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COMMENTARY

Striving for Respectful Maternity Care Everywhere

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Abstract *Purpose* The mistreatment of women during childbirth in health facilities is a growing area of research and public attention. *Description* In many countries, disrespect and abuse from maternal health providers discourage women from seeking childbirth with a skilled birth attendant, which can lead to poor maternal and neonatal outcomes. This commentary highlights examples from three countries—Kenya, Mexico and the United States—and presents different forms of mistreatment during childbirth, which range from physical abuse to non-consented care to discriminatory practices. *Assessment* Building on the momentum from the United Nations Sustainable Development Goals, the International Federation of Gynecology and Obstetrics, and the Global and Maternal Neonatal Health Conference, the global community has placed respectful maternity care at the forefront of the maternal and neonatal health agenda. *Conclusion* Research efforts must focus on context-specific patient satisfaction during childbirth to identify areas for quality improvement.

Keywords Respectful maternity care · Disrespect and abuse · Childbirth · Quality of care

Significance

This commentary highlights the growing global movement toward eliminating disrespect and abuse during childbirth and striving for respectful maternity care everywhere.

Introduction

International efforts to define, identify and address mistreatment of women at maternal health facilities have grown rapidly. Recent landmark studies on the mistreatment of women during childbirth have highlighted the widespread nature of the problem in global context [1]. Childbirth in facilities with trained health care providers equipped with adequate supplies can improve outcomes for women and newborns; however, there is growing evidence that women may experience mistreatment and abuse from health care providers, which may influence their decision regarding where to deliver [1]. Fear of mistreatment and reports of undignified care are major barriers to women considering facility-based childbirth [1]. Despite significant progress in many countries, the Millennium Development Goal 5 (MDG5) to reduce global maternal mortality to 95 from 210 per 100,000 live births by 2015 was not achieved. In response, global efforts to address maternal and neonatal mortality increasingly focus on the quality of care, which includes implementation of evidence-based practices and provision of respectful maternity care [2]. Furthermore, these efforts emphasize integration of care across the mother-newborn continuum and the need for multi-disciplinary engagement across health specialties.

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Early large-scale efforts to define disrespect and abuse in childbirth classified physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in health facilities as types of mistreatment [3]. A subsequent systematic review, conducted in collaboration with the World Health Organization (WHO), defined mistreatment in childbirth as any one of the following experiences by women as a result of a health care provider or health care system: physical abuse, verbal abuse, sexual abuse, stigma and discrimination, poor rapport between providers and patients, failure to meet professional standards of care, and health system constraints [1]. A group of multi-disciplinary experts defined disrespect and abuse in childbirth 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 [4]." The WHO systematic review included findings from 34 countries identifying mistreatment during childbirth across all regions, including Africa, the Americas, Asia, Europe, the Middle East, and Oceania. Furthermore, all types of providers, including nurses, midwives, and doctors, were agents of disrespect and abuse while delivering peripartum care. While individual-level factors, such as provider and patient beliefs and attitudes, contribute to negative interactions between providers and patients, social and organizational-level factors, such as working conditions, also create an environment that can lead to mistreatment [5].

Mistreatment during childbirth was a major focus of the International Federation of Gynecology and Obstetrics (FIGO) World Congress and the Global Maternal and Neonatal Health Conference in October 2015, and it rightfully deserves global attention. Although the majority of research on this topic is being conducted in low and middle-income countries (LMICs), this commentary underscores the global extent of the problem through examples in Kenya, Mexico, and the United States to reinforce the need for respectful maternity care everywhere.

Kenya

Kenya is a lower middle-income country that has aimed to reduce maternal mortality below 400 deaths per 100,000 live births over the last decade through national efforts to increase facility-based deliveries [6]. It is estimated that over half of women in Kenya deliver at home and less than half of all deliveries involve a skilled birth attendant [7]. Surveys of women in Kenya reveal that disrespectful and poor-quality care at health facilities impact their decisions to seek facility-based maternity care [7]. The conditions in public maternity wards in Kenya can be challenging for both patients and providers. High patient-to-provider ratios, limited resources, and overcrowded delivery rooms prevent providers from delivering basic services to all women. Higher rates of verbal and physical abuse of patients occur during the night shift when maternity wards have limited staffing compared to the day shift [8].

Even though the president of Kenya called for free maternal health care for all women in 2013, concerns about the quality of care and mistreatment of women at health facilities have posed obstacles to improving maternal and neonatal health outcomes. To document the extent of disrespect and abuse, Kenya's Population Council conducted exit surveys of 641 women who delivered in health facilities and found that 20 % reported some form of disrespect or abuse. Four percent reported physical abuse from providers, which consisted of slapping, pinching, pushing, beating, or poking. Eight percent were detained in facilities because they could not pay the delivery fees [6]. The results made national news in Kenya's *Daily Nation* in an article titled "Why expectant women shun hospitals." In September 2015, following the recent research and publicity on mistreatment of women during childbirth, the high court of Kenya ruled in favor of two women who were detained after deliveries at a major maternity hospital in Nairobi. Through the Heshima Project, the Population Council is working with the Kenya Ministry of Health to develop an intervention package to eliminate mistreatment of women during facility-based childbirth and to promote respectful maternity care [8].

Mexico

Mexico is a middle-income country that has made notable progress toward universal health coverage, yet vast socioeconomic and health inequities persist. Furthermore, quality of maternity care varies according to social and ethnic divisions. With regard to childbirth, there is a growing movement to highlight and denounce "obstetric violence"—a term used to describe physical and emotional harm to women, which can be viewed through the lens of the contemporary societal context of violence in Mexico [9]. One salient example of physical violence is the application of aggressive fundal pressure to hasten the second stage of labor, which has been recognized as ineffective and possibly traumatic [10]. The high rate of Cesarean deliveries without medical indications, the routine use of episiotomy, and routine manual examination of the uterine cavity continue to occur disproportionately in under-funded public-sector health facilities. In Mexico,

unnecessary Cesarean deliveries accounted for 7.5 % of deliveries in 2008, and the overall Cesarean delivery rate was 37.8 % [11].

Communication between providers and patients may be poor due to time limitations; however, subtle or overt discriminatory beliefs may also play a role. Lack of informed consent is particularly problematic in the context of forced contraception, such as postpartum intrauterine device placement and forced sterilization during Cesarean delivery [9]. An anthropologist who studied the "microaggressions" by physicians and nurses against women at a maternity hospital in Puebla, Mexico identified derogatory comments about patients' suitability for motherhood and perceived unbridled sexuality, which led to undignified birth experiences [12].

The profession of certified midwives is gaining prominence in the movement toward respectful maternity care in Mexico. Midwives were historically marginalized in favor of physician attendance at childbirth. Yet, within the past decade, two midwifery schools have gained approval from the Ministry of Health to grant midwives with professional licenses. The training curriculum emphasizes a respectful, humane, and dignified birth experience for all women. Additionally, the midwifery curriculum seeks to address structural violence—the systematic social structures in the patient-provider or patient-health system relationship that lead to harm—that can be inadvertently perpetuated during mainstream medical training and care. For example, many public medical facilities do not permit birth companions to accompany women during labor and delivery. Strict visitation rules often leave women to face childbirth alone.

In 2014, the Mexican Senate approved modifications to the national law called "Women's Rights to a Life Free of Violence" to include protection from obstetric violence and penalties for its practice. Additionally, several non-governmental organizations have been active in promoting respectful maternity care and denouncing cases of obstetric violence to the National Committee on Human Rights.

United States

Despite cutting-edge advances in medical innovation, health care providers in the United States struggle with delivering respectful maternity care to all women. Though practices such as the historical use of physical restraints have largely disappeared, other subtle forms of disrespect persist in labor and delivery units. Significant progress has been made to allow and even encourage birth companions and family visitation throughout labor, delivery, and the postpartum period; and the rate of routine episiotomies is on the decline. However, disparities in obstetric care suggest the persistence of concealed mistreatment, especially for marginalized groups of women. For example, immigrants to high-income countries perceive greater communication barriers and discrimination compared to non-immigrants, which in turn lead to undignified birth experiences [13]. In the current political climate regarding immigration, undocumented immigrants may not present to a hospital for delivery due to fear of deportation or legal action. On the other hand, women who choose to pursue a home birth and require transfer to a hospital due to complications may sense hostility from healthcare providers when they arrive at the hospital [14]. These delicate interactions can be saturated with feelings of guilt, shame, failure, blame, anger, and disappointment, which can jeopardize the patient-provider relationship.

Active patient participation in clinical care and decision-making has become a growing focus of team-based medical training. Without active patient engagement, the knowledge and power asymmetries between patients and providers can create divisions that lead to the perception of disrespect. For example, the complex dilemma regarding the increasing Cesarean delivery rate and the "overmedicalization" of labor are active topics of discussion in both the medical field and in the public arena [15]. While some women decline interventions such as Cesarean delivery, others request Cesarean delivery for a variety of reasons that may not be clinically justified. The American College of Obstetricians and Gynecologists (ACOG) and bioethics committees have published statements about women's autonomy regarding mode of delivery, which is an example of informed decision-making and represents a pillar of respectful maternity care.

Given the increasing focus on quality of care, many researchers, funders, and policymakers have turned to studies on patient-centered outcomes as a means to identify quality improvement opportunities. Though patient satisfaction with their childbirth experience is a growing area of research in the United States, few studies have developed validated tools for evaluating birth satisfaction among various populations, either in the United States or globally. More patient-centered research is needed to understand the existing forms of mistreatment and how they can be addressed at an institutional level.

Conclusion

The call for respectful maternity care represents a global movement toward improving maternal and neonatal outcomes through a focus on patient satisfaction and quality improvement. The three examples provided in this commentary highlight some of the ways in which women are at risk for mistreatment and abuse during childbirth. The cases also reveal how the impact of health system

interventions may be limited if the various barriers that prevent women from seeking childbirth in health facilities are not simultaneously addressed; chief among these is the fear of disrespect and abuse.

Beyond the MDGs, the new Sustainable Development Goal 3 aims to ensure healthy lives and promote well-being among people of all ages. To address the continued global inequities in maternal and newborn mortality, the WHO, FIGO, and the Maternal Health Task Force are leading research and advocacy projects to promote respectful maternity care with a focus on the mother–baby dyad [16]. The new Mother and Baby Friendly Birth Facility Initiative (MBFBF) includes criteria for providing dignified care for both mothers and babies, such as privacy in labor rooms, birth companions, immediate skin-to-skin contact, and exclusive breastfeeding support [16].

Despite the growing body of literature on disrespect and abuse, further research is needed in the following areas:

- Defining mistreatment through the experiences of women and their families within their social contexts in order to understand the social, gender, and cultural norms surrounding childbirth and the expectations of women during childbirth.
- Understanding women's desires for adequate pain control during labor and working with anesthesia providers to explore pain protocols and provide education to patients and families regarding options for pain relief.
- Identifying mistreatment of women in health facilities that may occur in other fields of medicine aside from obstetric care.
- Evaluating interventions that prevent and respond to mistreatment in health facilities.

Through a multi-disciplinary approach grounded in gender equality, patients, stakeholders, researchers, policymakers, clinicians, and advocates can work together to end widespread disrespect and abuse and strive for respectful maternity care everywhere [2].

This movement resonates with practicing maternal health providers, as we consider our own interactions with women during childbirth and throughout their life cycle. Childbirth is a time of complex decision-making for both women and their providers. With deeply held beliefs, hopes, and expectations for their birth experiences, some women may feel empowered to exercise their autonomy within the patient-provider relationship, while others may feel disempowered by the process. Respectful maternity care calls for mutual trust and respect between women entering a period of great physical and emotional vulnerability and the health providers charged with their care. That dynamic is created when women are provided with safe, evidence-based care, and accurate information to make informed decisions in an environment that honors their dignity. This is the essence of respectful maternity care.

Compliance with Ethical Standards

Conflict of interest The authors report no conflict of interest.

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