



PULLING BACK THE CURTAIN ON DISRESPECT AND ABUSE

THE MOVEMENT TO ENSURE RESPECTFUL MATERNITY CARE

Brief

Mary Beth Hastings
Consultant, White Ribbon Alliance

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Introduction

The global drive to improve maternal health has made striking progress in recent decades, vastly expanding women’s access to skilled providers during childbirth in most countries around the world. However, evidence about widespread disrespect and abuse of women and girls by health care workers during labor and childbirth lays bare the yawning gaps that persist between the stark realities many women and girls experience daily, and articulated human rights ideals and maternal health standards of care. To close these gaps, a rapidly-growing, multisectoral movement of providers, maternal health implementers, global institutions, and human rights advocates has advanced policy and programmatic support for respectful maternity care (RMC).¹

¹Respectful Maternity Care (RMC) focuses on the interpersonal interactions that a woman encounters during labor, delivery, and postpartum. While RMC primarily emphasizes the absence of disrespect and abuse by health care providers and other staff, its definition also advocates positive and supportive staff attitudes and behaviors that increase a woman’s satisfaction with her birth experience.

The movement for RMC has advanced rapidly in the past five years, culminating in significant recent successes. In 2014, the leading authority on global health

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standards – the World Health Organization (WHO) – has called for increased action at the global and national level to stem abuses of women in maternity care.² That same year, the Lancet called for a “shift in perspective” to assess maternal health services based on “what

² http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1

women need and want in pregnancy and childbirth.”³ Perhaps most notably given the importance of ownership by and engagement of medical professionals, the International Federation of Gynecology and Obstetrics (FIGO) in July 2014 approved guidelines for “mother-baby friendly birthing facilities.” These guidelines affirm women’s “right to be treated with dignity and respect,” and call for protections 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.”⁴

Transcending human rights, gender equality, gender-based violence, quality of care, and reproductive, maternal, newborn, and child health (RMNCH), the RMC movement has captured the attention of key and diverse stakeholders at the global, national, and local levels. As a result, the movement has facilitated common understanding of disrespect and abuse in childbirth, set global targets for respectful care, and developed appropriate interventions to address the individual and structural drivers of disrespect and abuse.

As global leaders look more critically at how to simultaneously advance women’s health and rights, particularly in light of the Sustainable Development Goals, it is important to examine where the momentum for respectful maternity care has led thus far, lessons learned in the process, and essential components that must be prioritized moving forward. This policy brief – informed by program documents, global and national policies, and interviews with key stakeholders who have worked for years to advance attention to this issue – seeks to review progress and provide recommendations for advancing maternity care that places women at the center.

3 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60859-X/fulltext?rss%3Dyes](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60859-X/fulltext?rss%3Dyes)

4 “Mother-baby friendly birthing facilities.” *International Journal of Gynecology and Obstetrics*. 128 (2015) 95-99.

Respectful Maternity Care: Seeds of a Movement

Recent progress on respectful maternity care has decades-old roots, as women’s health providers and human rights advocates began raising attention to incidents of disrespect and abuse during labor and childbirth in developed and developing countries alike in the 1970s and 1980s. These incidents span a range of provider behavior and systemic failures, including conducting procedures or examinations without consent, abandoning women during labor, depriving women of privacy, conducting procedures that are not medically indicated, not allowing women to choose their birthing position, directing abusive language at the birthing woman, slapping or hitting, placing multiple women in a bed, and holding women in a facility for non-payment.

Leading advocates posited that as birth moved into hospitals and clinics, some of what women had benefited from with traditional birth attendants – such as respect

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for cultural traditions and an existing relationship between the woman and attendant – was lost in the move to a clinical setting. Despite the fact that this move was focused in part on saving women’s lives, these observers and practitioners noted a profound lack of attention to the needs and preferences of birthing women. Many also protested the high rate of cesarean deliveries, particularly in Latin American countries, where grassroots movements launched to provide a more “humanized” approach to childbirth.⁵ In 2007, the Center for Reproductive Rights published “Failure to Deliver: Violations of Women’s Human Rights in Kenyan Health Facilities,” which folded maternity care abuses into a broader sexual and reproductive rights framework.⁶ Yet global efforts to address these abuses lacked coordination and a unifying agenda.

5 <http://www.midwiferytoday.com/articles/latinamerica.asp>

6 <http://www.reproductiverights.org/document/failure-to-deliver-violations-of-womens-human-rights-in-kenyan-health-facilities>

In 2010, the United States Agency for International Development (USAID) tackled this lack of coordination, funding a two-pronged effort to investigate the extent and dynamics of disrespect and abuse (D&A) in labor and childbirth, as well as advocate for increased attention to the issue among global, national, and local decision makers. To support research, USAID backed the Translating Research into Action (TRAction) project to fill knowledge gaps on pressing questions surrounding maternal and child health. This led to the groundbreaking landscape analysis of the evidence around D&A by Diana Bowser and Kathleen Hill. The analysis examined contributors to D&A and substantiated a link between D&A and the underutilization of skilled birth attendants.⁷ Cited as the launching pad for the new RMC movement, the analysis has shaped definitions of key concepts and established credible evidence of a critical problem.

To disseminate this evidence and build cross-sector support for policy and programmatic action, USAID supported White Ribbon Alliance (WRA) through the Health Policy Project to convene a working group of interested researchers, practitioners, human rights advocates, and maternal health leaders. WRA also worked with its chapters in several countries to build and enhance advocacy efforts promoting RMC. Most significantly, in 2011, WRA assembled a multi-stakeholder group to craft a charter on the Universal Rights of Childbearing Women based on existing human rights documents. Translated into eight languages, the charter has reached doctors, midwives, advocates, and women in maternity care around the world. Stakeholders in the RMC movement point to the charter as the most significant advocacy achievement of the early years because it created a positive and easily relatable set of principles that could be applied globally.

⁷ Diana Bowser and Kathleen Hill, “Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth.” USAID TRAction Project. September 20, 2010. Accessed at http://www.tractionproject.org/sites/default/files/Respectful_Care_at_Birth_9-20-101_Final.pdf

Emerging Successes

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understand the universality of both the problem of D&A and the rights embodied in the RMC charter. As a result, the RMC movement now benefits from and represents a broad range of organizations with truly global reach. The landscape analysis and charter solidified the concept of respectful maternity care, facilitating the spread of enthusiasm for global action to end disrespect and abuse in labor and childbirth. Key organizations and projects – including TRAction, WRA, and Maternal Health Task Force (MHTF) – propelled progress through grassroots and global advocacy, research, and implementation of projects to reduce D&A. Recent advocacy and implementation successes are detailed below.

Shaping Policy that Promotes RMC

As the RMC movement began, many countries were also beginning to realize that they were falling far short of their Millennium Development Goal 5 targets on maternal health. The link made in the Bowser and Hill landscape analysis between D&A and the underutilization of skilled attendants for childbirth gave RMC new meaning for national policy makers. This facilitated action at the country level, where in many cases WRA chapters were developing RMC advocacy strategies, drafting RMC legislation, and getting buy-in from health officials. At the global level, leading RMC organizations gained attention by presenting the issue at international conferences. They also reached out to World Health Organization (WHO) staff and clinical researchers to raise their awareness of the issue.

Notable advocacy successes as a result of these and complementary efforts include the following:

GLOBAL POLICIES AND SUPPORT:

- The WHO endorsed the Universal Rights of Childbearing Women, and in 2014, issued a statement calling on governments and donors to conduct research and launch actions on disrespect and abuse. The WHO also conducted a systematic review of D&A worldwide.
- In May 2015, WHO also issued a “Quality of Care Framework” for maternal and child health that includes both the provision of care and the experience of care as equal determinants of quality of care.⁸ This is significant as it situates RMC as a critical quality of care issue, and not exclusively a human rights issue.
- USAID’s 2015 Maternal Health Vision for Action highlights respectful maternity care as a critical strategic driver for success in reducing maternal death and D&A.
- In 2014, professional associations representing obstetricians, midwives, and pediatricians endorsed respectful maternity care and pledged to support mother-baby friendly birthing facilities.
- In July 2015, Human Rights in Childbirth convened advocates, legal scholars, researchers, and health care providers from around Africa for a summit. At the summit’s conclusion, participants affirmed a consensus statement pledging renewed efforts to combat D&A.

NATIONAL POLICIES AND SUPPORT

- The prominence that RMC has gained on the international policy agenda has been crucial for driving national-level progress, as it gives country leaders a framework and at times an incentive for action.
- Nigeria’s Federal Ministry of Health adopted the charter on the Universal Rights of Childbearing

⁸ “Quality of care for pregnant women and newborns – the WHO vision.” BJOG: An International Journal of Obstetrics and Gynaecology. 122:8. 1 May 2015.

Women as its national standard of care for public hospitals and clinics.

- Afghanistan has based its standards of care on the charter.
- In Nepal, the Ministry of Health successfully pushed for its parliament to include charter language in a maternal health bill. Although the bill has unfortunately stalled due to political changes in the country, RMC’s integration into proposed legislation remains a significant first step.
- In Malawi, the charter has been used as the basis for RMC training for midwives.
- The RMC movement’s growing influence and truly global principles have attracted the attention and support of organizations that work to improve women’s experiences of childbirth in Canada, United States, United Kingdom, and Australia. The U.S.-based group Improving Childbirth is using RMC as a frame for its social media outreach and mobilization among U.S. supporters.

Shaping Implementation of Maternal Health Services through Research

Armed with clearer evidence that disrespect and abuse was a global problem, key institutions took up the task of uncovering additional evidence about drivers of D&A and how to address it. The TRAction project worked through Population Council in Kenya and Columbia University’s Averting Maternal Death and Disability (AMDD) program in Tanzania to measure prevalence of D&A and assess different approaches to reduce it. At the same time, MHTF worked with partners in Tanzania

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and Ethiopia to similarly measure prevalence, explore drivers of D&A, and develop community-led solutions.

This research has contributed substantially to understanding of D&A. For example, each program

site found that the rate of D&A varies greatly. D&A observed by researchers is universally higher than D&A reported by patients or health staff. All studies found that health officials were commonly resistant to the idea that D&A was occurring with any frequency, and that health care providers often saw their behavior – including physical abuse – as necessary or even life-saving for the woman and/or baby.

While the types of disrespect and abuse varied, it was not always clear whether violations were caused by practitioner behavior or by systemic failures. For example, if staff abandon a woman during childbirth, it could be due to health providers' disregard of her needs, or it could be a result of poor client-to-provider ratio. Other abuses are easier to classify. Placing multiple women in one bed is generally a failure of the health system to provide sufficient beds, while physical and verbal abuse is a behavioral failure. However, the research noted that provider behavior can also be heavily influenced by the health system, as poor staffing, pay, and schedules create a stressful environment that can undermine respectful care.

This seminal implementation research has proven critical for accelerating attention to the knowledge gaps surrounding D&A. Many stakeholders have pointed out that while RMC was a scarcely known topic five years ago, now there is new RMC research emerging frequently, some of it in developing countries and conducted by researchers independent of the main RMC research projects. Stakeholders also noted that there is an increased interest in seeking out their research, with frequent requests to present on RMC at conferences, or citations of even unpublished work.

Lessons Learned

Stakeholders point to several key lessons learned over the past several years of coordinated advocacy, research, and implementation on RMC:

Advocacy, research, and implementation are highly interdependent. The RMC movement has benefited from a coordinating and convening mechanism that included these three elements. Researchers ensure critical evidence for advocates to use to advance

policy, and for implementers to use in developing interventions. Advocates provide a dissemination outlet for researchers' evidence, and ensure that policy changes support -- and grassroots mobilization sustains -- RMC implementation. Because of their close contact with the field, advocates and implementers are able to identify key questions for researchers to investigate.

Implementers test how well the research is capturing conditions in the field, and provide advocates with promising practices to build further institutional and political support.

Health professionals can be allies. RMC implementers discovered that doctors, nurses, and midwives often experience disrespect and abuse at the hands of the health system, which can contribute to poor patient treatment. While women must have legal recourse when they experience D&A, a punitive approach to reducing D&A under these circumstances is not always best. Addressing the structural drivers of D&A can transform health professionals into allies within a system that improves their understanding of the importance of RMC while holding them accountable to RMC standards.

Coordination of global and national advocacy is powerful. National-level advocacy efforts have been shown to be critical to success of any RMC initiative, because political will is essential to adopting and implementing needed changes. In Afghanistan, for example, although they have adopted language from the charter in their national standards of care, they have lacked the political will to ensure that these standards are met. In turn, advocacy gains at the global level are a tremendous boost to national advocates because they increase the stakes for national leaders.

Messaging matters. The RMC movement has shifted somewhat from an exclusive emphasis on D&A to more positive messaging about promoting RMC. This has facilitated important advocacy and implementation gains, as RMC depicts an

affirmative vision of what care can become. At the same time, continued discussion of D&A has ensured that the seriousness of the abuses is not lost. In addition, implementers have found success through messages that encourage mutual respect between providers and patients, while not detracting from messages that support universal rights.

RMC must include both specific changes and fundamental shifts in interpersonal dynamics. Increasing precision in defining D&A and RMC has helped propel the movement, creating an overarching frame that includes specific expectations within the charter about what kind of care women should experience. However, respectful care must be understood more broadly than one or two changes in a maternity ward, such as installing curtains or approving the presence of companions. Successful efforts to promote RMC consider and address the systems, structures, attitudes, and behaviors that are generating D&A within a given environment.

Advancing RMC is context-specific and more information is needed about what works. Although experiences of D&A are common across cultures, successful solutions thus far have been deeply grounded in local context. At this stage few interventions have been thoroughly tested, and none have been scaled up. Stakeholders involved in implementation thus far emphasize that their findings and specific interventions may not adapt to other cultures or countries.

Partnerships with other sectors are critical. The breadth of the RMC movement is cited by stakeholders as critical to its strength, in part because it brings together advocates who see the issue from different vantage points. Several stakeholders noted that the movement could have benefited from being even more inclusive from the beginning – by bringing in the experience and lessons from advocates and practitioners in the HIV movement, for example.

The Future of RMC and the Evolving Definition of Quality of Care

The successes of the RMC movement have created new opportunities, leading to an important juncture with the quality of care movement. For decades, global maternal health programs operated under the assumption that the solution to maternal morbidity and mortality was to increase women's access to skilled providers. When it became apparent that such access did not always equal success, maternal health leaders began paying more attention to quality of maternal health care. At the time and until recently, those concerned with health care quality exclusively emphasized the practitioner's clinical skills and behaviors, such as managing hemorrhage. Patients' rights or perceptions of their care were not originally considered relevant to this definition of quality.

The WHO's vision of quality of care for pregnant women and newborns that was published in May 2015 signaled an evolving departure from the original definition. The framework breaks quality of care into two equal parts that influence each other: the provider's provision of care (evidence-based practices, actionable information systems, and functional referral systems) and the patient's experience of care (effective communication, respect and dignity, and emotional support).

This marriage of the public health approach to quality of care with the human rights approach to health is potentially ground breaking. It presents a clear affirmation of RMC advocates' arguments that D&A is a health systems failure, and that women's experiences of how they are treated during labor and childbirth are just as important to health care quality as following evidence-based protocols.

Leading up to this shift, RMC and quality of care have been closely related and have influenced each other. Implementers have used quality of care frameworks in implementation of RMC interventions, for example. Also, just as with RMC, quality of care interventions have sought to change not only provider behavior, but the systems that influence that behavior. RMC's

influence on quality of care debates has brought increasing attention to patient perceptions.

Yet the two approaches have differed primarily in how each measures success. In the original quality of care approach, a successful interaction with the health system includes a skilled provider using evidence-based practices. In the respectful care model, that same interaction is only successful if the provider obtains consent for procedures, communicates effectively to the patient, and allows for necessary emotional support.

Moving forward, in order to ensure the equal status of provision and perception, the shift in quality of care's definition to explicitly include RMC will need to be accompanied by an equal shift in how it is measured.

Recommendations

Program Recommendations

Disrespect and abuse must be addressed at multiple levels because responsibility for D&A is broadly shared. D&A is generated by power dynamics between provider and patient, under-resourcing of the health sector, gender inequality, discrimination, and poor training. Successful responses must cross sectors, including legal cases, social accountability, provider values clarification training, health systems strengthening, and grassroots education to empower women as rights bearers.

Approaches to reducing D&A must be contextual and involve women. In developing responses to D&A, it is critical to keep women in the center. Women should be involved in the definition of their needs and preferences in maternity care, as well as in setting up systems to facilitate their ongoing feedback and participation. Interventions must be specific to their location, and elements that are transferable can only be adapted from one place to another with women's active involvement.

Process is important. The visibility of RMC has increased interest in rapidly developing and implementing responses. However, it is important to ensure that the process builds participation of and support from all stakeholders, including providers, health officials, community leaders, and women

themselves. Project designers should examine their assumptions and be quite careful that projects do not inadvertently cause harm. Because RMC is a fresh field, poorly implemented projects risk not only localized setbacks, but can cause a loss of political or donor interest in other RMC interventions.

RMC needs better definition and indicators. RMC is not simply the absence of D&A, yet its definition remains elusive. Program implementers should seek to define indicators that pinpoint what successful RMC interventions look like.

Isolated trainings are not the solution. As discussed above, the sources of D&A are at multiple levels. Interventions should address as many levels as possible, avoiding quick fixes that lack sustainability.

Policy Recommendations

RMC should be a global maternal health priority. The universality of the Sustainable Development Goals (SDGs) meshes well with the universality of RMC principles, posing an important opportunity to consolidate global progress on RMC. Global and national leaders should ensure that commitments to RMC are woven into their health strategies to achieve the SDGs, building on evidence of RMC's contributions to maternal health and human rights. Civil society organizations also have an opportunity with the SDGs to insist on integrating RMC into public and private sector approaches to maternal health.

RMC is a legitimate and important aspect of quality maternal health care. The WHO vision of quality care affirms RMC's legitimacy as an essential aspect of quality of care. Global and national leaders should incorporate this broader definition of quality of care into health policies, and ensure their measurement of success incorporates respect, protection, and fulfillment of human rights in the health care setting.

RMC is at a critical juncture; needs increased investment to ensure implementation. As a relatively new intervention area, RMC requires adequate resources to test approaches and expand its scope. Policy commitments are not sufficient without support

for policy implementation, participatory accountability systems, and programming. Donors and national governments should commit sufficient funds to make RMC an integral part of maternal health programs.

Ongoing advocacy is critical to sustainability, but cannot happen without funding. Donors interested in maternal health, sexual and reproductive rights, and quality of care should invest in global and grassroots advocacy, as well as implementation, to ensure RMC's success. Advocacy isn't only important for creating policy change. It is important for monitoring, sustaining, and deepening progress.

Women's voices must be central to policies that advance respectful care. Policies to promote respectful care – and the advocacy movements that advance these policies – must be guided by women and grassroots women's organizations to ensure legitimacy and effectiveness. Women do not have one set of ideas and preferences for childbirth, yet meaningful consultation with a range of groups, particularly those representing marginalized women, is essential to shaping policies that recognize and respect a diversity of views and needs. The RMC advocacy movement must continue to develop ownership of the movement by women themselves to ensure that their needs and preferences are prioritized.

Integration with other global health movements can feed success. D&A is strongly linked to human rights and quality of care failures within other health sectors. For example, young, unmarried, or otherwise marginalized women are more likely to experience D&A, particularly from providers of sexual and reproductive health services. The RMC movement is strong enough to position itself within a continuum of care model with an understanding of the intersectionality of discrimination, helping shape a positive and fully inclusive vision of respectful care throughout the lifecycle. By linking with gender-based violence, HIV, sexual and reproductive health, and adolescent health movements, RMC advocates can improve their understanding of the drivers of D&A, use this understanding to improve RMC

outcomes, and incorporate a more powerful analysis of rights-based health.

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Contact Us

White Ribbon Alliance
1120 20th Street NW, 500 North
Washington, DC 20036
www.whiteribbonalliance.org
info@whiteribbonalliance.org

White Ribbon Alliance formed over a decade ago to give a voice to the women at risk of dying in childbirth. Our mission is to inspire and convene advocates who campaign to uphold the right of all women to be safe and healthy before, during and after childbirth. We help citizens recognize their rights and hold their governments to account for commitments made to maternal and newborn health.