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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

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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

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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