Understanding the origins of a social catastrophe: Mistreatment in childbirth as normalized organizational deviance

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Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Public Health
under the Executive Committee
of the Mailman School of Public Health

COLUMBIA UNIVERSITY

2024

Abstract

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Mistreatment experienced by women delivering in healthcare institutions is a concerning pattern reproduced and normalized in health systems globally, causing widespread harm. Women's reports and observations of childbirth practices in institutions have revealed that disturbing proportions of deliveries are characterized by indignity, humiliation, and neglect. The enormity of the problem constitutes a social catastrophe, as potentially hundreds of thousands are affected daily at a profoundly important moment of personal, family, and social life. Growing global concern has elicited research on mistreatment's prevalence and characteristics, with limited attention to developing explanatory theory. The observed patterns indicate that mistreatment is systemic; therefore, social theory is required to understand why mistreatment persists, despite official norms that prohibit mistreatment and promulgate respectful care. Diane Vaughan's *normalization of organizational deviance theory* from organizational sociology, emerged from studies of how things go wrong in organizations. The theory posits that organizational structures and processes are distorted due to resource scarcity combined with production pressures resulting in normalized organizational deviance in daily micro-level transactions. Furthermore, regulatory systems are unable to capture and mitigate the problem. Vaughan's multi-level framework provided an opportunity for analogical cross-case comparison to elaborate theory on mistreatment as normalized organizational deviance.

To elaborate the theory, the Tanzanian public health system in the period of 2010-2015 was selected as a case because it was the site of a seminal study to measure the prevalence of mistreatment, explore its causes, and develop and test interventions to reduce its occurrence. My participation in designing and conducting this study provided understanding of the phenomenon which formed the foundation of this dissertation.

Novel theory was first elaborated through a systematic review of literature on maternal health care and the government health system in Tanzania. A broad Scopus search identified 4,068 articles published on the health system and maternal health in Tanzania of which 122 were selected. Data was extracted using a framework based on the theory and reviews of mistreatment in healthcare. Relationships and patterns emerged through comparative analysis across concepts and system levels and then were compared with Vaughan's theory and additional organizational theories, resulting in a nascent theory. A qualitative theory-driven approach was then applied to verify and expand the nascent theory using qualitative exploratory data from the study in Tanzania described above. The data included eight focus group discussions and 37 in-depth interviews involving 91 individuals representing community and health system stakeholders. Data were analyzed deductively and inductively using the theory's framework while allowing for emergent constructs.

Analysis based on the literature review revealed that normalized scarcity at the macro-level combined with production pressures that emphasized biomedical care and imbalanced power-dependence on limited financial sources altered values, structures, and processes in the health system. Meso-level actors strove to achieve production goals with limited autonomy and insufficient resources, resulting in workarounds and informal rationing. Biomedical care was prioritized, and emotion work was rationed in provider interactions with women, which many women experienced as disrespect. The nascent theory developed through literature review was largely supported by the qualitative data, while providing further nuance and elucidating new

components. Moral distress, which occurs when one knows the right thing to do but is prevented from taking the right action due to institutional constraints, emerged as an important systems effect of organizational dysfunction. In addition, the qualitative data revealed that managers coped with dual roles as both managers and providers and that the service interaction includes families, not solely providers, women, and newborns. The challenges in the regulatory environment also were clarified, highlighting that monitoring and observing mistreatment was hindered due to structural secrecy and the nature of mistreatment.

The nascent theory revealed the importance of emotional labor and emotion work in understanding mistreatment. Emotional labor has been widely acknowledged as an important aspect of healthcare provision, especially for a positive patient experience; yet there has been limited attention to emotion work as the underlying effort required to provide respectful maternity care and prevent mistreatment. Qualitative data from the exploratory formative research were further analyzed to explore the characteristics of emotion work. 22 interviews and 3 focus groups with 44 maternity providers from different levels of care provision in two districts were analyzed using thematic analysis combined with affinity diagramming.

Six key themes were identified that provide a deeper understanding of the emotion work required of maternity providers, including 1) expected to love and care for patients; 2) controlling emotions; 3) managing patient expectations in the face of system shortages; 4) providers are human beings too; 5) nurses are perceived as harsh; and 6) limited system support for emotion work. The themes and corresponding sub-themes highlight that the nature of childbirth care, the context, and gender norms influence the ability to exert emotion work and thus provide respectful care. Emotion work was expected but good performance was unacknowledged by the system. Additional resources are required, not only to ensure the most basic of resources to provide quality of care, but to ensure sufficient organizational support to address the emotional demands of providers. Systems need to

acknowledge the extra effort required for emotion work and support and train providers to provide this care, as well as help them to manage difficult emotions that they experience due to the nature of their work.

Analogical comparison with another case of organizational deviance enabled a novel approach to elaborate theory. Normalization of organizational deviance proved useful for understanding mistreatment. This theory and others from organizational sociology that explore why things go wrong in organizations may be relevant for other areas of persistent systems failure and underperformance.

Further theory testing in different contexts and types of health systems is needed to understand the generalizability of the nascent theory and advance its development. In addition, many of the constructs, such as emotional labor and moral distress, have not been widely applied in low- and middle-income settings and require deeper study.

This theory reveals the systemic factors driving mistreatment and can guide the identification of system leverage points to transform health systems towards ensuring a respectful experience during childbirth for women and their newborns. Ensuring that adequate resources are provided to achieve targets is essential, but organizational support to address the emotional demands of providers must also be provided. These changes will ease the burden among providers and managers struggling to provide care in under-resourced health systems. The extra effort required for emotion work should be acknowledged and appropriate training provided, as well as support for providers to manage the difficult emotions that they experience due to the nature of their work. The findings may also have implications beyond childbirth, as the theory highlights the conditions that may lead to burnout and poor mental health among providers, an ongoing problem worldwide that was exacerbated by the COVID-19 pandemic.

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Acknowledgements

I would like to thank Dr Godfrey Mbaruku in memoriam– a mentor and friend who guided me in understanding the Tanzanian health system and its maternity care. Sincere thanks also to my colleagues from the Staha Project, with whom I discussed and debated the causes of mistreatment/disrespect in childbirth over many years, including Lynn Freedman, Selemani Mbuyita, Wema Moyo, Aloisia Shemdoe, August Kuwenaruwa, Irene Mashasi, Stephanie Kujawski and Margaret Kruk. I am also grateful to the members of my dissertation committee including: Therese McGinn, who provided ongoing motivational and advisory support on an almost weekly basis for several years; Lynn Freedman who provided the opportunity to work on the project that formed the basis of this dissertation and helped inspire my thinking; and Diane Vaughan at Columbia University, who provided wonderful feedback and analysis support in understanding the theory she developed and how to talk about it with a healthcare audience; as well as Cassie Landers who came to my support in completing the final stages of this dissertation. Finally, I am indebted to the women, men, and healthcare providers and managers in Tanzania who shared their experiences and perspectives.

I also would like express my sincere appreciation for family and friends who have supported me in untold and numerous ways through this process.

Dedication

I dedicate this to my brother, Matt Ramsey, whose love was an immense support and whose creativity inspired me. Wishing you were still here to celebrate this achievement.

Introduction

Around the world, women experience humiliation, neglect, disrespect, and abuse when delivering in healthcare institutions. This mistreatment violates women's and newborns' rights to respectful and dignified care and increases the risk of poor outcomes (McNab et al., 2022; Sudhinaraset et al., 2019; White Ribbon Alliance, 2016). In low- and middle-income countries (LMICs), it may be an important reason that women in labor arrive late for delivery care or decide to deliver at home, thereby risking maternal and newborn mortality and morbidity (Bohren et al., 2014; Kruk et al., 2014). At an individual level, mistreatment may introduce increased fear, and sometimes trauma, in a fundamentally important moment of social and human life. The result is a social catastrophe with potentially hundreds of thousands of women affected daily either directly or through avoidance (Ramsey, 2022).

Improving patient-provider interactions has been a topic of interest for many decades (Mead and Bower, 2000). Similarly, patient-centered care or interpersonal care has long been considered an important, yet neglected, element in overall quality of care (Donabedian, 1988). The recent focus on mistreatment differs in that it frames the issue from a perspective of abuse, neglect, and humiliation, which is not merely poor professional competence, but active, and sometimes intentional, mistreatment by a provider or the broader health system (Freedman et al., 2014).

The problem of mistreatment in childbirth has risen to global consciousness only recently because it occurs too often among women who have little voice or recourse. Additionally, global efforts to improve maternal and newborn care in LMICs have in recent decades focused on increasing availability and clinical quality of maternity services, and thus mistreatment may have remained unacknowledged due to a narrowed focus on easily measurable results (Storeng and Behague,

2014). Reviews in 2010 and 2015 revealed that mistreatment was occurring around the world but reports often came from studies focused on quality or broader patient experience. At that time, it had rarely been researched systematically, except in a few countries (Bohren et al., 2015; Bowser and Hill, 2010). Now, the World Health Organization's (WHO) quality of care framework for maternal and newborn health emphasizes women's experience of care and notably respect and dignity (Tunçalp et al., 2015). Numerous efforts have been initiated to measure and address the phenomenon more systematically, yet there has been limited focus on examining the systemic factors driving mistreatment until recently (Reddy et al., 2022; Sando et al., 2017; Sen et al., 2018).

Various terminologies for the phenomenon have emerged. A global landscape analysis used the terms *disrespect and abuse*, categorizing incidents reported across the literature; although it is not clear whether these terms emerged from the analysis or were selected by the authors (Bowser and Hill, 2010). These terms have been used widely in research, advocacy, and programs that have followed. The term *obstetric violence* is often used in Latin America and other settings where it is framed as a women's rights issue and human rights violation (Sadler et al., 2016). WHO proposed the term *mistreatment* to incorporate incidents that are systemic or not intentionally abusive (Vogel et al., 2016). Women may be subjected to mistreatment, but not identify it as disrespect or abuse due to low expectations and normalization of the behavior (Freedman et al., 2018; Schaaf et al., 2023). Consequently, this dissertation uses the term *mistreatment* to describe what the system produces, and *disrespect* is used to indicate women's experience of mistreatment as humiliating, abusive or a violation of their dignity.

Defining what constitutes mistreatment or disrespect has been challenging. Most rely on describing the acts or observable events that can be considered mistreatment. Two widely referenced reviews identified categories and typologies for classifying observable events of mistreatment (Bohren et al., 2015; Bowser and Hill, 2010) (see Table 1).

Table 1. Comparison of Bowser & Hill's Categories with Bohren et *al*'s Typology

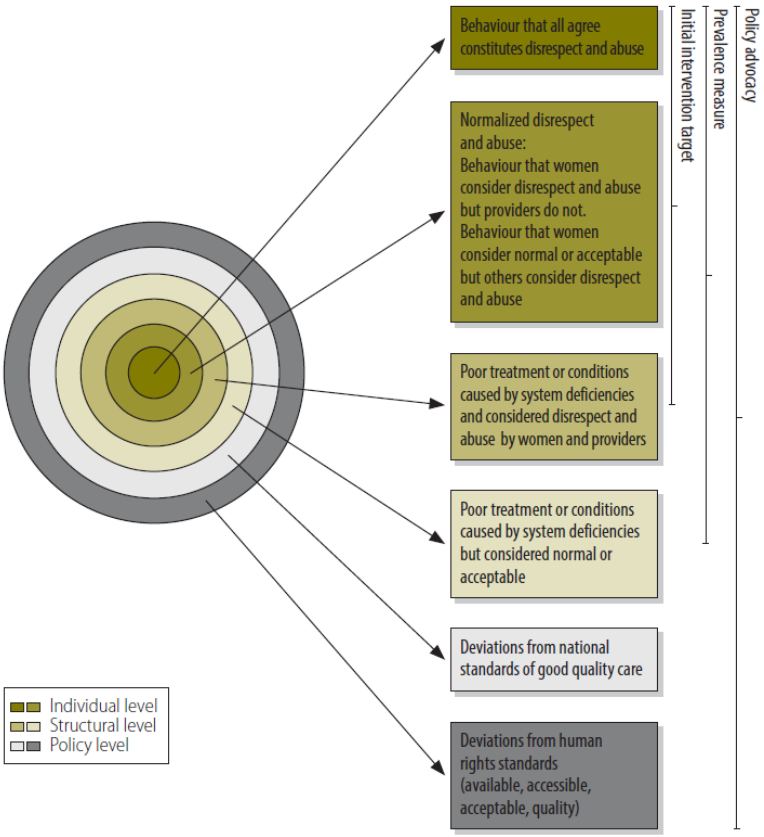
Bowser & Hill's Categories of Disrespect & Abuse (Bowser and Hill, 2010)	**Bohren et *al*'s Typology of Mistreatment** (Bohren et al., 2015)
• Physical abuse • Non-consented care • Non-dignified care (shouting, humiliating, sharing beds, etc) • Discrimination • Abandonment of care • Detention in facilities for failure to pay	• Physical abuse • Sexual abuse • Verbal abuse • Stigma and discrimination • Failure to meet professional standards of care • Poor rapport between women and providers • Health system conditions and constraints

These classifications highlight the challenge of understanding this complex phenomenon, which brings together numerous aspects of poor experience. Combining them may be problematic to address the phenomenon as different categories may be due to different root causes. For instance, ethics regarding confidentiality of information may be due to a lack of emphasis in training and supervision, while verbal abuse may be due to system's abuses of providers leading to dehumanization.

Freedman et al moved beyond categories by developing a definition of what might be deemed disrespect and abuse in childbirth, which points to the many layered aspects of the problem at policy, structural and individual level (Freedman et al., 2014). As shown in Figure 1, this layered definition considers the perspectives of those involved in daily interactions as well as international human rights and national standards frameworks. These are presented as concentric rings to visually represent that each interacts and is embedded within the other layers. At its core are those actions or conditions that all in a particular society – patients and providers – would consider disrespectful. Beyond this are the elements that either patients or health providers would consider

disrespectful, but the other does not. This is surrounded by the conditions of the organization which may result in structural abuses but are beyond the ability of health providers to change. Finally, all incidents are embedded in the norms established by consensus in international human rights agreements and through national processes. This framework is useful to disentangle which aspects of mistreatment are understood as disrespect within a given society.

Figure 1. Freedman *et al*'s diagram defining disrespect and abuse (Freedman et al., 2014)



Others have focused on emphasizing respectful maternity care, de-emphasizing negative aspects, and setting an aspirational direction. For instance, a global call for respectful maternal and newborn care outlines rights as per global human rights norms (White Ribbon Alliance, 2016). The distinction may be important, not as the inverse of mistreatment/disrespect, but because the absence of mistreatment does not mean that women will have a fully respectful experience

(Shakibazadeh et al., 2018). Some measures, such as the Person-Centered Maternity Scale, have recognized that both respectful care and lack of mistreatment are essential to encapsulate the full experience (Afulani et al., 2017). Yet, to fully understand the underlying causes, it may be more fruitful to study the presence of mistreatment rather the absence of respectful care.

Mistreatment is not limited to women and maternity care alone. A review by Berlan and Shiffman, highlights that services and systems are often not responsive to the needs of a variety of clients (Berlan and Shiffman, 2012). Yet, childbirth services may provide a unique case to understand the broader phenomenon. Childbirth is imbued with deep personal and social meaning and women are vulnerable physically and emotionally in this moment. Women and their families accordingly may have increased expectations of emotional support from providers, as compared to other services. Additionally, institutional childbirth is recommended in many countries to ensure timely access to biomedical care for preventing and managing complications, whereas many other primary healthcare services can be provided outside the facility environment. Clinical obstetric care is also complex with often unpredictable and contested complications that can arise, creating stressful situations for maternity healthcare providers (Dekker et al., 2013; Jaffré and Lange, 2021). Paradoxically, in some settings, obstetric care is considered low-skilled work; predominantly provided by female nurses and midwives who are at lower echelons of the medical and health system hierarchy and comprise the largest proportion of the workforce (Filby et al., 2016a).

While global efforts have begun yielding more understanding about mistreatment in childbirth, the most effective approaches to prevent mistreatment and promote respectful care are less clear. While the current literature sheds light on the types of mistreatment experienced by women and how they and providers perceive it, much less has focused on understanding the drivers of the phenomenon (Sen et al., 2018). The similar patterns of mistreatment within and across geographies and healthcare systems indicate that it is likely a systemic problem (Bohren et al., 2015). The

systemic causes that reproduce mistreatment in healthcare systems have been undertheorized. Theory, particularly behavioral and systems theory, is needed to tackle this complex problem that is unlikely to be eliminated through simple solutions, such as one-time training (Downe et al., 2023).

Mistreatment through the lens of organizational sociology

Theories from organizational sociology, particularly regarding failure, provide promising constructs for examining the root causes of mistreatment. Assessing the current organizational structures and processes in healthcare organizations can assist in identifying what factors enabled mistreatment to be institutionalized and sustained. Organizational failure and deviance theories have been applied to a variety of problems in the United States and Europe, including in some cases health care organizations, but not to dysfunctions of health systems in LMICs (Vaughan, 1999).[1]

Vaughn's theory of the normalization of organizational deviance provides a useful meta-framework for examining these factors (Vaughan, 1996). Organizational deviance is defined as

> *"an event, activity, or circumstance occurring in and or produced by a formal or complex organization, that deviates from both formal design goals and normative standards or expectations, either in the fact of its occurrence or in its consequences, and produces a suboptimal outcome"* (Vaughan, 1999)

According to Vaughan's definition, mistreatment in childbirth could be considered as organizational deviance, because it violates bioethics principles promulgated by countries, healthcare institutions, and the healthcare professions. For example, the World Health Organization formally acknowledges that disrespect and abuse during childbirth constitutes both a public health concern and a violation of human rights (WHO, 2014).

[1] Note: How I came to apply normalization of organizational deviance to mistreatment is more fully described in the introduction of Paper 1.

While organizational deviance contradicts normative standards, paradoxically, these maladaptive processes and behaviors may develop in pursuit of higher organizational goals. Maternity care providers across various settings, for example, often justify mistreatment as necessary to ensure the well-being and survival of both the mother and the baby during childbirth (Bohren et al., 2016; Downe et al., 2023; D-Zomeku et al., 2020). Hence, at least in their own sensemaking, they perceive that they are advancing the organization's goals.

The conceptual framework for normalization of deviance proposed by Vaughan includes the competitive environment, organizational characteristics, and the regulatory environment. The competitive resource environment creates conditions that distort organizational characteristics and produce deviant behaviors, which remain unmitigated due to a weak regulatory environment (Vaughan, 1996). The framework allows a holistic view of an organization, including the micro, meso- and macro- level factors, as well as external influences, that interplay to result in the observed organizational deviance. By design, it aims to incorporate multiple factors and study how they interact, as typically multiple factors underpin organizational failure (Perrow, 1986). To date, mistreatment has not been analyzed in a systemic way that examines how the dynamics between and among different systems levels reproduce and normalize this behavior, although some research has explored organizational factors at the meso level (Madhiwalla et al., 2018; Reddy et al., 2022). To fully comprehend and tackle this problem, case studies examining multiple levels of health systems are required.

Hypothesis

The reason why mistreatment has become normalized in maternities across the globe has been undertheorized. Because mistreatment is often a behavioral pattern occurring in social institutions, social theory is essential to understanding its persistence (Gilson et al., 2011). The normalization of organizational deviance as described above provided a promising possibility to better understand

the systemic nature of mistreatment. Thus, the main hypothesis was that mistreatment in childbirth is a case of normalized organizational deviance because these behavioral patterns persist despite contravening institutional and professional norms. While Vaughan's theory focuses on how normalized organizational deviance influences individual decisions culminating in disaster, I aimed to explore how it can explain the institutional persistence of mistreatment as observed in daily routines and practices across a health system (Vaughan, 1996). Tanzania was chosen as the case because it was the site of a quasi-experimental mixed methods study that explored drivers of mistreatment, measured its prevalence, and tested interventions to reduce its incidence (Kujawski et al., 2017).

In the first paper, this hypothesis was tested using analogical comparison, comparing mistreatment in childbirth in the Tanzanian government health system with Vaughan's study of the Challenger Launch decision at NASA (Vaughan, 2014, 1996). A review of existing literature on maternity care and the health system in Tanzania from the period of 2010 to 2016 was used to develop the case in Tanzania for comparison. A nascent theory of mistreatment in childbirth as normalized organizational deviance was developed. The second paper further elaborated and verified the nascent theory based on primary qualitative data that explored the nature and drivers of mistreatment in one region of Tanzania. Qualitative data from the above-mentioned study in Tanzania explored experiences and perspectives from a range of actors including individuals, community representatives, healthcare providers, and managers at multiple system levels. In the third paper, emotional labor, which emerged as an essential construct in the theory in the first two papers, was analyzed in further depth.

While the qualitative data in this dissertation is from 2010-2015, the main purpose is to develop theory. The specific details provide the case for comparison and ultimately theory development, but the constructs should ultimately hold true in other settings where the specific details might be

different or even in the same setting where they may have changed, but not sufficiently or in the right direction. For example, Vaughan's seminal work on the Challenger Launch explosion was published nearly a decade after it occurred, which allowed time for examination and some distance to understand the broader forces at play.

The dissertation uses the term emotional labor, as defined by Hochschild, to refer to work that requires management of others' emotions as well as one's own emotions, in which the appropriate emotions and displays of emotion are defined by the organization [38]. Emotion management or emotion work, according to Hochschild, is required both in work as well as personal lives; however, in the organizational setting it describes the extra effort required to conform to organizational rules and expectations.

Reflections

The origin of this dissertation is a study that took place between 2010 and 2015 in Tanzania through a partnership between Columbia University Mailman School of Public Health's Averting Maternal Death and Disability Program (AMDD) and Ifakara Health Institute (IHI), a Tanzanian non-governmental research institution. From when we began writing the proposal for this work in 2009 until 2012, I was living and working in Tanzania as an AMDD staff member, based with IHI colleagues at their offices. I continued to travel frequently to Tanzania to work with colleagues at IHI until the close of the project in late 2015.

The study was one of the first to systematically attempt to measure disrespect and abuse, understand the causes of these observed behaviors and conditions, and identify and test solutions to reduce its occurrence. The study, fully described by Kujawski *et al* [36], was a mixed methods design, including an exit survey, observations of labor and delivery, in-depth interviews, and focus group discussions, among others. The selection of each method was the result of long discussions about which would be appropriate for capturing the different dimensions of this understudied

problem. These conversations took place amongst our team, but also with the team conducting a parallel project in Kenya and a technical advisory committee. For each method, novel tools were developed from surveys to measure prevalence to interview guides to explore how people felt and what they perceived were the causes and conditions leading to this phenomenon. The methods and tools, and what we learned from them, provided a foundation for ensuing research conducted by the World Health Organization, as well as numerous other studies that have followed [39].

I was also present for data collection, including training data collectors and providing supervision and oversight. This included adapting and adjusting our approach and the tools as needed while data collection was taking place. In the initial stages, it required continued refinement as we tried to create an environment where people would feel comfortable to talk about this sensitive topic and adjusted questions in the qualitative guides as we learned.

Baseline data from quantitative surveys with women and the qualitative interviews and focus groups with a variety of stakeholders were first analyzed in 2011. I was directly involved in analyzing the qualitative data, which was done through framework analysis. The findings were presented to a variety of stakeholders from the community, health facilities, and healthcare management at district, regional, and national level. Stakeholders reflected on and provided feedback on these findings, which enabled deeper understanding of the problem. It was incredibly difficult to talk about the topic at that time, with many healthcare providers and managers reacting defensively or remaining silent in forums focused on our findings. At one early forum, it was only after an anonymous survey asking who had ever observed disrespect, in which 100 percent said yes, that we were able to move forward. In our early findings, we highlighted the challenges that maternity providers were facing and the need for mutual respect among all involved, which also helped to open the discussions. A series of participatory sessions with different stakeholders to develop the interventions further reinforced what we had learned, adding new nuance. The original data,

therefore, were validated with stakeholders, even if the specific analyses and findings presented in this dissertation have not been directly verified.

Most team members from the project are listed as authors on the second and third papers. As described in Paper 1, my own observations from working on this project and a long career in global maternal health shaped how I perceived the problem, including perspectives from different levels of the system where I had worked. Long discussions among our team and with the team in Kenya, as well as later discussions with the World Health Organization and other colleagues working on this issue, further shaped my understanding. Because the work was so new, I believe it also opened the opportunity for me to think about and approach the topic with a new perspective.

Paper 1. Systems on the edge: Developing organizational theory for the persistence of mistreatment in childbirth [2]

[2] This paper was published in March 2022. K Ramsey. Systems on the edge: Developing organizational theory for the persistence of mistreatment in childbirth, *Health Policy & Planning*, 2022, 37(3): 400–415, https://doi.org/10.1093/heapol/czab135

INTRODUCTION

Globally, women delivering in healthcare institutions report experiencing treatment that is humiliating, neglectful, disempowering, and undignified. Women have reported verbal and physical abuse; neglect or abandonment of care; and lack of privacy, confidentiality, and consent for procedures – mistreatment that appears to be routine in many healthcare organizations (Bohren et al., 2015). Women's experience of mistreatment as disrespect and abuse amplifies fear, sometimes causing trauma, in an important moment of social and human life (Lukasse et al., 2015). The consequences are significant in three ways: 1) it violates human rights; 2) it may deter women from seeking care thus risking maternal and newborn mortality and morbidity (Bohren et al., 2014); and 3) it potentially affects hundreds of thousands of women daily. The association between mistreatment in childbirth and health outcomes is not fully understood, but social and emotional support in childbirth is known to improve outcomes (Bohren et al., 2017), and one study found associations with newborn outcomes (Sudhinaraset et al., 2019).

Mistreatment in childbirth gained salience in global health recently, despite 1990s accounts in African settings and a humanization of childbirth movement in Latin America (Jaffre and Prual, 1994; Jewkes et al., 1998; Sadler et al., 2016). Increasing emphasis on biomedical care combined with gender norms silencing women's voices likely contributed to its invisibility. A global movement condemning disrespect and abuse in childbirth and promoting respectful maternity care was launched in the last decade (WHO, 2014), aligned with increasing attention to experience of maternal and newborn care (Tunçalp et al., 2015). Consensus is lacking on terminology and definitions of the phenomenon. Disrespect and abuse has been used to describe women's experience (Bowser and Hill, 2010; Freedman et al., 2014) while the terms obstetric violence and mistreatment characterize its systemic nature (Sadler et al., 2016; Vogel et al., 2016). This article uses the term *mistreatment* to describe what the system produces and *disrespect*, while an

imperfect descriptor, is used to indicate women's experience of mistreatment as humiliating, abusive or a violation of their dignity.

Although other healthcare users experience mistreatment (Topp and Chipukuma, 2016), mistreatment in childbirth provides a unique case to examine the broader phenomenon. Institutional childbirth is recommended globally to ensure timely access to biomedical care for preventing and managing complications. Childbirth is imbued with deep personal and social meaning and women are vulnerable physically and emotionally in this moment. Women and their families accordingly may have increased expectations of emotional support from providers. Work that requires the suppression or expression of emotions to meet workplace normative expectations is *emotional labor* (Hochschild, 1983; Riley and Weiss, 2016). When providers do not genuinely feel the expected emotions, they use *emotion work* to perform in ways that do not match their feelings, creating cognitive dissonance that can contribute to burnout.

The problem's complexity calls for efforts to tackle causes across health system levels (Freedman et al., 2014). While research exploring its causes is limited, existing reviews point to potential antecedents. Bowser and Hill list preliminary considerations of drivers, many of which are related to systems arrangements (Bowser and Hill, 2010). Some reviews on mistreatment have examined mistreatment from women's perspectives and from a gender equality lens (Betron et al., 2018; Bradley et al., 2019). Others more broadly looking at dignity violations and neglect, point to systems antecedents, including mechanisms to hold service providers accountable to clients (Berlan and Shiffman, 2012; Jacobson, 2009; Leape et al., 2012; Reader and Gillespie, 2013). These provide important insights, yet lack clear theoretical foundations, multiple perspectives, or are not specific enough for this phenomenon.

Social scientists working in global health have explored why system actors' practice differs from normative expectations. Healthcare applications of street level bureaucracy theory demonstrate that frontline providers have discretionary power in enacting policy and determining a service user's experience (Erasmus, 2014). Routines, such as rationing, are established to cope with insufficient resources and manage stress, but how they become institutionalized is rarely explored. Ethnographic studies on maternal healthcare in West Africa reveal that practical norms, including mistreatment, arise as providers navigate between official norms and contextual realities, yet do not explain how these are reproduced across systems and geographies (Olivier de Sardan et al., 2017).

Primary research on mistreatment has focused on characterizing and measuring the phenomenon, including how it is experienced by women, affects care-seeking and to some extent is perceived by providers (Sen et al., 2018). This research is important yet directs attention to the interaction between providers and women, inhibiting understanding of systemic factors that shape these interactions. The similar patterns of mistreatment across geographies and time indicates its systemic nature (Bohren et al., 2015).Gilson et al call for more routine application of social science theory in health systems research and similarly Sriram et all call for more research on dimensions of power within the system, noting respectful maternity care as a fruitful research area (Gilson et al., 2011; Sriram et al., 2018).

Mistreatment in childbirth as organizational deviance

Based on field work in Tanzania and emerging findings on mistreatment, the author recognized the need to analyze mistreatment in childbirth from a systems and organizational perspective. Organizational sociology provided a promising analytic lens because it recognizes that any 'system of action' is likely to produce consequences that are counter to its objectives, including unanticipated, suboptimal outcomes (Vaughan, 1999). Sociological research on organizational

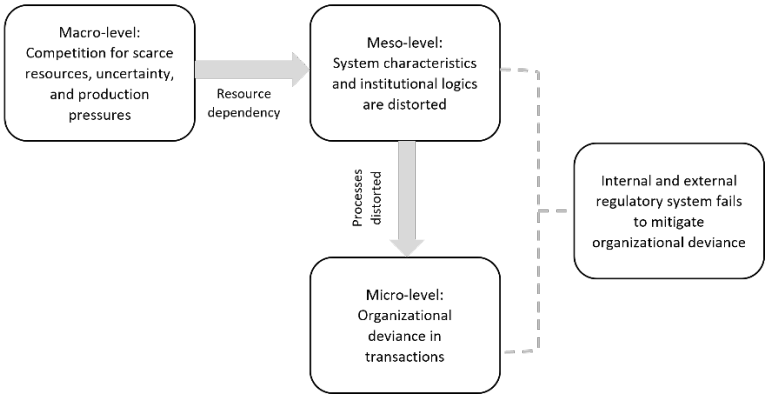
failures examines how things go wrong and produce harmful outcomes, such as mistreatment (Vaughan, 1999). This lens has been applied frequently to healthcare patient safety efforts (Dekker, 2011). The author further hypothesized that while the aim is respectful maternity care, mistreatment, as compared to the absence of respect, would be more fruitful to advance explanatory theory.

Diane Vaughan developed *the normalization of organizational deviance theory* based on her seminal study on the US National Aeronautics and Space Agency's (NASA) decision to launch the Challenger space shuttle despite known technical problems, which culminated in its explosion after takeoff. The author recognized similarities to mistreatment in this multi-level analytic framework which examines how organizational practices that deviate "*from both formal design goals and normative standards or expectations, either in the fact of its occurrence or in its consequences"* become normalized (Vaughan, 1996). From her definitions, mistreatment in childbirth qualifies as organizational deviance because it violates human rights and bioethics principles widely endorsed by countries, healthcare organizations and the health professions. WHO, furthermore, formally recognizes disrespect and abuse in childbirth as a public health and human rights violation (WHO, 2014).

Vaughan argues that organizational deviance is predictable, recurring, and to some degree inevitable. It arises due to a *competitive macro-level environment* characterized by resource scarcity, uncertainty, and production pressures. These factors distort the *meso-level organizational characteristics* due to dependency on limited sources for essential resources. High resource dependency increases the likelihood of changes in organizational structure, climate, and behaviors to align with source organizations (DiMaggio and Powell, 1983). Organizational actors may change values or withdraw motivation to "reduce the pains" of meeting more powerful groups' demands (Emerson, 1962). Distortion of *institutional logics*, the values that guide daily activity, enable

system actors to normalize deviant behaviors. Normalized deviance consequently manifests in frontline *micro-level transactions*. For example, actors may adopt *workarounds*, informal work processes, when faced with limited resources and competing priorities among formal processes (Halbesleben et al., 2008). Reproduction occurs as institutional logics are almost unconsciously transmitted to new staff in socialization processes, producing efficiencies but also masking better alternatives (Zucker, 1977). *Regulatory mechanisms*, internal and external to the organization, are unable to capture or mitigate the deviance. Figure 1 provides a simplified representation of the main concepts in Vaughan's theory.

Figure 1. Main concepts in Vaughan's theory of organizational deviance



These domains of inquiry aligned with extant mapping of potential drivers of mistreatment and the author's observations from field work in Tanzania and nearly twenty years working in maternal health (Bowser and Hill, 2010). Vaughan and others typically focus on how normalized deviance influences decision-making and culminates in disaster. Her theory can be extended to understand how organizational deviance is institutionalized, causing widespread harm without an observable catastrophic moment, like mistreatment in childbirth.

During analysis, the author sought to understand the relational power dynamics between system levels. The emergent findings corresponded with *power-dependence theory*, identified through reviewing literature and discussions with colleagues. In this theory, power is not an attribute of individuals or groups, rather a function of mutual dependence relationships in which each actor has power to influence the other (Emerson, 1962). Power imbalances arise due to dependencies for material resources (e.g., capital, people, supplies) and symbolic resources (e.g., trust, respect, status) (Biermann and Harsch, 2017).

Box 1. Concepts glossary

Organizational deviance: routine practices that deviate from formal design goals and normative standards or expectations in their occurrence or consequences

Power-dependence: power manifests in relationships of mutual dependence, rather than as a general attribute of individuals or groups

Institutional logics: social and historical pattern of assumptions, values, and practices by which members of an organization attribute meaning to their daily activities

Emotional labor: work that requires the suppression or expression of emotions to meet workplace normative expectations

Emotion work: effort required to manage personal or others' emotions in the workplace, such as service users and colleagues

Workarounds: substitutions of formally defined work processes with alternative, informally designed processes

The author, therefore, sought to develop a case using a specific healthcare organization, enabling analogical comparison with Vaughan's *normalization of organizational deviance* theory to elaborate theory for mistreatment.

METHODS

Analogical comparison was used to elaborate theory on mistreatment in childbirth, an approach in which cross-case, or cases from differing types of organizations and phenomena, rather than same case comparisons are used to generate innovative theory (Vaughan, 2014). For this article, Vaughan's theory of *normalization of organizational deviance*, based on the Challenger study, was compared to mistreatment in childbirth, using the case of the Tanzanian public health system. Similarities and differences were examined and as differences emerged, other theories, such as *power-dependence theory*, were compared with the selected case, thereby enabling new theory development.

To develop the case for the Tanzanian government system, a systematic review and framework synthesis were conducted on maternal healthcare and the health system from 2010-2015. Systematic review provided a transparent means to assemble published literature and reduce bias and framework synthesis enabled use of an *a priori* framework to analyze large amounts of heterogeneous information that was not specifically aimed at capturing the theory's constructs (Barnett-Page and Thomas, 2009; Walt and Gilson, 2014).

Context/setting

The period of 2010-2015 in Tanzania was selected because it was the location and timing of a prevalence and intervention study on disrespect (Kujawski et al., 2017). Additionally, Tanzania's government was actively striving to reach maternal health goals leading up to the 2015 Millennium Development Goals (MDG) deadline. The government system was selected because it provided 82% of institutional childbirth care in the period (MoHCDGEC Tanzania Mainland et al., 2016).

For the case, the government system includes the administrative units responsible for healthcare at national and sub-national levels and the healthcare facilities owned and operated by the government. At the time, government healthcare was managed by two national units, the Ministry of Health and Social Welfare (MoHSW) and the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG). The former was responsible for normative functions, while the latter was responsible for operations, which were mostly decentralized to district governments. Healthcare was organized in a pyramid of community health workers; dispensaries; health centers; and district, referral, and national hospitals, with increasingly complex services provided in fewer sites at the top of the pyramid. The government owned and operated 5,000 health centers and dispensaries and 55 hospitals (United Republic of Tanzania, 2009). Childbirth care was provided at all levels, except by community health workers, but only hospitals could manage most obstetric complications despite expectations that health centers and dispensaries would handle some (United Republic of Tanzania, 2008). Medical personnel designated as skilled birth attendants in Tanzania included: obstetricians, medical officers, assistant medical and clinical officers, registered nurse midwives, enrolled nurses and nurse midwives, and maternal-child health aides (Adegoke et al., 2012). Institutional childbirth steadily increased in the period from 51% to 63%. Despite these increases, there was no evidence of change in maternal mortality over the previous decade (MoHCDGEC Tanzania Mainland et al., 2016).

Systematic search and screening

To select articles, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed (Shamseer et al., 2015). A broad SCOPUS search was conducted in September 2016 and again in February 2017 to identify articles on Tanzania published between 2011 and 2016 in the subject areas of medicine, social sciences, economics, business, psychology, nursing, multidisciplinary, health professions and decision sciences. The selected

search period reflects delays in publishing to approximate the 2010-2015 period more closely. The search included articles across disciplines and data types, including critical analyses, qualitative, quantitative, and mixed methods articles. Reference lists were used to identify additional articles.

Articles were included that met the following criteria: 1) included the government, its health system and/or childbirth care in its facilities; 2) presented primary data or analysis as appropriate for the study's discipline; 3) included findings relevant to the macro-level environment, the meso-level organizational characteristics, micro-level transactions around childbirth and/or the regulatory environment. Article selection followed a process of reviewing titles and then abstracts and reading articles. Early screening stages erred towards inclusion. Additionally, relevant policy documents were identified through government websites, the development partner group website, and article references.

Data extraction and analysis

Each of the articles was read at least twice. An analytic framework for data extraction was developed based on Vaughan's theory. Preliminary concepts for each system level were developed based on global literature and experience researching mistreatment in Tanzania (Berlan and Shiffman, 2012; Bowser and Hill, 2010; Filby et al., 2016b; Jacobson, 2009; Leape et al., 2012; Reader and Gillespie, 2013; Sadler et al., 2016). The framework was revised as new concepts emerged during article selection and data extraction (see Table 1). Extraction was conducted using Dedoose, a cloud-based application for analyzing qualitative and mixed methods research, and included qualitative themes, qualitative and quantitative findings, supporting quotations, concepts introduced in discussions, and any relevant data tables, figures, or images.

Analytic memos were written for each concept. Iterative comparison was then conducted among other concepts in the same domain, across domains and across system levels to determine

patterns and relationships (Vaughan, 2014; Walt and Gilson, 2014). Negative cases and literature gaps were explored to test assumptions. As patterns and relationships emerged, *power-dependence* theory and additional organizational theories, such as *emotional labor*, were compared to explain differences between Vaughan's theory and mistreatment. Findings were reviewed for validation by experts in the Tanzanian healthcare system, maternal health, mistreatment in childbirth, and organizational sociology.

Reflexivity statement

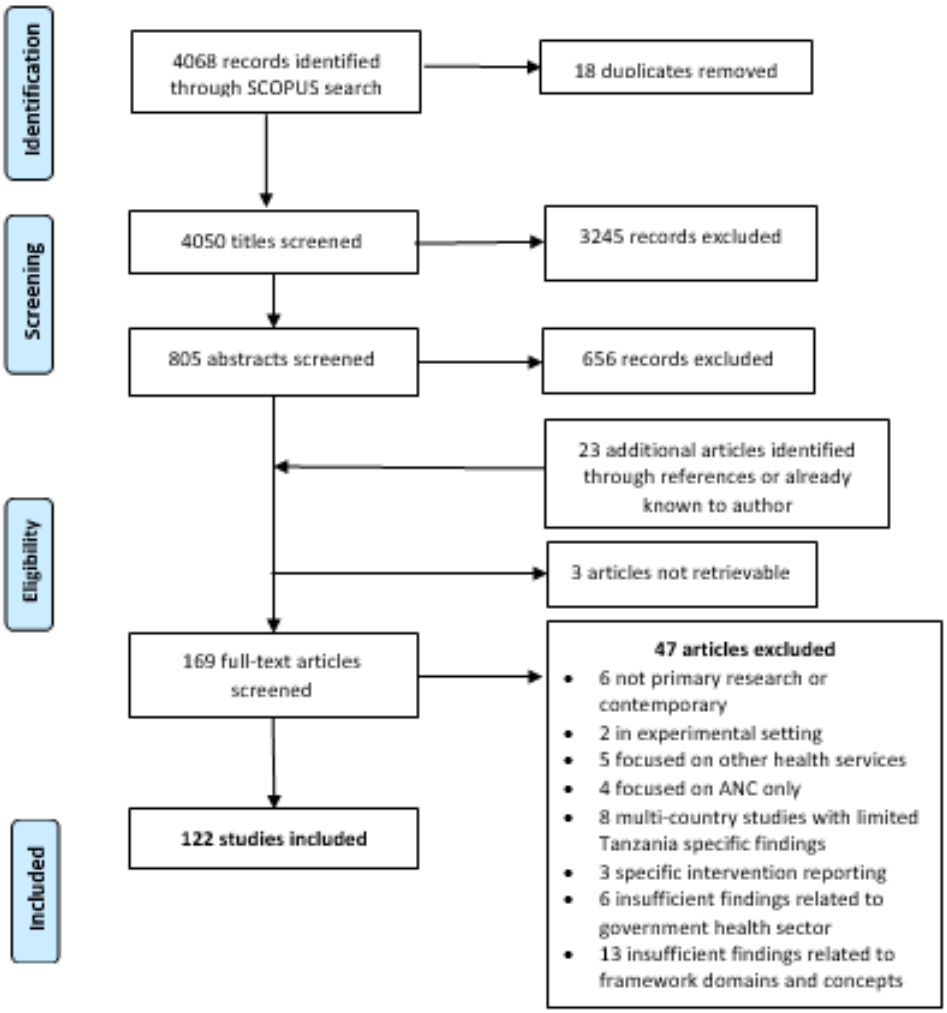
The author lived in Tanzania from 2009 to 2012 and worked there frequently until 2016. A white woman raised in the United States with a graduate degree in public health, she has worked in the global maternal health field, and particularly in sub-Saharan African countries, for nearly 20 years and on the above-referenced project. During the project, she contributed to designing and conducting qualitative research and participatory co-creation of interventions, frequently discussing, and exchanging ideas with Tanzanian colleagues and others studying the issue globally. Observations made while living in Tanzania and learning from these discussions contributed to conceptual thinking for this paper.

SEARCH RESULTS

The SCOPUS search yielded 4068 articles. An additional 23 articles were identified by searching reference lists. After screening titles, 805 articles were retained and further reduced to 169 articles after abstract review. After reading the full text, 122 were retained (see waterfall, Figure 2). Among the articles, 32 were national in scope, eight were conducted in unspecified sub-national areas and the remaining focused on specific geographic areas, covering at least 18 of the 24 regions in Tanzania as per the 2012 census. The articles were mixed methods (29), qualitative (65) and quantitative (28) and included data about the macro-level competitive environment (21), meso-level organizational characteristics (82), micro-level transactions (21), and the regulatory system

(23). Policy documents reviewed included 12 national health plans, health surveys and strategies and norms for health care. Most but not all articles reviewed are cited in this article. A complete list is available upon request.

Figure 2. Search results



ANALYSIS RESULTS

Mistreatment in childbirth as organizational deviance

Mistreatment in childbirth, or any health service, deviates from Tanzanian policy as well as health professional codes of conduct. The National Health Policy encourages "the health system to be more responsive to the needs of the people," calling for a client service charter between the

government and citizens (United Republic of Tanzania, 2003). The charter outlines numerous citizen rights, including treatment with respect, privacy and confidentiality (United Republic of Tanzania, 2013). The Medical Council of Tanganyika and the Tanzania Nurses and Midwives Council codes of conduct call for providers to "observe clients' right to respect" and to "promote an environment in which the human rights, values, cultural and spiritual beliefs of an individual are respected" (Medical Council of Tanganyika, 2005; Tanzania Nurses and Midwives Council, 2007). Despite these precepts, similar patterns of mistreatment and experiences of disrespect were reported across geographically dispersed sites, indicating that it was systemic phenomenon (Kruk et al., 2018; McMahon et al., 2014; Mselle et al., 2013; Sando et al., 2016; Shayo et al., 2016; Solnes Miltenburg et al., 2016).

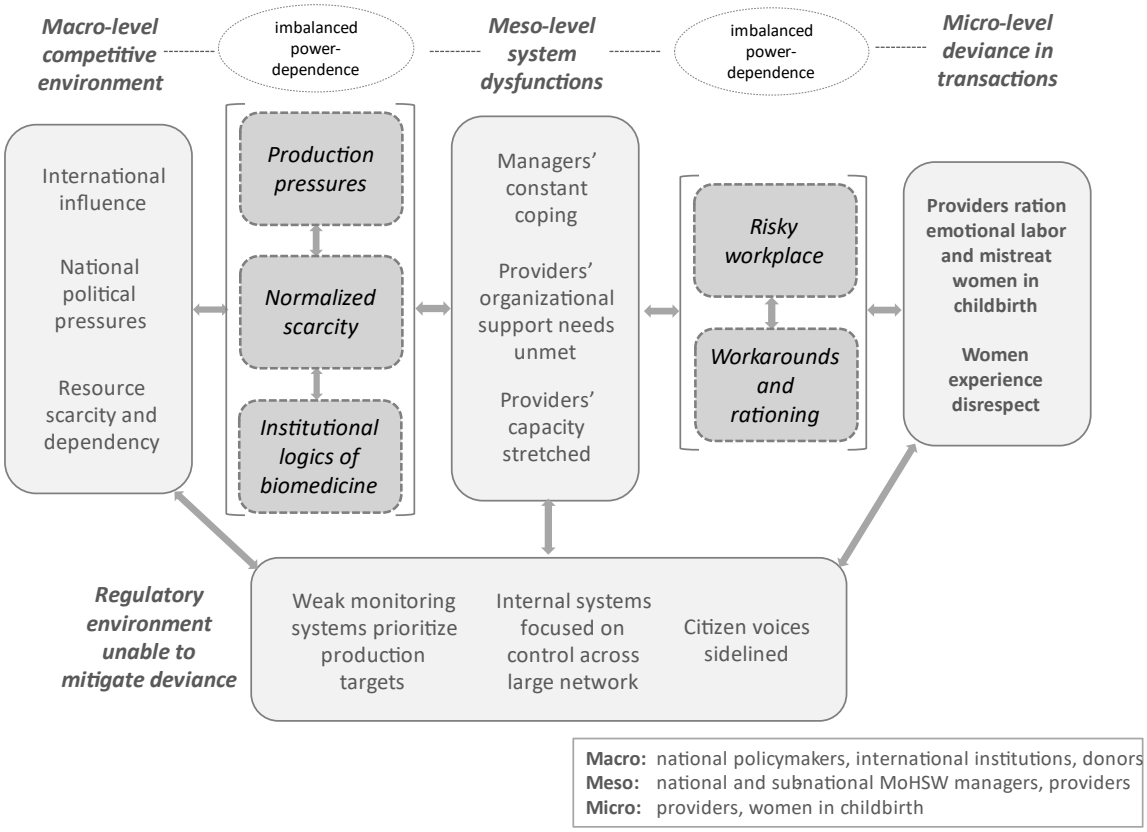
How mistreatment was normalized as organizational deviance

The following elaborates findings from the macro-, meso- and micro-levels and their relationships to elaborate theory on how mistreatment in childbirth became normalized and persisted in the Tanzanian government's health system. Figure 3 visualizes key concepts and relationships that emerged from the findings.

The macro-level competitive environment

The macro-level environment was characterized by the interplay among senior political figures and government leaders, international donors working in Tanzania and globally, and multilateral institutions. As shown in Figure 3, these relationships were characterized by international influence, national political pressures, and resource scarcity and dependency. The government health system's resource base was insufficient, unpredictable, and shaped by national and international pressures for legitimacy.

Figure 3: Mistreatment in childbirth: Normalization of organizational deviance



National political pressures

Since independence in 1961, Tanzania had undergone massive transformations in its political economy – transitioning from socialism towards capitalism in the 1980s, from single to multi-party democracy in the early 1990s and from free universal healthcare to market-influenced health reforms in the late 1990s. Nonetheless, the population's expectations for healthcare continued to be shaped, with some generational variation, by the first national government's premise that healthcare is a right for citizens and an obligation of the state (Aminzade, 2013; Fouere, 2014; Shayo et al., 2013). Progressive democratization and decentralization at least theoretically created more space to demand these rights and register complaints about access to and quality of healthcare (Fouere, 2014; Maluka et al., 2011a; Nyaluke et al., 2013). Corruption scandals and

disappointment with economic liberalization created impetus for politicians to return to popular social policies and embark on ambitious health plans in the 2000s (Aminzade, 2013; Fouere, 2014; Nyaluke et al., 2013).

International influence and resource dependency

To reach these aims, Tanzania relied on donors for 30 to 40 percent of its health budget in the 2005-2015 period (Martínez Álvarez et al., 2016; Mtei et al., 2014), although donor assistance for health began to decline in 2010 (Swedlund, 2013). More than 40 donors were providing health funding through various mechanisms, from the health sector basket (a pooled funding mechanism) to vertical projects implemented by non-governmental organizations, creating a complex negotiating environment in which national priorities for health systems strengthening were sometimes shelved (Chimhutu et al., 2015; Fischer and Strandberg-Larsen, 2016; Mwisongo et al., 2016; Swedlund, 2013). Donor funding streams were unpredictable, making government planning difficult (Martínez Álvarez et al., 2016; Mwisongo et al., 2016). National financing was barely sufficient to maintain key services and pay for recurrent costs, such as provider salaries (Afnan-Holmes et al., 2015; Armstrong et al., 2016; Martínez Álvarez et al., 2016). When combined with donor contributions, available financing was well below the WHO recommended $44 per capita (Mann et al., 2016). The shift from socialized care to market mechanisms, such as health insurance and cost-sharing, led to rising out-of-pocket costs, particularly user fees, even though maternal health services were exempted. These constituted an increasingly greater proportion (30%) of health expenditures in the period (Armstrong et al., 2016; Masanyiwa et al., 2015; Mtei et al., 2014). Maternal health was especially dependent on government resources, the basket fund and out-of-pocket costs due to less vertical donor financing than other health areas, such as infectious diseases (Afnan-Holmes et al., 2015; Mann et al., 2016; Mkoka et al., 2014b).

Pressures to produce maternal health coverage results despite constraints

Maternal health was a long-term political priority, with increased emphasis following the MDGs and President Kikwete's engagement as an international figure for women's and children's health (Afnan-Holmes et al., 2015; Mahiti et al., 2015). Targets in the 2008-2015 national strategy for maternal, newborn and child health (One Plan) were ambitious and aligned with global priorities, such as increasing skilled birth attendance from approximately 50% to 80% (United Republic of Tanzania, 2008). Scarcities were acknowledged but did not appear to moderate target setting. Targets for the plan were focused on gaining high coverage of biomedical interventions to reduce mortality, while respectful care was nominally mentioned in a One Plan Annex. Some targets, such as skilled birth attendance, were subject to MDG reporting and tracking by international actors (Adegoke et al., 2012; Afnan-Holmes et al., 2015). At midterm in 2013, lack of significant progress compared to other countries generated pressures to accelerate improvements (Chimhutu et al., 2015; Mboera et al., 2015; United Republic of Tanzania, 2014a).

The meso-level organizational characteristics

These ambitious goals, in a context of resource scarcity, created challenges to organizational functioning. As Figure 3 depicts, MoHSW national and sub-national managers constantly coped with conflicting demands and scarcity and were unable to meet providers' support needs. Providers were overstretched and working in risky environments, and therefore made choices, conscious or unconscious, to ration the emotion work required to care for patients.

Balancing national and international priorities at central level

National MoHSW managers faced substantial challenges in implementing the One Plan, battling for resources, and negotiating for implementation support. Lack of a costed implementation plan may have made this more difficult, as well as inability to track expenditures (Afnan-Holmes et al., 2015; Mann et al., 2016). Provider shortages of up to 64% were a major challenge, with the largest gaps among skilled personnel in rural areas. Assessments revealed that supply shortages and stockouts

remained a significant impediment to progress until the plan's final year. (Afnan-Holmes et al., 2015; United Republic of Tanzania, 2014a, 2014b) National managers found it difficult to advocate for funding with the Ministry of Finance because the health sector received more donor financing than other sectors (Martínez Álvarez et al., 2016; Ng'ang'a et al., 2016).

Donors and international organizations provided support as well as complications for these managers. For example, while basket funding provided discretionary funds for maternal health, donors used soft power and global evidence to influence how the money was utilized (Fischer and Strandberg-Larsen, 2016; Swedlund, 2013). In some instances, large initiatives were driven by donors and politicians without consulting national technical managers about the solution's suitability (Chimhutu et al., 2015). The government may have chosen to be passive in order to obtain necessary financial resources (Fischer and Strandberg-Larsen, 2016). Nonetheless, donor groups sometimes assisted MoHSW managers in advocating with the Ministry of Finance for resources (Martínez Álvarez et al., 2016). Data were limited on how meso-level managers prioritized strategies and allocated funding given the need for rationing, and there were no data on how national managers cognitively coped with these circumstances.

Constant coping with limited autonomy and resources in districts

Council health management teams (CHMTs) at district level juggled central directives to achieve targets with responsiveness to population and health workforce needs without adequate resources or authority to make decisions. In the late 1990s decentralization devolved authority to districts for planning and budgeting, but actual decision-making space was constrained Districts were authorized to mobilize resources locally but they were rarely able to raise significant amounts and depended largely on central financing (Mollel and Tollenaar, 2013). CHMTs thus managed complex relationships with central budget holders, including PMO-RALG, MoHSW and donors, while responding to local communities' needs. Annual plan approval, and thus funding, depended on

alignment with strict budget allocation formulas and centrally defined ceilings and directives. CHMTs complained that central directives were often divorced from ground realities and failed to account for contextual diversity. (Chitama et al., 2011; Fischer and Strandberg-Larsen, 2016; Frumence et al., 2013; Maluka et al., 2011a; Masanyiwa et al., 2014; Mollel and Tollenaar, 2013) Additionally, directives tended to prioritize vertical activities to improve service coverage rather than investments in strengthening the health system, such as the human and physical resources required for increasing skilled delivery (Armstrong et al., 2016; Mkoka et al., 2014b).

Districts rarely received the full ceiling or timely disbursements, so official planning was often symbolic and aimed at legitimacy with approvers. CHMTs instead made actual decisions *in situ* as funds became available (Armstrong et al., 2016; Goddard et al., 2016; Maluka et al., 2011b; Mollel and Tollenaar, 2013). Funds for salaries typically were sufficient and timely, while discretionary funds for other needs, such as provider supervision, training and allowances; monitoring activities; and service quality improvements, were limited and unpredictable (Armstrong et al., 2016; Bradley et al., 2013; Frumence et al., 2014a). Maternal health programs were particularly reliant on pooled basket funding, which often arrived late, requiring workarounds, such as borrowing from other projects to cover basic service functioning, cancelling activities and/or foregoing allowances (Armstrong et al., 2016; Frumence et al., 2014a; Goddard et al., 2016; Mkoka et al., 2014b). CHMTs reported struggling to finance maternal services due to exemptions for service fees and limited vertical donor (Maluka, 2013; Mkoka et al., 2014b).

CHMTs also struggled to comply with reporting and performance measures, which could impact resource flows (Gaspar and Mkasiwa, 2015; Goddard et al., 2016). Data for making timely and accurate decisions was often not available or of good quality (Afnan-Holmes et al., 2015; Chitama et al., 2011; Mboera et al., 2015) and cumbersome procedures were required to transform routine data from multiple data collection systems into usable information (Igira, 2012). District managers

might also engage in practices such as falsifying documents and even sometimes paying auditors to ensure that resource flows continued (Gaspar and Mkasiwa, 2015).

CHMT members were typically clinicians, tended to focus on biomedical issues, and lacked skills in planning, management, and data interpretation (Chitama et al., 2011; Shayo et al., 2013). Per policy, the district staff member responsible for maternal health was not a full member of the CHMT, potentially resulting in insufficient allocations for maternal health (Chitama et al., 2011; United Republic of Tanzania, 2008). CHMT staff were able to describe supportive supervision principles and practices and were concerned about their inability to make routine visits to all facilities (Bradley et al., 2013). Like national counterparts, there were limited data on how they cognitively coped with these challenges and ultimately how they prioritized given shortages.

Emotional Labor, Emotion Work: Providers' capacity stretched thin

Providers bore the brunt of the scarcity because, although they served as the main interface with patients, the system failed to ensure a safe workplace and meet their support needs and contractual entitlements. This environment left the providers struggling to provide basic clinical care, but not always able to exert the emotion work required for respectful care.

Only about a third to a half of provider posts were filled, well below WHO standards, and with the greatest shortages in rural areas (Afnan-Holmes et al., 2015; Armstrong et al., 2016; United Republic of Tanzania, 2014a, 2014b). Women comprised 70% of maternal care providers, typically as nurses or midwives, while more senior clinical positions, such as doctors, assistant medical officers and clinical officers, were held by men (United Republic of Tanzania, 2014b). Some peripheral dispensaries were staffed solely by medical attendants who are not clinically qualified, but were the only means to ensure access for remote populations (Hanson et al., 2013; Munga et al., 2012; United Republic of Tanzania, 2014b; Zinnen et al., 2012). Provider absenteeism, often for

official purposes such as training, also routinely affected availability (Armstrong et al., 2016; Manzi et al., 2012).

Many providers perceived their workload as too high, taking on clinical tasks, including obstetric care, that were not part of their job descriptions and for which they were neither trained nor legally authorized (Adegoke et al., 2012; Lobis et al., 2011; Munga et al., 2012; Ng'ang'a et al., 2016; Songstad et al., 2012). Informal task-shifting was a widespread workaround, with the system reliant on less qualified providers to maintain services without formal policy support (Lobis et al., 2011; Munga et al., 2012). Less qualified providers in rural areas were more likely to shoulder additional tasks (Manzi et al., 2012; Munga et al., 2012; Prytherch et al., 2013). Providers described an increasing workload of non-clinical tasks, such as data collection, reporting and pharmacy management (Mkoka et al., 2014b; Wiedenmayer et al., 2015; Wilms et al., 2014; Zinnen et al., 2012). Findings on actual workload were contradictory across studies. Some studies found that providers usually worked more than contractually stipulated, including expectations to be available 24 hours a day (Mkoka et al., 2014b; Songstad et al., 2011; Zinnen et al., 2012). Other studies showed several hours of unproductive time daily; although these studies focused on outpatient services (Maestad and Mwisongo, 2013; Manzi et al., 2012). Whether providers were experiencing an actual shortage, many felt they were overstretched.

Providers described frustration with expectations to achieve unrealistic standards. Workforce shortages compelled them to make difficult choices about who would receive care (Mselle et al., 2013; Spangler, 2011; Tibandebage et al., 2015). Many recognized that constraints hampered performance of clinical standards and were troubled by compromises to patient safety (Mkoka et al., 2014a; Mselle et al., 2011; Ng'ang'a et al., 2016; Penfold et al., 2013; Shemdoe et al., 2016).

Providers organizational support needs unmet

Maternal care providers worked in risky environments without expected support from supervisors and the system, either psychologically, professionally, or materially. They gained satisfaction from their profession, but were unsatisfied with workplace conditions (Prytherch et al., 2012). Motivation findings across qualitative and quantitative studies were mixed, with qualitative data typically presenting a more negative picture.

The working environment and tools habitually failed to meet standards for safety and were an important determinant of satisfaction and retention (Mbaruku et al., 2014; Prytherch et al., 2012; Shemdoe et al., 2016). Essential medicines and protective supplies were often stocked out, and orders to central level might be delayed for many months or filled incorrectly (Masanyiwa et al., 2015; Mkoka et al., 2014a; MoHSW [Tanzania Mainland] et al., 2015). A 2014 national review of stockouts found that in all but two of the regions, more than half of facilities were missing at least one essential medicine (Armstrong et al., 2016). Providers were particularly troubled by glove shortages given the personal risk of exposure to bodily fluids during deliveries (Mselle et al., 2013; Ng'ang'a et al., 2016; Prytherch et al., 2012; Shemdoe et al., 2016).

CHMTs and providers sought workarounds and, while sometimes able to obtain stocks from nearby facilities or the private sector, it became unofficial national practice to ask women to bring gloves and other medical supplies for deliveries (Mkoka et al., 2014a; Mselle et al., 2013; Penfold et al., 2013; Spangler, 2011). Women might also be asked to pay for medicines or supplies, which they suspected was a ploy to demand informal; payments (Mahiti et al., 2015; Masanyiwa et al., 2015; Mkoka et al., 2014a; Spangler, 2011). Providers rationed use of oxytocin, using this workaround to save limited resources for emergency needs rather than routine prevention of hemorrhage (Hanson et al., 2013; Mkoka et al., 2014a). Health facilities often lacked basic clinical equipment and utilities, including water for drinking and handwashing, toilets, and electricity (Armstrong et al.,

2016; Mbaruku et al., 2014; Penfold et al., 2013; Ueno et al., 2014). Deficiencies in supplies, equipment and infrastructure risked safety, heightened tensions with women and affected providers personally and professionally (Mahiti et al., 2015; Mbaruku et al., 2014; Mkoka et al., 2014a; Penfold et al., 2013; Songstad et al., 2012; Tancred et al., 2016). Providers staying for long durations at a facility may have begun to normalize this environment (Mbaruku et al., 2014; Shemdoe et al., 2016).

Providers' morale was further affected by an unsupportive interpersonal environment and poor management (Mbaruku et al., 2014; McAuliffe et al., 2016a; Shemdoe et al., 2016). They described supervisors who were not psychologically or professionally supportive, and sometimes displayed favoritism. Managers and providers reported that expected quarterly supervision visits did not always occur, leaving some peripheral providers feeling isolated (Bradley et al., 2013; Manzi et al., 2012; McAuliffe et al., 2013; Mkoka et al., 2015; Ng'ang'a et al., 2016). Providers despaired that visits often focused on fault finding, prioritized records review rather than consultation, and lacked encouragement, moral support and respect (Maestad and Mwisongo, 2013; Manzi et al., 2012; McAuliffe et al., 2013; Mselle et al., 2013; Prytherch et al., 2012; Shemdoe et al., 2016). Providers felt the context was not adequately acknowledged in performance reviews, had reduced morale due to negative feedback and feared blame if a woman died (Litorp et al., 2015; McAuliffe et al., 2013; Mselle et al., 2013).

Providers struggled with avoidable deaths caused by lack of resources and did not feel psychologically supported by colleagues and seniors, even less so in facilities providing basic obstetric care (Mbaruku et al., 2014; Shemdoe et al., 2016). Relationships with colleagues sometimes created more stresses, such as poor teamwork between nurses and other clinicians (Litorp et al., 2015; Ueno et al., 2014), competition for informal payments (Mæstad and Mwisongo, 2011) and senior clinicians failure to respond when called for emergencies (Tibandebage et al.,

2015). Approaches to improve care, such as maternal death reviews, sometimes created an emotionally, professionally, and politically charged atmosphere (Armstrong et al., 2014; Litorp et al., 2015). Positive relationships with the community incentivized some providers to stay, but more commonly negative relationships, such as when blamed for a death, made them feel undervalued (Shemdoe et al., 2016).

Across studies, providers complained of being denied contractually stipulated entitlements. Decisions regarding entitlements were considered neither fair nor transparent, and often attributed to favoritism. (Mkoka et al., 2015; Ng'ang'a et al., 2016; Prytherch et al., 2012; Songstad et al., 2011) Many expressed dissatisfaction with their pay vis-à-vis workload and routine failures to pay allowances for overtime and additional duties (Mkoka et al., 2015; Ng'ang'a et al., 2016; Ye et al., 2014). Maternity providers were especially demotivated due to the frequent need to work off hours and at night (Mkoka et al., 2015; Tibandebage et al., 2015). Failed expectations for career advancement and learning were commonly mentioned, such as contractually-stipulated promotions every three years (McAuliffe et al., 2016b; Ng'ang'a et al., 2016; Shemdoe et al., 2016; Songstad et al., 2011; Zinnen et al., 2012).

Despite difficult conditions, providers often remained in government employment, preferring the salaries, job security and pension benefits as compared to private sector alternatives (Prytherch et al., 2013; Songstad et al., 2011; Zinnen et al., 2012).

Normalization of deviance in micro-level daily transactions

Tanzanian women delivering at health facilities across the country had widely varying clinical and interpersonal experiences (Armstrong et al., 2016). They sought good interpersonal care, preferring above all characteristics, a kind provider with good medical knowledge (Larson et al., 2015). Depending on when and where they were asked, 15 to 28% of rural women and 19.5% to 70% of

urban women reported incidents of mistreatment during institutional delivery. The most reported behaviors were: being ignored or abandoned, verbal abuse (e.g., being shouted at and threatened), and physical abuse. (Kruk et al., 2018; Sando et al., 2016) Observations of institutional deliveries in a rural setting found that nearly 70% experienced a form of mistreatment, indicating that women also likely normalized mistreatment (Freedman et al., 2018).

Poor women and their families were disillusioned by perceived differences in care, accentuated by their inability to bring medical supplies and meet providers' tacit expectations for informal payments despite policy exempting fees (Mæstad and Mwisongo, 2011; Masanyiwa et al., 2015; McMahon et al., 2014; Shayo et al., 2016; Spangler, 2011). Women feared repercussions if they made complaints, such as denial of services or closing of the local facility, or expected that no action would be taken (McMahon et al., 2014). While some women opted to deliver at home, others who sought care may have resigned themselves to experiences of disrespect if able to access care of sufficient clinical quality (Kruk et al., 2014; Larson et al., 2015).

As described above, obstetric providers expressed frustration with long and late hours and a system that did not respect their entitlements and concerns. Obstetric care was perceived to be physically risky, due to exposures to blood, and professionally and psychologically risky due to pressures within and outside the system around maternal and newborn survival (Armstrong et al., 2014; Litorp et al., 2015; Mselle et al., 2013). Similarly, maternity posts were perceived as a heavier workload than others (Prytherch et al., 2013). Midwives were aware that mistreatment was not acceptable to women, but felt that other clinicians and the community did not respect them (Litorp et al., 2015; Ng'ang'a et al., 2016; Tibandebage et al., 2015). Providers described feeling overwhelmed, powerless and abandoned, especially when facing difficult choices about how to provide care (Mkoka et al., 2015; Mselle et al., 2013; Prytherch et al., 2012; Spangler, 2011; Tibandebage et al.,

2015). Accordingly, they may have been less willing to exert emotion work without additional incentives (e.g., informal payments) or entitlements (e.g., allowances) (Mæstad and Mwisongo, 2011; Songstad et al., 2011).

Regulatory systems

Despite widespread mistreatment and non-compliance with standards, internal regulatory systems did not capture or mitigate these behaviors due to system weaknesses, focus on production targets, and emphasis on control (see Figure 3). Participatory mechanisms, rather than ensuring system accountability to citizens, were co-opted to advance organizational goals and lacked autonomy.

Weak monitoring systems prioritize production targets

Regulatory systems were unable to capture mistreatment, part because indicators to monitor system performance focused on coverage of biomedical care, rather than quality and processes of care (Afnan-Holmes et al., 2015; Kumalija et al., 2015; United Republic of Tanzania, 2008). No indicators related to women's experience were included as part of the One Plan monitoring framework (United Republic of Tanzania, 2008).

The health management information system, a primary data source, included registers for data collection and reporting from health facilities. Facility and district data were typically of poor quality and considered unreliable for district planning and national analyses (Afnan-Holmes et al., 2015; Chitama et al., 2011; Kumalija et al., 2015; Mboera et al., 2015). A mismatch between registers and the data necessary to calculate indicators for reporting drove managers and providers to find workarounds, such as creating separate registers, adding columns, and using old forms (Igira, 2012; Wilms et al., 2014). The TSPA found that 10% of health facilities had a system for client

feedback in place, but it is not clear what these mechanisms were and how the data were used (MoHSW [Tanzania Mainland] et al., 2015).

Internal systems focused on control across a large network

It was impracticable for supervisors or other regulators to observe and monitor most deliveries, let alone mistreatment incidents, creating structural secrecy. Between 2010 and 2015 an estimated 11.9 million births occurred in Tanzania. At an institutional delivery rate of 51% (MoHCDGEC Tanzania Mainland et al., 2016), approximately 2,700 births per day occurred across a network of more than 5,000 primary care facilities and 55 hospitals, which were dispersed among 21 administrative regions, 113 districts and nearly one million square kilometers (United Republic of Tanzania, 2009; World Bank, 2010). Periodic assessments included observations of service delivery and interviews with women; but these focused on antenatal rather than delivery care (MoHSW [Tanzania Mainland] et al., 2015). Reviews and audits of adverse outcomes were an important mechanism for documenting maternal health care quality but were focused on clinical care. Human resource shortages made them infrequent and when conducted, they were often incomplete or of poor quality and professionally stressful events (Armstrong et al., 2014; Litorp et al., 2015; van Hamersveld et al., 2012).

Supervisory systems had dual, sometimes conflicting, roles of supporting providers and enforcing national standards. Supervision frequency and content was intermittent and patchy with some facilities visited monthly, while others only annually (Bradley et al., 2013; Shemdoe et al., 2016). Infrequent visits were attributed to staff shortages at district and facility levels and limited transport and fuel (Bradley et al., 2013; Shemdoe et al., 2016). Supervisors found it hard to balance holding providers accountable while understanding that working conditions contributed to poor performance (Tibandebage et al., 2015). They had limited options for sanctioning providers, and instead used transfers or withheld entitlements or training opportunities (Maluka and Bukagile,

2016; McMahon et al., 2014; Spangler, 2011). No articles described how district or facility level supervisors were held accountable for supervision practices. The role of professional regulatory bodies and associations was absent as well.

Community and women's voices sidelined

Decentralization aimed at greater responsiveness to the population, including through increased citizen participation. Several committee types with elected representatives were established at village, facility and district levels for bottom-up healthcare decision-making and oversight. In practice, participatory planning varied across districts. CHMTs were often unconvinced about the ability of non-medical personnel with limited education to make legitimate contributions (Frumence et al., 2013; Kilewo and Frumence, 2015; Maluka et al., 2011a; Shayo et al., 2012). The committees were also dependent on the district for operational funding (Frumence et al., 2014b; Kilewo and Frumence, 2015), were sometimes bypassed in annual planning, and had limited ability to sanction CHMTs (Kilewo and Frumence, 2015; Maluka et al., 2011a). National guidelines were unclear about each community structures' authority, and guidelines and other documents were in English rather than Swahili (Kilewo and Frumence, 2015; Maluka et al., 2011a). CHMTs rarely trained committee members as expected (Kilewo and Frumence, 2015; Maluka et al., 2011a; Maluka and Bukagile, 2016; Mollel and Tollenaar, 2013).

Districts that supported these mechanisms often co-opted them to achieve system goals, such as mobilizing resources, enrolling people in community insurance, supporting daily operational tasks or promoting health information, rather than learning about community needs or enabling their accountability role (Frumence et al., 2014b; Kilewo and Frumence, 2015; Maluka and Bukagile, 2016). When community structures mobilized resources, such as for community health insurance, they were not always involved with or informed about funding allocations (Maluka and Bukagile, 2014; Mkoka et al., 2014a). Community members recognized their limited influence in decision-

making, which may have made them unwilling to invest in participation (Masanyiwa et al., 2014; Mollel and Tollenaar, 2013). Within committees, women's participation was limited by spouses and structural issues and their contributions were often ignored or questioned by male community members (Masanyiwa et al., 2015; Shayo et al., 2012). Nonetheless, HFGCs were successful in monitoring purchases of medicines and supplies and sometimes in holding negligent providers accountable (Frumence et al., 2014b; Maluka and Bukagile, 2016; McMahon et al., 2014).

DISCUSSION

Using analogical comparison, this article developed an organizational theory on why mistreatment in childbirth persisted in the public health system of Tanzania in the period of 2010-2015 drawing from Vaughan's *normalization of organizational deviance* theory, supplemented by *power-dependence* theory. Mistreatment in childbirth, a form of organizational deviance, was found to have been normalized in the system, persisting over time. While national norms called for respectful care, similar behavior patterns across a large geography indicate its systemic nature, despite some exceptions among providers and sub-units. Societal expectations were also violated as respectful care was desired by women and their families. These behaviors may have been institutionalized during colonial era medicine (Bradley et al., 2016), yet mistreatment in childbirth persisted due to contemporary motivations and processes (Zucker, 1977). Reviews exploring the phenomenon have identified factors similar to those identified in this article (Betron et al., 2018; Bowser and Hill, 2010; Bradley et al., 2016); however, article advances understanding by examining the relationships among these factors.

Providers described feeling distress about patient safety and struggling to provide quality care, casting doubt that the pattern was due to conscious intention to harm. They adopted workarounds and rationed emotion work, which was reproduced and justified due to organizational constraints and system signals as to what was important. As shown in Figure 3, these behaviors were

influenced by production pressures and normalized scarcity occurring at the macro-level that distorted the system. In her study of the Challenger launch decision, Vaughan found that managers at NASA did not knowingly engage in wrongdoing, rather, production pressures and scarcity altered organizational processes leading to incrementally normalized risk, masking of important signals, and ultimately resulting in the fateful decision to launch the shuttle (Vaughan, 1996). While mistreatment in childbirth rarely results in a headline grabbing moment of catastrophe, its consequences for the individual and society are significant, turning expectations for profound joy into experiences of humiliation, fear, and trauma. The spatial and temporal dispersion of individual events prevents recognition of their culmination as a social catastrophe.

Findings reveal that in the Tanzanian health system power-dependence among macro-, meso- and micro-levels was imbalanced due to dependence for goal attainment, status and resources (Emerson, 1962). The system and its subunits changed priorities and behavioral focus to align with external sources and those holding more power (DiMaggio and Powell, 1983) as highlighted in the boxes between the levels in the Figure 3.

In macro-meso level interactions, macro-level actors relied on the meso-level to achieve goals but directed goals towards priorities of resource holders (i.e. production of institutional deliveries). Driven by global and national legitimacy pressures, macro-level actors normalized scarcity, prioritized institutional logics of biomedicine, and emphasized production of coverage. Internal regulatory systems reinforced these priorities, narrowing the focus at meso-level. Dependency reduced managers' ability to resist formal and informal pressures to adopt these priorities and strategies (DiMaggio and Powell, 1983). Information on how managers coped with this cognitive dissonance was limited, other than some references to power balancing strategies, such as compromising plans to obtain resources and occasionally forming coalitions with donors (Emerson, 1962).

Although beyond this article's scope, macro-level actors were influenced by similar dynamics in the global arena. Global maternal health actors intentionally narrowed focus to standardized biomedical interventions and measurable targets as a legitimating strategy to compete against other disease-focused health initiatives (Freedman, 2011; Storeng and Behague, 2014). A five-country study in sub-Saharan Africa similarly found that targets focused on service statistics, donor earmarking of funds based on international biomedical priorities, and limited maneuvering space for meso-level actors resulted in priority setting distortions (Jenniskens et al., 2012).

In meso-micro level interactions, providers' dependency for material and symbolic resources shaped relationships with managers, who relied on providers to achieve organizational goals. Providers continued to perform despite a risky workplace that did not ensure their physical and psychological safety due to limited employment alternatives. Given stresses, managers likely withdrew emotion work in supervision as a coping mechanism, as they sought balance to reduce the effects of their limited power to plan, budget and support providers (Emerson, 1962). While research on emotion work in healthcare typically focuses on patient interactions, other literature points to poor relationships between supervisors and colleagues and perceived lack of organizational support as a source of negative performance outcomes (Rhoades and Eisenberger, 2002; Safran et al., 2006).

These dynamics also manifested in micro-level interactions between providers and women. Women were dependent on providers for positive health outcomes and had limited alternatives for healthcare. Yet, providers also relied on women's cooperation to achieve production goals and to avoid the costs associated with a maternal death. Providers facing constraints likely either shifted values or withdrew to cope with distress at their powerlessness to perform according to standards (Emerson, 1962; Häggström et al., 2008). Emotional labor that goes unacknowledged by organizations has the potential to create psychological costs that are estranging (Hochschild,

1983). Healthcare research on emotional labor indicates that providers tend to withdraw emotion work when resource constrained, coping with cognitive dissonance through distancing and focusing on biomedical care (Riley and Weiss, 2016).

Community accountability mechanisms might have balanced these dynamics, but lacked autonomy due to dependency for financial, informational and status resources. Managers and providers sustained this imbalance, potentially as a strategy to prioritize responsiveness to organizational demands, but also due to doubts about their legitimacy. Pressures to find alternative income sources further led meso-actors to co-opt these groups for organizational goals, such as enrolment in community insurance.

A study in India similarly found that workplace conditions led staff to ration care and exhibit disrespectful behaviors, which was justified through institutional logics focused on hierarchy and authority over adherence to standards (Madhiwalla et al., 2018). Two reviews of community accountability mechanisms in LMICs identified that mismatches between bureaucratic systems and participatory processes, resistance from managers and providers, and community actors' limited capacity weakened their effective functioning (Cleary et al., 2013; Molyneux et al., 2012).

Recommendations for reform

Eradicating institutional mistreatment in childbirth is not likely to be straightforward. An iterative approach that engages actors across the levels, including women, is required to disrupt persistent negative cycles and create more 'virtuous' cycles, tackling emergent problems as others are resolved (Burns et al., 2013). Working at the fringes, relying solely on providers to change behavior, is unlikely to bring about transformation. Importing solutions or indicators from other settings without meaningful attention to their relevance and local application may exacerbate problems (Olivier de Sardan et al., 2017). While evidence of what works remains limited, immediate efforts

can be taken to co-create and test solutions to transform the organizational culture. Testing in average rather than exceptional cases would help to understand what the system is designed to produce, rather than relying on positive deviance. The elaborated theory points to potentially fruitful intervention areas, if women's experience of care remains a centralizing focus.

At the macro-level, immediate reflection and action is needed to counteract normalization of scarcity, ensuring practicable production goals and targets and investments in basic system resources. Goals, targets, and standards may align with global agendas, but require careful review for feasibility so that meso- and micro-level actors are not forced into workarounds. Similarly, strategies replicated from other contexts require examination for any unintended consequences, identifying meaningful adaptations and/or co-creating new solutions to reflect extant practices and available resources. Internal and external regulatory systems should be examined to ensure that they are emphasizing organizational priorities, including respect as a foundational value.

At the meso-level, shifts in organizational culture will require strong leadership that affirms emotion work as an explicitly valued task, directing resources and reshaping relationships to affirm trust and respect. This includes ensuring a physically and psychologically safe environment for providers and actively reducing stress and promoting mental well-being. Strengthening autonomy and reducing cooptation of community accountability mechanisms can buttress emphasis on population priorities, particularly if women's voices are given real rather than symbolic space.

Methodological Considerations

Original theory was elaborated using analogical comparison in a novel way based on a systematic review of literature for a specific case. The nature of the theory and approach required an assemblage of articles that examined different parts of the system, thus requiring interpretation of concepts, assessing their relative importance, and triangulating across disciplinary perspectives.

The aim was interpretation to transform data into theory rather than for synthesis (Barnett-Page & Thomas 2009). Reflexivity, checking for negative cases, and validation with other experts were used to mitigate against potential bias.

Future research will be needed to apply the theory in other contexts as it was developed based on a particular case. Future applications should explore each of the theoretical concepts carefully, as they have been mostly developed and applied in North America and Europe. In addition, reliance on existing literature revealed gaps in existing areas of research. For example, gendered dimensions of the problem did not emerge strongly, requiring further examination given other findings across the literature (Betron et al., 2018). The experiences of managers and their coping mechanisms were also not well documented, creating gaps in understanding at the meso-level. Furthermore, examining relationships and power dynamics between system levels would deepen understanding of how power-dependence shaped system actions.

CONCLUSION

Mistreatment in childbirth, and women's experience of this as disrespect, has harmful social and health consequences calling for immediate attention to disrupt this normalized deviance. This is among the first studies to elaborate theory about mistreatment in childbirth based on a case. A novel approach to theory development, based on analogical comparison, enabled new perspectives on the factors that perpetuate mistreatment. Although further application is needed, this review provides an important step towards explaining how and why mistreatment persists as organizational deviance in healthcare institutions.

Using a multi-level framework, such as Vaughan's theory, draws the lens back from the patient-provider interaction to understand what is shaping that interaction from multiple system levels. Organizational sociology provided a fruitful theoretical lens, characterizing the relationships

between seemingly disparate factors. Its application to other challenges in health systems should be considered more broadly. Theory elaboration revealed how power-dependence relationships among levels, compounded by resource scarcity, enabled mistreatment to persist. Additional research exploring relationships among and within levels would assist in strengthening the theory and identifying intervention leverage points. Other theoretical lenses are also needed to comprehensively understand and address mistreatment in childbirth.

While Tanzania was used as the case for theory elaboration, extant reviews and research have highlighted similar factors indicating that the theory may be relevant to other geographical settings, as well as different types of healthcare systems and other healthcare services. The theory demonstrates that tackling mistreatment is not merely a matter of training providers in ethics, initiating specific programmatic responses or identifying exceptional cases that resist institutional logics. Systemic change in structures, processes and culture, and the embedded power dynamics, is needed to disrupt normalized patterns that have been reinforced and reproduced. Without this transformation, it is unlikely that any efforts to promote respectful maternity care will be sustained.

Paper 2: Hidden in plain sight: elaborating theory on how health systems enable the persistence of mistreatment in childbirth

INTRODUCTION

Mistreatment in childbirth has emerged as an important social pattern reproduced in health systems globally. Women's experiences delivering in healthcare institutions often go beyond poor interpersonal care to violations of their rights to freedom from harm, respect, consent, equality, and autonomy (Bohren et al., 2015; White Ribbon Alliance, 2016). Incidents of mistreatment, such as physical or verbal abuse, represent a deviation from norms and standards established by global and national health institutions and healthcare professional organizations (Vogel et al., 2016). Consequently, public trust in healthcare institutions deteriorates as this trust depends on relationships with healthcare providers (Gilson et al., 2005).

Research shows that mistreatment in childbirth has been normalized among women using institutional delivery services, as well as by system actors (Schaaf et al., 2023). Although some women may forego institutional delivery due to mistreatment, others are resigned to or no longer recognize experiences as mistreatment (Bohren et al., 2016). System actors often justify mistreatment, such as shouting or slapping, as an important means to obtain women's cooperation and thus ensure survival of the woman and her newborn (D-Zomeku et al., 2020; Warren et al., 2017).

Given similar patterns of mistreatment across different times and places, it is increasingly clear that organizational arrangements and system characteristics play an important role in producing and perpetuating mistreatment (Afulani et al., 2020; Reddy et al., 2022). Strategies to combat mistreatment therefore require approaches recognizing its systemic nature. The social nature of mistreatment and healthcare institutions also indicate a need for social theory to underpin interventions, with theoretical insights required to develop the appropriate interventions (Downe et al., 2023). Developing theory from a variety of social science lenses can help to unearth the

underlying structures and mental models that enabled the normalization of mistreatment (Gilson et al., 2011).

Developing theory

To explore how health systems normalized mistreatment, the first author applied organizational sociology to examine the case of mistreatment in childbirth in Tanzanian government facilities. It was hypothesized that mistreatment was a case of normalization of organizational deviance because it counters explicit organizational goals and showed systemic patterns (Ramsey, 2022). Analogical comparison with a different case of normalization of organizational deviance in the government space program in the United States enabled development of novel theory (Vaughan, 2014, 1996). The case study, based on systematic literature review, revealed that normalized scarcity combined with production pressures for biomedical childbirth care at macro-levels of the health system distorted system functioning. Power dependence imbalances between macro- and meso-levels led to shifting of values, structures, and processes as meso-level actors, including sub-national managers and health workers, struggled to achieve production targets with limited material and symbolic (e.g., trust, respect, status) resources and autonomy. Given institutional logics which prioritized biomedicine, clinical care was prioritized over interpersonal care, and providers rationed emotion work, the effort to manage emotions in the workplace, in their interactions with women. Providers' behavior generally did not appear to be intentionally harmful and institutional logics were used to justify any acts of mistreatment.

From the analysis a nascent theory of the organizational causes of mistreatment of women in childbirth in health care institutions emerged but requires further elaboration and verification to ensure that it adequately captures the phenomena as well as remains relevant across other health systems and contexts (Vaughan, 2014). As a first step, a case using primary data that is specific to

mistreatment can help to further elaborate the theory. Therefore, the authors sought to test and iterate the theory in the original context using qualitative data from a project in Tanzania focused on mistreatment.

METHODS

A qualitative theory-driven approach was used to verify and expand the nascent theory developed by the first author (Meyer and Ward, 2014; Ramsey, 2022; Vaughan, 2014). In this approach, *a priori* theory is used to drive initial deductive analyses, complemented by inductive and abductive inference allowing for emergent ideas. It enables qualitative research to verify, expand, and test extant theory while avoiding problems of missing important data that lie outside the theoretical framework.

A case was developed with data that were part of formative qualitative research for a quasi-experimental study, "The Staha Project"[3], conducted between 2011 and 2015 in the Tanga Region of Tanzania (Kujawski et al., 2017). The research was conducted by Ifakara Health Institute and Columbia University in collaboration with government health officials and staff. Qualitative data aimed at understanding perspectives on mistreatment and its causes.

Study setting

The data were collected in Korogwe District of Tanga Region, the study's intervention district. At the time of the study, Tanga's institutional delivery rate of 66.8% was slightly higher than the national average (62.6%) (MoHCDGEC Tanzania Mainland et al., 2016). Baseline quantitative research found relatively high levels of reported disrespect and abuse in the study districts. In interviews, 19% of women discharged from study facilities reported experiencing at least one form of mistreatment, with the prevalence rising to 28% when reported in home interviews five to ten weeks after delivery

[3] *Staha* means respect or esteem in Swahili.

(Kruk et al., 2018). Observations by trained nurses found a prevalence as high as 69.83%, indicating potentially high levels of normalization (Freedman et al., 2018).

Sampling

We used maximal variation sampling to ensure diverse perspectives on mistreatment across the health system (Creswell and Poth, 2017). Focus group discussions (FGDs) and in-depth interviews (IDIs) were conducted with purposive samples of women, men, community leaders, health workers, health facility managers, and national, regional and district government staff, as well as national professional normative bodies and implementing organizations.

National, regional and district level respondents were identified by their roles and contacted by letter and phone. Four government health facilities and their catchment areas in Korogwe were purposively chosen to reflect the range of settings, including one district hospital, three health centers and one dispensary. Health facility managers included facility in-charges as well as maternity ward heads in larger facilities. Providers in the maternity ward who attended or supported deliveries were included. They were recruited via an official letter that was first sent to the district government and then contacted by phone. For community-based focus groups, local key informants assisted in identifying the participants. A total of eight FGDs and 37 IDIs involving 91 individuals were conducted as shown in Tables 1 and 2.

Table 1. FGD participants

Participants	Number of FGDs	Number of participants
Community		
Women who delivered in health facilities in the last 12 months	2	19
Women who delivered at home in the last 12 months	1	8

Participants	Number of FGDs	Number of participants
Men with partners who delivered in the last 12 months.	2	12
Health system		
Clinical officers	1	8
Nurses and midwives	1	7
Medical attendants*	1	7
TOTAL	8	54

* Medical attendants are neither trained nor authorized to provide delivery care; however, they often attend deliveries using skills learned on-the-job.

Table 2. In-depth interview participants

Participants	Number of IDIs
Health system - Government	
National government and non-governmental managers	13
Regional healthcare managers	3
District healthcare managers	3
Health facility managers	4
Healthcare providers	7
Community	
Community government and leaders	4
Community influencers	3
TOTAL	37

Data collection

Guides were developed by the study team and informed by literature review. Guides were developed in English and translated into Swahili by bi-lingual researchers. IDIs and FGDs were

conducted by fluent Swahili speakers, either research staff from Ifakara Health Institute or research assistants with previous experience conducting qualitative research who had received training on the topic, the guides, and research ethics. Data collection took place between August 2011 and January 2012. Audio recordings were used to complete verbatim transcriptions. Swahili transcriptions were translated into English by professional translators and reviewed for accuracy.

Data analysis

Data were analyzed using Meyer and Ward's approach . Constructs from the nascent theory elaborated by Ramsey were used as the *a priori* theoretical framework to develop the initial codebook (Ramsey, 2022). The first and second authors independently coded three interviews and compared results, discussing coding decisions until consensus was reached. Thirty percent were double coded, while the remaining were divided between the first and second author to complete coding. Emergent constructs beyond the theoretical framework were coded in one code. Data under this code was reviewed and new codes agreed upon between the two authors. Memos were written throughout the process to capture emerging thoughts and highlight reflections on the data. The two coders met to discuss the themes emerging from across all the data.

Ethical clearance

Ethical approval was received from the internal review board of Ifakara Health Institute and the National Health Research Ethics Review Committee at the National Institute of Medical Research, and Columbia University. All participants were informed about the study and gave written consent. Permission to conduct the research was also obtained from relevant government authorities.

RESULTS

Analysis of primary data revealed many similarities with the nascent theory. Participants' perspectives largely supported key constructs within and relationships among the different levels of the system elaborated in the original theory. Some additional nuance was added to two

constructs and another emergent system effect was added between the meso- and the micro-level. The regulatory environment was revised the most, adding specifics to what was previously more generally about regulation of the health system. Figure 1 visualizes key concepts and relationships in the theory, with changes from the original shown in bolded red font. Table 3 provides a description of each construct and how it has been revised from the original.

Figure 1. Organizational causes of the normalization of mistreatment in childbirth

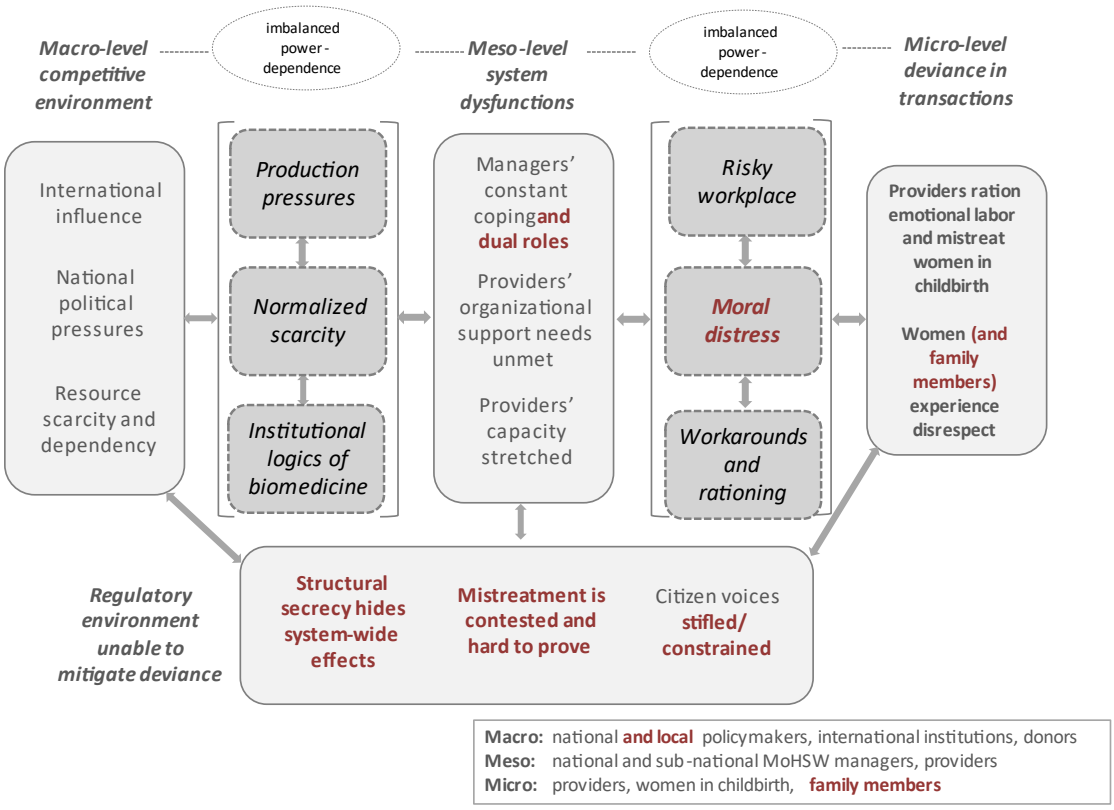


Table 3. Theory constructs, descriptions, and findings

Construct	Description	Findings
Macro-level competitive environment		
National political pressures	Pressures to achieve production targets, namely increase institutional deliveries	Confirmed

Construct	Description	Findings
Resource scarcity and dependency	Insufficient resources to achieve system goals resulting in dependency on external actors	Confirmed
International influence	International actors use resource dependency to influence policy and implementation	Did not emerge in the analysis, perhaps due to the lack of high-level policy makers included in the sampling
Emergent system effects		
Production pressures	Unrealistic goals set by the system felt by actors at the meso-level	Confirmed
Normalized scarcity	Ambitious goal setting without sufficient resources to achieve system targets	Confirmed
Institutional logics of biomedicine	Focus on biomedicine as the guiding logic behind system actions	Confirmed and clinical outcomes used to justify 'strict' behaviors with women
Meso-level system dysfunctions		
Managers' constant coping **and dual roles**	Managers struggle to mobilize sufficient resources with limited means.	Confirmed and managers at district and facility levels hold dual roles, also providing patient care
Providers' capacity stretched	Limited number and skills of providers stretches their physical and cognitive capacity	Confirmed and limitations in material resources further stretch this capacity
Providers' organizational support needs unmet	Material resources, such as financial remuneration, and symbolic resources, such as recognition and psychological support, not adequately provided	Material resources such as 'working tools' moved to the above construct
Emergent system effects		
Risky workplace	Psychologically and physically unsafe work environment for providers	Confirmed
Moral distress/ residue	Moral Distress: Negative experience when a provider knows what to do but is unable due to system constraints Moral Residue: Lingering feelings of distress which if unresolved can lead to burnout, anxiety, depression, and withdrawal.	New construct that emerged from the findings
Workarounds and rationing	Providers create new informal practices or withhold certain services due to resource shortages	Confirmed
Micro-level deviance in transactions		
Providers ration emotional labour and	Providers either consciously withhold or lose the ability to exert the emotion	Confirmed

Construct	Description	Findings
mistreat women in childbirth	work necessary to provide respectful care	
Women **and family members** experience disrespect	Mistreatment experienced as humiliating or undignified by women and/or their families	Confirmed
Regulatory environment unable to mitigate deviance		
Structural secrecy hides system-wide effects	Resolution of mistreatment complaints at facility/district level without reporting up the system	Changed from weak monitoring systems prioritize production targets
Mistreatment is contested and hard to prove	System leaders not able to observe mistreatment; contested interpretation of events based on verbal accounts	Changed from internal systems focused on control across a large network
Citizen voices stifled/ constrained	Mistreatment complaints withheld due to fears of retribution	Changed from citizen voices sidelined

Mistreatment in childbirth as organizational deviance

You know, maybe I should say it is a problem in Tanzania because everywhere people do complain on how the services are being provided, people are not satisfied yet. Community leader_01, IDI

Health systems actors at all levels and community actors recognized different aspects of respectful care as elements of patients' rights. All mentioned respect: although community members emphasized being received well, empathy, and compassion while providers spoke more about being polite and using good language. All emphasized the right to appropriate and timely medical care as a primary right, hence that patients should not be neglected or abandoned. Many also recognized that women have the right to be listened to and to express themselves about their problems. Similarly, they described the right to be counselled or informed about the diagnosis and the treatment, as well as the right to refuse treatment.

... the patient is to be respected when they get to the health center. They deserve to get sympathy from the nurse on duty, with a compassionate voice and a comforting heart. This will make them feel free to express their problems and bring in hope and relief despite the diseases they might be

having. Community influencer_01, IDI

Under these circumstances she has all the rights; she has the right to accept what you want to give her, and she has the right to refuse the service. You, the health care provider, have no right to refuse to give service to a patient, but the patient has the right to refuse the services. Health facility manager_01, IDI

System actors were aware that mistreatment was not acceptable per norms and standards. They cited policies and guidelines that guide the interaction with all patients, not just women seeking childbirth care. Yet, the types of policies and guidelines mentioned varied across different system stakeholders from clinical guidance to civil service regulations to health professional codes of ethics. The numerous relevant policies, some of which were described as quite long, created a degree of confusion, especially among providers.

Competitive macro environment

The big problem in the working field is that we are always told that "there is no money" and that has become a national song! National manager_01, IDI

Resource scarcity

The health system and its services were characterized by overall scarcity. Health system and community actors described scarcity in terms of funding, supplies, infrastructure, and health personnel. District and national managers complained that 'dismal' amounts of funding caused failures to provide services and reach health system goals. They lamented the health sectors low priority in national resource allocation and the mismatch between available resources and the volume of services required to meet demand.

But it is difficult to fulfil all of that [patient rights] due to the shortage of service providers. There are not enough facilities to meet the demands of the population that we have here in Tanzania. We do not have enough equipment, infrastructure such as buildings, and so we do not have the ability to

help the Tanzanians, most of whom are very poor. National manager_02, IDI

National political pressures

Health system actors at all levels felt political promises to provide delivery services at no charge worsened the situation. The policy exempting fees for maternity services, aimed at increasing facility delivery, was perceived as financially unrealistic. When medicines and supplies were unavailable, providers were frustrated by the burden of explaining that there were insufficient resources to meet this promise. Rising facility-based deliveries without resource improvements further stretched the system's capacity.

The government has said that everything is free, but it doesn't run itself free; everything is free, but you find that in that working area they are not available. So, I cannot provide money from my pocket to buy those things. How many mothers shall I buy for? So, they should be informed that the service is like this and this! Health facility manager_02, IDI

District and facility level staff were frustrated with politicians who they felt failed to support the health system. They wanted politicians to inform people about the realities, rather than making grand promises. Some indicated that politicians lied to obtain constituent support, failed to understand the costs of providing services, and then blamed the system when things didn't work, creating significant discord between system actors, politicians, and citizens.

For example, the honorable Councilors, sometimes the members of parliament, they fail to tell them about the real situation in service delivery…Later, instead they join hands with the people in condemning health workers. Thus, they create a gap between the people and the service providers, while we expected political leaders to be an important link. District manager_01, IDI

Resource dependency

Leaders from the community to the district spoke about dependency upon donors when

government resources were insufficient. For instance, at district level, they turned to international non-governmental organizations (NGOs) for support. International funding often only provided temporary relief due to the unpredictability of NGO's presence and corresponding support. Nonetheless, most participants remarked on the positive impact of donor support.
It was acknowledged that there had been system-wide improvements in delivery care as illustrated by the increase in women delivering in health facilities.

Meso-level system dysfunctions

You can judge that it is a problem of the civil servant's behavior to disrespect customers. If you take it simply that way without looking further, maybe you will be thinking in a cage... But if you look at the environment which has caused this situation to occur there are plenty of issues. District manager_01, IDI

Scarcity and dependency combined with political promises created dysfunctions in system operations affecting managers' and providers' ability to perform to expected standards. Hence, they relied on workarounds and rationing to continue functioning, leading to moral distress.

<u>Managers' constant coping and dual roles</u>

Managers were limited in what they could do to address the resource shortages. They often mentioned their inability to cover shortages with funds from 'their own pocket,' emphasizing the dire nature of shortages.

National and regional managers expressed frustration at their inability to meet district needs. While national strategies brought significant improvements, it was not yet enough to overcome the great needs. National managers struggled with limited channels to mobilize resources for even basic

needs. Regional managers tried to assist the districts, but they also had insufficient funding, such as for conducting supervision.

So, as I told you we are trying to ensure that we get enough workers, but we have not achieved that yet. So, those are the steps we have taken because as an individual you cannot buy a bed or say today am going to build a ward which will be enough for all patients. The step that I have taken is to raise the issue when we have meetings and find different ways that we can use to solve that problem. National manager_03, IDI

District managers worked within tight resource constraints, striving to keep the system functioning without sufficient budgets. When funds from outside partners were unavailable or withdrawn, they were often unable to execute essential activities and had to remove or reduce important elements of their plans, employing workarounds.

In fact, many programs were better when they were in one way or another sponsored by donors. But I think right now after the budget for everything has been left under the district health intensive program, the budget…has become restricted, so it doesn't cover all the programs. So, this causes things to slow down, or other things are left out. District manager_02, IDI

The workarounds carried risks, as they wanted to support the health facilities, but sometimes the situation was beyond their purview, for example when there were system-wide stockouts. To ensure continuity of services, they had to ask providers to continue working even without sufficient resources. Given system shortages, they also spanned roles of both providing and managing care, making them profoundly aware of the challenges of care provision in a context of scarcity.

…the example I have given you for the one who works the whole day and night. Do not think that when they are called, they will be paid for the overtime today or tomorrow… however, you try to

figure out with this limited budget available how many will you be able to pay for overtime. Where will the money come from to pay all these people? District manager_02, IDI

Providers' capacity stretched in a risky and unsupportive workplace.

The capacity of providers was stretched due to the demands of providing care without adequate numbers, skills, working tools, or essential organizational supports. Without clear guidance on how to prioritize, they made decisions about what would be provided to which patients and employed workarounds. They described how emotion work was often withdrawn due to frustration, fatigue, and moral distress.

Large gaps in available personnel meant providers had many tasks. They were often called from their homes or expected to stay long hours. During shifts, they were pulled in different directions, often unable to pause for a meal or a break. Providers also described feeling an obligation to continue serving patients who were present and doing their best to help, even when overwhelmed.

…most of the available specialists must overwork because there are a lot of patients and once they are in the clinic, you cannot leave them unattended. And so, no matter how few we are, we are obliged to serve. Some overwork from morning to night with no break. Clinical officer, FGD

… at the dispensary level, you might find that there is only one nurse-midwife, and she has the responsibility of doing all the work and helping all the women deliver, be it in the morning or at midnight, be it sunshine or rain. She works most times without enough rest. Healthcare provider_01, IDI

All respondents spoke of a risky environment not conducive to the safe provision of high-quality care, including psychological and physical risks. They expressed concern about not providing care to expected standards. Their cognitive capacity was stretched as they strove to find workarounds to provide care without basic resources. Many also found themselves providing care without proper

training. The physical risk of caring for patients without protective gear created high distress levels. Shortages of protective supplies, like gloves, symbolized risks as well as the failure of the system and the community to care about their safety.

You attend childbirth even though you didn't attend the seminar; and that is very risky for us when we do things that we are not trained in. Your colleague may come and teach you with blah, blah, then you take that as well as read posters. What else can you do? You must do, so long as you are on shift. Medical attendant, FGD

You work while praying to God to preserve you. For example, there was a case in which we operated a woman, we were stitching her, just imagine, without the gauzes! … You see that operation was carried out without proper tools. We had to perform it to save life. District manager_03, IDI

Providers also felt unrecognized and unsupported. Salaries were deemed too low in relation to workload, experience, and qualifications, and for a decent standard of living. They described the work as 'voluntary', due to lack of allowances for overtime, but they kept working for 'humanitarian reasons.' The limited salary affected their mental and physical presence, as they were distracted by concerns about supporting their families, but also might be absent while seeking other income.

I remember one day when I went there, and I picked one woman. That woman told me directly, "Thank you very much for bringing me home. Today I have helped eighteen women to deliver, but I don't have any money to return to town." The fact is that her salary is very low, she cannot even budget it; and she added, "I don't have anything, I don't know what my children are going to eat." District manager_01, IDI

They also felt underappreciated, expressing their desire to be respected by both patients and system leadership, not only for what they do, but also as human beings. Managers were perceived as only noticing their work when there were problems and mistakes. The community seemed to

easily turn against them, only remembering negative incidents.

What do we deserve? To be respected, that is, we should be appreciated for what we do. Therefore, they should not just blame us for the negative deeds, but also congratulate us for the other things which are positive. Someone will be motivated; they will be working. But if you work with a willing heart and you end up being complained against, I think I will be discouraged to work hard. Health facility manager_02, IDI

Normalization of deviance in micro-level transactions

Service users, managers and providers had varying perceptions about the source of negative service interactions. Each tended to assign blame to the other, yet providers acknowledged that sometimes they were unable to exert emotion work given working conditions.

Women and men showed resignation about the likelihood of experiencing disrespectful care. They described their expectations for good quality interpersonal care, including a warm reception combined with attentiveness, soothing care, and listening throughout their childbirth. Overall, dissatisfaction with nurses was high and doctors were perceived as more kind. The distinction between male and female providers was noted by some. Women were more satisfied with providers' attitudes at smaller nearby facilities; however, they expressed a preference for hospital delivery in case of any complications.

You go there and explain the way you feel. You are listened to and may be instructed to have a test at the laboratory, or to collect some medicine. I don't find anything bad with the male doctors because they pay attention to you. The problem is with the nurses. Woman who delivered in a health facility, FGD

As soon as you arrive there you are asked, "How can we help you?" You don't have to call the nurses, they just come; you really feel happy. It's not like that here. I think there should be an inspection in [this] hospital. Man, FGD

Providers, particularly nurses, were perceived as uncaring and having forgotten their education, which was attributed to poor management and supervision. Neglect, harsh language, and humiliation seemed of most concern. Women and men complained of favoritism towards high status persons or people who could afford to pay bribes, who received 'Mzungu' (foreigner) service. They also noted that mistreatment occurred even when providers were not overwhelmed with patients, indicating its likely normalization.

If you go to hospital for delivery and at night you get labour pain the nurse examines you and tells you to go to bed. She leaves that room and goes to stay in another ward, chatting with other nurses. Personally, I once went there for delivery and when it was time to give birth I decided to go to the ward where the nurse was and scolded her. Despite following her there, she still didn't care. I went alone to the labour room, and when the nurse arrived, she found the baby out already. Woman who delivered in a health facility, FGD

I was told, "We told you to buy injection liquid to prevent/stop bleeding. You refused. So, if you bleed to death, we will have no mercy. We will just take you to the mortuary and your relatives will bury you." I really didn't like that. I felt bad because she was not just telling me, but she was talking to the whole ward, so everyone knew about it. Woman who delivered in a health facility, FGD

Providers felt overwhelmed and frustrated by patient volumes and inadequate rest. Many described situations when they were no longer capable of the emotion work required to cover their exhaustion and frustration. In these moments they described using harsh words with patients and sometimes hitting them. These actions seemed normalized, justified by the need to save lives.

There are many reasons but mainly it is that the nurses are overloaded with patients, and each has their own demands. And this hinders the nurses from being able to handle all of them at the right time. And sometimes this causes them to be harsh or over serious to control the situation, "You stop doing that, do this. Stop that; you are going to kill your baby." Some are stubborn and so the

nurse has to slap them so that the baby can come out. And so, at times the words used might not be pleasing, but they will help to save a baby. Health facility manager_03, IDI

Providers, nonetheless, generally perceived a good relationship with the community, as they interacted with people outside the health facility as well. They attributed most poor interactions to the community's lack of understanding, especially those of certain cultural backgrounds. Providers were frustrated when they perceived women and their families as not following hospital norms or cooperating. They felt that their expertise was sometimes not respected when families demanded certain treatments. Providers and managers also complained that the community had a preconceived negative bias, setting the stage for bad interactions.

For example, maybe you have attended to the first patient and before you finish attending that one, another one needs service simultaneously. Maybe the one you are attending comes to scold and insult you. "Hey nurse, why don't you come while I'm calling you?" She speaks strange offensive words without considering that you are attending to someone else, and you are alone. So, she starts insulting you for nothing and since you also have feelings, sometimes you want to insult her back. But because you're at work and you know that she is sick then you ignore her, but she has already done strange things to you. Nurses and midwives, FGD

Nonetheless, they may not be aware of how the interaction is perceived by the woman or believe that ultimately whatever they do is necessary for her to have a healthy delivery and baby.

But for those who know, she will come back with her baby laughing and saying, "If you were not strict, I would have lost my baby." You see, eh? The way she conveys her message, that if you were not strict, I wouldn't get my baby alive. Do you see? District manager_02, IDI

Regulatory environment

Mistreatment was hidden in plain sight from many managers and the regulatory mechanisms. The regulatory system relied on the following:

Table 4. Components of the regulatory system

Component	Description
Internal systems	Largely carried out by managers in their roles as supervisors and reporting data
Professional regulation	Professional councils provided registration and licensure for healthcare professionals, and may censure professionals or remove licensing
Community accountability	Numerous mechanisms which allowed citizens to provide input and oversight to health system and health facility performance and management

While the community described mistreatment as routine, the pervasiveness of mistreatment was not captured by the regulatory system. The challenges ranged from system structures creating secrecy to the nature of mistreatment to women's reticence to make complaints.

Mistreatment is contested and hard to prove

Facility managers and community representatives were tasked with monitoring performance of healthcare facilities. Community representatives serving on facility committees would visit occasionally to observe and ask clients about their experience. Facility managers were also expected to observe providers, but their many tasks, including service provision, meant this was infrequent. Both described challenges in catching behaviors "red-handed" because the providers' behavior changed when observed, indicating their knowledge that mistreatment is not acceptable.

It was easy to catch them when I was not a medical officer in charge, but right now they cannot do that when I am around. I don't even know what to tell you. But currently I have not seen such a situation and by the way I do not often go to the maternal wards, I rarely go there. And so, it's not easy to catch someone red-handed, we only get reports and then we work on them. Health facility manager_03, IDI

Local leaders, and even providers. felt that district managers and supervisors were not fulfilling their routine supervision roles, which they believed would reduce mistreatment.

I personally think there should be enough supervision. We shouldn't wait for the problem to happen and then find the supervision. I think when supervision will be there permanently, then it's easy if any problem happens to control it. Clinical officer, FGD

Regulation of mistreatment depended on receiving and responding to complaints locally, which could be lodged with community and health system leaders. Complaints were described as frequent by facility managers and community leaders, while fewer reached district managers. Yet, complaints were often difficult to prove and pursue. For example, a complaint might be vague because patients feared being recognized. Evidence was rare and typically relied on verbal accounts, resulting in conflicting accounts between patients and providers. Managers tended to accept the patient's word because providers would rarely admit wrongdoing, although without details they might only be able to generally advise staff. Providers often felt that there was no one to defend them.

A civilian can come forward and say, "I came on a particular day and a particular civil servant demanded a bribe and I am ready to point him out," therefore, they have helped us. …a civilian could be saying it, but when you ask them who has done this, they don't say and are afraid that when they come the next time they won't be received nicely. District manager_01, IDI

… you find out that the relatives of the patients have already called the member of parliament of the constituency and accused the doctor or nurse in charge. And so, you find out sometimes that we are mistreated with no one to defend us. And so, we just have to stand up for ourselves and defend ourselves. Clinical officer, FGD

Citizen voices constrained

Community respondents emphasized fear as the reason there were not more formal complaints. Women described fearing retribution from providers, since they knew that they would have to return to the same facility. Men felt that their wives kept their experiences secret so that they would not report what happened. Women feared being scolded, treated harshly, or ignored by providers and believed that providers might do something harmful to them or their children in retribution.

You may report something, but if a nurse discovers that you have done that, she can do something bad to you. We know what they do. Your child can be given a bad injection or be overdosed. This has already happened, so we hurt ourselves by telling the truth. Woman who delivered in a health facility, FGD

They also may have believed that reporting would not result in any changes.

It's obvious that people write about their complaints, but there is no follow-up. Someone may open the box and take a card with the complaint to the concerned person to alert them and take it away so they don't reach the targeted people. They help each other; you may hear that there is an emergency meeting for the nurses. In this meeting they tell each other what is said about them and it will end there. Those who may take action don't see the complaint. Woman who delivered in a health facility, FGD

Structural secrecy hides system-wide effects

At higher levels of the system, national professional bodies set the standards for conduct and the MoHSW laid out policies and guidelines. They were not involved in the daily monitoring and

disciplinary processes. The disciplinary process was described similarly by health system actors and local leaders. After a complaint, the process began at facility level, starting with verbal warnings, followed by a written warning if the behavior continued, and then ultimately sent to the district if the provider did not change their behavior. Transfer was the typical disciplinary action for these persistent cases.

For example, if a provider has bad language to those who are coming for services, we take them to our committee. We talk to them. They admit. We then finish a case. But if it becomes chronic, we take it to their employer. Fortunately, we haven't had such occurrences…that we need to send a staff to the Director; no, we just finish the case. Community leader_01, IDI

The system was designed for issues to be handled at facility level and in some difficult cases at the district level, but this created structural secrecy, meaning that the pervasiveness of complaints was concealed due to the system organization (Vaughan, 1996). Most complaints were resolved at facility level, with only some making their way to the district and very rarely to higher levels. Hence, managers at district, regional and national levels were not able to observe the scope of mistreatment across the system.

Nonetheless, when actions were taken, they were perceived as effective. The introduction of facility governing committees was believed to have improved responsiveness to community needs. Warnings were also considered effective for most providers. Yet, it was acknowledged that the effectiveness had not been evaluated.

Let's be honest; these interventions to change habits are very complex. And we did not have the means to examine them. District manager_01, IDI

DISCUSSION

Overview of key findings and implications

Experiences and perspectives from system and community actors highlight how system dysfunctions cause suffering for those working within the system and ultimately mistreatment of women delivering in its health facilities. Like the initial elaboration of the theory, which might be called *the organizational normalization of mistreatment theory*, primary qualitative data show people struggling to perform in a system that does not meet their needs for either material or symbolic resources. Due to the macro-context of scarcity and production pressures, providers engaged in workarounds and rationing to continue performing in the dysfunctional and risky environment. These behaviors then were reproduced and normalized as standard, making high quality interpersonal care an exceptional level of service. These findings align with a recent review of the impact organizational factors on providers, which found that high workload, low pay, inadequate training, and poor supervision likely had implications for mistreatment. While the review focused on the meso-level, it acknowledged that macro-level factors are influential [9]

Frontline actors' discretion to implement policy and standards has been recognized in the literature on street-level bureaucrats (Erasmus, 2014). The *theory of organizational normalization of mistreatment* shows how the macro-environment shapes the health system which then influences the behaviors of system actors, resulting in reproduced patterns of behavior, e.g., mistreatment, across place and time. Observed street-level bureaucrat behavior is therefore not always individualized and can be an unintended consequence of system characteristics.

While most of the nascent theory resonates with these findings, some constructs were less emphasized and new constructs emerged as important factors in the meso- and micro-levels, as well as in the regulatory environment. Figure 1 shows the revised diagram of the organizational

normalization of mistreatment with new or changed constructs in bolded red text. Table 3 provides a description of each construct as well as changes from the original theory.

For the macro-environment, a context shaped by interconnected national political pressures, resource scarcity and dependency emerged like the original findings. The political goal to increase deliveries through fee exemptions created further scarcities in the system. Political pressures came not only from national policymakers, but also at local levels, such as among council politicians and members of parliament. System managers and providers were reliant on policymakers to allocate sufficient material resources, but also for symbolic resources, such as respect and support in the face of conflicts with the community. The unpredictability and uncertainty of financing was strongly emphasized by system and community actors, while it appeared to be normalized by policy makers, although policymakers' experiences require further exploration. Dependence on foreign funding was referenced by many system and community participants, but they did not describe a situation where this was used to influence policy and implementation.

At the meso-level, the findings align with the nascent theory, although some new system effects emerged. Additionally, the interconnection as well as distinction between the original constructs became clearer. In the original theory, 'Providers' capacity stretched' was limited to the number and skills of the providers, but it became clear that insufficient working tools, such as medicines, supplies and equipment, also greatly stretched their physical capacity and cognitive ability as they sought workarounds. Other support needs were mainly related to financial remuneration as well as symbolic resources, such as respect or appreciation and psychological or moral support. Concerns about workplace risks strongly emerged from the data, with the lack of gloves symbolizing these risks and the system's failure to care for providers.

It newly emerged that providers experienced moral distress: the situation "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984). Moral distress has been associated with similar work environments as those described by participants, including insufficient resources for service delivery, unsafe staffing levels, inadequate staff skills, and poor ethical climate and collaboration in the work environment (Burston and Tuckett, 2013; Lamiani et al., 2017). Signs of moral distress include frustration, anger, guilt, regret, withdrawal, and self-blame, all of which were described and exhibited by provider participants (Burston and Tuckett, 2013; Epstein and Hamric, 2009). Moral residue describes the lingering feelings of distress that remain after the incident has passed that can be long lasting, which may over time lead to burnout, anxiety, depression, and withdrawal (Epstein and Hamric, 2009). The withdrawal and burnout due to moral residue may have resulted in providers rationing their emotion work. There has been limited research on moral distress in low-income settings, but many of the factors associated with moral distress in high-income settings are more severe in these contexts (Ulrich et al., 2018). Häggström *et al*, found that Tanzanian nurses' experience workplace distress and ethical dilemmas leave them working on the 'edge of life and death' (Häggström et al., 2008).

The dual roles of health system managers as both managers and providers also emerged. They struggled with planning and finding resources for service delivery, but also directly experienced the effects of those constraints, including moral distress. Power dependence between the macro- and meso-levels confirmed that providers and managers relied on macro-level support for resources to provide services, while policymakers expected them to perform regardless to meet system goals.

In micro-transactions, it emerged that women's families need to be considered as part of the interaction. Women and men desired caring behaviors from health care providers, but seemed resigned to experiencing mistreatment, especially at hospitals. Yet hospitals were often preferred

due to the higher level of clinical care available. They acknowledged the stresses experienced by providers but noted that mistreatment occurred even when providers were not overwhelmed by patients, indicating the normalization of these behaviors. At the same time, providers described struggling to provide good quality care while sometimes losing their ability to exert emotion work when overtired or overworked. Yet, they expected women and their families to follow institutional rules, such as abiding by visiting hours or following delivery instructions and felt provoked when rules were disregarded. They spoke of being 'strict' to force women to comply, justifying their behavior as necessary for women and newborn survival. This indicates institutional logics that actions are justifiable if they lead to a good biomedical outcome.

Some providers complained of harassment and disrespect from women and their families, but their comments also hinted at discrimination against women who were less educated or from certain traditional backgrounds. They wanted to be respected as health experts, depending on the community for this symbolic resource, while women depended on them for their own lives as well as their newborns'.

Limited information was available about the regulatory environment in the extant literature; hence the analyses led to changes in all the original constructs. While the original constructs are still relevant, the refined constructs are more specific to mistreatment. Structural secrecy emerged as a key factor for the failure of system-wide action on mistreatment. Structural secrecy refers to incomplete and partial knowledge due to the division of labour and hierarchy in an organization which minimizes the ability to detect deviance from normative standards (Vaughan, 1999). In this case, complaints of mistreatment were typically handled at the local level, without reporting up the system, meaning that the pervasiveness of the problem across place and time was 'hidden in plain sight.'

Strengths and limitations

Given the need for theory-informed interventions to tackle mistreatment, it is essential to examine the organizational characteristics of health systems, a recognized factor in the persistence of mistreatment (Reddy et al., 2022). This analysis builds upon nascent theory (Ramsey, 2022), helping to verify as well as further elaborate and iterate the theory with primary data. It provides a more in-depth case specific to mistreatment that complements the system-wide literature review that was the basis for the initial theory elaboration. The specific case of a district, the primary administrative unit for Tanzania's health system, bolsters evidence for the original theory, while adding new nuance and more specificity for the case of mistreatment.

Nonetheless, there are some limitations. The case is centered in one district which may differ from other parts of Tanzania, and thus not reflect the country. For example, most of the study participants worked and lived in peri-urban and rural settings, and their experiences of the health system and mistreatment may differ from urban areas. The confirmation of many observations by national managers helps to improve the generalizability beyond the case district, as well as the alignment with the system-wide literature review. Mistreatment was a challenging topic to discuss with providers and system actors, and sometimes women, who despite reassurances may have been afraid to speak negatively about the health system. Providers and managers, knowing that mistreatment is not formally acceptable, may not have been fully open about mistreatment and the conditions that surround it. Yet, they did admit to behaviors that would be considered mistreatment. Gender issues emerged peripherally, such as preferences for male over female providers, but were not fully explored. Other research has indicated that the gendered nature of health systems, including the largely female workforce providing delivery care, requires further examination (Betron et al., 2018).

CONCLUSION

Verifying and further elaborating the theory with primary data has helped to further strengthen the evidence for the nascent *organizational normalization of mistreatment theory*. The theory's relevance in different types of health systems in other contexts needs further testing. For example, verification in government health systems in other countries as well as privately run health systems would provide further evidence for the theory's generalizability. Advancing this theory and others will help uncover the systemic factors driving mistreatment towards sustainable solutions to ensure a respectful experience for not only women and their newborns, but those struggling to provide care in overburdened and under-resourced health systems. It would shift the blame from individuals to the systemic factors that continue to reproduce this behavior.

Paper 3: “Be close to the patient”: Unpacking the emotional labour required to provide respectful care and prevent mistreatment in childbirth in Tanzania

INTRODUCTION

Hochschild's groundbreaking work on emotional labor exposed the unacknowledged workplace expectations to manage the emotions of oneself and others required when interfacing with the public. Unlike personal social exchange which is shaped by social norms but not regulated, acceptable expressions of emotions are defined by the organization and codified in manuals, supervision, and training. These 'feeling rules' guide how employees express emotions through facial expressions, body language and their voice in daily client-facing encounters. When employees do not feel as expected, they engage in emotion work, the extra effort required to conform to organizational feeling rules and expectations. They may employ two possible tactics – surface or deep acting. In surface acting, they cover up what they are really feeling, while in deep acting, they try to shift their own feelings to match the expected emotion. (Hochschild, 1983; Theodosius, 2008) Ultimately, if unacknowledged or unaddressed, the emotive dissonance and strain from the effort of emotional work can lead to alienation, depersonalization, and burnout (Hochschild, 1983; Mann, 2005).

Emotional labor among healthcare providers has been widely acknowledged as an important aspect of healthcare and critical for patient experience (Riley and Weiss, 2016; Theodosius, 2008). Most research in healthcare has focused on emotional labor among nurses, likely due to expectations of nurses as intrinsically caring and working in a female profession (Riley and Weiss, 2016; Theodosius, 2008). Healthcare providers' emotional labor is bound by codified feeling rules from professional associations and healthcare organizations. Their emotion work differs from some other service sectors due to the stressors related to situations involving life and death. Although intrinsic motivation may drive many providers, certain situations may make it difficult for even the most public service-oriented providers to present a positive face (Mann, 2005).

Childbirth, by nature, is often imbued with high emotion. Clinical obstetric care is complex, a risky technology, where there is high uncertainty about if, when, and how things may go wrong (Dekker et al., 2013). In addition, it is a profound moment in personal life, which brings a mix of emotions, including joy, but also pain and fear. Jaffré & Lange note that the interaction during childbirth is "shaped by the event of a woman in labor 'invaded' by pain and a professional 'invaded' by stress" (Jaffré and Lange, 2021). Unlike many other services, childbirth care also requires women's active cooperation while often overwhelmed by strong emotions and pain (Brown, 2010; Getahun et al., 2023). These factors create conditions that may lead to mistreatment in childbirth, but also underscore its unacceptability in this moment of extreme vulnerability. Mistreatment is concerning intrinsically, but also because it can cause women to feel humiliated or undignified or may be intended by providers as humiliating or undignified (Freedman et al., 2014). It may directly impact maternal and newborn health (McNab et al., 2022; Sudhinaraset et al., 2019), as well as negatively influence future care seeking. While mistreatment occurs in micro-level interactions across geographies and time, its widespread nature and impact constitute a social catastrophe (Ramsey, 2022).

The provision of maternity care that is respectful and does not include acts of mistreatment inherently requires emotion work by the healthcare provider. The person-centered maternity scale, a widely used and validated scale for measuring respectful care, includes aspects such as whether providers treated a pregnant person in a friendly manner and with respect, talked to them about how they were feeling, and supported them in their anxieties and fears (Afulani et al., 2017). Each of these would require emotional labor to manage the woman's emotions. Similarly, the effort required not to mistreat a patient, such as holding back harsh language when feeling frustrated, overwhelmed, or provoked, requires emotion work to suppress these emotions and display friendliness rather than frustration or anger (Mann, 2005). As per the typologies of mistreatment

described by Bohren *et al*, emotion work is likely required in some situations to prevent physical abuse, verbal abuse, stigma and discrimination, and poor rapport between women and providers (Bohren et al., 2015). Other aspects of respectful care, such as privacy and confidentiality, consent, and facility environment, however, would not typically require emotion work, although they might affect the relationship between the providers and women and their families (Ndwiga et al., 2017; Reddy et al., 2022).

Like Hochschild's finding that emotions are often absent from sociological analysis, healthcare providers' emotions have rarely been discussed in the literature on respectful care until recently. Aspects of person-centered care for women and newborns that are related to managing emotions tend to be neutralized to categories such as preserving dignity and engaging in effective communication. This masks the emotional effort required, especially when associated with other aspects of respectful care that do not require this skill and effort. Emotional labor in healthcare has not been well researched in low- and middle-income countries. In sub-Saharan Africa, only two studies, one each in Ghana and Malawi, have explored emotional labor among healthcare providers (Lartey et al., 2020; Msiska et al., 2014). These studies, which focused on nurses, found that emotional labor has important effects on numerous aspects of their work, and there is limited support or acknowledgement of this task.

There is also nascent research on stressors experienced by childbirth providers in relation to respectful care and mistreatment. A study in Malawi among maternity care providers found that depression and emotional exhaustion, as factors of burnout, are likely to negatively influence respectful maternity care (Burnett-Zieman et al., 2023). In Kenya, research similarly found that emotional health has a potentially important influence on mistreatment and that work-related stressors create difficult emotions (Getahun et al., 2023; Ndwiga et al., 2017). Midwives in Benin and Burkina Faso were found to face challenges in balancing socio-emotional duties and technical

skills when providing childbirth care (Jaffré and Lange, 2021). This research, among others, highlights the importance of better understanding emotional labor in the context of respectful maternity care and African health systems.

In previous analyses focused on theory for the normalization of mistreatment in healthcare organizations, the authors identified the rationing of emotional labor as a key factor in the persistence of mistreatment in childbirth in the Tanzanian public health system (Ramsey, 2022; Ramsey et al., 2024). The theory outlines the macro- and meso-level factors that created an environment where rationing emotional labor became normalized and consequently women were mistreated and may have felt disrespected or humiliated. The current paper further explores health system expectations of maternity providers' emotional labor, how these providers engage in emotional labour, and specific situations which may strain their ability to manage the emotions of others and themselves.

METHODS

A quasi-experimental study, "The Staha Project", was conducted between 2011 and 2015 in two districts in the Tanga Region, in the northeast corner of Tanzania (Kujawski et al., 2017). The research was conducted by Ifakara Health Institute and Columbia University's Averting Maternal Death and Disability Program in collaboration with the district government, healthcare providers and communities. Prior to the intervention, exploratory qualitative research was conducted among a diverse array of health systems and community participants aiming to uncover the nature of mistreatment and its drivers. Emotional labor emerged as an important theme in analysis of the data, which focused on developing new theory about systems determinants of mistreatment. It was thus decided to analyze this theme in more depth from the perspective of healthcare providers (Ramsey et al., 2024).

Study setting

At the time of the study, Tanzania was designated as a low-income country by the World Bank and had high maternal and newborn mortality rates, at 556 deaths per 100,000 live births and 25 deaths per 1,000 live births respectively (Ministry of Health et al., 2016) The study took place in government health facilities in two districts in the Tanga Region, where the overall institutional delivery rate was 67% (Ministry of Health et al., 2016). At that time, the government health system provided 82% of institutional delivery care nationally (Ministry of Health et al., 2016). High levels of reported disrespect and abuse in the study districts were found in baseline quantitative research. Among women discharged from study facilities, nearly 20 percent reported experiencing at least one form of mistreatment, and the prevalence increased to 28 percent when asked again in home interviews five to ten weeks after delivery (Kruk et al., 2018). When observations were conducted in the same facilities, the prevalence was found to be almost 70% (Freedman et al., 2018).

In the Tanzanian government health system, childbirth services were provided in dispensaries; health centers; and district, referral, and national hospitals, with increasingly complex services provided in fewer sites at the top of the pyramid. Nonetheless, only hospitals could manage most obstetric complications, although health centers and dispensaries were expected to manage some cases (United Republic of Tanzania, 2008). According to policy, childbirth services were free for women at public facilities (United Republic of Tanzania, 2014a). The system was plagued by scarcity (Afnan-Holmes et al., 2015; Ramsey, 2022). Only about a third to a half of provider posts were filled, with shortages most acute in rural areas (United Republic of Tanzania, 2014b). Essential medicines and protective supplies used for childbirth services were often stocked out (Afnan-Holmes et al., 2015; MoHSW [Tanzania Mainland] et al., 2015).

The main cadres providing delivery and newborn care included Medical Officers, Assistant Medical Officers (AMOs), Clinical Officers, Nurse-midwives, Nurses, and Medical Attendants. Medical Officers, AMOs and Clinical Officers, often referred to as doctors by patients, were predominantly male, moved in and out of the maternity, often only assisting with delivery when there was a complication. Nurses, some of whom were nurse midwives, were typically female, and handled most deliveries, remaining in the maternity with women as they labored. There were several categories of nurses, but they were generally all referred to as nurses. Medical attendants, who are support staff, were neither trained nor authorized to provide delivery care; however, they often attended deliveries using skills learned on the job. (Exavery et al., 2013; Ueno et al., 2014).

Sampling

Facilities were selected to represent the different service levels in the two districts. The facility sampling process is described elsewhere (Kruk et al., 2018). Healthcare providers at these facilities who provided childbirth care were selected, in addition to other participants at district and community level. The interviews and focus groups with healthcare providers from both districts, including district and facility managers who were still involved in maternity care provision, were used for this analysis. Maternity providers were asked about their perceptions of why women sometimes experience disrespect and abuse during institutional childbirth, as well as to describe their relationships with patients and the community and their working environment. A total of 44 providers participated in focus group discussions (FGDs) and in-depth interviews (IDI). Three FGDs were conducted with health care providers, including clinical officers, nurses and nurse-midwives, and medical attendants. In addition, IDIs were conducted with district managers, health facility managers, and providers of different cadres. District manager selection focused on those responsible for maternity care, so were more likely to include those with nursing backgrounds.

Provider cadres included Medical Officers, AMOs, Clinical Officers, Nurses, Nurse-midwives, and Medical Attendants.

Table 1. FGD participants

Participants	Number of FGDs	Number of participants	Gender
Clinical officers	1	8	Mixed
Nurses/Nurse-midwives	1	7	Female
Medical attendants	1	7	Mixed
TOTAL	3	22	

Table 2. In-depth interview participants

Participants	By Cadre	Female	Male	Total
District healthcare managers	Medical Officer or AMO	1	1	5
	Nurse	3	0	
Healthcare facility managers	Medical Officer or AMO	1	2	7
	Clinical Officer	0	2	
	Nurse	1	1	
Healthcare providers	Medical Officer or AMO	0	2	10
	Nurse	5	1	
	Medical attendant	1	1	
TOTAL		12	10	22

Data collection

Guides for interviews and focus groups were developed collaboratively by the study team. The guides were developed in English and then translated into Swahili by bilingual Tanzanian

researchers. Interviews were conducted in Swahili by researchers from Ifakara Health Institute or research assistants who had received training on the topic, the guides, and research ethics. IDIs and FGDs were digitally recorded, and the audio files were used to complete transcriptions. Transcriptions were translated into English by a professional translator and reviewed by bilingual researchers.

Data Analysis

Thematic analysis was applied following the approach described by Braun and Clarke combined with affinity diagram techniques to visually map out data, concepts, themes, and relationships (Braun and Clarke, 2006; Otieno, 2023). Codes were identified inductively by reading each transcript. Concepts and data were mapped and clustered in affinity diagrams on the digital whiteboard Miro to show patterns (Realtime Board, 2023). These were compared with literature on emotional labor and a code book was created. Two to three transcripts were then line coded using Nvivo 12.0 (Lumivero, 2017), and the codebook was revised. Each remaining transcript was then line coded. Data in each code were read to identify relevant themes. Themes and relevant quotes were mapped on the digital whiteboard for each code, and relationships between codes were drawn. Memos were written to process and reflect on the identified themes and their relationships. Continual iteration between the data and literature on emotional labour and respectful maternal and newborn care further deepened the interpretation of the themes.

RESULTS

Six key themes were identified that provide a deeper understanding of emotional labor among providers in childbirth care, including 1) expected to love and care for patients; 2) controlling emotions; 3) managing patient expectations in the face of system shortages; 4) providers are human beings too; 5) nurses are perceived as harsh; and 6) limited system support for emotion work. These themes and corresponding sub-themes bring into focus how the nature of childbirth

care, the context, and gender norms influence the ability to provide respectful care. An overview of the themes is provided in Table 3.

1. **Expected to love and care for patients**

Through their descriptions, it was clear that providers were cognizant of organizational feeling rules, either communicated through training, supervisors, or guidelines. They were expected to create warm, or at least polite, relationships with patients and their families. In some cases, they believed that they should develop genuine caring relationships, built on love, respect and good communication. Yet, providers also expressed hopes of mutually respectful and caring relationships with their patients and the community.

1.1 Being close to the patient

A nurse is supposed to be close to the patient, treat a patient with care, love and provide the proper services and be available to the patient whenever she is needed. District Manager, Nurse, female_04

Healthcare providers of all cadres emphasized the need to genuinely feel love, respect, and care for patients. Providers often described this as "being close to the patient" in a variety of ways, both figuratively and literally. Healthcare was considered a calling or a vocation, which drove the ability to feel this way about patients. Love for the job was expected to translate into compassionate care. In turn, the love and respect would be returned to the provider.

If you treat a patient well, she will love you. If a patient comes and in the first day hears something bad about a patient who was disrespected, it will discourage her. What is important is respect for a patient in whatever you do. Facility manager, CO, male__04

Empathy and imagining the patient as a family member were used by providers to feel this love and respect. Male providers expected female providers to think about their own experiences during delivery or imagine it as their own baby. Some female providers also remarked that their own experiences influenced their caring behaviors towards laboring women.

I must confess that I cannot use abusive language to the patients as long as I know what they are going through, I also have three children and I am aware of the pain during the labor process so I cannot do that, I am so afraid. Nurse, female_06

Many reflected on the positive aspects of good relationships with patients and the community, such as friend-like connections. Patients sometimes went to their homes seeking care, which was seen as a sign of good relationships. Some spoke of creating deep and meaningful relationships with patients, connecting with patients on a variety of levels, although relationships of this depth seemed to be rare.

My relationships with the patients are very wide and holistic relationships, I must be connected to the patient in every aspect spiritually and physically and that does not mean because he or she is sick. Sometimes I may sit with the patients even if she does not need services and talk about family and holistic matters during the time when they are in the hospital. Facility manager, Nurse, male_07

Providers acknowledged that things might not always go smoothly with patients, but they still must maintain this love and respect and tolerate whatever might occur. This meant applying love and respect equally to all patients without discrimination. Patients, regardless of their economic means, education, or background, should all be treated equally.

Each patient deserves to get a standard service. You shouldn't insult or cost her her life or cause complications because she doesn't have money. It shouldn't be, "because you did not come with a bucket." AMO, male_01

1.2 Communication skills: good language and empathic listening

Providers often spoke about using good language as part of showing respect and care for patients. They emphasized the need to be polite and avoid harsh language that insults the woman or might be considered offensive. For some, it was painful to think about patients being mistreated.

First of all, speaking harshly or insulting a patient is one of the ways of disrespecting a patient, also mocking a patient like telling them "You wanted this situation, so why are you crying?" Facility manager, AMO, male_01

Really it is not good, and you don't become satisfied when you hear that someone has been attended to but not properly, they have not been treated well. As a human it hurts you to find that someone can be treated so. District manager, Nurse, female_03

Building a relationship also required empathic listening to learn about the patient, understand their problems, and develop closeness. It was tied as well to clinical aims to provide the right solution to their problems. A friendly environment making the patient feel comfortable enabled this close communication, although lack of privacy could sometimes make this difficult.

We must have a close relationship with them so that they will be able to tell us about their health problems. Others may hide their health problems but if you have a good relationship with them, they may tell you their internal health problems. M Facility manager, Nurse, male_07

1.3 Desire for reciprocity

Providers also wanted the community and their patients to respect and love them in return. Reciprocity was particularly described in relation to respect; nonetheless, some spoke about a mutual feeling of love between patient and provider when they treat each other well. Providers highlighted that respect is deserved because patients' health and lives depend upon their care.

They also wanted appreciation and acknowledgement for the risks they take working in an unsafe environment.

There should also be respect between the service providers and the entire community in general because if you look at the environment in which we work it is an environment that endangers even our lives. But someone from outside normally does not notice this or they don't value the service which is being provided. You may suffer and attend to someone with all your heart but at the end of the day you end up with awful words. So, they have their rights, and we are required to follow them; and we, as service providers, also have our rights. Facility manager, Nurse, female_06

First, society should have some faith in health workers. If we start from there, we can progress well. Most of what you hear is due to lack of faith, that most Tanzanians lack faith in health providers…Therefore, the trust, the love in the society should be like in other places like a bank; they relax, they get service even if the queue is long and people do not shout but the service continues. We are also here to provide services to the people and not mistreat people. District manager, MO, male__02

2. Controlling emotions

To maintain a respectful relationship, providers needed to control a variety of emotions that arose due to the nature of childbirth care, the working environment, and how patients and their families interacted with them. Their descriptions show how they were coping with their own fear, frustration, exhaustion, anger, and irritation while caring for patients. They also noted the need to manage similar emotions that might arise in patients and relatives during their interactions. In some moments, strong feelings or exhaustion overcame them, and they were unable to manage their emotions to maintain a pleasant and respectful interaction with the patient or their relatives.

2.1 Dealing with emotions around the risky technology of obstetric care

Fear rose due to a variety of factors, but particularly around the potential death of laboring women or their babies. Given the nature of delivery, they were unable to predict when complications would arise and it could deteriorate quickly, heightening tension and fear. Maternity was thus considered a difficult place to work, especially as compared to other units in hospitals. Low stocks of essential medicines and inadequate equipment heightened this fear, especially the lack of gloves which exposed them or the patient to potential infections. Women also sometimes arrived with serious complications after trying to deliver at home. Finding workarounds in this difficult environment in moments of crises took cognitive and emotional resources (Ramsey, 2022). In these circumstances, a provider might become harsh and yell at or slap a woman if they felt she was not complying with their instructions, especially around the second stage of labor. They often justified this behavior due to the priority of saving her or the baby's life and seemed to consider harsh treatment in these situations as important for the well-being of the mother and baby.

You may think that it [the labor ward] is an easy task, but it is not an easy place; it is a tough place especially when it comes to the task of helping the mother to deliver safely. So, there are things that can make a patient think of being abused, but, in the real sense, that nurse was just trying to save life. You, see? District manager, AMO, female_01

I have seen them because the women differ in the way they take the labour pains. There are some who take it well, but some cannot. Some are so stubborn to the extent that a nurse has to yell at them in the delivery stage. All this is done so as to avoid the death of the baby. It is done for the benefit of the woman and the baby, but it is taken as disrespectful. Nurse, female_07

Yet, some Medical Officers and AMOs felt that nurses were trained to use tactics that scare women, such as yelling or slapping, to ensure a safe delivery. Some had observed this behavior among

nurses during their training period. They, and some other providers, noted that calmly instructing the woman was effective as well, and perhaps the negative effects of any yelling or physical abuse might have consequences in terms of raising her fear and creating a lifetime memory. Nurses seemed to have received signals, either in their initial training or subsequent experiences, that they could and perhaps should yell or use harsh words or slap women during delivery, if women did not 'cooperate' with instructions. Therefore, emotion work might have been required to be harsh or appear angry with women.

I think the nurses during their studies they were not told that generosity and kindness help a pregnant woman during her delivery time. They are always angry; they do not encourage the woman like saying 'when you feel labor pains sit this way'. The abusive language you use to a pregnant woman threatens her. Medical officer, male_03

2.2 Finding the inner resources when overwhelmed

All provider cadres, but particularly nurses, were described as frequently working alone or without sufficient staffing while handling large patient caseloads. They felt overwhelmed when they were needed in several locations or had multiple tasks. They might work the whole night by themselves, involving long hours with little support. Hunger sometimes set in as they had no time to stop and eat. Nurses were concerned that they could not provide women care that met quality standards given their limited time. Providers' exhaustion and frustration with the working conditions sometimes made it difficult to prevent expressions of anger or irritation with patients.

Sometimes it may happen, for example, you're alone there in the ward, the work has become more intense, you find this one here needs your help, that one there wants you to help her/him and since morning until now, at twelve, you haven't put anything in your mouth; you are alone in the ward, unrelaxed. Now you find yourself really that the time you would attend that one, you go to attend

someone else there, then that one comes to you, everyone blames you why didn't you do this to me, why didn't you do this to me, and you're alone. So, your head get confused, 'whom should I begin with and whom should I finish with.' So, you can find yourself forgetting and giving a statement that is not good, but it is due to the busy state you are in and the hunger you have made you say something unpleasant, but that is not your intention. Nurses and midwives FGD, Female_04

2.3 Keeping calm when provoked by families and patients

All cadres also spoke about controlling anger or annoyance when provoked by patients or relatives. There was a widespread feeling that the community had generally negative perceptions of providers, which was considered unfounded and rumor based. Providers felt this created an underlying defensiveness in interactions with patients and their relatives. They described situations when patients or their families insulted them, spoke offensively, or shouted at them. When this occurred, they needed to keep themselves calm as well as try to calm down the patient or relative. If they did not, they recognized that they would pay the consequences rather than the patient or family. This meant they might receive a verbal or written warning if patient complaints reached their managers.

Even if she insults you, you are the one to bring her on the right line, to talk to her nicely until she understands. But if you become above her, being harsher, she will give you those disgusting, rude answers. Since at that time you are at work, you have to bring her on the line you want so that you can understand each other so that she will find the service to be good. But if both of you will insult at the end of the day you, the nurse, will often be regarded as the troublemaker. Nurses and midwives FGD, female_05

Nevertheless, providers also spoke about understanding that patients are sometimes not their typical selves when sick, especially during labor. They spoke about women in delivery experiencing

severe pain and the delivery affecting them not only physically but psychologically. They knew that they needed to recognize the patients' state and do what they could to soothe women and tolerate any rude or confusing behavior.

Generally, all of us should use proper language with the patients, especially when we are in the labour rooms. You know there is a book I read that when a pregnant woman is at the second stage of giving birth, they usually get confused and so we should try to calm her down and bear with her. Nurse, female_04

2.4 Enforcing facility rules and norms

Providers of all cadres, however, felt that patients and relatives needed to abide by health facility rules and norms. They cited failures to cooperate with facility policies as a key factor creating conflict. Providers felt that they had the right to be angry in these situations because breaking facility rules might risk patients' health or was unfair to other patients. For example, they noted that many patients or families try to argue that they should be able to bypass the queue or become angry when they see another patient going before them. For deliveries, medical attendants and nurses were very concerned about women's relatives entering the labor ward at times that were not allowed. Facility rules about when patients could have visitors were flagrantly ignored in their opinion, creating risks for women in labor.

Regulations are there that need to be adhered to, but they aren't, that's when arguments arise. For example, if the patient is admitted, there is a specific time for relatives to come and see their sick, and they have to know it. But you'll find that they are not following those regulations. They come at their own time and offend us; they are causing arguments. There are times when the nurse leaves angrily. Medical attendant FGD_02

2.5 Concealing worries about their personal lives

Coping with worries at home also might affect their ability to manage their emotions. They particularly talked about financial difficulties, tied to what they considered to be low salaries. Sometimes they worried about having enough money for food for their children or even to pay for transport to and from their workplace. This might be compounded by wide financial obligations to a large extended family. Conflicts with their own family members, such as an argument with a spouse, might also make it hard to present a pleasant demeanor.

Economically, sometimes you leave home having nothing, or you had a quarrel at home with your family. So, such things sometimes you may find yourself bringing them to work, because we are also human beings so at the end of the day you find the patient has not got what she deserved. In one way or another we harass and do them wrong. Nurses and midwives FGD, female_02

3. Managing patient expectations in the face of system shortages

Health system-wide shortages often led to friction between providers and patients. Providers, as the frontline of the interaction between patients and the health system, had to explain why patients experienced delays in receiving care or were forced to pay for medicines or transport that should be free. This frayed the trust between providers and patients, leading to persistent beliefs that, for instance, providers were trying to personally benefit by asking patients for money.

If you tell them [some patients] to wait, they feel like you have disrespected them. They don't understand that there is a shortage of equipment and personnel. A patient comes in and even though they find other patients, they still want to be attended to first and when you tell them to wait, they feel they are disrespected. Clinical officers FGD_03

<u>3.1 Delayed care due to provider shortages</u>

Delays in receiving care due to provider shortages were a significant source of friction. Women in labor were expecting the nurses to remain by their side during delivery, but the nurses had to make

choices about who they would attend to and when. They would be unable to calm women's fears and be close to her at key moments, creating anger and complaints from women and their families. At the same time, patients were concerned that they were not getting appropriate and timely care and would ask for help multiple times.

For example, today we are only two nurses. Therefore, I cannot follow the procedures I have been taught at school. I am supposed to examine the size of the baby, the condition of the woman, contractions, heartbeat, and labour pain, after every thirty minutes to all six women. So sometimes I just ignore some of them, I have to pay attention to what is very important, especially for those who are about to deliver, even if there are others who are in need of my help at the same time. So, there are things I cannot do to other patients. When it happens like that, the job becomes difficult because some patients are not satisfied, she wants you to be there when she needs you. Nurse, female_07

3.2 Unexpected costs due to supply shortages

Due to frequent stockouts and shortages, providers would also have to explain when medicines and supplies were unavailable, which then required patients to buy them from outside the facility. While policy stated that delivery services should be free, women often encountered these unexpected costs, creating confusion and anger. They might suspect that the provider was stealing the medicines for their own pharmacy or lying to obtain money for themselves, which was disheartening for the providers. Some patients were unable to afford these costs, making providers feel frustrated and powerless as well.

The patients really hate to be told to go and buy medicine; this is because they think that we have stocks of medicines but we refuse to give them, when [we] tell them to go and buy.…so they just leave very disappointed…and later they might return and tell you "I have not bought medicine or I

don't have money, what should I do?" and we have no way to help them. And we just feel helpless. Clinical officers FGD_01

3.3 Unpredictable referral services

Emergency referrals were fraught moments of high emotion when the lives of the mother and baby were at risk. Some women did not want to be referred and could not understand why they must go to another facility. Others were angry about delays in transport arrival, paying for ambulance fuel when it is unavailable, or finding their own transport for the referral. Providers were also feeling high stress as they try to save the woman and baby while confronted with emergency complications that were beyond their capabilities to manage. With high emotions on both sides, the situation could lead to tension and arguments.

I am working at a health center; health centers have transport but sometimes there is shortage of fuel for transporting patients. The patient has already seen the car outside and needs to go to the district hospital. Then they are told the car has no fuel. They create ideas, they don't understand why the car is there, but it has no fuel! When they are told to contribute for fuel that's when the health worker has created a big crisis. [The patient thinks] "Maybe they want our money, maybe they just want us to contribute some money, but the fuel is available." Nurses and midwives FGD, female_07

4. Providers are human beings, too

Providers wanted to be recognized as human beings who are 'not angels' and sometimes might make mistakes, especially considering that they are working in difficult situations.

Even though we have done a good job, it's possible that we have slipped in a way or two. You know there are always missteps and that is why I said we should all be responsible, love our patients and treat them well. Nurse, female_04

Like other humans, not all healthcare providers are the same in terms of their ability to display the expected emotions with patients. Providers attributed this to different characters, natures, or personalities which makes them speak in ways that are offensive or harsh, be less talkative, or have more trouble connecting with others. This might also spill over to relationships with other colleagues. They noted that all humans have weaknesses, and it may not be in their nature to easily respect the patients.

The other thing is individual differences. Some are always using abusive language, that is how they have been created. Even in normal conversation they can say something which may upset others. So, you can tell them that this is not good, after all you are an adult person, you must respect yourself and others. Words may seem okay to you but to others they are offensive. Facility manager, AMO, female_02

I think it is just personal weakness, some people are mute, some are talkative, but in our training, we advise them that even if you are mute or calm by nature, try to smile or talk to the patient to make the patient feel comfortable. Even in offices there are people who are introverts, they do not talk to others. I know it discourages a patient so in our nursing ethics, we emphasize that they be charming to the patients. District manager, Nurse, female_04

A few noted that some providers may not have joined the healthcare field as a calling to provide service to others. They may have seen healthcare as a source for stable employment and a regular salary. It was felt that these providers were less likely to engage in emotion work, because they did not have a love or passion for the job.

5. **Nurses are perceived as harsh**

Medical officers and AMOs described nurses as being harsher than other cadres and that the community perceived them that way as well. Since most nurses are female, they wondered why they did not empathize with other women going through labor. They said that patients prefer them, or the rare male nurse, because they are more polite and gentle with the patients.

Well, I think if you see a male nurse, they always attend the women well. I think women do not love one another. Previously male nurses were not allowed to enter in the labour ward, but nowadays they are allowed, they are incorporated now because female nurses do not have mercy to their fellow women even during their labour pains. Medical officer, male_03

Through their descriptions, it was clear that the Medical Officers and AMOs spent less time in the maternity, only passing during rounds or when there was a complication. It seemed from some comments that there might be conflicts between them and nurses as well, with one describing the need to 'push nurses until they become furious' to force them to do what was needed. Women therefore spent most of their time during labor and delivery with the nurses. Nurses felt that they had to take on many additional tasks, such as cleaning, and were forced to interact more with patients at moments of potential friction, like explaining medicine stockouts. They further felt neglected and unacknowledged by health system leadership for the important services they provide.

6. **Limited system support for emotion work**

Many providers noted that managers often only appeared when there were problems, and rarely recognized when they did good work. Given what they accomplish in a difficult working

environment, providers wanted to be recognized for their achievements, but felt that it was rare to be acknowledged for positive performance.

First motivation, respect, and recognition; nothing else. Doing something and becoming recognized even through a letter; so, it should not wait until you have a problem. You get a problem and then they begin to recognize you. Facility manager, AMO, male_01

Nurses particularly felt that their accomplishments were unrecognized by the system as compared to other types of providers. They wanted better pay and status within the medical hierarchy given their important role and the risks that they take.

The government should know that nurses are doing a very difficult job. The government is only paying attention to the doctors. We are doing our job in a very difficult environment. We deal with patients directly regardless of what they are suffering from, be it TB or HIV, I will just put on my gloves and help her to deliver, the doctor just writes down medication. The government should care for us like the way doctors are cared for. Nurse, female_07

Table 3. Overview of themes and sub-themes

Theme	Overview	Sub-themes
1. Expected to love and care for patients	Providers are expected to be warm and polite with patients, and create genuine relationships with them	• Being close to the patient • Communication skills: good language and empathic listening • Desire for reciprocity
2. Controlling emotions	Providers need to control their own emotions and those of patients that arise due to workplace circumstances or personal situations	• Dealing with emotions around the risky technology of obstetric care • Finding the inner resources when overwhelmed • Keeping calm when provoked by families and patients • Enforcing facility rules and norms • Concealing worries about their personal lives

3. Managing patient expectations in the face of system shortages	Shortages of personnel and supplies, as well as poor infrastructure, create friction between providers and patients that needs to be managed	• Delayed care due to provider shortages • Unexpected costs due to supply shortages • Unpredictable referral services
4. Providers are human beings too	Providers want to be recognized as humans who make mistakes and have different personalities and motivations	• Making mistakes is human • Some providers' character or nature makes emotional labor more difficult • Not everyone is intrinsically motivated
5. Nurses are perceived as harsh	Nurses are distinguished as more harsh than other cadres, but this may be due to gender norms or the nature of their role in childbirth/facilities	• Other clinicians (predominantly male) say that nurses are perceived as harsher • Nurses spend extended time with women during labor and delivery • Nurses (predominantly female) may be expected to be more caring due to gender norms
6. Limited system support for emotion work	Health providers only receive feedback when they do something wrong	• Only recognized when mistakes are made • Nurses have less recognition compared to other cadres

DISCUSSION

With the growing focus on respectful maternal and newborn care, there is increasing interest in the experience of healthcare providers working in maternities in low- and middle-income countries (Reddy et al., 2022). This article is one of only a few studies that have explored emotional labor in healthcare in sub-Saharan Africa, and the first to explore the emotion work required to provide respectful care and not mistreat women during childbirth. It highlights emotional labor as a distinct task that requires resources; not merely training, but also system support to address the emotional strain and triggers in the workplace that make it difficult to perform this task (Msiska et al., 2014; Riley and Weiss, 2016).

When asked about mistreatment and respectful care, providers in Tanzania identified emotional labor as an important factor and were able to clearly describe feeling rules, even though not aware of these concepts. They were expected to feel genuine love and care for patients, and this was often coupled with the perception of healthcare as a 'calling.' Deep acting, when a person tries to genuinely feel an expected emotion in the workplace, was likely required to feel love for all patients (Hochschild, 1983). One tactic used or expected for deep acting was to imagine the woman or baby as a family member or themselves. However, it was remarked that some providers worked in healthcare for stable employment, rather than as a calling. These providers likely engaged in surface acting, displaying emotions that they did not feel. Lartey *et al* found similarly among nurses in Ghana who did not see nursing as a vocation (Lartey et al., 2019).

Providers were expected to be polite and use good language, regardless of the situation. They had to try to calm angry and frustrated patients or relatives while controlling their own similar emotions. Surface acting was therefore likely required in numerous situations, as even the most dedicated providers described moments of feeling challenged to maintain a polite facade. While emotion work was common, it appeared that it was not rewarded or supported. Providers complained that it was only acknowledged in its absence, such as when they might be reprimanded for mistreatment. They were rarely rewarded or appreciated when work was done well. Perceived lack of organizational support made emotional labor in Ghana more challenging as well (Lartey et al., 2020, 2019).

Interestingly, providers expressed a desire for reciprocity of love and respect from patients. Theodosius also highlights the reciprocal nature of the nurse-patient relationship, although she focuses on the exchange of care given by a nurse and gratitude from a patient rather than love or respect (Theodosius, 2008). There were some providers who sought respect based on their

qualifications and status as clinical professionals, as well as because of the service that they provide. Yet, others had expectations of emotional attachment by the provider and corresponding love from the patient that went beyond gratitude. Research in Malawi similarly found mutual love to be more salient than respect in describing expected relationships between midwives and women (de Kok et al., 2020). Providers did gain satisfaction from good interactions, wanted to provide good quality care, and there were some who had built strong connections with patients. Bolton has argued that some nurses may offer emotional support as a 'gift' which comes from authentic feeling, rather than a product of workplace emotional demands (Bolton, 2000).

Providers described or alluded to emotions such as happiness, satisfaction, fear, frustration, irritation, emotional exhaustion, and anger. According to feeling rules, happiness and satisfaction were typically acceptable to show, but the others usually had to be masked in encounters with women and families. Lartey *et al* also identified that Ghanaian nurses experienced a "bouquet of emotions," or emotional mixed bag, ranging from joy to sadness to anger, and all at once in some situations (Lartey et al., 2020). In Kenya, researchers identified that stressors among childbirth care providers create feelings of "frustration, hurt, sadness, demotivation, exhaustion, demoralization, discomfort, incompetence, loss of control, and other negative thoughts or actions" (Getahun et al., 2023). Hiding these feelings may take intense cognitive and emotional resources, which can be further challenged by resource constraints. For example, Burnett-Zieman et al found that maternity providers have high levels of emotional exhaustion and depersonalization, which affects their ability to provide respectful care to women (Burnett-Zieman et al., 2023). While providers in this study did not mention these mental health challenges, a recent study among childbirth providers in Tanzania showed high levels of burnout and increased levels after providers were informed about the concept (Marchand et al., 2023).

Studies of emotions and stress among maternal and newborn care providers have found similar triggers to those identified here, which reduced the ability to sustain emotion work (Bradley et al., 2019; Filby et al., 2016b; Getahun et al., 2023; McKnight et al., 2020). System shortages created conditions that stretched providers' cognitive and emotional resources. For example, when they were working alone for long hours with many patients to attend to and no time to rest or eat, they might lose their patience and become angry as frustration and exhaustion took hold. They also did not have time to 'be close to the patient,' staying by their side and providing emotional support, as they moved from one urgent situation to the next. Previous work by the authors has also identified that system shortages combined with production pressures led to the rationing of emotional labor and thus resulted in mistreatment (Ramsey, 2022; Ramsey et al., 2024). McKnight *et al* found similar circumstances among neonatal nurses in Kenya and concluded that patient-centered care may not be feasible due to insufficient time in resource constrained environments (McKnight et al., 2020). Ndwiga *et al* also found that maternity providers in Kenya had inadequate time to provide clinical care to standards or respectful care (Ndwiga et al., 2017). Numerous organizational factors affecting providers, such as high workload and poor systems support, have been identified across research on respectful maternity care (Reddy et al., 2022).

Providers were also at the frontline of explaining system shortages to patients, requiring them to manage expectations. A recent review highlighted that resource shortages can compound conflicts with families as identified in this study (Reddy et al., 2022). System shortages, such as medicine stockouts, created conflict because patients were then required to buy medicines in contradiction to policies stating that delivery services were free. Free maternity policies in Kenya and South Africa led to similar challenges and overwork, affecting relationships with patients and families (Ndwiga et al., 2017; Walker and Gilson, 2004). These moments created feelings of frustration and powerlessness in the providers as well, especially when patients could not afford to buy the

medicines. Hochschild also highlighted the challenges of emotion work in environments with cutbacks, and Riley *et al*'s review of emotional labor in healthcare highlights how it is often withdrawn by providers when facing constraints (Hochschild, 1983; Riley and Weiss, 2016).

Fear exacerbated tensions as providers worried that women or babies would die because they could not care for them safely or refer them in a timely manner. Other studies in Nigeria and Ghana have found that providers' distress during labor may lead to mistreatment, emphasizing particularly the second stage of labor (Bohren et al., 2016; Dzomeku et al., 2020). The maternity was described as a difficult environment, requiring additional effort. They relied on women to be active patients, pushing at the appropriate moments, but also expected passive compliance with their instructions. The expectation of compliance, often described as 'cooperation' has been highlighted as a source of disconnect between providers and women (Béhague et al., 2008; Brown, 2010).When women did not comply with instructions, nurses seemed to be socialized to use harsh language, yelling, or slapping to 'motivate' them, which has been found in other studies (Downe et al., 2023).This may also have required emotional labor, such as surface acting, if they did not genuinely feel anger. Or harsh treatment might have also been an expression of concern to ensure good outcomes for the mother and newborn (Jaffré and Lange, 2021). Lombart's concept of "transient empathic blindness" as applied by Jaffre &Lange characterizes how a provider might overlook a patient's pain and demands to act for their perceived good (Jaffré and Lange, 2021).

The findings also highlight the potential gendered expectations of emotional labor, particularly among nurses. Hochschild's theory and nursing studies of emotional labor highlight the gendered aspects, with greater expectations for women and female-dominated professions (Hochschild, 1983; Riley and Weiss, 2016; Theodosius, 2008). For instance, women are typically presumed to have more natural caring ability. In Tanzania, where most nurses are female, there were expectations that maternity-based nurses would genuinely feel empathy for other women and

consider their own experiences in labor. They were perceived as harsh when compared to more male-dominated professionals, which could be due to expectations of them as females. Yet, nurses spent more time with women, managing their labor over many hours, sometimes through the night, while the male-dominated professions would only pass through for rounds or when there was a complication. This might have created more opportunities for friction between nurses and laboring women, as well as more exhaustion among nurses. Finally, nurses also often had to deliver bad news, such as when families needed to pay for delivery materials that they expected to be free, which might have created more opportunities for friction between nurses and patients. Reviews have identified that gender discrimination experienced by female maternity providers can inhibit the provision of quality of care (Betron et al., 2018; Filby et al., 2016b). More research is needed to understand the gendered aspects of emotional labor in this context.

Although strategies to support emotional labor were beyond the scope of this analysis, some authors have provided potential systems, collective and personal approaches that might be considered. More generally, Riley *et al*'s review highlights the need to make the often-invisible emotional labor more explicit and recognized in health systems, including training programs (Riley and Weiss, 2016). Lartey *et al* identified that perceived organizational support was protective for nurses in Ghana, indicating that improving system supports, such as emotional and social relationships with supervisors as well as material resources, could improve the ability to provide emotional labor (Lartey et al., 2019). Other studies have looked at how providers in resource limited contexts deal with stressors. Getahun *et al* discovered that Kenyan maternity providers' most common individual coping mechanisms include talking to friends or relations, engaging in religious practices, sleeping, or spending time with family or friends (Getahun et al., 2023). Alternatively, McKnight *et al* found that Kenyan newborn nurses engage in collective strategies, such as routinizing care, organizing patients according to criticality, applying their autonomy, and

improvising as needed (McKnight et al., 2020). Ultimately, this study highlights that emotional labor requires that the essential system resources are in place, as well as specific acknowledgement of emotional labor as a distinct task requiring specific skills and resources.

Methodological considerations

The study was based in two nearby districts in the same region which may differ from other parts of Tanzania, and thus not reflect the country given historic geographic, political, social, and economic differences. The districts include peri-urban and rural settings, but these may differ from urban areas which encounter even higher volumes. The participants are a mix of hospital, health center and dispensary staff, but there are not enough of each to distinguish differences between them. It has been noted that high volume hospital conditions are likely to differ from smaller facilities (McKnight et al., 2020). The study was not designed to specifically ask about emotional labor. It was identified as a theme in descriptions of providing respectful care or explaining instances of mistreatment in childbirth. Consequently, there are many areas that could be further explored in depth, such as surface as compared to deep acting, how providers cope, strategies to maintain emotional labor, how age and length of working affect emotional labor, and more. Further research is needed to better understand gendered aspects. They were raised in by participants, but not enough to fully disentangle the complex factors related to gender, medical hierarchy, and the nature of maternity care.

CONCLUSION

Emotional labor is essential to providing respectful maternity care and preventing mistreatment in childbirth. While it only applies to some types of mistreatment, these aspects are important to women and their families. However, emotional labor's relationship to respectful maternity care has not been well studied, especially in low- and middle-income settings. To the authors' knowledge,

this study is the first to explore emotional labor and maternity care in a Sub-Saharan African setting. The studies' findings highlight the need to acknowledge that system shortages compromise not only the technical work of providers, but also their emotional labor. Resources are required, not only to ensure the most basic of resources to provide quality of care, but to ensure sufficient organizational support to address emotional demands. Emotional labor was expected but unacknowledged. Systems need to acknowledge it and support and train providers to provide this care, as well as help them to manage difficult emotions that they experience due to the nature of their work. Further research is required to understand emotional labor in low- and middle-income settings and identify ways to better support providers in emotion management.

Conclusion

Overview of the dissertation

This series of studies, each of which builds upon the previous, develops novel theory to explain the persistence of mistreatment in childbirth, which was hypothesized as normalized organizational deviance. The first paper used analogical comparison, comparing the case of mistreatment in childbirth in Tanzania with the normalization of organizational deviance theory elaborated from analysis of the Challenger launch explosion at NASA. A systematic review of literature on the health system and maternity care in Tanzania was used to develop the case. In the second paper, the nascent theory developed in the first paper was verified and amended using qualitative data from a study conducted in a region in northeastern Tanzania. Finally in the third paper, emotional labor was further analyzed to understand its characteristics and constraints in the context.

Summary of the Findings

Through systematic review and analogical comparison, novel organizational theory was developed to explain why mistreatment in childbirth persists in healthcare institutions in the first paper. The resulting theory for mistreatment aligned with the main constructs of the NASA case, in which normalized scarcity, combined with production pressures, distorted system functioning. In the case of mistreatment, production pressures focused on increasing institutional childbirth to meet national political promises and ambitious global goals, despite insufficient financial and material resources and a limited health workforce. Power dependence imbalances between macro- and meso-levels caused values, structures, and processes to shift. Consequently, meso-level actors, who found themselves without adequate resources – either material or symbolic – engaged in workarounds and rationing to cope with the discordance between expectations from the system

and the realities of the work environment. They prioritized clinical care, given system signals which emphasized biomedicine, and rationed emotional labor, resulting in mistreatment, which could be experienced as disrespect by women and their families. Regulatory systems were ill-equipped to capture the problem, due to the breadth of the system and the emphasis on biomedicine.

Building on this nascent theory, the second paper analyzed qualitative data which elicited perspectives on the characteristics and drivers of mistreatment among women and men, maternity care providers, facility managers, and district, regional and national healthcare managers in Tanzania. With one district as the center of the case, theory-driven analysis enabled verification and further elaboration of the theory. The analysis confirmed many of the constructs in the original theory, while unearthing new perspectives and constructs in a few key places. For example, moral distress experienced by providers emerged as an important systems effect, which may contribute to providers withdrawal of emotional labor. In addition, managers were found to span the roles of management and service provision, meaning that they likely experience moral distress as well. The nature of the interaction at the micro-level was also expanded to include family members, who can play a role in creating tensions. The regulatory environment was revised most significantly, as the qualitative data provided more detail on the specifics of how the system handles mistreatment. Mistreatment was hidden in plain sight, due to the nature of mistreatment and systems designed to mitigate the problem.

In the final paper, emotional labor was examined more closely, using qualitative data in which maternity care providers and managers described their working conditions while answering questions about mistreatment. Emotional labor was found to entail expressing love and care for the patients, controlling emotions that are not considered acceptable, and managing patients' and families' expectations when faced with system shortages. Providers felt that their needs as humans were not acknowledged by the system or communities, and that there was limited support for them

to exert emotional labor. There was some indication of gendered expectations, as nurses, who are predominantly female were perceived to be harsher than other cadres. Disentangling this with their role in care provision proved challenging and requires further research.

Considerations

The primary and secondary data used in this dissertation are from the period of 2010 to 2015. Since that time, things may have changed in Tanzania. Nonetheless, analyses of these data are still useful for developing theoretical understanding of the problem of mistreatment. Because of the Staha Project and other studies conducted in the same period in Tanzania, as well as ensuing advocacy work, the problem of mistreatment is acknowledged openly by the government, an important step forward (Tinkasimile et al., 2022). Numerous additional studies have also followed, some of which have also tested interventions. Nonetheless, recently published papers still report ongoing disrespect/mistreatment in Tanzanian maternities (Lavender et al., 2021; Mwasha et al., 2023).

The dissertation and analysis use care for the woman during childbirth as the focus for the case. While the newborn experience is important, the woman can remember and discuss her experience, while only being able to describe the newborn's treatment. In addition, her experience is likely to influence future care seeking for herself and for the child. Nonetheless, care for the newborn was mentioned in focus groups with women, although largely in relation to essential clinical care. Since the study has been conducted, there has been an emergence of concern about a respectful experience for the newborn (Palgi Hacker et al., 2022). The area still needs further research, including understanding about whether the theory and constructs identified here remain relevant.

While male partners' perspectives were included, at the time of the study, men were not allowed to accompany their partners in the labor and delivery rooms. In large facilities, female companions were also typically not allowed to remain with the woman throughout childbirth. Family members

typically waited outside and were only called upon if money or supplies were needed. Therefore, only women and providers could speak about the experience directly. Since the time of the study, Tanzania, and numerous other countries, have started to allow female companions, typically family members, to remain with women during childbirth (Chaote et al., 2021). With this change, future research could benefit from including companions' perspectives and experiences with childbirth, as well as exploring how this changes the dynamics.

Implications and public health significance

Mistreatment is a significant public health problem, with social, psychological, and health consequences for thousands of women and newborns daily. To date, these are some of the only studies to explicitly elaborate theory about mistreatment based on a case. Many of the elements in the theory had been identified as potential drivers of mistreatment by others, but they had not been analyzed cohesively as theory to explain the dynamic relationships between them. Theory is essential to understand the means to disrupt the patterns of mistreatment because it is a social, behavioral, and systemic problem, as highlighted in these papers and by other authors (Downe et al., 2023; Reddy et al., 2022) This nascent theory also aligns with the understanding of mistreatment as a pattern of behaviors and conditions that has been normalized by actors within the system, as well as women and their families (Schaaf et al., 2023; Wright et al., 2022). While Tanzania was used as the case, similar factors have been highlighted in reviews, which indicates that the theory may be relevant in other contexts, especially in low- and middle-income (LMIC) settings.

By applying a multi-layered framework, the analyses drew back from the interaction between women and providers, which has now been the subject of increasing research, to understand what shapes that interaction, not just at the meso-level, but in the macro-environment which drives the

policies and norms expected among systems actors. By outlining the challenges at each level, and the power dynamics between actors, the theory can contribute to identifying leverage points within the system that can drive change to reduce mistreatment and promote respectful maternity care.

Highlighting emotional labor within the theory, and specifically as a construct, also emphasizes that not mistreating a patient and providing respectful care requires a particular type of skill and effort. While providers may be trained in ethics or to be respectful and kind to patients, the effort of providing this aspect of care is often unacknowledged and under resourced. It requires systemic support in the form of basic system resources, but also specific training and social and emotional support from peers, supervisors, and communities to be maintained. In environments with limited resources and where it is unacknowledged, it may be one of the first aspects of care to be rationed.

The findings may also have broader implications, beyond maternity care and mistreatment, considering worldwide concerns about the well-being of the health workforce. Even before the COVID-19 pandemic, burnout among healthcare providers was high, as well as the likelihood of other mental health conditions. For example, a meta-analysis of studies, with only 3 out of 60 from during the pandemic, found that nearly one-third of primary health care professionals in low- and middle-income countries were experiencing at least one aspect of burnout (Wright et al., 2022). These existing problems were heightened by the COVID pandemic with researchers finding high levels of psychological distress among healthcare providers during this period, including high levels of burnout, depression, anxiety, and post-traumatic stress disorder (Abdul Rahim et al., 2022; Ulfa et al., 2022). The World Health Organization released a report in 2022 highlighting the failure to support healthcare providers, especially regarding their mental health and well-being, and recommending actions at system level in addition to individual-level interventions (Abdul Rahim et al., 2022). Many of the conditions that lead to poor mental health and well-being among providers have been identified throughout the papers in this dissertation. The findings could be a useful lens

for understanding the less direct systemic factors that require transformation to create a better working environment.

Organizational sociology proved to be fruitful in examining the dynamics of health systems functioning and performance. Normalization of organizational deviance might apply to other maladaptive patterns and behaviors that have been observed in health systems, such as actions outside of norms taken by street-level bureaucrats (Erasmus, 2014). Where health systems are failing or underperforming, the branch of organizational sociology that studies failure, or more simply why things go wrong in organizations, can provide deeper analysis of system actors and why their behavior is patterned in ways that do not align with system policies and standards. As Gilson *et al* note, the field of Health Policy and Systems Research in LMICs requires multiple lenses, including social science from a variety of disciplines, to understand the complexity of systems, which are social and political constructions (Gilson et al., 2011).

Future research directions

Although further application is needed, the theory developed through this series of papers provides an important step towards explaining how and why mistreatment persists as organizational deviance in healthcare institutions. To strengthen the theory, further empirical testing in other public health systems with different social, political, and economic foundations, as well as in private sector healthcare organizations is needed. Further research would enable identification of which elements of the framework are more universal as compared to those which have more context specificity.

Within the framework, there are areas requiring further research. Relationships and power dynamics between different levels of the health system require more study, including how structures and processes play a role in defining the interaction. Among system actors, there has

been growth in research about healthcare providers' experiences in LMICs, but more limited understanding of how managers at sub-national and national levels cope with decision-making when resources are constrained, but goals remain ambitious. Additionally, many of the constructs have limited application and research in LMICs. Concepts, such as institutional logics, emotional labor, moral distress, and workarounds, among others, have rarely been studied in African and Asian healthcare contexts, for instance. Future research could focus on how these constructs are experienced or perceived differently depending on the social and political context. Emotional labor was found to be relevant with further analysis but needs continued exploration to understand how it differs between cadres and types of healthcare facilities and reflects gendered expectations.

While the theory developed in these papers provides an important step forward, other theoretical lenses are needed to comprehensively understand and address mistreatment in childbirth. For instance, the qualitative data indicated that there are important gender aspects to consider within the health system but were insufficient to fully explain its role. In addition, the power dynamics and relationships between patients and providers could be more fully explored with other sociological or anthropological lenses.

Conclusion

This series of papers underscores that preventing mistreatment and promoting respectful care is not merely a matter of training providers or simple programmatic interventions. Systemic change in structures and processes, and the embedded institutional logics, are needed to ensure that meso-level actors, including managers and providers, have the right conditions to support emotional labor for women in childbirth. To enact these changes, macro-level actors also must be cognizant of system resources and capabilities when setting goals and standards which drive meso-level action. Without essential resources in place, it will be challenging for providers to be able to provide

good quality clinical care and emotional labor, especially as they worry about the risks to their own lives. Furthermore, respect and social support among actors in the system needs to be fostered, creating a more psychologically safe environment. This includes acknowledging the strain of emotional labor, including the emotional toll of working in under resourced facilities where maternal and newborn lives are too often unnecessarily lost.

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