 2011, safe motherhood encompasses both physical safety and maintenance of the women's respect and dignity.

Disrespectful maternity care is becoming an issue of concern that need serious consideration to ensure that respectful maternity care. Women need to be empowered to identify and act in case of abusive treatment. Some studies noted that some women and some health workers take physical and verbal abuse during childbirth as a form of discipline and tend to normalize it.

1.2.1 Factors contributing to disrespect and abuse of women

There are various factors that were highlighted in different studies as contributory factors to disrespect and abuse of women during childbirth, some of the identified causes of abuse; frustrated health personnel as a result of burnout syndrome resulting from chronic stress, governing of the health system, women's level of education, age, parity and problems of the health system.

Warren et al.[6] , grouped contributing factors into categories; policy and governing of the system, problems of the health systems, client and community factors. The authors identified; failure to enforce policies, health systems that are not running smoothly, and normalization of mistreatment by some women and other communities especially in sub-Saharan Africa where is it thought as a form of discipline to women so that they do not jeopardize the baby's condition, especially during labour.

In addition to the above factors, a study by Fulani [5] further identified the following routine behaviour in certain facilities; lack of accountability, staff attitudes, shortage of resources leading to frustration of the health worker, and women's level of empowerment as some of the contributors to mistreatment.

Bobo et al.[7] in their study carried out in Ethiopia, highlighted the following as some of the issues that led to mistreatment of women; lack of an escort/companion during maternity care who usually acts as an advocate for the woman, poverty and residential area with those from rural areas being at higher risk of abuse. Among all these issues, Bobo et.al highlighted that non-consented care was the highest form of mistreatment women suffered.

1.2.2 Effects of disrespect and abuse of women during maternity care

When women are pregnant or in labour, they suffer a number of physiological and psychological changes that may affect their behaviour and understanding and at this stage they need a loving and understanding health personnel as disrespect and child birth may aggravate their problems and lead to permanent damage for some women. They therefore need love and patience.

Martin [8], in her study explained that women got worried and felt uncomfortable when midwives did not explain their progress of labour and those midwives who took their time to explain procedures to mothers were considered confident and giving hope to the women which made them feel confident and relaxed. If midwives explained procedures and the labour progress it boosted the women's confidence and encouraged them to face the challenges of childbirth in a calm state and they felt safe in the hands of such healthcare providers [9].

Communication helped mothers to feel empowered and free to decide on their care. According to a study in done by Balde et al.[10], abusive treatment like application of fundal pressure, made women feel unworthy and incapable. In this study it is also highlighted that, abusive maternity care created some form of attitudes towards health care workers and labelling every as bad. Some women have developed attitudes towards utilization of certain health care facilities due to fear of being abused, preference of male midwives even if cultural it maybe not proper for some women because male midwives were said to be polite and calm, feeling of neglect especially in cases of abandonment, unhappy and discontent.

Abuya's results were similar to those identified by other authors that women feel safe, respected, have their dignity maintained when provided with quality care and given opportunity to decide own their health. This motivated them to trust caregivers and willingness to use same health facilities with their subsequent pregnancies.

Abuya [11], stated that mistreatment of mothers during delivery is one of the barriers to mothers seeking skilled birth attendance use as they felt that their dignity is compromised.

1.3 Conceptual framework

The WHO framework for the quality of maternal and new-born health care's two domains help in the explanation of care given to women and how it can be perceived by consumers.

Provision of care and Experience of care are the two domains, that can explain how and what type of care women are receiving and how women and providers perceive the care. For example, in some studies, midwives felt slapping or shouting at a woman they perceived difficult is not bad but is for the benefit of helping her behave and deliver a healthy baby and some women and elderly relatives accept it as a way of discipline. In some institution's episiotomy is performed routinely to every prim gravid as a way of increasing the outlet which is not proper but because women do not know they accept it. In most circumstances' women do not ask questions or challenge the care they are offered because in the first place there is no communication on what type of care they are supposed to receive. There is little or and at sometimes no communication at all between service providers and women living women blank on what is right and wrong on what is being offered to them or they may expect more than what they should receive.

According to the World Health Organisation's framework, women's experience of care is an important aspect of clinical care. Care offered without respect cannot be quality care no matter what service offered as long as there is no respect; it is not quality care.The twelve domains of respectful maternity care incorporated in the care of women during childbirth to ensure quality care and prevention of childbirth complications.

1.4 Justification of the study

According to Bohren et al.[2], countries with high maternal mortality rates are mostly those where women avoid visiting facilities for maternity care due to fear of disrespect and abusive experiences.

In sub-Saharan Africa maternal and neonatal mortality rates remain higher compared to the rest of the world because most women chose to deliver at home disrespect and abuse as one of the reasons for their choice. Home deliveries pose a threat to women's health and life, as this has direct and indirect effects on maternal and neonatal complications and to achieve the global community desire to decreasing the

globally maternal mortality ratio to less than 70 deaths per 100,000 live births by 2030, there is a need to avail favourable environment in public health facilities which will attract women to the facilities, thereby increasing utilization of health facilities thereby reducing maternal mortality rates [12,13].

This study will help avail evidence on factors that contribute to disrespect and abuse of women during maternity care and the effects of abuse in sub-Saharan Africa and finding a collective way of reducing this problem to reduce maternal and neonatal mortality rates in sub-Saharan Africa.

1.5 Objectives of the study

1.5.1 Broad objective

This study aims to determine the factors and effects of mistreatment of women during childbirth in sub-Saharan Africa.

1.5.2 Specific objectives

To determine the factors contributing to disrespect and abuse of women during antenatal, labour and postnatal care. To define the effects of disrespect and abuse of women during maternity care.

To evaluate successful strategies other countries have employed in implementing respectful maternity care.

1.6 Research Questions

What are the contributory factors to disrespect and abuse of women during antenatal, labour and postnatal care?

What are the effects of disrespect and abuse of women during antenatal, labour and postnatal care?

What strategies have other countries used to ensure the implementation of respectful maternity?

CHAPTER TWO: METHODOLOGY

2.1 Type of research study

A systematic review was conducted using already published articles of studies conducted in sub-Saharan Africa (South Africa, Botswana, Zambia and Zimbabwe), and the Preferred Reporting Items and Meta-Analysis (PRISMA) protocol was followed in this review.

2.2 Study area

Sub- Saharan Africa is a geographical region in Africa that lays on the southern side of the Saharan desert and is composed about 46 countries. The region that faces economic challenges and some of the countries in this region are the poorest in the whole world. After article selections using the Critical Appraisal Skills Program (CASP) quality assessment tool, studies that remained for use in this review were from few countries covering three regions of sub-Saharan Africa and three countries in each region. There is a lot of documented and undocumented information on disrespectful maternity care in this region's public and private health facilities. The research seeks to determine the factors and effects of disrespect and abuse of women during childbirth in the region.

Over the past decades, home deliveries in sub-Saharan countries had a higher proportion than facility deliveries with the assistance of a skilled provider, but facility-based deliveries have increased. Some studies have revealed that a study done in Tanzania has shown that over 44% in 1999 was a percentage of facility deliveries with the assistance of skilled providers, and from 2015 to 2016; it has increased by 63%. Poor quality of care during childbirth has been associated with these differences [14]. According to the Demographic Health Survey in Malawi, skilled birth attendances have increased from 55 % in the past decade to 91%, there is a need to ensure the women receive all the respect they need so that they can be motivated to deliver in health facilities [15].

2.3 Study population

Women of childbearing age have either delivered or attended Ante-natal-care (ANC) or post-natal care (PNC) services in health facilities irrespective of parity.

2.4 Types of interventions

Exit interviews were effective in identification of women’s experience of respectful care and reduce abuse during maternity care, Training midwives on respectful

maternity care and incorporating respectful maternity care into the midwifery curriculum.

2.5 Types of outcomes measures

2.5.1 Primary outcomes

The review intended to highlight the benefits of utilization of health facilities as it reflects mothers' confidence in health care providers and services offered.

Women's experience of care was one of the evaluating methods during the review on factors leading to disrespect [14].

2.5.2 Secondary outcomes

According to Megersa [16], besides having different variables that contribute to reduced complications of pregnancy, labour and puerperium, if mothers are treated with respect and dignity, these complications can be reduced as mothers will be seeking skilled attendance during maternity care and help in reduction of maternal and neonatal morbidity and mortality.

2.6 Search strategy

A list of narrow and broad terms and keywords; were used to search for relevant articles published from January 2015 to March 2021, retrieval follows up and return of other cited articles was done. (extent, degree, factors, causes, barriers to respectful maternity care, effects, consequences, outcomes, impact, determinants, maternity services, during pregnancy, ANC, PNC, childbirth, disrespectful maternity care, respectful maternity care, abuse, obstetric violence, mothers, women, developing countries, sub-Saharan Africa). The terms were listed multiple times to ensure retrieval of many studies and the Boolean commands were used to join key word until more articles were retrieved.

2.7 Information source

All studies thoroughly screened with the assistance of colleagues to identify relevant studies that address factors leading to disrespect and abuse of women and the effects of disrespectful maternity care. The search engines used were to retrieved articles published on issues of disrespectful maternity care from the following search engines PubMed, Google Scholar, African Journals Online (AJO), and Cochrane library and further screened according to inclusion criteria to ensure use of correct studies.

2.8 Search limits

The literature search was restricted to the study inclusion criteria, and written in English. Grey literature such as technical reports and web-based guidelines were

included in this review. Studies published between January 2015 and March 2021, the period was chosen to utilize up-to-date evidence on the topic. Articles screened according to search strategy using the inclusion and exclusion criteria to ensure the selection of correct studies.

2.9 Subject area

The searches were restricted to maternal and neonatal health.

2.10 Inclusion criteria

2.10.1 Population

The study focused on women of childbearing age, who have received maternity care during the antenatal period, labour, and puerperium in sub-Saharan Africa as the target population. In the study, sub-Saharan Africa referred to Botswana, South Africa, Zambia and Zimbabwe.

2.10.2 Intervention

Among the studies that were reviewed exit interviews were used to find out about women's experience of respectful care and reduction of abuse during maternity care, Training midwives on respectful maternity care and incorporating respectful maternity care into the midwifery curriculum. It becomes an intervention when health personnel's behaviors towards mothers change due to training on respectful maternity care. Respectful maternity care trainings conducted in other countries using workshops and in-services training and adding it in midwifery curricula, training them to ensure they treat women well during maternity care [4].

Some studies, like a study done in Ethiopia by Asefa et.al, on lessons learned through 4-hour respectful maternity care training also mentioned these trainings.

Use of evidence-based practices for routine care management of complications

Actionable information systems will improve communication skills, availability of resources and avoid unnecessary delays in treating or referring women during maternity

care [4].

Functional referral systems help health facilities and midwives to refer women to next facilities of care on time and avoid unnecessary delays in care.

Effective communication if the system has effective communication methods were mothers are free to air their views and report any forms of abuse without fear, it will help midwives improve their quality of care.

Respect and preservation of the women's dignity is an important aspect of every mother

and midwives should be aware of that and improve their behaviour towards women during maternity care.

Offering emotional support during labour should be part of the skills a midwife should possess because ignoring a woman who is in pain, or use of offensive language is abuse.

Support visits are essential parts of maternity care to ensure that women do not suffer unnecessary complications.

Bettering salaries of midwives and doctors will boost their moral leading to improve care of their clients.

2.10.3 Comparison

None

2.10.4 Outcome Primary outcomes

Women's experiences of care.

The utilization of public health facilities and confidence in healthcare providers

2.10.5 Secondary outcomes

Reduction of maternal and neonatal morbidity and mortality

2.10.6 Type of studies to be included

Qualitative and quantitative studies carried out in sub-Saharan Africa from January 2015 to March 2021 that answered the research question were included in this study. All publications in sub-Saharan Africa from January 2015 to March 2021 that answer the research question were included in this study. All used publications were in English as the researcher could not and did not have translation skills. All studies whose study participants were women of childbearing age who have had or witnessed mistreatment during pregnancy, labour and the puerperium period as study participants were part of the inclusion criteria.

2.11 Exclusion criteria

2.11.1 Population

Studies that did not involve women of child bearing age (14 to 49years) and done outside sub-Saharan Africa.

2.11.2 Type of studies to be excluded

Studies not done in sub-Saharan Africa and published before January 2015 and beyond March 2021, did not use women as participants and written in any other language not English were not part of this study.

CHAPTER THREE: RESULTS

3.1 Introduction

The chapter is a presentation of results on factors and effects of disrespect and abuse of women during maternity in sub-Saharan and strategies that other countries used to reduce disrespect during maternity care from the information deduced from the studies done in sub-Saharan Africa on disrespect and abuse of women during maternity care.

3.2 Results

Searching through African journal online (AJO), PubMed, Cochrane Library and Google Scholar led to retrieval of 8974 articles. Using Mendeley referencing application 4693 duplicates were removed. The remaining 4251 articles were assessed for eligibility using the inclusion and exclusion criteria, this led to exclusion of 4239 articles and 42 articles remained,3 abstracts were removed and 39 full articles remained for a thorough assessment of which 23 fell in the exclusion criteria. The remaining 16 articles were used in this review as they met the inclusion criteria by answering issues to do with factors that contribute to disrespect and abuse of women during maternity, and effects of abuse and how they can be reduced see Figure 1 for the study selection process.

3.3 Included articles

The articles included in this study used different study designs, 43.8% (n=7) of the included articles used cross-sectional research design, 50% (n=8) used qualitative research design, and 6.2% (n =1) article used quantitative study design. The study by Matatji and Siphiwe [17] had were more specific to the review and study sort to explore the experiences and examining the outcomes and at least tried covering all the three questions of the review: factors, effects, disrespect and abuse during childbirth in midwives-led obstetric units in South Africa. Four [7,19–20]of the studies had information on both effects and factors of disrespect that lead to mistreatment of women during maternity care. Seven[17,19–23] studies had information that at and some strategies which the researcher could pick up. Three[25–27] had results on factors only clearly laid out, one study had information on characteristics and strategies only, and the two had results on effects only.

Studies included in this review were from different countries; Ethiopia, Malawi, Mozambique, Tanzania, Zambia, South Africa, Kenya, Nigeria, Guinea, and Ghana and were conducted in rural and health facilities see Table 1.

3.4 Quality Assessment

The researcher took and used Critical Appraisal Skills Program CASP [29] assessment tool to assess all studies in this review. The assessment focused on the following areas: aim, methodology, study design, recruitment strategy used, data collection and data analysis methods, ethical considerations if they were taken care of, contributions of the study and any recommendations. The studies were graded high, moderate or low quality using the Critical Assessment Skills Programme assessment tool scores.

3.5 Factors contributing to abuse

Thirteen selected studies identified some factors [29–41] that contribute to abuse of women during maternity care. The factors contributing to disrespect and abuse of women during maternity care listed in three categories for easy explanation: factors due to system or organization failure, health care provider factors and clients/ patients' factors. System failure factors trigger some of the individual and health care provider factors, see Table 2.

3.6 Effects of disrespect and Abuse

Effects of disrespect and abuse of women during childbirth emerged in eleven articles, primarily identified through women's expressions of their feelings and encounters while seeking maternity care. Several effects of disrespect and abuse were identified; risk of maternal and neonatal complications, failure of utilization of health facilities, loss of trust in health workers, feeling of embarrassment, stress and mental problems, feeling of being alone and isolated and delivering alone without help. Most studies were concentrating on the types of abusive care women encounter during childbirth except for one study by Auma in Kenya which had a specific aim that looked into effects of disrespect and abuse of women seeking ANC in Nairobi.

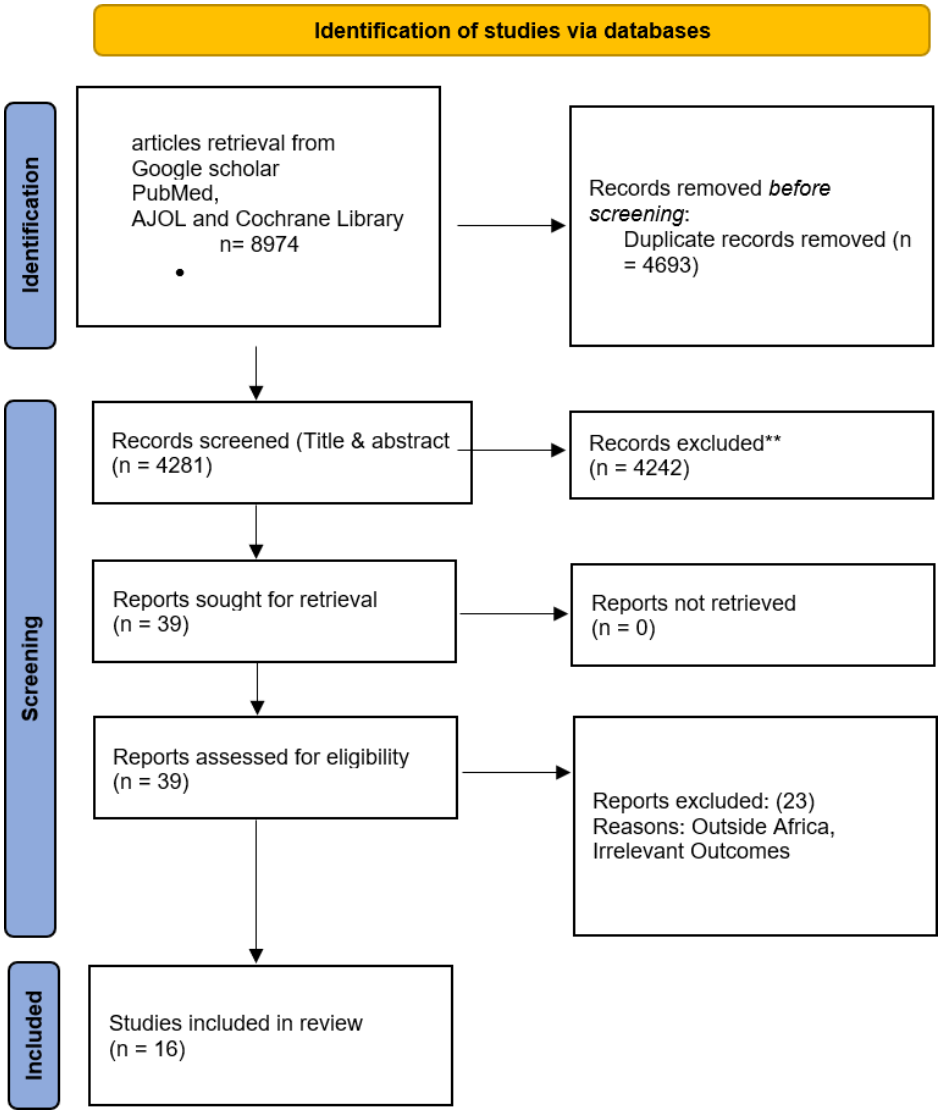

Figure 1: PRISMA Flow Chart of study identification & selection

3.7 Strategies

Findings from nine among the selected studies of this review showed that some health facilities have tried different strategies to prevent or tried to reduce disrespect and mistreatment of women during childbirth [30,32,33,35,37,38,40,42,43]. There is a study by Manaharlal [41] that used two interventions; respectful maternity care (RMC) workshop and Open-birth days, which included participatory health education sessions and touring of the facility by all women who attended antenatal care at the facility during their third trimester for them to familiarize with the environment. Disrespect and abuse of women by staff was reduced from 70% before RMC workshops to 18% after training on RMC. Selected studies identified different strategies that could help stop disrespectful maternity care, which were used in some countries with positive

results; Examples were Respectful Maternity Care (RMC) training, workshops, community empowerment, improving infrastructure to make it conducive to offering privacy, availing both human and material resources and increasing salaries, supportive leadership and changing organization cultures for the better.

Table 1: Characteristics of selected studies

Year	Author	Country	Study setting	Study design	Approach	participants	Factors	Effects	Strategies	Aim	CASP quality grading
2017 [1]	Alex Stuwart Chimseu and colleagues	Malawi	Health facility	Quantitative	Questionnaire	40	Staff attitudes Poor practices	Maternal and child complications Failure in utilization of maternal services Increase in maternal morbidity		To determine the attitudes and practices of midwives during labour at Bwaila District hospital	High quality

								and mortality			
2021 [2]	Megersa, Hirut Paul', St Lindahl, Anne Karin	Ethiopia	Urban training hospital	Qualitative	Focus group discussions -Individual interviews	86	Scarcity of equipment Lack of supportive supervision Wastage of supplies [bed linen cut to pack instruments]		Supervision of how mothers are treated -Good attitudes, knowledge and skills -Patients empowerment on their rights and responsibilities -Availing enough human resources	To explore women, experience of disrespect and abuse in one of tertiary teaching hospitals in southwest part of Ethiopia	High quality

2016 [3]	Meghan A. Bohren A	Nigeria	Health facility	mixed-methods	Focus group discussions In-depth interviews			Accepting abuse when done for good intention -Abuse has serious public health and human rights implications -Feeling of abandonment and neglect		To explore how women are mistreated during childbirth in Nigeria	High quality
2018 [4]	Gertrude S. Avortri and Lebitsi M. Modiba	Ghana	Health facility	Qualitative	Audiotaped semi-structured interviews	15	Agitation Disobedient/ uncooperative/unruly women Belief that slapping will make a woman		Improve staff attitude Promoting open communication	To investigate women's perceptions about the factors that	High quality

							cooperative -Age -Acceptance of abuse Women not knowing their rights			hinders or facilitates the provision of quality childbirth services in Ghana's health care services to guide improvement efforts	
2019 [5]	Teshome Gebreamanuel BIrhane	Ethiopia [Addis Ababa]	Health facility	cross–sectional	Structured face to face interview Questionnaire	319	Lack of supervision Policies Normalization of abuse Ineffective communication Female providers Night deliveries Lack of companion			To assess magnitude of disrespect and abuse faced by women during facility-	High quality

							Lack of empathy by health worker Workload and dissatisfaction by midwives			based children	

Table 2: Characteristics of selected studies

Year	Author	Country	Study setting	Study design	Approach	participants	Factors	Effects	Strategies	Aim	CASP quality
2018 [6]	Mengistu Welday Gebremichael and colleagues	Ethiopia	Rural and urban health facilities	Community-based cross-sectional study	Interviewer-administered questionnaire	1125	Residential area Level of education Being head of family Duration of labour	Life threatening complications Increased mortality and morbidity rates Increase in perinatal mortality rate	Availing resources Improving infrastructure	To assess the extent of factors associated with disrespectful and abusive maternity care reported by mothers who utilized facility-based services in Northern	Moderate quality

										Ethiopia	
2019 [7]	Firew Tekle Bobo and colleagues	Ethiopia	Public health facilities	facility-based cross-sectional study was	Exit interviews	612	- Lack of companion -Age -Marital status -Occupation -Residential area -Parity -Time of delivery -Sex of provider -Poor working environment -Burnout syndrome -Frustration	Failure to use health care facilities during subsequent deliveries Increased chances of maternal mortality and morbidity Lack of community governance in health care Poor motivation due to burnout		to examine the prevalence and associated predictors of Disrespect and Abuse as reported by women during labour and delivery in public health facilities of western Oromia region in South-	High quality

								syndrome Poor remuneration		western Ethiopia	
2019 [8]	Wubetu Yonas Azanow	Ethiopia	Urban facility	Institution-based cross-sectional study	Interviewer-administered structured questionnaire	412	Lack of companion Time of delivery Woman's level of education Number of ANC visits Lack of communication - Ignorance of ethical principles by providers		-Allowing companions during care - Educating women	To assess the proportion of respectful delivery care and associated factors among women delivering in Debre Berhan town public health facilities	High quality

Year	Author	Country	Study setting	Study design	Approach	participants	Factors	Effects	Strategies	Aim	CASP quality grading
2019 [9]	Judith Auma Kibuye A	Kenya [Nairobi]	Health facilities	Cross – sectional survey	Structured questionnaires	111	Shortage of resources Ethnicity Age Education status Workload Poor communication Demoralizing atmosphere Socio-economic status	Poor birth outcomes Stress and mental problems Nosocomial infections due to unconducive environment Increase in mortality rates Lack of trust and fear of future pregnancies Life-		To assess the effects of disrespect and abuse on women seeking ANC services at JOOTRH	High quality

								threatening complications Discontinuation of ANC or total avoidance of ANC visits Risk of complications Changing health facility			
2017 [10]	Mamadou Diouldé Balde and colleagues	Guinea	Health facilities	qualitative methods	In-depth interviews Focus group discussions	48	Lack of cooperation from women Failure to pay bribe Staff attitudes Insufficient training	Feeling embarrassed and humiliated	Increasing competent staff Training and sensitization of staff on disrespectful maternity care	To explore the perceptions and experiences of mistreatment during childbirth, from the perspectives of women	High quality

										and service providers	
2016 [11]	Hannah L. Ratcliffe and colleagues	Tanzania	Health facility	Direct observation Baseline assessment	Open birth day Workshop	362	Lack of empowerment Provider attitudes Poor communication and interaction between providers and patients		Open Birth Day session RMC Workshop	to improve women's comfort with the facility and increase birth preparedness by facilitating communication with providers and providing a step-by-step guide to what to expect when they arrive at the facility for	Moderate quality

										delivery	
2020 [12]	Anna Galle and colleagues	Mozambi que	Health facility	cross sectional descriptive survey	Exit-interviews	572	Age Lack of companion Place of delivery	Maternal and neo natal complications	Labor companions Ensuring privacy by having one patient per labor room Adhering to Respectful Maternity Care Charter Supervision and control mechanisms	To explore the experience of women giving birth in hospital in different settings in Maputo City and Province, Mozambique	High quality
2020 [13]	Malatji, Refilwe Madiba, Sphiwe	South Africa	Health facility	exploratory qualitative study	interviews and FGDs	36	Considering disrespect and abuse to be justifiable	Complications of both the baby and mother if they	Training on respectful care Change in attitude	To explore the experiences and examine the outcomes	High quality

							Attitudes and behaviours of midwives Lack of birth companion lack of information during childbirth failure to recognize women's rights to privacy	need immediate care. Barriers to accessing healthcare in time.	Strengthening of the professional ethics training of midwives Embedding humane clinical care into routine birthing care	of disrespect and abuse during childbirth in midwifery led obstetric units.	

Table 3: Characteristics of selected studies continued

Year	Author	Country	Study setting	Study design	Approach	participants	Factors	Effects	Strategies	Aim	CASP quality grading
2019 [14]	Yasmin Jolly and colleagues	Malawi	Health facility	qualitative study	Focus group discussions In-depth interviews, Key-informant interviews	73	Staff attitude Lack of resources Poor communication lack of privacy staff shortages Lack of commitment Lack of autonomy in women to speak out about their care	Delivering without assistance	-Educational talks and counselling sessions, Care givers receive regular updates to improve their knowledge of evidence-based care/ Appropriate training to improve their skills, need for	To explore knowledge and understanding of the seven domains of the RMC Charter among healthcare providers and to explore women's percep tions regarding respe ctful maternity	High quality

									professional development portfolios for maternity care providers to ensure critical self- reflection and help instil gradual positive change in health care providers -Empowering women through community mobilization for respectful maternity care rights, advocacy and	care	

									dissemination of information and education regarding maternal health		
2020 [15]	Jana Smith and colleagues	Zambia	Health facility	Qualitative study	Audio recorded in- depth interviews Observation	46	Belief that cost of disrespect and abuse outweigh benefits Failure of mothers to follow instructions Consumption of herbs Delay in reporting to facility for care	Delay in reporting to health facility Consumption of herbs		To understand the behavioural drivers of disrespect and abuse and to develop solutions with health workers and women that improve the experience of care during delivery in Zambia.	High Quality

2018 [16]	Jaki Lambert and colleagues	South Africa	Health facilities	descriptive phenomenological	In-depth interviews Focus group discussions Key informant interviews	82	Shortage of staff Shortage of supplies. Lack of leadership support and supportive caring by leaders at the workplace Lack of conducive working environment for both health care providers and women Attitude of midwives	Feeling of being alone and isolated Delivering alone Hurt by insults Feeling embarrassed Reporting late in hospital already in advanced labour	Having in place respected clinical leadership, mentoring and role models Promoting the role of the midwife as compassionate career and advocate Promoting and facilitating the role and responsibilities of a companion for women during labour with internal monitoring and	To explore experiences of care during labor and birth from the perspectives of both the healthcare provider and women receiving	Moderate Quality

									audit. Community awareness in terms of how the system functions and the services the institution can offer Ensuring enough resources		

CHAPTER FOUR: DISCUSSION

4.1 Discussion

The researcher categorized the identified factors into three major groups: factors due to system or organization failure, health care provider, and client/patient factors. When it comes to disrespect and abuse of women during maternity care, the health care providers are at the forefront, yet system failure[25] is a major contributory factor. Rules, regulations, and policies of the health system to be used to monitor the conduct of health care providers during maternity care and the type of care they give to women and act accordingly when abusive workers are compromising care. If supervisors and senior managers are relaxed [25], everything in the system will collapse.

Failure of the system to reinforce policies, failure to follow statutory instruments or code of conduct documents to control the operating of the system and guide workers on proper conduct encourages people to behave the way they want at the expense of mothers. This is why issues like midwives slapping women, insulting them, asking for bribes, segregating patients according to ethnicity, parity, and education age, booking status and sleeping on duty and ignoring mothers till they deliver alone without help [7,24–27]. All these are a result of system failure, which becomes a significant driver of some individual and health care provider factors; if the system is not functioning well, somehow it will affect the service provider and the recipient of the care. Unfortunately, when it comes to disrespectful maternity care, researches concentrate more on the caregiver's shortcomings, and forget that the operating and performance of the system affect everyone.

The other big problem is the African culture, which treats women like children who need to be controlled and guided by their husbands or in-laws and the same make decisions for them when it comes to helping care seeking. Cultural even traditional midwives used to torture women during childbirth. For example, if the woman experienced obstructed labor, she would be tortured by the traditional midwives, and asked mention sleeping with other than the husband, this was believed to be the reason for the baby not coming out; they even received slaps during labor if they misbehaved. This enculturation has caused the majority of African communities to normalize abusive behaviors like slapping, pinching and shouting during childbirth if the woman fails to follow instructions. Therefore, most of the women take such abusive behavior as normal as long as it was for a good reason. In such cases, even if women suffer abusive care, they do not see the reason for reporting it.

Health care providers seemed to take women for granted and forget that they are not manicures/models but human beings who need to be informed of every decision taken about their health; they felt that if given feedback and involved in their care, they will understand some actions taken by health workers. In one of the studies, a woman mentioned that for her to cooperate, she needed an explanation of every procedure performed on her, but instead health care providers just shared information concerning her among themselves without involving her; she felt like her privacy was being invaded. Community empowerment on how the health system functions, especially on what to expect and client's rights, was identified as one of the strategies that could reduce or prevent disrespect and abuse of women during maternity care. One of the studies mentioned that it helped empowering the community through community [16,22]groups, media and political leaders to give information to the community. The issues of referral protocols, user fees, who is expected to pay and who is not, all requirements so that when mothers visit the hospital, they know what to expect and what happens if referral protocols are not followed so that they are aware of how the system functions and why.

Availing both human and material resources to ensure a conducive environment for health care providers and women is another way of reducing disrespect and abuse. The issues be addressed were; staff remuneration and ensuring enough resources to help boost staff morale and in [10,22,23]crease their zeal to work and perform well. In one of the studies [22] that used both women and caregivers as participants, one of the caregivers said '*we are only four here and expected to manage ten delivery rooms, it is not possible, and women should understand that'* this shows that besides being overworked she was already overwhelmed and frustrated by the situation. Among the review studies some authors alluded that a supportive system is paramount in such cases; it needs supportive leadership who can offer supportive and supervisory visits to encourage the midwives and doctors. One of the studies mentioned this as one of the interventions to blaming them; managers should at least support them through supportive departmental visits to monitor the situations and give advice [10,17,7,19,22,25,26].

Most African countries health systems are struggling in terms of resources. Some also had poor/ inadequate infrastructure and needed to improvement to ensure privacy and enough patient space. It was highlighted in some of the studies that, at times, boosted the worker's morale instead of women would labour on benches or

monitored sitting on benches post-delivery while waiting for rooms to be vacated. This environment frustrates both women and midwives, leading to some midwives becoming aggressive and abusive towards mothers and women and failing to understand the immediate health care provider's situation.

In as much as there are system failure issues, some health care providers who lack good morals and professional utter and portray unbecoming behaviours towards patients ranging from lack of empathy to insults and judgemental statements. Such go scot-free because of the failure of the system to reinforce organisational policies and charge them with misconduct; because of the inability to remunerate workers according to senior, no one is bothered about the other's business in most institutions.

4.2 Limitations

The inclusion criteria used in this study may have led to the exclusion of some studies that could have limited the researcher to more helpful literature for the review. For example, language exclusion and only sticking to the English language may have limited or excluded important studies.

Many publishers widely use the databases used in the review, but this does not mean that some critical studies that could have affected the review missed in other databases. Some studies needed payment but the reviewer used only free articles due to financial constraints.

Table 4: Factors contributing to disrespect and abuse of women during maternity care

System failure factors	Provider factors	Client /Patient factors
Poor remuneration	Lack of communication	Foreigner
Insufficient training	Lack of empathy	Ethnicity
Shortage of resources	Sex of provider	Failure to book for ANC
Failure to pay bribe	Consumption of herbs	Head of family
Place of delivery	Poor communication	Age
Consumption of herbs	Attitudes	Level of education
Overloaded health worker	Failure to book for ANC	Time of delivery
Demoralizing environment	Parity	Mental status
Lack of empowerment	Time of delivery	Occupation
Failure to re-enforce policies	Failure to pay bribe	Consumption of herbs
Duration of labour	Mental status	
Residential area		
Failure to book for ANC		
Time of delivery		
Foreigner		
Failure to pay bribe		

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Maternal and neonatal mortality and morbidity are high in sub-Saharan Africa, and women need the best care necessary to reduce the rates by identifying and preventing all the causes. This review identified disrespect and abuse of women during maternity care using studies were from different search engines; the PRISMA was used to select studies suitable for the review and used the CASP quality assessment tool to assess the quality of each study that was selected as indicated on Figure 1 in the study. The study looked into disrespectful maternity care focusing on three variables that is, factors contributing to disrespect of women during childbirth, effects of abusive maternity care and strategies employed by different countries to implement respectful maternity care.

Midwives highlighted different reasons that lead to disrespectful maternity care shortage of staff, shortage of infrastructure, lack of both manpower and material resources, lack of knowledge and training on RMC, staff attitudes and lack SOPs [standard operational procedures] and policies that strengthen RMC. If issues are addressed, women will not suffer and it will help reduce maternal neonatal rates.

Identifying strategies that reduce and prevent disrespectful maternity care would help reduce maternal and neonatal morbidity and mortality in sub-Saharan Africa. During the review some strategies were helpful and were tested in other hospitals, these are client exit interviews or client satisfaction surveys, support and supervision should be consistently carried out to promote RMC, a study by Fulani [42] in Kenya highlighted training of midwives on RMC as having been helpful in improving respectful maternity care. As a component of RMC midwives were taught on ensuring client dignity, respect, communication and autonomy and supportive care. During evaluation post- training surveys were conducted, 6 months after trainings targeting new deliveries to assess their experiences with midwives and findings showed 15% increase in maintaining of dignity and respect, 87% improvement on communication skills during interactions with women, 55% increase in supportive care. These results are an indication that RMC in- service training and pre-service training; are helpful in reduction of disrespectful maternity care and will help reduce maternal, neonatal and infantile complications.

Fotso[43] also did a study in northern Ghana and agreed with Fulani and other scholars that empowering women on their rights, strengthening health systems to

respond to specific needs of women at birth, improving providers' training, implementing and enforcing policies on respectful maternal care will help in reduction of abuse of women during childbirth.

To add to the identified Wubetu [27] also added the issue of allowing companions during care as being another helpful strategy in reducing disrespect and abuse. Counselling and equipping midwives with regular updates to improve their knowledge can be a way of motivation and empowerment for them to do their job well. Midwives should ensure critical self-reflection mentorship added indicated as one of the strategies. Do monitoring and evaluation of services to get a good picture of what is on the ground.

Professionalism and ethics reinforcement during midwifery training, and more frequently through in-service training workshops to help health care providers, especially midwives, change their abusive behaviors towards women. Disciplinary measures should be in place to control of bad behavior, and acting against health care workers who disrespect women during maternity care.

Many women have been affected negatively by disrespectful behaviors by midwives some opting to either deliver at home or come late for booking or coming late during labour and these contribute to the increase in maternal morbidity and mortality, neonatal and infant morbidity and mortality, increase in home deliveries and promotion of unskilled birth attendants leading to birth complications.

5.2 Recommendations

a) More research that involves all stakeholders on the effects of disrespectful maternity care and the strategies for reducing or preventing abuse of women during maternity care.
b) Stakeholders' health care providers should have in place disciplinary actions to deal with midwives that misbehave with women.
c) Ensuring availability of both human and material resources to ensure a conducive working environment for midwives [it reduces burnout syndrome].
d) Reinforcement of organisational policies
e) Disciplinary action to be in place against midwives that are found with issues of disrespectful maternity care.
f) Ensuring that mentors are availed in all maternity units to support and supervises women.
g) Monitoring and evaluating to take place more frequently.

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APPENDICES

Appendix 1: COMREC ethical clearance

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.02/21/3275 - DISRESPECT AND ABUSE OF WOMEN DURING MATERNITY CARE IN SUB-SAHARAN AFRICA: A SYSTEMATIC REVIEW by Reign Ndou

On 04-Mar-21

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 some of which are indicated on the next page for your study

04-Mar-21

Prof. E. Umar -Chairperson (COMREC) — Date

Approved by College of Medicine 04-Mar-2021 (COMREC) Research and Ethics Committee