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Dignity and respect in maternity care

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Mistreatment of pregnant women, adolescent girls and persons, as well as newborns is a pervasive problem around the globe.[1] Anecdotal reports and research evidence collected in maternity care systems from the wealthiest to poorest nations worldwide, irrespective of the state of the health systems, paint a disturbing picture. In fact, mistreatment of persons seeking maternity care, whether subtle or overt, intentional or unintentional,[2] is being recognised as an urgent problem and a growing global movement has been created that spans the domains of healthcare research, quality and education; human rights; and civil rights advocacy.[3]

Mistreatment of parents and newborns around the time of birth is often 'normalised'[4] in the hospital culture and exacerbated by the lack of awareness of patients' rights, gender discrimination and deficiency in clinical empathy skills and humane perspective. At the individual and community level, there is tacit acceptance of mistreatment as customary and even expected. There are many instances of physical and verbal abuse, humiliation, neglect and abandonment of care of women from some segments of society, including certain racial, ethnic and religious groups, migrants, adolescents, women with disabilities and others.[5] For people in disadvantaged groups without the agency to speak for themselves, mistreatment keeps them from accessing services and those who access services may be mistreated.

The healthcare workforce, often seen as the perpetrators of the mistreatment, are themselves frequently overworked, underpaid and demoralised—while usually conducting themselves as they were taught in an environment that is disrespectful to clients and health workers alike.

WHAT WE KNOW

Respectful Maternity Care (RMC) requires more than the elimination of mistreatment. What is essential is 'care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth'.[6]

Beyond upgrading the health system to provide clean and safe conditions for an enabling environment, respectful treatment is not predominantly reliant on availability of funds or even personnel. In both high- and low-resource settings, respect is largely dependent on the goodwill, professionalism and commitment of people within the system.

Types of mistreatment vary widely, and it can be challenging to categorise the drivers.[5 7] They could be a result of systemic deficiencies or behaviours of the providers or a mix of both. For example, if staff abandon a woman during childbirth, it could be due either to health providers' lack of awareness or it could be a result of poor client-to-provider ratio or both. Combating mistreatment requires concentrated efforts across sectors and needs to be addressed as a societal issue and by multisectoral groups of people working together.

'Caring for the carers' is critical.[8] Healthcare providers and staff who may be overworked

Summary box

⇒ Mistreatment in childbirth is a consequential issue for human rights and healthcare.
⇒ Serious violations of human rights, standards of care and basic humanity are currently taking place for childbearing people and newborns, particularly around the time of birth.
⇒ Labouring people are wheeled into surgery for caesarean delivery without informed consent.
⇒ Postpartum mothers are detained for days after childbirth to extort payments for care.
⇒ Babies are swapped in nurseries to families with more power and wealth. Newborns are treated roughly.
⇒ Childbearing persons are beaten and humiliated. Women are told to clean the floor and bed immediately after birth.
⇒ Mothers and newborns are separated from each other.
⇒ Childbearing people are ridiculed for their choices and coerced to endure treatment they do not want.

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and underappreciated, working shifts to cover '24/7' service availability and dealing with anxious people and subtle diagnoses, as well as life and death emergencies, need support.

FILLING GAPS IN EVIDENCE FOR RESPECTFUL MATERNITY CARE

Strides have been made in the past decade to provide evidence of the types and incidence of mistreatment. The study by Bohren *et al*: How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys[9] significantly advanced this understanding. This WHO study provided methodological development of tools and its database in community-based surveys conducted in Ghana, Guinea, Nigeria and Myanmar and facility-based observations conducted in all but Myanmar. Observational newborn data through 2 hours after birth were analysed by Sacks *et al*.[10] Within this supplement, secondary analyses based on prioritised questions using this multicountry study data aim to inform future strategies to tackle this issue.

Through a multicounty community survey, Maung expands our knowledge of women's satisfaction during their childbirth in health facilities and explores the difference in the experience of mistreatment with overall satisfaction for services received.[11] While companionship in labour had been associated with improved birth outcomes, Balde's paper describes the association between lack of labour companionship and mistreatment of women during childbirth that had not previously been deeply explored.[12]

The Irinyenikan analysis has illuminated the situation of adolescents (15–19 years) and young women (20–24 years) and found that experiences of mistreatment were high across both age groups (44% and 36%, respectively) and included non-consented episiotomies and vaginal examinations, physical and verbal abuse, and stigma and discrimination.[13]

What had not been previously studied in-depth was the incidence and impact of mistreatment of women during vaginal examination, including non-consented examinations and lack of privacy. In the Adu-Bonsaffoh analysis on mistreatment during childbirth, exposure of genitalia and breasts was common (28% and 25%, respectively). Furthermore, almost 60% were observed to receive non-consented care.[14]

A key obstacle in measuring the prevalence of mistreatment is a scarcity of validated measurement tools and techniques which could be used within health systems. The Berger and Leslie papers used the full versions of the validated WHO tools for observation and community survey and developed shorter versions for easy use. Berger tested a set of three concise measures of mistreatment for facilities that 'can be adapted and used in future research and quality improvement initiatives to quantify the burden, frequency and overlap of multiple types of mistreatment in a standardised way that can be compared across studies, settings and time periods'.[15 16] These papers advance our understanding of measurement issues of mistreatment and provide new knowledge of methodologies and scales that can be used and adapted by programmes in many countries.

RESPECTFUL MATERNITY CARE IS ACHIEVABLE

RMC is not just a vision for the future—it is the bare minimum that should and can be provided to everyone, everywhere, now. Progress is being made. Efforts to promote RMC that focus on the systems, structures, attitudes and behaviours that generate mistreatment have shown success in decreasing mistreatment in programme areas in Kenya and Tanzania.[8 17] The India LaQshya programme, a national level, multipronged approach to improve the quality of care in the intrapartum and postpartum period, provides a noteworthy example that combines availability of infrastructure, equipment and human resources to enhance the status of all pregnant persons and promote RMC in healthcare facilities.[18]

At the policy level

Acknowledgement that RMC is a legitimate and essential aspect of quality maternal healthcare which needs to be incorporated into health policies nationally and globally is critical. Measurement of progress must incorporate respect, protection and fulfilment of human rights in the healthcare setting. Regular monitoring of RMC should be undertaken at national, provincial/state and district levels based on standards of care and human rights. It is essential to ensure participatory processes with a range of stakeholders, including providers, health officials, community leaders and parents themselves. Zero tolerance for any kind of abuse with robust accountability and redressal mechanisms should be put in place.

At the facility level

To a great extent RMC depends not only on the attitudes and behaviours of providers but also on the availability of good health infrastructure and adequate number of service providers, prioritising interdisciplinary approaches, to create the environment for healthcare services to be provided with dignity and respect. Setting expectations, training, modelling and mentoring healthcare providers in interpersonal skills, empathy and patients' rights will go a long way in ensuring RMC norms. This will also encourage permitting a birth companion of choice, who can be an advocate, to be present with persons during labour and birth. Importantly, sustained leadership in health facilities must engender an ethos of dignity and respect.

At the individual and community level

Social accountability approaches to reducing mistreatment must be contextual and involve women and the

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Figure 1 Dignity at the centre of Care. Source: What Women Want Campaign. White Ribbon Alliance for Safe Motherhood, India.

community. Childbearing people should be at the central of planning processes and voice their needs and preferences in maternity care, as well as in setting up systems to facilitate their ongoing feedback and participation. The normalisation of mistreatment can be overcome only by active involvement of parents and the community in demanding and expecting RMC as their basic and fundamental human right.

People need to be working simultaneously in a concerted manner at all levels of the health system, including referral transportation: at community level to challenge the normalisation of mistreatment, at facility level to support the caregivers and at policy level to ensure a supportive policy and accountability environment.

Central to advancing respectful care is the need to recognise and address inherent power hierarchies,[2] as well as the cultural patterns of behaviour, which can drive mistreatment. Influence and direction of community leaders, midwives and doctors, policy-makers and champions are already showing progress in tackling the entrenched obstacles to promoting human rights, dignity and respect for all childbearing persons.

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