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REPRODUCTIVE HEALTH

The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother—baby friendly birthing facilities initiative

Suellen Miller [a,*], Andre Lalonde [b,c]

[a] Department of Obstetrics, Gynecology and Reproductive Sciences, Bixby Center for Global Reproductive Health and Policy, University of California, San Francisco, CA, USA
[b] University of Ottawa, Ottawa, Ontario, Canada
[c] McGill University, Montreal, Quebec, Canada

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ABSTRACT

Recent evidence indicates that disrespectful/abusive/coercive service delivery by skilled providers in facilities, which results in actual or perceived poor quality of care, is directly and indirectly associated with adverse maternal and newborn outcomes. The present article reviews the evidence for disrespectful/abusive care during childbirth in facilities (DACF), describes examples of DACF, discusses organizations active in a rights-based respectful maternity care movement, and enumerates some strategies and interventions that have been identified to decrease DACF. It concludes with a discussion of one strategy, which has been recently implemented by FIGO with global partners—the International Pediatrics Association, International Confederation of Midwives, the White Ribbon Alliance, and WHO. This strategy, the Mother and Baby Friendly Birth Facility (MBFBF) Initiative, is a criterion-based audit process based on human rights' doctrines, and modeled on WHO/UNICEF's Baby Friendly Facility Initiative.

1. Introduction

In the past few years the relationship between lack of quality of care and adverse maternal outcomes is being highlighted globally. The WHO recently issued a statement for the prevention and elimination of disrespect and abuse during facility-based childbirth [1]. The United Nations issued a resolution on preventable maternal mortality as a human rights violation, and issued a technical guidance on the application of a human rights-based approach to reduce maternal deaths in 2012 [2,3].

The present article documents examples of disrespect and abuse and the lack of quality care in maternity facilities, and demonstrates connections between these and continuing high maternal mortality, despite increasing facility-based deliveries with skilled attendants [4,5]. The global efforts to reduce disrespect and abuse in facilities are described and we discuss FIGO's Mother and Baby Friendly Birth Facility (MBFBF) Initiative—a human-rights and criterion-based audit process, which FIGO's Safe Motherhood and Newborn Health Committee developed in collaboration with the International Pediatrics Association (IPA), International Confederation of Midwives (ICM), the White Ribbon Alliance (WRA), and WHO [6].

2. Background

Despite an emphasis on facility-based birth with skilled providers, many women still choose to deliver at home, due in part to poor conditions in facilities or because of perceived or verified abuse/coercion/neglect at facilities [1,7]. International and national organizations have documented the lack of quality care and professional accountability at birthing facilities [4,7,8] and various types of abuse, such as physical abuse, non-consented care, and discriminatory care [9], which have been termed disrespectful/abusive care during childbirth in facilities (DACF). Evidence collected in diverse settings documents associations between poor quality care and negative maternal and newborn health outcomes [10–14]. A 2014 review of maternal and newborn quality of care found that improving access to facilities did not guarantee improved maternal outcomes [5]. In the same year, WHO published their statement on disrespect and abuse in facilities and called for greater action, dialogue, research, and advocacy on disrespectful and abusive treatment [1].

3. History of quality of care, patient—provider interaction, patient-centered care

As early as the 1970s, midwives, nurses, and doctors in low-resource countries began relating improved outcomes, including fewer cesareans, enhanced bonding, improved breastfeeding, decreased reports of

* Corresponding author at: Department of Obstetrics, Gynecology and Reproductive Sciences, Bixby Center for Global Reproductive Health and Policy, University of California, San Francisco (UCSF), 550 16th Street, 3rd floor, San Francisco, CA 94158, USA. Tel.: +1 415 476 5916.
E-mail address: suellenmiller@gmail.com (S. Miller).

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stress after birth, and reduced need for operative deliveries, when women had companions during labor and birth, were treated as equals in the birth process, and were allowed to hold and breastfeed their babies immediately after birth. Midwifery education and practice emphasized the concept of respect and compassionate care in childbirth [15]. Even emergency procedures, such as those described in the American College of Nurse-Midwives' "Life Saving Skills Manual for Midwives" [16] included not only the steps to performing lifesaving functions, but caveats about the importance of gentleness and always explaining procedures and rationales for procedures to the woman and her family.

In the context of woman-centered reproductive health, "quality of care," became shorthand for not only improving physical standards of care and skills, but also of interpersonal relationships between healthcare workers and women with reproductive health needs. Quality of care was sometimes framed in a human rights perspective, particularly after the 1994 International Conference on Population and Development in Cairo, Egypt [17], where the human rights of girls and women, and the concepts of rights and dignity were strengthened in the context of reproductive health and health care [18,19].

4. Human rights and maternity care

This human rights lens failed to focus as rapidly on abuses during childbirth or links between adverse maternal outcomes and abusive practices and lack of quality of care. In 2000, women's rights to dignity and respect in childbirth became acknowledged in Latin America where, following a Birth Humanization Conference in Brazil, the Latin American and Caribbean Network for the Humanization of Child Birth (RELACAHUPAN) was founded [20].

In 2003, Miller et al. [21] noted paradoxically high rates of maternal mortality in the Dominican Republic, despite 98% facility delivery by skilled attendants, high literacy rates, and well-developed transport systems. In this multidisciplinary, multisite qualitative assessment, observers found these conditions in the labor ward of the largest referral hospital: "Women were not informed of the results of their examinations. Women with complications labored together with those labeled 'normal' in the one large, brightly lit and noisy ward. Some women were naked, most were lying on bare plastic mattresses, the one sheet having been soiled with urine, feces, or drenched in amniotic fluid. There was no privacy, no dignity, and no attempt to honor the human and reproductive rights of the laboring women" [21].

Study results demonstrated that DACF, poor quality of care, and lack of accountability were contributors to preventable maternal mortality.

5. Categories of DACF

Since that time, much has been done to document DACF, leading to a categorization of the types of DACF conceptualized by Bowser and Hill [9] in their USAID Translating Research into Action Project (TRAction) Report. The seven categories formulated are shown in Table 1, along with DACF examples. Categories of abuse may overlap; for example, the provider electing to perform an unnecessary episiotomy and not asking for the woman's consent would be considered non-consented care and physical abuse. If this is performed in an open delivery ward without privacy curtains, than it is also non-confidential care. The White Ribbon Alliance has noted that the categories of abuse occur along a continuum from subtle discrimination to overt violence [22].

6. Groups and agencies working in DACF and recent publications

The concept of DACF is so recent, that definitions of disrespect/abuse and even quality of care are still being formulated [23,24]. Work is underway to create definitions of DACF by varied organizations, which are also working toward consensus on evidence-based interventions to decrease DACF. Some of these agencies include the White Ribbon Alliance, Columbia University's Averting Maternal Death and Disability's and Ifakara Health Institute's STAHA Project, Harvard's Hansen Project, USAID/Jhpiego's Maternal and Child Health Integrated Program (MCHIP), Respectful Maternity Care (RMC), and others working across many countries.

Table 1
Seven categories of disrespect and abuse.[a]

Abuse category	Example
Physical abuse	Hitting, roughly forcing legs apart, fundal pressure for normal delivery
Non-consented care	No informed consent for procedures, such as when provider elects to perform unnecessary episiotomy
Non-confidential care	No privacy (spatial, visual, or auditory)
Non-dignified care	Humiliation by shouting, blaming, or degrading
Discrimination based on specific patient attributes	HIV status, ethnicity, age, marital status, language, economic status, educational level, etc.
Abandonment of care	Facility closed despite being 24/7, or if open, no staff can or do attend delivery
Detention in facilities	Not releasing mother until bill is paid

[a] Adapted from Bowser and Hill [9].

Most of these groups have statements rooted in human rights doctrines; including the White Ribbon Alliance [22] and the International MotherBaby Childbirth Initiative (IMBCI) [25], which each have human rights-based guidelines and steps for providing humane practices promoting optimal birth. The IMBCI has rights-based demonstration projects in Quebec, Canada and Uruguay.

Further, these groups recognize that underlying etiologies of DACF can lie in abuse of healthcare providers in facilities. Provider demoralization related to weak health systems and shortage of human resources and professional development opportunities led Kenyan midwives to observe that many nurses and midwives had difficult personal situations, they were underpaid, had to commute long distances to work, and often received no breaks during their work [9].

DACF studies are summarized in the evidence synthesis of Bohren et al. [4], which served as a basis for the WHO 2014 DACF statement [1]. A series of papers was published in 2014 in BMC's Reproductive Health Series, summarizing the evidence for lack of quality of care in maternal and newborn health [12], including a review of facility-level inputs for improvement [26].

The work on DACF is continuing to grow. In 2014, Freedman and Kruck [27] contextualized the global definition of disrespectful care to include care that local consensus finds undignified or humiliating. Furthermore, in 2015, Bohren et al. [28] used a mixed-methods systematic review of evidence on DACF and expanded Browser and Hills' typology [9] to include not only interpersonal interactions, but systemic failures at health systems and health facility levels.

7. Links between DACF, low quality of care, and negative maternal and newborn outcomes

The links between negative maternal and newborn outcomes and DACF are both direct and indirect. DACF indirectly affects outcomes because women who have previously experienced DACF or who have heard of others who have may avoid delivering in facilities, even if they have complications. DACF directly affects outcomes when women are ignored or abandoned during labor or birth and deliver unattended. One case from the Dominican Republic noted a woman in a facility for over 24 hours, but no-one noted that fetal heartbeats were absent or that she had a ruptured uterus [21].

8. Strategies for eliminating DACF

Numerous attempts are currently underway at a number of levels: community, civil society, individual providers, professional associations, district level facilities, and at highest levels of national, regional, and international policy making. Many of the interventions are multifactorial

and reach across stakeholder groups; others aim at single groups or certain aspects of the continuum of DACF. Jhpiego's RMC country experiences categorize these strategies and interventions into various approaches and/or health system levels: advocacy, legal approaches, health facility, educational and training programs, community, research, monitoring, and evaluation [20].

9. Strategies for professional associations to effect facility-level changes to eliminate DACF

A thorough review of these strategies is beyond the scope of this paper; we focus on strategies for professional associations at the facility level. Such strategies include training, awareness raising, values clarification, supportive supervision, and criterion-based audits, which are objective, systematic analyses of the quality of care measured against a set of criteria of best practice [23].

9.1. Rights-based, criterion-based audits

The certification process of the MBFBF includes criterion-based checklists and, even more importantly, observations of care delivery. Thus, the MBFBF process can serve as both a tool for certification as well as an approach for quality improvement. The criteria used for certification as an MBFBF are rights-based. FIGO, ICM, WRA, IPA, and WHO developed the MBFBF initiative in response to findings that low quality of care and DACF are violations of women's human rights and are intrinsically linked to poor maternal and neonatal outcomes [6]. One of the major human rights documents that supports the MBFBF initiative is the WRA's Charter on the Universal Rights of Childbearing Women [22], which raises awareness of childbearing women's rights and clarifies links between human rights and quality of care.

10. FIGO, ICM, WRA, IPA, and WHO MBFBF initiative

FIGO believes that every woman has the right to a positive birth experience and to compassionate care from knowledgeable, skilled providers. Professional associations and facilities should provide the best evidence-based quality of care, and provide women with dignity, privacy, information, supportive care, pharmacological or nonpharmacological pain relief, and choice of birthing companion(s), without abuse, financial extortion, or differential care based on age, ethnicity, or marital, HIV, financial status, etc.

The FIGO, ICM, WRA, IPA, WHO Mother and Baby Friendly Birthing Facilities Initiative states, whereas:

- Every woman has the right to be treated with dignity and respect by facility staff regardless of background, health, or social status, this includes, but is not limited to, women who are young, older, single, poor, uneducated, HIV positive, or a minority in her community.
- The gap between rates of maternal and newborn mortality of women with access to quality care and those without access to quality care is unacceptable.
- Every woman has the right to a positive birth experience and to dignified, compassionate care during childbirth, even in the event of complications.
- Every woman and every newly born baby should be protected from unnecessary interventions, practices, and procedures that are not evidence-based, and any practices that are not respectful of their culture, bodily integrity, and dignity.
- A woman's ability to have a health delivery outcome and to care for her newborn is significantly influenced by a positive birthing environment.

Table 2 summarizes the criteria and indicators for qualifying a facility as mother and newborn friendly.

Table 2
Summary of criteria and indicators for qualifying a facility as mother and newborn friendly.[a]

Criteria	Indicators
Adopt preferred positions in labor for women and provide food and beverages	Written policy and implementation
Non-discriminatory policy for HIV-positive women, family planning, and youth services	Implementation of guidelines for HIV-positive women, family planning, and youth services
Privacy in labor/delivery	Curtains, walls, etc.
Choice of birthing partner	Accommodation of partners
Culturally competent care	Training, posters, policies
No physical, verbal, emotional, or financial abuse	Written policy, display Chart of Human Rights
Affordable cost, free maternity care	Costs in line with national guidelines
No routine practice	Evidence-based interventions
Nonpharmacological and pharmacological pain relief	Training on pain relief
Skin-to-skin mother — baby care, breastfeeding	Provide combined care for mother/baby, breastfeeding

[a] Reproduced with permission from FIGO et al. [6].

10.1. Criteria

A FIGO, ICM, WRA, IPA, WHO mother–baby friendly birthing facility:

1. Offers all birthing women the opportunity to eat, drink, walk, stand, and move about during the first stage of labor and to assume the position of her choice/comfort during the second and third stages, unless medically contraindicated.
2. Has clear, nondiscriminatory policies and guidelines for the treatment and care of HIV-positive mothers and their newborns, as well as policies for counseling and provision of postpartum family planning, and youth-friendly services.
3. Provides all mothers with privacy during labor and birth.
4. Allows all birthing women the comfort of at least one person of her choice (e.g. father, partner, family member, friend, and traditional birth attendant as culturally appropriate) to be with her throughout labor and birth.
5. Provides culturally competent care that respects the individual's customs, nonharmful practices, and values around birth, including those women who experience perinatal loss.
6. Does not allow physical, verbal, emotional, or financial abuse of laboring, birthing, and postpartum women and their families.
7. Provides care at affordable costs in line with national guidelines and assures financial accountability and transparency. Families will be informed about what charges can be anticipated and how they might plan to pay for services. Families must be informed if any additional charges apply for complications. Health facilities should have a process for payment that does not include detention of the woman or baby. Refusal of care for the mother or the baby because of inability to pay should not be permitted.
8. Does not routinely employ practices or procedures that are not evidence-based, such as routine episiotomy, induction of labor, or separating mother and baby care etc., consistent with international guidelines and action plans. Each birthing facility should have the capacity, staff, policy, and equipment to provide neonatal and maternal resuscitation, minimize the risk of infection, provide prompt recognition and prevention/treatment of emergent maternal and neonatal needs, have established links for consultation and prospectively planned arrangements for stabilization and/or transport sick mothers or sick/premature infants.
9. Educates, counsels, and encourages staff to provide both nonpharmacological and pharmacological pain relief as necessary.
10. Promotes immediate skin-to-skin mother/baby contact and actively support all mothers to hold and exclusively breastfeed

their babies as often as possible and provides combined care for mother and baby as appropriate.

Facilities that adhere to these criteria will be awarded a FIGO, ICM, WRA, IPA, WHO Mother and Newborn Friendly Birthing Facility certificate. The certificate will be posted on the organizations' web sites and the web sites of other organizations that support this project.

10.2. Process

International and national agencies will develop cadres of assessors to conduct site visits to certify and monitor this process. Assessors will be equipped with checklists to observe policies, informational posters and, most importantly, direct observation of provider—patient interactions. Facilities will be held to these criterion-based audits during the certification process, and instructed on how to improve through constructive critique and two-way feedback. FIGO, WHO, and ICM will work with national governments to start this process. Annual certification could be considered if the hospital adheres to the criteria. Certificates could be prominently posted for inclusive viewing.

11. Conclusion

Improving attitudes and behaviors of facility-based providers alone will not be adequate to improve facility-based quality of care and eliminate DACF. The problem of DACF is multifactorial; therefore, the response to DACF must be between, among, and across all stakeholder groups involved in maternity health and between, among, and across ministries of health, education, finance, and gender. It is likewise imperative that all professional associations, governmental, nongovernmental, and grassroots organizations, as well as community and family members, work together to provide for and demand that MBFBFs provide high quality, evidence-based care. FIGO joins with IPA, WRA, ICM, and WHO to utilize a criterion-based audit approach to certifying facilities as mother—baby friendly to improve maternal and newborn health directly through improved care and a rights-based approach, and indirectly, by overcoming barriers to women's acceptance of facility-based, skilled providers.

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Conflict of interest

The authors have no conflicts of interest.

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