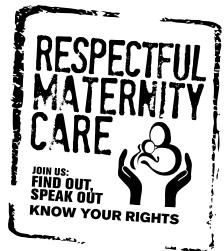


Disrespect and Abuse in Childbirth and Respectful Maternity Care



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This brief describes the problem of disrespect and abuse during facility-based childbirth and the importance of respectful maternity care. It is intended to be used by program planners and practitioners seeking a basic overview of the field, or who wish to advocate for greater attention to respectful maternity care.

Defining Disrespect and Abuse

Disrespect and abuse of women during facility-based childbirth is not a new phenomenon. Women's health and rights advocates have long complained of poor treatment in reproductive and maternal health services, especially for poor and marginalized women. Although recognized as an issue since the 1950s (Diniz et al., 2015), it was not until 2007 that human rights organizations began to formally document incidents of disrespect and abuse (D&A) in maternity care (Ogangah et al., 2007; Amnesty International, 2010). Since then, the field of work on D&A has grown, and with it the challenge of defining and measuring such a complex phenomenon.

D&A, sometimes referred to as mistreatment, obstetric violence, or dehumanized care, can be defined generally as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified" (Freedman et al., 2014). D&A has many manifestations, both individual (specific provider behaviors experienced or intended as disrespectful or humiliating) and structural (systemic deficiencies that create a

disrespectful or abusive environment). A 2015 systematic review of 65 qualitative, quantitative, and mixed-methods studies proposed a seven-category model for classifying instances of disrespect and abuse: physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care (i.e. lack of informed consent and confidentiality, painful examinations and procedures or failure to provide pain relief, and neglect and abandonment); poor rapport between women and providers; and health systems constraints. Health system constraints include lack of resources, such as infrastructure to ensure privacy, supplies to ensure standards of care are met, and personnel to ensure that providers are not overly stressed and can effectively attend to the needs of each woman and baby. They also include lack of policies sanctioning inappropriate behavior, and facility cultures that promote bribery and extortion; have unclear fee structures; or make unreasonable requests of women by health workers (Bohren et al., 2015).

The definition and measurement of D&A is further complicated by the subjective nature of experience and the normalization of certain disrespectful and abusive practices. In many instances, women do not perceive behaviors as disrespectful or abusive because the practices are common and even expected in their health care context. Similarly, women may perceive a behavior as an act of D&A that providers do not because it is engrained in their practice (Freedman et al., 2014). A complete definition of D&A must "[capture] the complex relationship among expectations, normalisation, and rights, while acknowledging the link between individual action and the systemic conditions that sustain it" (Freedman & Kruk, 2014).

D&A can occur in both low- and high-income settings, but may manifest in different forms depending on the context (Schroll et al., 2013). In their systematic review, Bohren et al. (2015) found evidence of all seven types of D&A across geographic regions.

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Why Should We Care About D&A in Childbirth?

D&A can be harmful for several reasons. First, it can constitute a human rights violation that undercuts women's citizenship and autonomy. It may also erode satisfaction and trust in the health system, ultimately leading to adverse health outcomes. It can also contribute directly to adverse health outcomes. Finally, D&A can have negative economic ramifications.

At its core, D&A is a **human rights** issue. Disrespectful and abusive care is a violation of women's rights to life, health, bodily integrity, self-determination, privacy, family life and spiritual freedom, and freedom from discrimination (Lokugamage & Pathberiya, 2017; World Health Organization, 2015). While D&A is perpetuated and experienced by individuals, the practice is a manifestation of structural violence and gender inequality that has become normalized in societies around the world (Sadler et al., 2016; Jewkes & Penn-Kekana, 2015). According to psychologist Rachelle Chadwick (2017), "Obstetric violence functions as a mode of discipline embedded in normative relations of class, gender, race, and medical power" (p.1).

When women feel that their rights are violated during healthcare, it can undercut their **satisfaction and trust** in health care facilities and providers (Kujawski et al., 2015; Kowalewski et al., 2000; Bohren et al., 2014; Turan et al., 2008). A woman's satisfaction with health care services is associated with her utilization of those services; a study of women in Tanzania found that women who had experienced D&A reported lower satisfaction and intent to deliver at the facility (Kujawski et al., 2015). Delayed utilization can in turn affect women's health. Women delaying care seeking – either by skipping prenatal care or laboring at home – in order to minimize experiences of D&A can lead to **additional complications or put their health or their baby's health at risk** (Bowser & Hill, 2010). By birthing at home without a skilled attendant to manage clinical complications, women have a

higher risk of maternal or neonatal morbidities and mortality (Gao et al., 2010; Kowalewski et al., 2000; Bradley et al., 2016; Oyerinde et al., 2013; Moyer et al., 2014; Bohren et al., 2014). Moreover, some research has found that mistreatment by providers during pregnancy or delivery demotivates mothers from utilizing public health facilities in the long term, including for their children. Women's previous experiences with the health care system and their perceptions of quality of care at facilities can influence their care seeking for their newborns and children (Atuyambe et al., 2009; Syed et al., 2008; Colvin et al., 2013).

D&A can also directly contribute to poor outcomes. Provider neglect or abandonment, for example, **can prevent timely or proper diagnosis and treatment of complications**. Over-medicalization of childbirth, including excessive or inappropriate use of uncomfortable interventions, can also contribute to morbidity and mortality. Though sometimes effective or lifesaving, when overused, these procedures, including induction, augmentation, continuous electronic fetal monitoring, episiotomies, cesarean section, and enemas, can cause maternal or neonatal complications, such as uterine rupture, perineal laceration, or uterine prolapse (Miller et al., 2016). In a study of public health facilities in Uttar Pradesh, India, women who reported mistreatment during childbirth were more likely to experience complications during delivery and in the postpartum period (Raj et al., 2017).

Poor physical outcomes are not the only health impact of disrespectful and abusive care. D&A can **adversely affect mental health** by creating a fear of childbirth (Lukasse et al., 2015; Schroll et al., 2013), affecting sexuality and desire to have children (Schroll et al., 2013), and generating life-long feelings of guilt and grief (Forssén, 2012). Some women have even shared that their experience with D&A in childbirth had triggered memories of sexual assault (Reed et al., 2017).



In addition to being a health issue, D&A can have **negative economic implications**. Unnecessary use of harmful technologies and noncompliance with correct procedures are not only detrimental to women; they may also cost facilities both money and time. Unnecessary interventions are costly to health systems, and these costs can be even greater if overuse of intervention causes avoidable harm or sets off a cascade of interventions. By improving quality of care, facilities can minimize costs and increase efficiency (Hulton et al., 2007; Miller et al., 2016).

What Can Be Done About D&A? The Respectful Maternity Care Movement

In light of the growing body of evidence of D&A, health and human rights organizations have deemed D&A during maternity care a violation of women's human rights. When defining D&A, it is important to note that the absence of D&A does not equal respect; respectful, quality, woman-centered care requires conscious effort and should be prioritized by both care providers and health systems (Freedman & Kruk, 2014). Thus, campaigners have called for respectful care and protection of all childbearing women, especially the marginalized and vulnerable, such as adolescents, minorities, and women with disabilities (Amnesty International, 2010; White Ribbon Alliance, 2011; World Health Organization, 2015). Although there is no consensus on what constitutes respectful care, the emerging **respectful maternity care** (RMC) movement generally advocates for a patient-centered care approach based on respect for women's basic human rights and clinical evidence. The RMC Charter, a normative document that was developed collaboratively by researchers, clinicians, program implementers, and advocates, outlines a rights-based approach to many aspects of care. The Charter is based on universally recognized international instruments to which many countries are signatories, such

as the International Covenant on Civil and Political Rights; International Covenant on Economic, Social, and Cultural Rights; and the Convention on the Elimination of all Forms of Discrimination against Women.

The seven rights of childbearing women it describes are the rights to:

- freedom from harm and ill treatment;
- information, informed consent, and refusal, and respect for choices and preferences, including the right to a companion of choice wherever possible;
- confidentiality and privacy;
- dignity and respect;
- equality, freedom from discrimination, and equitable care;
- timely health care and the highest attainable level of health;
- and liberty, autonomy, self-determination, and freedom from coercion (White Ribbon Alliance, 2011).

Efforts to flesh out the content of these rights have identified the importance of services such as continuous care during labor and birth; freedom of movement during labor; freedom to eat and drink during labor; and non-separation of mother and newborn (USAID MCHIP, n.d.; Positive Birth Movement, n.d.). Respectful maternity care will vary in different contexts, and more research is needed to define and promote effective RMC behaviors. The RMC movement seeks to generate further evidence on D&A, advocate for quality care for all women, and offer solutions to improve maternity care and maternal health outcomes.



To Learn More

This factsheet offers a brief overview of disrespect and abuse in childbirth and respectful maternity care.

For more information, please refer to the following resources:

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