Accountability for respectful maternity care

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Worldwide, maternal health efforts are shifting from an emphasis on boosting service utilisation to improving quality of care. This change has been accompanied by a growing body of work on how women are treated during facility-based childbirth, which was first brought to global attention in 2010 by Bowser and Hill's landscape analysis.[1] Several studies have documented the ubiquitous nature of disrespectful care and its adverse effects on care-seeking behaviour,[2] and calls to action on quality of maternal health care have prioritised women's experiences.[3]

Before 2015, most of the research on women's experiences during childbirth was qualitative in nature.[2] Since then, several studies have sought to quantitatively measure the extent of disrespect and abuse during childbirth. These initial attempts highlighted that disrespect and abuse of women during childbirth are prevalent, although the estimates varied widely (from 15% to 98%) because of several methodological issues, including inconsistencies in how disrespect and abuse were measured.[4] In *The Lancet*, Meghan Bohren and colleagues[5] describe their efforts to address this issue by using tools that were rigorously developed for continuous observations of women during the intrapartum period and for community-based assessments at up to 8 weeks post partum.

Their analysis of more than 2000 birth observations and community surveys in Ghana, Guinea, Myanmar, and Nigeria showed that, irrespective of the measurement approach, more than a third of women experienced some form of mistreatment. For example, 838 (41·6%) of 2016 observed women and 945 (35·4%) of 2672 surveyed women experienced physical or verbal abuse, or stigma or discrimination. The investigators also found other forms of mistreatment such as lack of consent for vaginal examinations, episiotomies, and caesarean sections.

A key strength of this study was the use of standardised and evidence-informed measurement tools, which were applied in two different ways. Like most studies involving self-reporting of potentially subjective experiences, social desirability and recall bias are limitations of the community survey. However, the Hawthorne effect is a potential limitation when people are observed, with likely underestimation of undesirable behaviours. However, the combination of approaches and the similarities in the results across methods provide strong evidence for the validity of the findings. The study is limited in generalisability given that only three facilities were selected from each country in urban areas in a non-random fashion. Nonetheless, it is one of the few studies to examine mistreatment across different settings, using the same standardised tools.

Bohren and colleagues' study extends the evidence that many women are mistreated during facility-based childbirth in low-resource settings. In addition, other studies—including a birth observation study in five countries (Ethiopia, Kenya, Madagascar, Rwanda, and Tanzania)[6] and more recently another study that used a validated person-centred maternity care scale in surveys with women in Kenya, Ghana, and India[7]—have highlighted that the problem is not just about the presence of negative interactions such as verbal and physical abuse but also an absence of positive interactions such as effective communication and supportive care.[6,7] Furthermore, studies in high-income countries have shown that mistreatment is not just an issue in low-resource settings.[8]

Bohren and colleagues' study also extends the evidence on disparities in how women are treated on the basis of age and socioeconomic status. Sources of disparities highlighted in other studies have included the type of facilities women receive care in and race and ethnicity.[8,9] Additionally, the study affirms that the

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aspects of mistreatment requiring prioritisation will likely differ across settings.

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In a campaign by the White Ribbon Alliance on what women want worldwide, the top demand from more than 1 million women from 114 countries was respectful and dignified health care. However, it is clear from these results that many women are not getting such care. Yet there have been very few studies documenting the drivers of mistreatment and even fewer studies documenting interventions to prevent it.[10,11] Perhaps most importantly, there has been a surprising dearth of discussion regarding accountability. Governments, facilities, and individual providers are increasingly acknowledging the prevalence of mistreatment, perhaps even committing to reduce it—but where is the accountability? Although measurement remains important, we need to move beyond assessing prevalence of mistreatment and begin using the validated tools that have been developed to drive efforts at increasing accountability and tracking change.

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