Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth

Report of a Landscape Analysis

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Executive Summary

This report is a review of the evidence on the topic of disrespect and abuse in facility-based childbirth. The primary purpose of the report is to review the evidence in published and gray literature with regard to the definition, scope, contributors, and impact of disrespect and abuse in childbirth, to review promising intervention approaches, and to identify gaps in the evidence. Despite the agreed importance among maternal health and human rights stakeholders of achieving respectful, non-abusive birth care for all women, there has been a relative lack of formal research around this topic.

Lack of respectful and non-abusive care at birth may encompass many points along a continuum that spans dignified, patient centered care, non-dignified care, and overtly abusive maternal care. Examples of disrespect and abuse include subtle humiliation of women, discrimination against certain sub-groups of women, overt humiliation, abandonment of care and physical and verbal abuse during childbirth.

While it is likely that disrespect and abuse are often multi-factorial and may be perceived differently and sometimes normalized depending on the specific setting, many stakeholders and maternal health experts agree that disrespect and abuse in facility-based childbirth represent important causes of suffering for women, an important barrier to skilled care utilization (a key MGD-5 indicator), important quality of care problems, and often a violation of women's human rights. This document reviews reports of disrespect and abuse in facility-based childbirth across a range of birth care settings in low, middle and high income countries. The report intentionally focuses on care provided at the time of birth given the intense vulnerability of women during childbirth.

Building on the results of an extensive review of the published and gray literature as well as results from a structured group discussion and individual interviews with expert informants, seven categories of disrespect are identified: physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in facilities. Categories of disrespect and abuse draw on human rights and ethics principles and are intended to help synthesize a complex body of evidence. It is understood, however, that manifestations of disrespect and abuse often fall into more than one category. Categories are not intended to be mutually exclusive but rather to be overlapping along a continuum.

After a review of categories of disrespect and abuse in childbirth, the report explores evidence for potential contributors to disrespect and abuse focusing on individual and community, law and policy, leadership and governance, service delivery, and provider factors (see Table 1). In the absence of clear evidence, the report does not attempt to characterize the specific interactions between different categories of drivers of disrespect and abuse in childbirth. However, it is assumed that the contributors to disrespect and abuse summarized in Table 1 interact in many dynamic ways within a given setting.

Growing evidence for the negative impact of disrespect and abuse in facility-based childbirth on skilled birth care utilization across a range of countries is reviewed including recent qualitative and quantitative studies that suggest disrespect and abuse may sometimes act as more powerful deterrents to skilled birth care utilization than other more commonly recognized deterrents such as geographic and financial obstacles.

The report describes several categories of promising interventions concerned with the promotion of respectful, non-abusive care for both childbirth and other health care areas. Evidence from related health care areas such as participatory reproductive health approaches (health workers for change) and HIV stigma reduction approaches is reviewed to supplement the relatively small body of evidence for effective approaches to reduce disrespect and abuse during childbirth.

Historically, maternal health care and human rights interventions concerned with this area have tended to focus on either the promotion of "positive" dignified maternal care often as part of quality improvement approaches, (e.g. "caring" interpersonal provider behaviors; humanization of childbirth interventions) or the reduction of "negative" abusive maternal care (e.g. human rights and accountability/redress interventions), with some interventions trying to combine elements of both approaches. The section on intervention approaches deliberately reviews the evidence from a range of intervention approaches with the aim of informing evidence-based approaches to future programming, research and advocacy that can address different expressions of disrespect and abuse. Table 2 summarizes broad categories of interventions reviewed including Quality Improvement Interventions; Caring Behavior Interventions; Humanization of Childbirth; Health Workers as Change Agents; Accountability; Human Rights; Legal; HIV/AIDS Stigma reduction interventions; and Tools for Measurement. Many of the interventions summarized in Table 2 were implemented as part of broader quality improvement initiatives given the importance of disrespect as a quality of care problem and its common association with other quality problems such as poor clinical quality of care, poor patient satisfaction, and lack of community engagement, among other quality issues.

The report concludes with an analysis of gaps in the evidence. Despite extensive documentation of many individual cases and institutional assessments, the published evidence does not include a prevalence estimate of abuse or disrespect in facility-based childbirth. The lack of prevalence estimates is likely in part due to the lack of a consistent operational definition and validated measurement method for comprehensively assessing disrespect and abuse in childbirth. While abusive maternal care is often defined using the human rights language of "freedom from torture and cruel, inhuman or degrading treatment" (e.g. physical or sexual abuse), evidence reviewed does not include examples of an operational definition of "respectful care at birth" or validated measurement methods that encompass basic human rights principles of right to respect (respectful interpersonal care), right to equality and non-discrimination, right to information (informed consent), right to redress (accountability) and right to privacy (confidentiality), among others.

A compelling gap in the evidence concerns a lack of impact studies relative to specific interventions. While there are many reports of programs implementing various combinations of interventions, there are very few examples of impact studies to guide evidence-based policy and future programming. There is an urgent need in light of the evidence presented in this report for advocacy and active programming linked to implementation research and rigorous evaluation of established or planned interventions to accelerate the evidence base for effective interventions, policy, and eventual scale up of effective interventions. It is hoped that the review of the evidence presented in this report will help to stimulate concurrent program action and research to illuminate and address the drivers, consequences and effective interventions for achieving respectful, non-abusive care at childbirth and improved maternal health outcomes for all women.

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Introduction

The fifth Millennium Development Goal (MDG 5: Improve Maternal Health) has helped to galvanize attention to and action for improving maternal care and survival for all women especially during childbirth. Progress, however, has been slow for increasing "skilled birth attendance", a key MDG 5 indicator, due in part to obstacles to skilled birth attendance that include cultural and provider-client interpersonal barriers as well as economic and geographic barriers. Although the extent of disrespect and abuse in facility-based childbirth has not been systematically documented or even well defined, many maternal health and human rights experts believe that disrespect and abuse in childbirth represents an important barrier to utilization of skilled birth care and constitutes a common cause of suffering and human rights violations for women in many countries.

In March 2010, the USAID-funded Translating Research into Action Project (TRAction) convened a meeting of governmental and non-governmental public health and human rights organizations active in the area of maternal health to review the topic of respectful and disrespectful birth care, including abusive maternal care. Meeting participants generally agreed that the issue was an important one and recommended as a next step a landscape review of the evidence with regard to major categories and drivers of "abusive maternal care", including a review of prior interventions to promote respectful care and/or reduce disrespect and abuse in childbirth. Based on the March 2010 meeting recommendations, the TRAction project commissioned this report to review previous research directions on this topic, including available evidence on the scope, contributors, impact and promising intervention approaches. A primary purpose of the report is to help stimulate dialogue and an implementation research agenda in this area.

Methods

A desktop review of the published and gray literature, individual interviews with nine expert informants and a structured group discussion on the topic of disrespect and abuse in facility-based childbirth and related topics were used to gather evidence for this report. Sources of evidence were taken from many different disciplines including midwifery, nursing, medicine, anthropology, health systems, health policy and human rights.

The desktop literature review employed a web-based search of over 150 documents as well as review of references provided by key informants. Relevant evidence from related topics such as HIV stigma research and the broader reproductive health and human rights literature was reviewed when relevant to the topic. Journal publications, reports, documents, books, as well as relevant policies, legislation, and national demographic and health surveys published by governments, organizations, and individuals on the topic of disrespect and abuse during facility-based childbirth and related topics were reviewed. Main search terms included abusive care, disrespectful care, dignified birth, caring behavior, humanization of childbirth, discrimination during childbirth, stigma, detention, neglect, accountability, human rights and childbirth, health workers for change, empowerment, redress, health systems and childbirth, quality of care, barriers to treatment of obstetric emergencies, and women's perceptions of maternal care. Up to seventy peer reviewed articles were reviewed from leading journals including The Lancet, the
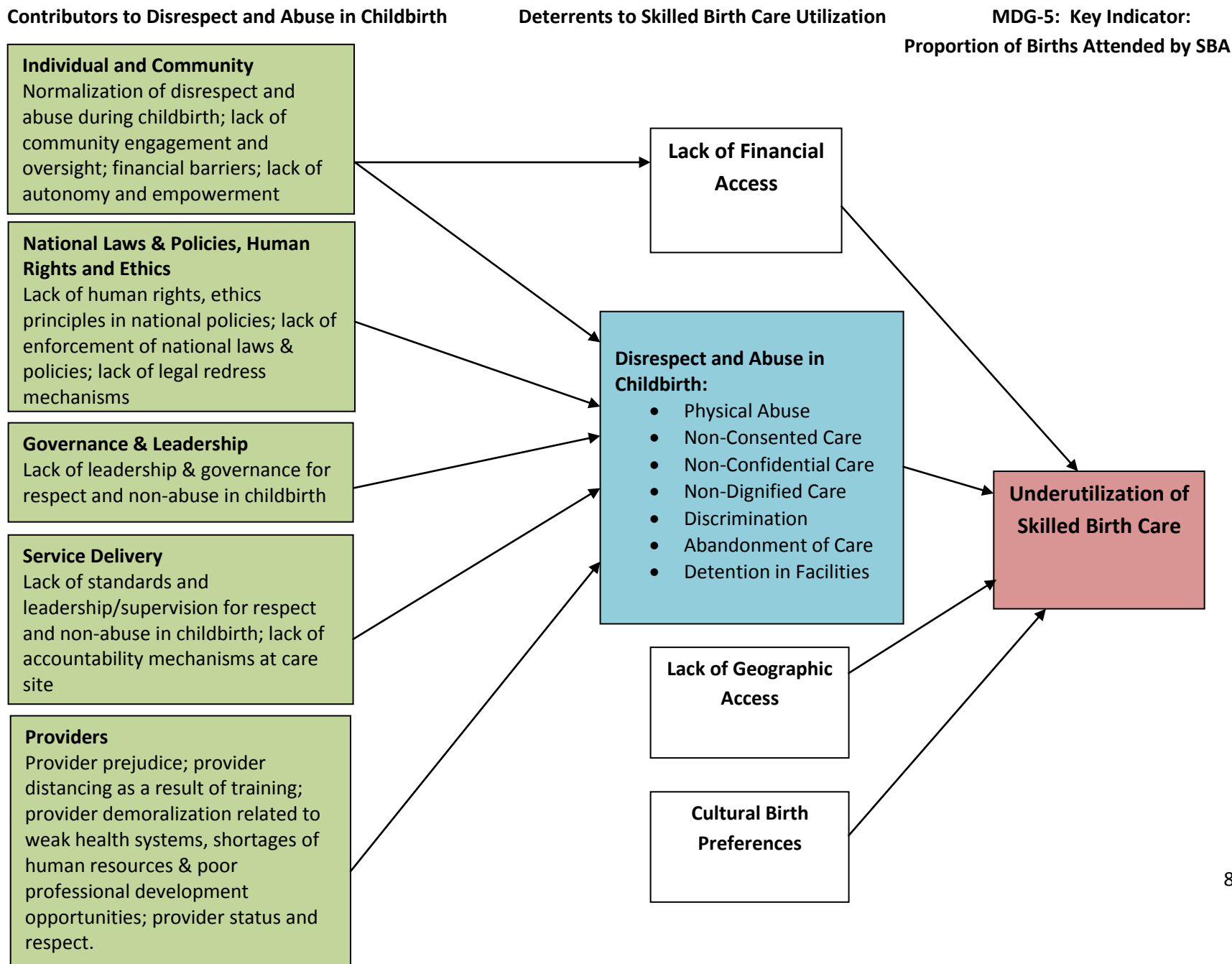
International Journal of Gynecology and Obstetrics, Reproductive Health Matters, Social Science and Medicine, Bulletin of the World Health Organization, Health Policy and Planning, Reproductive Health, World Development, Midwifery Today, and Studies in Family Planning among others. Two books and one piece of legislation on abusive behavior in India were reviewed. Up to fifty documents were reviewed from the gray literature including reports from human rights groups (Amnesty International, Center for Reproductive Rights, Human Rights Watch, and Physicians for Human Rights) as well as the World Bank, The Change Project, Family Care International, Ministries of Health, University Research Corporation, USAID, School of Public Health, UNICEF, the United Nations and the World Health Organization. The stories extracted and documented in the report are taken from over 18 countries, including South Africa, Kenya, Burkina Faso, Burundi, Tanzania, Zimbabwe, Malawi, Ghana, Sierra Leone, Sudan, Peru, Dominican Republic, Brazil, Pakistan, Lebanon, India, United States and Canada.

A structured group discussion was held as a follow-on activity to an open satellite breakfast meeting convened at the Women Deliver Conference 2010 by the TRAction Project (a list of breakfast meeting attendees is available on the TRAction website). Recruiting of participants at the satellite Women Deliver meeting and for the structured group discussion was done by email invitation two weeks prior to the Women Deliver meeting. Although 7-8 participants agreed to participate in the structured group discussion, unfortunately only two women were able to participate due to the many competing activities at the Women Deliver Conference. Informed consent was obtained from both participants prior to the structured group discussion. The structured group discussion was moderated by Mona Moore, a URC consultant, and facilitated by Deb Armbruster, a Senior Maternal Health advisor at USAID. The discussion was recorded and three TRAction Project staff took detailed notes.

Nine in-depth individual interviews were held with a small informal sample of experts (see Annex A for a list of individuals interviewed). The sample of individual interviewees was a purposive sample of maternal health policy makers and senior program planners, proposed by USAID, URC and participants at the Women Deliver and March 2010 meetings. Individual interviews were conducted by Kathleen Hill (Senior Technical Advisor TRAction project), sometimes with the assistance of Diana Bowser (consultant author of this report) using a modified version of the semi-structured open-ended questionnaire tool developed for the structured group discussion by Mona Moore and the team. The adapted individual interview tool focused on informant perceptions of the scope, drivers, and promising intervention approaches in this area. Informants were also asked to prioritize research directions.

Building on an early pre-report road map of potential drivers of abusive maternal care and the results of evidence reviewed for the report preparation (literature review, individual interviews and the structured group discussion), a schematic was developed to summarize identified categories of disrespect and abuse in facility-based childbirth and to illustrate both contributors to disrespect and abuse and the negative impact of disrespect and abuse (along with other deterrents) on skilled care utilization (see Table 1 below). The schematic was in turn used to organize the report sections on categories of disrespect and abuse and potential contributors to disrespect and abuse in facility-based childbirth.

Table 1: POTENTIAL CONTRIBUTORS TO AND IMPACT OF DISRESPECT AND ABUSE IN CHILDBIRTH ON SKILLED CARE UTILIZATION

Contributors to Disrespect and Abuse in Childbirth   Deterrents to Skilled Birth Care Utilization   MDG-5: Key Indicator:
Proportion of Births Attended by SBA

Individual and Community
Normalization of disrespect and abuse during childbirth; lack of community engagement and oversight; financial barriers; lack of autonomy and empowerment

National Laws & Policies, Human Rights and Ethics
Lack of human rights, ethics principles in national policies; lack of enforcement of national laws & policies; lack of legal redress mechanisms

Governance & Leadership
Lack of leadership & governance for respect and non-abuse in childbirth

Service Delivery
Lack of standards and leadership/supervision for respect and non-abuse in childbirth; lack of accountability mechanisms at care site

Providers
Provider prejudice; provider distancing as a result of training; provider demoralization related to weak health systems, shortages of human resources & poor professional development opportunities; provider status and respect.

Lack of Financial Access

Disrespect and Abuse in Childbirth:
- Physical Abuse
- Non-Consented Care
- Non-Confidential Care
- Non-Dignified Care
- Discrimination
- Abandonment of Care
- Detention in Facilities

Lack of Geographic Access

Cultural Birth Preferences

Underutilization of Skilled Birth Care

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Results

Defining Disrespect and Abuse in Childbirth

Based on a comprehensive review of the evidence, seven categories of disrespect and abuse in childbirth are identified: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. Proposed categories of disrespect and abuse draw on human rights and ethics principles, and are intended to help synthesize and organize the broad range of manifestations of disrespectful and abusive birth care reported in the literature. It is understood, however, that manifestations of disrespect and abuse often fall into more than one category, so that categories are not intended to be mutually exclusive. Rather categories should be seen to be overlapping along a continuum.

Physical Abuse

> **"When a woman goes into the second stage of delivery, you don't want her to close her legs, so you're beating her" [Kenya]**
> (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007)

As reflected in the quote above taken from a report by the Center for Reproductive Rights on maternal care in Kenya, there are numerous reports of physical abuse during childbirth from health facilities around the world. In South Africa, women report being beaten, threatened with beating, and slapped during childbirth at midwifery units, clinics, and hospitals (Jewkes, Abrahams, & Mvo, 1998). In Peru, multiple reports describe nurses slapping women when they are pushing during delivery (d'Oliveira, Diniz, & Schraiber, 2002; Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM)/ Legal Center for Reproductive Rights and Public Policies (CRLP), 1998). It is reported that women in Kenya do not attend the hospital for fear of being beaten and "roughed up" (Family Care International, 2003). In Burkina Faso, a male nurse reported that he occasionally had to "slap or pinch pregnant women because they don't want to push and this can harm the baby" (Amnesty International, 2009b). In Tanzania, a woman reported "some nurses are good, they console. Others are quite irksome. They are so discouraging, even slapping pregnant women" (Family Care International, The Skilled Care Initiative, 2005). In Lebanon, women in 23 out of 39 hospitals surveyed reported being tied down during labor (Khayat & Campbell, 2000). There are widespread reports of the practice of birth attendants strenuously pushing on a woman's abdomen to try to force the baby out as well as excessive physical force to "pull babies out". Physical abuse has also been described in the context of unnecessary extensive episiotomies (sometimes for financial gain) and post-partum suturing of vaginal tears or episiotomy cuts without the use of anesthesia (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007).

There are rare, isolated reports of sexual abuse during skilled birth services, although the evidence for sexual abuse during antenatal care and broader reproductive care services is more extensive. In a CRR report from Kenya, a woman reported being sexually abused during childbirth by a male health provider which included examining the woman very forcefully while touching his own private parts, roughly pulling her legs apart, as well as forcefully and repeatedly shoving his fingers into her vagina (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007).

Non-Consented Care

There is evidence of a widespread absence of patient information processes or informed consent for common procedures around the time of childbirth in many settings (e.g. cesarean sections, episiotomies, hysterectomies, blood transfusions, sterilization, or augmentation of labor). Interviewees from LAC, sub-Saharan Africa and Eastern Europe regions all confirmed the lack of routine patient information communication and consent protocols for obstetric procedures in their respective settings, including the widespread practice of episiotomy without patient notification or consent. Escalating and excessive rates of unnecessary cesareans have been documented by many in the LAC, Asia, North American and other regions. Reports from Kenya, the United States, Dominican Republic, and Peru document women's stories of feeling coerced into a cesarean section (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007; S. Miller et al., 2003; Physicians for Human Rights, 2007; Amnesty International, 2010). A soon to be released report from the Center for Reproductive Rights documents non-consented sterilization at the time of childbirth in Chile (Center for Reproductive Rights/Vivo Positivo, Forthcoming 2010).

Non-Confidential Care

A recurrent theme in the literature and communication with expert informants is the lack of privacy and confidentiality for many women around the world who deliver in facilities. Lack of privacy relates to both a physical lack of privacy in facilities where women may often labor and deliver in public view (without any privacy barriers) and lack of privacy related to sensitive patient information such as HIV status, age, marital status, medical history, etc. Non-confidential care is an especially important problem in high-prevalence HIV settings, where failure to respect the confidentiality of a woman's HIV status may increase the discrimination a woman experiences in a facility and her community and act to deter her use of facility-based childbirth care.

Non-Dignified Care

"One nurse told me: 'Lady can't you see that you are in the way? Go over there, you aren't anything but an animal and talking to you is like talking to an animal!'"
[Dominican Republic]
(S. Miller, Tejada, Murgueytio, & et al., 2002)

Non-dignified care during childbirth is described in the literature as intentional humiliation, blaming, rough treatment, scolding, shouting, publicly divulging private patient information, and negative perceptions of care.[1] It is important to note that a woman's description of and perception of non-dignified care may be very context specific, so that an example from one country may not be relevant in other countries. For example, eye contact, a smile, and a handshake from a male provider in one culture may be perceived as disrespectful by a woman in another culture. In contrast to more overt forms of abuse such as hitting or abandonment of care, the defining characteristics of the sub-category of non-dignified care may be more nuanced and context specific.

The box below summarizes several country-specific examples of non-dignified care in the literature.

Examples of Non-Dignified Care at Birth

Women "being shouted at to push or yelled at to stop pushing…yelling, cries of pain, screams during the episiotomy…" [Dominican Republic] (S. Miller et al., 2002).

Nurses "put fear in me and threatened that they would take me to the theatre [for a cesarean section] if I dared push again" [Ghana] (d'Ambruoso, Abbey, & Hussein, 2005).

"Poor staff attitude included, rudeness, undeserved or inappropriate reprimand, shouting at women in labour, lack of empathy, refusal to assist, and threatening patients in labour with poor outcomes if they did not comply with instructions" [Ghana] (d'Ambruoso et al., 2005).

Midwives scolded the patients and told them they were stupid [South Africa] (Jewkes et al., 1998).

Women are told to "stop pretending you are in pain" and "do not cry as [I] am not the one that made you pregnant" [Kenya] (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007).

"The kind of speech directed at patients like insults would drive away women to those who treat them with dignity and respect" [Kenya] (Family Care International, 2003).

If provider attitude were improved in Tanzania home deliveries would have decreased by 17% (Kruk, Paczkowski, Mbaruku, Pinho, & Galea, 2009).

Indigenous women feel disrespected and report that when they go to the hospital to deliver they are told "these Indian women who come here smell, 'Go and bathe yourself first.'" [Ecuador] (Ministerio de Salud Pública del Ecuador, 2007).

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[1] Non-dignified care as described here is consistent with how d'Oliveira et al. (2002) define verbal abuse.

Discrimination Based on Specific Patient Attributes

There are many examples of discrimination during childbirth based on a woman's race, ethnicity, age, language, HIV/AIDS status, traditional beliefs and preferences, economic status, and educational level.

Race/Ethnicity: Data from an Ecuadorian household survey show that 18% of the time, Indian women in Ecuador who preferred to deliver at home did so because of poor interpersonal behavior by providers ("Maltrato") (ENDEMAIN, 2004). In a report from Peru, providers were reported to demonstrate little respect for local cultures (Kayongo et al., 2006) and the indigenous population has been forced to deliver in health facilities through use of police or threats of incarceration in health facilities (Physicians for Human Rights, 2007). In the United States, a woman reported that the staff at the hospital where she delivered "were racist and assumed that because I am black, poor, and live in this neighborhood, I must have had many abortions" (Esposito, 1999).

Age: In Kenya, nurses tell young, teenage mothers: "You young girl, what were you looking for in a man? Now you can't even give birth" (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007). In India, the Janani Suraksha Yojana program is only available to women over age 19 and those with two children or less, discriminating against young mothers (Human Rights Watch, 2009).

HIV/AIDS: Stigma for women living with HIV during child birth is especially pervasive (Christian Aid, 2008; Amnesty International, 2009b; Center for Reproductive Rights/Vivo Positivo, Forthcoming 2010). An interview with a woman from Sudan described the case of a woman going to the hospital for early-term labor and when her husband reported that she was HIV positive she was refused service and deprived of a delivery room. The doctor finally arrived wearing 12 gloves and delivered the premature baby, weighing 1kg. The woman and the baby were never given any more services. There are a number of studies assessing levels of stigma for HIV/AIDS in the general health care setting that may have high relevance for the HIV infected women in labor, although specific examples in the literature were not found (World Bank, 2010; Ezedinachi et al., 2002; Kemppamen, Dubbert, & McWilliams, 1996; Reis et al., 2005; UNAIDS, 2000; Uys et al., 2009; Brown, Trujillo, & Macintyre, 2001).

Traditional beliefs: Traditional beliefs may influence care during childbirth. For example, in some areas in Sierra Leone it is believed that obstructed labor is caused by infidelity, which may result in a blaming of the obstructed labor on a woman's past behavior and an insistence on confession and addressing the "immoral behavior" instead of a focus on managing the health situation at hand (Amnesty International, 2009b).

Economic Status/Education: A human rights report from Burkina Faso states that one of the reasons that poor and rural women in Burkina Faso do not use health care facilities is because they are treated with disrespect (Amnesty International, 2009a). The focus group discussants reiterated that being "low status" and "less educated" leads to discriminatory behavior on the part of the health care provider because he/she knows that this woman will be "more likely to accept that sort of treatment and this is why they get treated this way…..she will accept it and she won't yell back at you and say, 'I deserve to be treated better'". A report from South Africa describes

statements by health workers "that providing explanations to less educated women [is] not a good use of time as 'they just can't understand'" (S. Fonn & Xaba, 2001).

Abandonment of Care

"After the injection, I gave birth. The doctor had left by then and the nurse said she would not help me until the head of the baby came out. I was assisted by one of the patients who was waiting to give birth. [The nurse] later came and took the baby . . . [and] told me to get off the bed and wipe the bed" [Kenya]
(Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007)

Several examples of abandonment that include women being left alone during labor and birth as well as failure of providers to monitor women and intervene in life-threatening situations are given in the box below.

Examples of Abandonment of Care

In Brazil, in the late 1990s, a study examining birthing in a rural hospital noted that many women delivered alone, were left unattended and were not allowed to bring a companion into the birthing area (Misago et al., 2001).

Although large scale prevalence estimates are not available, in South Africa it is reported that five out of fifteen women interviewed said they delivered on their own—a prevalence rate of 33% (Jewkes et al., 1998).

In Sierra Leone, there are citations of women being denied care and dying because hospital staff are not called, or report being "too tired" to work. One woman arrived to the hospital with obstructed labor. However, upon arrival the doctor was away on another assignment. Even though it was an emergency, the staff did not call the doctor until the next day and the woman died (Amnesty International, 2009b).

Another woman from Sierra Leone reported arriving at the hospital with complications of her labor. She had to wait six hours for the physician to finish delivering another baby. When he was done he reported he was "too exhausted to operate after working for three days without rest and that she and another woman would need to be transferred to another hospital" (Amnesty International, 2009b).

"Even when [the woman's] water broke, no staff member came to help her, so she made her own way to the delivery ward. [The woman] recalled that the nurses did not have the proper equipment ready and had to leave to find it" (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007).

"You just call (for the nurse) until you get tired and then you finally deliver by yourself and die. I have even witnessed it myself" (Family Care International, The Skilled Care Initiative, 2005).

In India, a mother was left unattended after delivering a still born baby, developed post-partum hemorrhage, and died within two hours (Human Rights Watch, 2009).

In Ghana it has been reported that women in labor are denied services, moral support and encouragement (d'Ambruoso et al., 2005).

Detention in Facilities

> ## "When I got the bill, the doctor said to me, 'Since you have not paid, we will keep you here'" [Burundi]
> (Human Rights Watch, 2010)

Detention of recently delivered women and their babies in health facilities, usually due to failure to pay, has been described in a number of countries, including: Kenya, Ghana, Zimbabwe, Peru, Burundi, and the United States. A woman from Burundi is quoted in the box above after having a caesarean delivery. She reported that life in detention was difficult and she did not have permission to leave with her baby, she was often hungry, and could not stand the situation for much longer (Human Rights Watch, 2010). In Burundi, it has been reported that patients may be held for weeks and months and in one case for over a year until the bill could be paid (Human Rights Watch, 2006). In Ghana, a woman reported visiting her baby in a large hospital for up to three weeks in order to breast feed as the baby was being detained because she could not pay the bill (IRIN, 2005). Detentions in Kenya have been documented including detention of women who have lost their babies (Center for Reproductive Rights & Federation of Women Lawyers-Kenya (FIDA), 2007). In the United States, there are reports of deaths of pregnant women while being detained in immigration facilities (Human Rights Watch, 2010). There are similar stories in the Democratic Republic of the Congo (Initiative Congolaise pour la Justice et la Paix, 2006), Zimbabwe (The Herald, 2004), India (Human Rights Watch, 2009).

Potential Contributors to Disrespect and Abuse in Facility-Based Childbirth

Individual and Community

Normalization of disrespect and abuse during childbirth

A core theme that emerged during many interviews concerns the "normalization" of disrespect and abuse in facility-based childbirth for many women who have never known any other system of care or been exposed to concepts of patient rights. One of the discussants in the structured group discussion stated "I think most of our women don't know they have the rights to respectful treatment. If we do a patient satisfaction survey now, you will find [patient satisfaction] is high. Because women [in my country] by character…they never say they are mistreated...maybe that is the fact, but they never speak the truth. They don't object or speak out. They accept what they get." Another structured group discussion participant reported that older women in her country may believe and assert to younger women that abusive treatment is the norm. An older woman [from her country] once commented to our informant that young women expect too much nowadays and that "women should be beaten" because this is how life was for her. The normalization of disrespect or even abuse has been described in the Dominican Republic. An observation team observing a maternity ward in the DR witnessed a number of very forceful, rough deliveries. The team then interviewed the women who had received this rough treatment, some of whom had not yet seen their babies. These women expressed gratitude

that they were able to deliver here, saying "This is the best place to have a baby" and that this delivery ward was a "special place" (S. Miller et al., 2002). Clearly, publicly shared perceptions of respect and disrespect may vary by observer and setting, representing a complex but important challenge for those concerned with promoting core human rights principles as an essential component of respectful, non-abusive birth care.

Lack of community engagement and oversight

Community and civil society oversight and participation in management of facility health services have been demonstrated in some studies to improve demand for quality of care and to increase accountability of facility providers and managers. For example, in a humanization of childbirth study in Ecuador, community health members worked closely with facility providers, sometimes as part of quality improvement teams, to improve responsiveness of childbirth services to client needs and preferences with some success (Ministerio de Salud Publica del Ecuador, 2007; USAID Health Care Improvement Project, 2008).

Financial barriers

One of the important barriers to both respectful and non-abusive care in childbirth as well as skilled birth care utilization is the financial status of the woman and her family. As is reported in Kenya, "Only money keeps women away from getting skilled care. In total, it's money" (Family Care International, 2003). User fee or some type of monetary charge on the part of the woman and her family is one of the more frequently mentioned reasons why women suffer disrespect and sometimes detention in facilities. In Nigeria, user fees in both the public and private sector are barriers to receiving quality maternal care (Center for Reproductive Rights (CRR), 2008). In Kenya, if women do not pay for health care services, they can be detained in health care facilities for years at a time and detained with their newborn babies for extended periods (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007). In Burkina Faso, financial barriers limit transportation to district hospitals (when the husband cannot pay) and purchase of needed medicines and blood tests (Amnesty International, 2009a).

Lack of autonomy and empowerment

While there is little empirical evidence explicitly linking a lack of women's autonomy and empowerment to disrespectful and abusive birth care, there is evidence that female autonomy and empowerment are associated with improved choices for childbirth. For example, Bloom et al. (2001) in India find that women with more autonomy (freedom of movement) used more antenatal care and safer delivery care (trained care attendant). Matthews et al. (2005) similarly find that in Mumbai higher female autonomy, measured through having money set aside or control over finances, has a strong influence on having an institutional birth. Similarly, in Sierra Leone, a study by CARE found that 68% of mothers said the decision on where to deliver the child was usually made by the husband at the onset of labor (Amnesty International, 2009b). In Burkina Faso, one of the drivers of high maternal mortality is the frequent delay to seek care because women usually depend on their husbands or in-laws to make the decision to go to the health center (Amnesty International, 2009a). This is confirmed in interviews with

individual women in Burkina Faso one of whom stated, "when you live with a husband, you cannot go to a dispensary without informing him. It would show a lack of respect. As a woman, you cannot decide to go to the dispensary even if you have the money for treatment" (Nikièma, Haddad, & Potvin, 2008). Interviews with men in Burkina Faso also reveal that men often believe women are feigning illness and are "too sensitive to pain" and do not need professional intervention (Nikièma et al., 2008). A woman will often delay care-seeking while she waits for her husband to say whether or not he will permit her to visit a health facility (Nikièma et al., 2008). Autonomy has also been shown to be correlated with the likelihood of delivering in a facility in Kenya, demonstrating a strong interaction with wealth but not with education (Fotso, Ezeh, & Essendi, 2009). Despite a lack of explicit evidence linking lack of autonomy and empowerment to disrespect and/or abuse in facility-based birth, this subcategory is included because it likely contributes to disrespect and/or abuse and is deemed to merit further investigation.

National Laws & Policies, Human Rights, and Ethics

Basic principles of human rights and ethics relevant to respectful and non-abusive care at birth are briefly summarized, followed by an exploration of how lack of established policies and lack of implementation and enforcement of established policies, including lack of redress mechanisms, may contribute to disrespect and abuse in childbirth.

Human rights principles relevant to respect and non-abuse in childbirth

　　Recognition, ratification, as well as enforcement of human rights treaties is one important strategy for reducing disrespect and abuse in childbirth, that is gaining increasing traction in recent years. The human rights principles most highly relevant to respectful and non-abusive care at birth include: equality and non-discrimination, information, redress, privacy, participation, dignity and freedom from torture and cruel, inhuman, or degrading treatment. Each of these human rights principles are contained in key international human rights treaties and covenants including the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), among others. ICCPR, ICESCR, and CEDAW are well known documents that are recognized by many countries. ICCPR, for example, as of July 2010 had 72 signatories and 166 parties.[2] ICESCR, as of July 2010, had 69 signatories and 160 parties.[3] CEDAW has 79 signatories and has been ratified by 99 States (United Nations, 2010).[4] The fact that core human rights principles are recognized by so many countries in these international treaties provides a strong human rights platform from which to promote respectful and non-abusive birth care.

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[2] A signature is not binding by a State until it has also been ratified by that state. A State may become party to a treaty in a single act called an accession instead of signing first and then ratifying a treaty.
[3] The United States has signed, but not ratified the ICESCR.
[4] The United States has not signed or ratified CEDAW.

Bioethics principles relevant to respect and non-abuse in childbirth

Bioethics principles relevant to respectful and non-abusive care at birth are clearly laid out in many provider professional association statements and guidelines governing ethical conduct of care (Cook et al, 2003). Bioethics principles of care complement legal and human rights frameworks and can "enable professional associations to provide leadership on this issue through the development of guidelines on respectful care at birth, and the integration of these guidelines into teaching and training" (Communication Rebecca Cook, September 2010). For example, the International Federation of Gynecology and Obstetrics (FIGO) Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health issued a report on Ethical Issues in Obstetrics and Gynecology that includes many recommendations relevant to promoting respectful care at birth. In discussing the role of obstetricians as advocates for women's health, this report states that "Obstetricians-Gynecologists have an ethical duty to be advocates for women's health care… [and that] this obligation is increased by the unique vulnerability of women because of their reproductive function and role" (FIGO 2009). The report asserts that obstetricians and gynecologists "are obliged individually and as a profession to monitor and publicize indices of reproductive health and provide data to sensitize the public to health issues and rights of women" (FIGO 2009). The report reviews several categories of ethics principles highly relevant to respectful care in childbirth including among others informed consent, confidentiality and privacy, and ethical issues in the doctor patient relationship (FIGO 2009).

Many professional associations representing a broad range of provider cadres (e.g. midwives, family physicians, obstetricians, nurses) maintain explicit guidelines governing ethical conduct of care for the provider cadre they serve. Such guidelines can be leveraged to promote respectful care at birth through training, supervision, licensure and certification maintenance, investigation of complaints by patients or peers, and other mechanisms.

Lack of existence or enforcement of national laws and policies

National laws and policies and their enforcement are a critical component of strategies for improving respectful and non-abusive birth care and for governments to hold citizens accountable to such care. Often, national laws and policies do not codify core principles of ethics and human rights relevant to respectful and non-abusive birth care. In many countries, a maternal health policy that protects a woman's right to high-quality, accessible and respectful maternal care is missing. In the absence of such national policy, it is very difficult for policy-makers and managers to enforce standards of respectful and non-abusive care at birth or for lawyers to support legal redress measures.

In some countries where national policies that codify ethics and human rights principles of respectful and non-abusive maternal care may exist, formal processes for enforcing such national laws and policies, including human rights treaties, do not exist or are poorly implemented and enforced. For example, in many settings there is no designated authority in either the legal or the health care sector charged with overseeing and enforcing compliance with established maternal health laws and policies. Frequently operational mechanisms through which fellow providers and clients can lodge complaints when national policy and laws are violated are non-existent or weakly enforced. In many countries, there is an absence of professional regulatory bodies, such as medical and nursing boards, charged with overseeing certification, licensure maintenance, and oversight of provider performance, including

compliance with professional association principles of ethical conduct, in both the public and private sectors. In the absence of such professional regulatory bodies it is very difficult to enforce compliance with principles of ethical conduct of care even when such principles may be explicitly stated in professional association guidelines and codified in national law. Similarly, in the absence of professional regulatory bodies and legal authorities well versed in health care law, it is difficult to hold individual providers or facilities accountable.

The WHO's Department of Reproductive Health and Research and the Harvard School of Public Health's Program on International Health and Human Rights has developed a tool that assesses a country's human rights commitments alongside legal/policy and public health data to reveal discrepancies and gaps between their commitments and their health outcomes. This tool has been field tested in a number of countries and adapted to conduct analyses related to maternal and newborn health, sexual and reproductive health as well as adolescent sexual and reproductive health. Use of the tool has been shown to increase understanding of human rights among stakeholders and has led to recommendations on key issues aimed at achieving the highest attainable standard of health for all populations (Cottingham et al., 2010). It is important to use "the impetus provided by human rights law to move beyond the legal realm into the realm of good, evidence-based, rights conscious medical and public health practice" (Freedman 2003). Using a "rights-based approach" (RBA) to health policies and programs gives academics, governments, and non-governmental organization an "exciting range of ways….to incorporate human rights into public health efforts" (Gruskin, Bogecho, & Ferguson, 2010).

Lack of legal redress mechanisms

The right to redress, a core human rights and legal principle, is critical for enforcing established policies and laws that may have been ratified or adopted at the national level but are often not backed by strong implementation and enforcement mechanisms at the local service delivery level. As mentioned above, however, legal redress depends on the existence of proactive maternal health policy if it is to be used to promote respectful birth care and reduce abusive care. Further, right to redress is closely linked to the right to information and informed consent, since users cannot ask for redress in circumstances where they do not have access to essential information. Even where redress mechanisms are legally in place, other disincentives to redress manifest, such as long processing times in the court as well as high costs for hiring lawyers to work on the case (Human Rights Watch, 2009). Lack of legal redress mechanisms is closely tied to lack of accountability at the care site. In the section below on lack of accountability at the care site additional examples related to lack of redress mechanisms are given highlighting problems of who to report to, where to register complaints, and lack of enforcement of any redress mechanisms that are in place.

Governance & Leadership

Lack of leadership & governance for respect and non-abuse in childbirth

The published literature and results of interviews with key informants emphasize repeatedly the importance of committed leadership for achieving respectful birth care and reducing and eventually eliminating abusive birth care, including the strong negative impact of disengaged or obstructive leadership. At the individual facility level, leadership is critical for enforcing standards of respectful birth care among all staff. As noted in a study from South Africa disrespectful care at birth was in part due to "the failure of nursing leaders to impose a system of ethics on the profession which precludes abuse of patients (Jewkes et al., 1998). At the national level, leadership is essential for establishing proactive maternal health policy that is linked to implementation and enforcement mechanisms at the highest levels of government as is noted when examining similar issues with implementing policy changes related to human rights and health (Cottingham et al., 2010). At the regional and district level, leadership is essential for supporting local implementation and oversight of national policy and for promoting innovative approaches to reducing disrespectful childbirth care which would involve a concurrent analysis of the health system (Roberts, Hsiao, Berman, & Reich, 2004). Moreover, the success with which this issue is put on the national policy agenda involves coordination of many levels as well as the need for evidence, lobbying, and overcoming resistance from certain stakeholders.

Service Delivery

Lack of standards & leadership/supervision for respect and non-abuse in childbirth

In general, maternal health care standards in most settings prioritize evidence-based clinical care standards and include relatively little emphasis on standards of respectful and non-abusive birth care such as dignified interpersonal care, information and consent, privacy, non-abandonment of care and right to protection from physical abuse. In many facility service settings, there is very weak leadership and supervision for even basic standards of clinical care, much less standards of respectful care. In some cases, supervisors themselves may model disrespectful childbirth care. Lack of leadership and supervision at the service delivery site is mentioned as a potential contributor to disrespectful birth care. One of the discussants in the structured group discussion commented that weak supervision at the service delivery site impacts services. "[If there] is very weak supervision of the health provider [the health care provider will] take advantage of that. The provider knows the boss is not going to come and hear all these stories." When individuals are treated poorly, they say, "Don't say anything" because they think the health care worker, with whom they have a grievance, will remember and retaliate later. In other instances it was reported that the "providers cover for each other" when inappropriate action occurs. Lack of supervision can contribute to a facility culture in which health care workers cover up for one another. "People do cover up for each other. Unless it goes to drastic issues, we [as managers] don't know about it" (Statement from a Structured Group Discussion participant).

Lack of accountability mechanisms at the care site

Most of the reviewed reports and interviews with individuals confirmed widespread lack of accountability mechanisms at the service-delivery site in low-income countries. There are few examples of patient charters, complaint boxes, and processes for registering complaints by patients or "incident reports" by staff, and even fewer reports of effective enforcement of accountability mechanisms.

For example in Burkina Faso it is reported that "medical personnel responsible for abuses and misconduct against patients are rarely, if ever, held to account" (Amnesty International, 2009a). The same report describes a patients' Charter in Burkina Faso that was developed in 2007; however the Charter is infrequently displayed and upon questioning patients did not know their rights set forth in the charter. A recent report by Human Rights Watch highlights health system accountability failures in Asia, Latin America, Africa, the United States and Europe. The report stresses the importance of accountability for reproductive health through establishing mechanisms to enable patients to lodge grievances, address patient complaints, and establish health standards in order to correct health system failures. In most settings, even where grievance mechanisms may exist, it is extremely difficult for marginalized women and illiterate women to assert grievances.

The Indian government has created several mechanisms through which women can register grievances (making complaints directly to superintendents or medical officers, Patient Welfare Committees to "ensure accountability of health care providers"). Despite these efforts, human rights reports from India quote women who say, "We don't know where to go and complain about anything....We have no information about it" (Human Rights Watch, 2010). Even where accountability mechanisms may be in place, there is usually an absence of procedures or even awareness on the part of the women about how to use accountability mechanisms (Human Rights Watch, 2009). In addition, there are reports of rural women in India stating that they are too scared to complain against doctors or nurses for fear of reprisals.

Even in countries like Kenya that stipulate formal mechanisms through which women can file a health care related complaint, rules are often not enforced and the actual process for the appeal is lengthy and "tests patience and tolerance" (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007).

Providers

Provider prejudice

Unfortunately, provider prejudice is a potential contributor to disrespect and abuse in facility-based childbirth that may manifest as discriminatory behavior against certain sub-groups of women based on race, ethnicity, age, HIV status, financial and education status and other attributes of a woman. Provider prejudice can lead to discrimination and mistreatment, racism and assumptions about a woman's prior behavior based on false stereotypes linked to race[5], being scolded for being too young to get pregnant, being refused services because of HIV/AIDS status, being reprimanded for immoral behavior by the provider, poor treatment linked to low educational status, and discriminatory care linked to caste and tribe. Adolescent girls may be

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[5] A black woman in the US reported that her physician assumed that her retained placenta was from having too many abortions when she had never, in fact, had an abortion (Esposito, 1999).

particularly vulnerable to discrimination based on young age during childbirth services (interview with Vicky Camacho).

Provider distancing as a result of training

Provider training is often described as harsh, punitive and encouraging a culture of social distance between provider and client. Commonly, trainers and professionals model birth care that is disrespectful and/or abusive, normalizing such care for young trainees.

Jewkes et al. describe how training in South Africa, following the British system, trains young nurses to be different from their communities. The training system "was designed to give them a new identity, far removed from the ignorance and superstition, the barbarity and bestiality of native life" (Jewkes et al., 1998). Jewkes et al. argue that provider training itself creates separation between providers and patients that can lead to the disrespect often described by patients in South Africa. In the Dominican Republic, medical training is described as overly medicalized without much attention to the laboring woman or the dynamics of interpersonal care. During medical training on birth care "no attempt [is] made to teach the students how to relate to the women as women, not just laboring bodies" (S. Miller et al., 2002; S. Miller et al., 2003).

There are also a number of accounts of how providers want to train and discipline the patients rather than treat them ("moral instruction"), which can be interpreted incorrectly by the patient. For example, in South Africa it is reported that providers are not able to separate teaching about "bad behavior" from providing treatment (Jewkes et al., 1998). Health workers have told of using punishment (such as not giving pain medications) as a way of educating women (d'Oliveira et al., 2002). Moral instruction—which is often seen by patients as abuse—is often times part of being a good nurse (d'Oliveira et al., 2002; Jewkes et al., 1998).

There are also a number of examples where health care workers are taught in their training to use violence in the treatment process. A senior midwife in South Africa said that midwives are taught to hit patients during their training (Jewkes et al., 1998).

Many of the recommendations by interviewees for promoting dignified, non-abusive maternal care involve addressing the pre- and in-service training conditions of maternal health providers from all cadres (midwife, physician, nurse, auxiliary nurse, etc.).

Provider demoralization related to weak health systems, shortages of human resources & professional development opportunities

The chronic effects of under-resourced and strained health systems on provider motivation are frequently described as important contributors to disrespect and abuse in facility-based childbirth. In Nigeria, for example, it is reported that the negative attitude of health-care staff toward women can be attributed in part to being understaffed, overworked, and underpaid (Center for Reproductive Rights (CRR), 2008). "If we had at least two nurses in a clinic, they could take shifts, but when there is just one person he is overworked, and if he is not around there is no access to health-care services" (Center for Reproductive Rights (CRR), 2008). In Sierra Leone, it was reported that women die because the doctor on call for the facility is away on another assignment and no other doctor is available to call (Amnesty International, 2009b). An experienced midwife in Kenya once reported delivering 11 babies in 12 hours admitting being tired and sleepy by the ninth. In India, government officials and doctors report that they do not have the facilities to meet the "demands" for institutional delivery that have been put in place by Janani Suraksha Yojana (JSY) (Human Rights Watch, 2009). In the Dominican

Republic, there is a perception on the part of providers of frustration due to their working conditions and lack of staff: "We need more general doctors to help during the consultations so that we can decrease the number of women seen by nurses. There aren't doctors to oversee the labor and deliveries. All the work falls on the nurses" (S. Miller et al., 2002; S. Miller et al., 2003). In Jamaica, a study of conditions in hospitals found that overcrowding, shortage of supplies and staff shortages resulted in alienation of nurse midwives and dissatisfaction among clients (Sargent & Rawlins, 1992). In a large Kingston Hospital, it was estimated that 65% of births were not attended by a physician or midwife and the women complained about indifference (Sargent & Rawlins, 1992). In an analysis of "violence against women in the health care setting" the authors conclude that the heavy workload, long hours, inadequate equipment or facilities, and personal danger can demoralize and traumatize staff and lead them to take their frustrations out on patients (d'Oliveira et al., 2002). The humanization of childbirth project in Brazil also points out that disgruntled health care workers become complacent, protecting themselves by saying, "I did something and that is all I can do in this limited setting".

The lack of a career path for many health professionals may contribute to staff demoralization and frustration that in turn may be associated with an increase in non-dignified birth care. Health workers that are rewarded for good care and provided career options for professional development may provide more dignified birth care (Mumtaz, Salway, Waseem, & Umer, 2003). In Burkina Faso, midwives often leave obstetrics because they cannot specialize and one makes a higher salary with specialization. A midwife reported that "because of this [brain drain] we're losing the most experienced and competent people and we constantly have to train new recruits" (Amnesty International, 2009a) . In Sierra Leone, midwives and doctors leave the public sector for higher paying salaries in the private sector (Amnesty International, 2009b).

Provider status and respect

There is some evidence that if the atmosphere in the health facility is that of disrespect and abuse, for example where lower level providers are the victims of disrespect and abuse by higher level providers or managers, then it is more likely that these lower level providers will abuse and disrespect patients (Mumtaz et al., 2003). One of the structured group discussion participants reported a discussion with town residents and providers during which residents of the town were disgruntled with the local health worker because they thought he was charging them for medicines that should have been free. However, in discussion with the provider it became clear that due to lack of procurement from the central authorities the local health provider was buying medicines with his own money and asking clients for reimbursement. The heath care worker "feels let down…he does not want to come to work". Similarly, the second focus group discussant commented, "We can't go around blaming [the health providers] if we [as managers] are not providing the support for the type of treatment [they need to provide]…it needs a lot of interventions in this respect; stacking the health facilities and motivating these healthcare workers to provide the proper care." An experienced midwife from Kenya observed that many nurses have difficult personal situations: they are underpaid; commute long distances to work, and often receive no food or tea during their shifts. She suggested, "If you care for [these nurses] they will care for the patients" (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007). Nurses in India also get little respect. The Uttar Pradesh Nurses Association explained how the working conditions (lack of a complaints

procedure, poor ratio of staff nurses to patients) causes patient-nurse conflict. "There are a number of cases where [the] nurses get suspended, dismissed, [have] gone to jail .... I have nurses who are beaten and are scared to work" (Human Rights Watch, 2009). A Regional Manager in South Africa commented on the lack of respect for health care workers by saying, "The public are demanding. They don't come back and say 'Thank you for the service'. Nursing staff also have human rights. The public expect too much" (McIntyre & Klugman, 2003). This is reiterated by the Health Worker for Change project that focuses on participatory processes for improving worker conditions because they believe that "It is very unlikely that health workers set out to treat patients badly. Thus there must be reasons why the end result of the provider–client relationship often turns out to be negative" (S. Fonn & Xaba, 2001).

Impact of Disrespect and Abuse in Facility-Based Childbirth on Skilled Care Utilization and MDG 5

Disrespect and abuse in facility-based childbirth often acts as a deterrent to current and/or future utilization of facility-based childbirth services. Multiple studies highlight the connection between disrespectful and abusive facility-based childbirth care as described by women users and a decision by women users not to use facility based childbirth services (see box below).

One of the key strategies for achieving MDG 5 is to increase skilled birth coverage for improved maternal health outcomes. The negative effect of disrespect and abuse in childbirth on skilled care utilization constitutes an important barrier to increasing skilled care utilization and improving maternal health outcomes as defined by MDG 5.

**Disrespect and Abuse in Facility-Based Childbirth acts as a Deterrent
to Skilled Care Utilization**

In Tanzania, using a Discrete Choice Experiment, the most important facility characteristics identified by women as influencing their choice of a facility delivery were provider attitude and drug availability. The authors estimate that improving these facility characteristics would lead to a 43-88% increase in facility delivery (Kruk et al., 2009).

Data from an Ecuadorian household survey demonstrated that 18% of the time, Indian women in Ecuador who preferred to deliver at home did so because of poor interpersonal behavior by providers ("Maltrato") (ENDEMAIN, 2004).

In South Africa, women reported not going for antenatal care because midwives were so rude and would only go when in labor (Jewkes 1998).

In Nigeria, there is evidence that women do not seek maternal health care at hospitals and clinics due to prior embarrassing experiences or the fear of being humiliated by the health-care staff. A six-month-pregnant interviewee who had registered at a private hospital explained that the discouraging attitude of health-care workers at public/government hospitals had influenced her decision (CRR 2008).

In Family Care International's report on care-seeking during pregnancy in Kenya (2003) there are numerous anecdotes from women reporting that insults, lack of dignity and respect "make mothers fearful of seeking care at health facilities".

In Kenya, women report that ...."the nurses don't take care of the patients so we opt for traditional birth attendants. [We] fear going to the hospital" (Center for Reproductive Rights & Federation of Women Lawyers--Kenya (FIDA), 2007).

In Peru, many women are reluctant to utilize Emergency Obstetric Care (EmOC) facilities because they felt services paid little attention to their needs and showed little sensitivity toward local culture. After implementation of a program based on improving infrastructure, staff development, training, supervision and quality, access and use of EmOC increased as well as access to cesarean sections for complicated deliveries (Kayongo et al., 2006).

In Burundi, women who hear of other women being detained in hospitals delay seeking care which can lead to additional complications and risky medical situations (HRW 2006).

Interventions to Promote Respectful and non-Abusive Care at Birth

A review of the evidence demonstrates a number of interventions that have been implemented or are currently being implemented that are relevant to the topic of respectful and non-abusive care at birth. Table 2 summarizes categories of interventions as well as some tools and is followed by a narrative description of the background context and specifics relative to the nine categories of interventions described: Quality Improvement interventions; Caring Behavior Interventions; Humanization of Childbirth; Health Workers as Change Agents; Accountability Mechanisms; Human Rights Interventions; Legal Approaches; HIV/AIDS Stigma Reduction Interventions; and Tools for Measurement.

Many interventions summarized in Table 2 can be classified under more than one category. For example, the Caring Behavior, Humanization of Childbirth, and Health Workers as Change Agents interventions were implemented as part of broader quality improvement initiatives and could be classified as quality improvement interventions. Several of the human rights, legal and accountability interventions are overlapping across categories. The general categories of interventions outlined in Table 2 are not intended to be absolute independent categories but rather to provide a general framework for describing broad categories of interventions that may often be overlapping.

Due to the relative lack of evidence for respectful care interventions focused specifically on childbirth care, many of the interventions reviewed are extrapolated from other health care areas (e.g. HIV stigma reduction interventions, broader reproductive health interventions). Summarized interventions are in no means intended to be exhaustive and represent a first review of the evidence. It is anticipated that interventions will be added as additional evidence becomes available.

Table 2: Tools and Interventions to Promote Respectful and non-Abusive Patient Care

Where, Who, When, Duration	Category of Intervention (e.g. Caring Behaviors)	Study Design	Study Description	Focus	Experience/Evidence/ Outcome/Impact
Quality Improvement Interventions					
USAID Health Care Improvement PISAF Benin bilateral project (Jennings et al. 2009)	Counseling Intervention	Pre and post counseling QI intervention, including training	Baseline assessment of quality of skilled and auxiliary provider counseling skills (antentatal, intrapartum and post-partum), including interpersonal dimensions of counseling	Maternal Newborn Skilled and Auxiliary Provider counseling skills	Increased patient satisfaction (self-reported), improved provider counseling skills including interpersonal skills (observed)
Tehran University of Medical Sciences, Iran (Aghlmand et al. 2008)	Maternal Care QI Study	Pre and Post QI intervention assessment	Baseline qualitative assessment of patient's care preferences; QI intervention implementing a new protocol combining women's expressed care preferences with evidence-based clinical care standards.	Maternal newborn skilled providers and clients	A pre and post assessment of women's satisfaction with services demonstrated an improvement in measures of women's satisfaction and a decrease in rate of cesareans (from 42% to 30%).
Other: see examples of other general categories of QI interventions summarized below.					
Caring Behavior Interventions (*QI approach*)					
Family Care International, Skilled Care Initiative 2000-2005 Kenya (Family Care International, The Skilled Care Initiative, 2005).	Caring Behavior within a broad set of other interventions	Baseline followed by Training	Baseline Assessment of Caring Behavior (more details in Tools section above) followed by competence-based interpersonal care training was integrated into ongoing clinical training using a four part training module;	Provider Skills	No formal assessment of caring behavior module. However caring behavior training module was reportedly positively received by maternity care providers and after the training maternity clients perceived an appreciable difference in the way the trainees treated them versus

			No formal assessment caring behavior component.		regular hospital staff.
CARE AMDD FEMME Project (Foundations to Enhance Management of Maternal Emergencies) 2002 Peru (Kayongo et al., 2006)	Quality, human rights, non-discrimination	Some baseline community assessments, Multi-part training initiative with certain interventions focused on quality, human rights and non-discrimination	Five facilities; Implementation Stages Framework; Training on a number of activities; Quality, human rights and non-discriminatory activities included: new signs on health services in local languages, birthing chairs with different positions, curtains for privacy, microwave oven to heat food, patient's name on bed	Providers and patients and community	No results specific to quality, human rights or non-discrimination; number of EmOC services increased, better referral system, more receptive, rather than hostile environment for referrals.
Humanization of Childbirth (*QI approach*)					
Japanese International Cooperation Agency (JICA) MOH Brazil 1996-2001 State of Ceará Brazil (Misago 2001)	Humanization of Childbirth	Rapid Anthropological Assessment (RAP); Pre-post assessment with Intervention	Pre-post assessment of childbirth (10 interviewing instruments) combined with a "humanization of childbirth" intervention using seminars, workshops, in-service training and training of trainers	Patients and providers and community	Greater self-esteem, commitment and teamwork for health professionals; Women did not deliver alone as they were encouraged to bring a family member or friend to birthing area; Women were encouraged to use their preferred birthing position; Less reported vaginal exams; More monitoring of uterine contractions and fetal heartbeat; Women in general thought the labor room was more comfortable, reporting "quiet ambience, relaxing music, adequate air conditioning and curtains that separated each bed"
UNICEF 2007	Cultural Adaption of	Unknown	Eliminate cultural barriers between health care	Providers and Patients	Increases coverage, reduces maternal death, more gratifying

Peru	Maternity Services		providers and other staff		relationship between patient and provider
FCI Health Care Improvement (HCI) Project 2007 Ecuador (USAID Health Care Improvement Project, 2008)	Cultural Adaption of Childbirth	Operations Research Intervention (intervention and control facilities)	Intervention in four county hospitals to make delivery care more responsive to users' cultural expectations through coaching visits during 2008 to support improvement teams	Providers and Patients	Increased presence of family members during delivery; Increased client satisfaction; Increase in institutional deliveries
Université de Montréal PhD Thesis 2008 Japan (Behruzi 2010)	Humanization of Childbirth	Qualitative Field Research Design	Individuals and institutions were included in the study design; data was collected through observation, field notes, focus groups, informal and semi-structured interviews	Providers and Patients and Institutions	Main barriers to humanized birth care was the restriction of a birth companion; Main facilitator was a women's own cultural values and beliefs in a natural birth and institutional strategies designed to prevent unnecessary medical interventions.
Health Workers as Change Agents (*QI approach*)					
UNDP WHO Country Collaborators 1995-2001 South Africa Tanzania Ghana Kenya Argentina (Onyango-Ouma et al., 2001)	Participatory Continuous Training for Health Workers	Training followed by Qualitative Assessment	Participatory, continuous training, identifying/analyzing problem, health system drivers; "Problem posing" : presenting back to the health care worker what is going on at the health facility and having them analyze it	Providers	Improved provider–client relations, facility level functioning and aspects of staff interrelationships, and some impact at the system level
Canada Society of Obstetrics and Gynecology ALARM Training 2009	Rights based approach to Sexual and Reproductive Health	5-Dayy Human Right based Training	Self-assessment of compliance with SRHR standards by providers; role-plays as patient and provider; developed	Providers	Not analyzed as yet, forthcoming publication

Ukraine (Mogilevkina et al., Forthcoming 2010).			implementation plan to make changes to achieve rights based SRHR		
Accountability Mechanisms					
Academy of Nursing Studies 2002 Andhra Pradesh, India (George 2003)	Accountability	Anecdotal Results after Intervention	Mahila arogya sanghas (women's health groups) were trained in empowerment, self-esteem and bargaining skills with a specific focus on health and given an official badge when done with training	Providers and Community	The badges increased accountability in the system; with badge sanghas were allowed to pass with patient after initially being refused entrance to hospital;
Human Rights Interventions					
Family Care International Skilled Care Initiative 2000-2005 Burkina Faso Tanzania Kenya (Family Care International. The Skilled Care Initiative, 2005)	Rights Based Approach	COPE Tool with an added focus on the right to caring, compassionate care	The Skilled Care Initiative included quality assurance activities with an added rights component focusing on caring behavior and was conducted in coordination with Caring Behavior intervention (summarized above).	Providers and patients	Effect of intervention on compassionate care not formally assessed.
CARE AMDD FEMME Project (Foundations to Enhance Management of Maternal Emergencies) 2002 Peru (Kayongo et al., 2006)	Quality, human rights, non-discrimination	Some baseline community assessments, Multi-part training initiative with certain interventions focused on quality, human rights and non-discrimination	Five facilities; Implementation Stages Framework; Training on a number of activities; Quality, human rights and non-discriminatory activities included: new signs on health services in local languages, birthing chairs with different positions, curtains for privacy, microwave oven to heat food, patient's name	Providers and patients and community	No results specific to quality, human rights or non-discrimination; number of EmOC services increased, better referral system, more receptive, rather than hostile environment for referrals.

			on bed		
HSPH (PIHHR) LACE CARE CHAK COVAW 2010 Kenya	Human rights and legal issues	Training	Trainings in hospitals and clinics on: human rights and legal issues for PLWHA, national and international HR laws, issues affecting survivors of gender based violence, economic empowerment, and basic paralegal training	Providers and Patients	Assumed link to pregnancy intentions and maternal care concerns of clients; evaluation of the impact of trainings through assessing changes in the HR/legal knowledge of trained versus untrained clients/SPs using comparative quizzes: no final results as yet.
WHO HSPH 2010 (Cottingham et al., 2010)	Human rights Tool	Assessment	Assesses a country's human rights commitments alongside legal/policy and public health data to reveal discrepancies and gaps between their commitments and their health outcomes	Policy	Results are country specific
Initiative on Maternal Mortality and Human Rights (IIMMHR) Steering Group 2010 India (SAHAYOG) Kenya (FCI) Peru (CARE) (FCI/IIMMHR, 2009)	Human rights maternal health interventions	Interventions	FCI in Kenya: "Right to Care" uses a human rights approach to improve women's rights around safe pregnancy and childbirth and engage health facility staff and health facility management committees and communities to identify possible violations of women's rights to maternal health, and ways to ensure those rights are not violated and engage; Peru: "No Woman Behind" uses a human rights approach to strengthen the capacities of local civil society networks.	Patients and Community	Initial results from Kenya show increased accountability by the community for women's health, fewer violations of client's rights by health care workers, increased community forums on rights, increased attention to quality of maternal care, increased attention on rights based approaches to health.
Center for	Documenting	Human rights	Addressing abuses of HIV-	Documenting that	Advocacy is ongoing, case

Reproductive Rights/Vivo Positivo (Chilean HIV group) (will be released October 2010) *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities*	human rights violations as a form of accountability/ Rights based Approach	factfinding methodology including literature review and interviews with women and healthcare providers	positive women in healthcare facilities including coercive sterilization during childbirth	such violations are taking place, Using evidence in advocacy with policy makers, government officials and key stakeholders, identifying possible litigation	identified and developed for litigation to address discriminatory practices against HIV-positive women
Center for Reproductive Rights (released 2008) *Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change*	Establishing accountability and use of legal interventions/ Rights based Approach	Human rights factfinding methodology including literature review and interviews with women and healthcare providers	Examining legal and accountability strategies for maternal health in India	Outlines strategies that advocates and lawyers can use to promote accountability	Has been used to help develop maternal mortality litigation at the state level in India
			Legal Approaches		
Family Care International CONAMU 2007 Ecuador (Benavides Llerena, Valladares Tayupanta, Ernst, Jaramillo, & Mansilla, 2007)	Legal Interventions	Improving maternal and child health through legal rights	Development of a guide to guarantee the maternal and child rights that are outlined in the law; User Committees at the community level; a guide on how to explain procedures for filing claims related to quality in health care	Individual and Community	Legal Guides Created—No quantitative results

Center for Reproductive Rights and Vivo Positivo (ongoing)	Rights based approach/Legal Intervention	Case against Chilean government to address coercive and forcible sterilization of HIV-positive women during childbirth	Case filed before Inter-American Commission on Human Rights	Establishing government accountability for this type of violation occurring in a healthcare facility	Case has been filed.
Center for Reproductive Rights and Advocaci (Brazilian human rights organization) (ongoing)	Rights based approach/Legal Intervention	Case against Brazilian government to address discrimination in provision of maternal healthcare services resulting in maternal death of young Afro-Brazilian woman	Case filed before CEDAW Committee	Establishing government accountability for this type of violation occurring in a healthcare facility	Case has been filed.
Center for Reproductive Rights/ FIDA Kenya (ongoing)	Rights based approach/Legal Intervention	Case against Kenyan government to address abuses during provision of maternal healthcare during childbirth in private healthcare facility/highlights lack of redress	Case filed before Kenyan Constitutional Court	Establishing government accountability for this type of violation occurring in a healthcare facility	Case has been filed.
Center for Reproductive Rights/ FIDA Kenya (ongoing)	Rights based approach/Legal Intervention/estab lishing	Request to Kenya National Commission on Human Rights to	Inquiry Request submitted to Commission highlighting scope of problem	Generating awareness about systemic nature of violations/	Request has been approved, inquiry is in preliminary stages.

	accountability	hold a public inquiry on abuses during provision of maternal healthcare during childbirth s		Establishing government accountability for this type of violation occurring in a healthcare facility	
HIV/AIDS Stigma Reduction					
World Bank 2010 South Asia (World Bank, 2010)	HIV/AIDS Stigma and Discrimination Reduction	Case Study Methodology and Project Monitoring and Evaluation	Evaluation of 26 Stigma and Discrimination Reduction projects funded through the South Asia Region Development Marketplace (SARDMO). Results are based on project monitoring and evaluation and six case studies.	Providers and Patients and Community	Each intervention was evaluated for what type of intervention it was and how it added to the reduction of HIV/AIDS for specific populations (see report for additional information on the 26 interventions that were evaluated).
University of California 2009 South Africa Malawi Tanzania Lesotho Swaziland (Uys et al. 2009)	HIV/AIDS Stigma	Case Study Approach combined with pre-post measurement Intervention	10 nurses and 10 people living with HIV or AIDS (PLHA) in each setting and facilitating a process in which they planned and implemented a stigma reduction intervention, involving both information giving and empowerment	Providers and Patients	Positive results for PLHA (less stigma and more self esteem); Nurses had no reduction in stigma or increases in self-esteem; however their own HIV testing behavior increased.
Physicians for Human Rights U. Michigan Harvard Medical School Policy Project Nigeria Center for Right to Health, Nigeria 2002 Nigeria	HIV/AIDS Stigma	Prevalence/Assessment of HIV/AIDS Stigma	To assess, measure, and describe health-care professional practices and attitudes towards people with HIV/AIDS	Providers and Patients	High level of stigma of HIV/AIDS patients; 9% of professionals had refused care for an HIV/AIDS patient; 59% agreed that people with HIV/AIDS should be on a separate ward; 40% believed a person's HIV status could be determined by his or her appearance; 20% agreed that

(Reis et al. 2005)					many with HIV/AIDS behaved immorally and deserve the disease.
University of Calabar WHO Center for AIDS Prevention, TX Southern University 2002 Nigeria (Ezedinachi et al. 2002)	HIV/AIDS Stigma	Longitudinal Randomized Controlled Trial	Training in clinical management, health education, attitudinal change to people with HIV; pre and post intervention data were collected in intervention and control areas	Providers	Positive changes post intervention including: more willingness to treat HIV, less fear and discrimination, increased understanding of clinical, psychosocial and human rights issues
UNAIDS 2000 India Uganda	HIV/AIDS Stigma	Qualitative Research Study (key informant interviews, secondary sources of data, focus groups)	To examine the forms and determinants of HIV/AIDS-related stigmatization, discrimination and denial	Providers and Patients and Community	HIV/AIDS-related stigmatization, discrimination and denial can appear in a variety of forms, at a variety of levels and in a variety of contexts with key determinants related to culture, perceived stigma, finances and gender.
Tools for Measurement and Intervention					
CHANGE Project 1997-2002 Kenya Guinea Bangladesh (CHANGE Project 2005)	Caring Behavior	Tool Development and Testing	Tool developed to understand provider-client behaviors, provider-provider behaviors, and provider-community behaviors.	Providers and Patients	Tools helped identify factors at the provider and patient level that influenced skilled care seeking.
Family Care International Skilled Care Initiative 2000-2005 Kenya (Family Care International. The	Caring Behavior	Qualitative Baseline Assessment followed by Intervention	Adapted the CHANGE Project tools to develop qualitative instruments for exploring community attitudes and decision-making related to maternal health.	Providers and Patients and Community	Found considerable concern among community members about interpersonal communication skills of maternity care providers and the way that pregnant women are treated at

Skilled Care Initiative, 2005)					health facilities.
Family Care International, MOH Ecuador, QAP/USAID 2007 Ecuador (González Guzmán, D., 2007)	Cultural adaptation and humanization of childbirth	Tools Development	Manual for cultural adaptation and humanization of childbirth	Providers and Patients and Community	Tools help sensitize health providers to cultural practices around childbirth to ensure that these practices are respected.
NorVQ Questionnaire : Denmark, Finland, Iceland, Norway and Sweden (Swanberg et al. 2007)	Tool for measuring abuse in health care	Prevalence Estimate	Measured the response to three questions related to abuse in health care in sample population of women aged 18-64 years old.	Female Patients	13-28% of women reported abuse in health care.
WHO Counseling for MNH : a Handbook For Building Skills 2010	Training	Training Tool	Handbook for building skills for Counseling for Maternal Newborn Health	Providers	WHO publication 2010 http://www.who.int/making_pregnancy_safer/documents/9789241547628/en/index.html

Context and Description of Interventions Summarized in Table 2

 Quality Improvement Approaches

Disrespect and abuse in facility-based childbirth constitutes an important quality of care problem and is often closely associated with other quality of care problems such as poor clinical quality of care and poor patient satisfaction with care. Many of the interventions summarized in Table 2 to promote respectful care at birth were implemented as part of a broader quality improvement initiative. Quality improvement interventions have historically included a strong focus on client satisfaction and needs and there are many examples of maternal health quality improvement initiatives implemented by a range of partners that include a focus on respectful care at birth as part of a broader quality improvement initiative that addresses clinical quality of care, community and client preferences, as well as other quality issues. Examples of organizations that have implemented quality improvement initiatives that include a focus on respectful care at birth include EngenderHealth (COPE), JHPIEGO (standards-based management and recognition (SBM-R) approach, University Research Co. (Quality Assurance Project (QAP)/Health Care Improvement (HCI) project), FCI, and CARE among many others.

FCI and URC have collaborated in Ecuador to improve the cultural responsiveness of maternal care services to patient preferences through client and provider QI teams who work together over several months to identify obstacles and to improve the cultural responsiveness of maternal care services (e.g. choice of birthing position and companion, etc.). This quality improvement work is described in more detail under the Humanization of Childbirth/Cultural Adaptation of Childbirth intervention section below. As mentioned above, FCI is currently applying this methodology in Bolivia.

A quality improvement study in Iran incorporated the results of a qualitative assessment of women's needs, values and preferences (using in-depth structured interviews) into a maternal care protocol that integrated both high-impact and evidence-based clinical care interventions with changes to health service delivery to make services more responsive to women's expressed preferences. The care protocol consisted of the introduction of 10 recommendations not currently being implemented in participating hospitals and the redesign of maternity care to incorporate the new protocol recommendations. A pre and post assessment of women's satisfaction with services demonstrated an improvement in measures of women's satisfaction and a decrease in the rate of cesarean sections from 42% to 30%.   Like humanization of childbirth interventions and many quality improvement interventions, this study actively integrated women's stated preference and needs into the implementation of an evidence-based protocol (Aghlmand et al., 2008).

A quality improvement initiative carried out in Burkina Faso focused on improving the quality of obstetric care, both technical quality and interpersonal quality (better understanding between provider and patient, better reception and better visiting hours). Interventions included home visits for women who had caesarean sections to monitor their progress, users-providers meetings to improve interpersonal relationships, and reinforcement of midwife training to provide more patient-centered care. Questionnaires completed at the end of this project showed improved satisfaction from the women (Amnesty International, 2009a).

Criterion or standards-based clinical audits, including direct observation of care services, have long been a central method in clinical care quality improvement initiatives in the developing and developed world and have been used recently to improve quality of maternal health counseling, including interpersonal dimensions of counseling. Both the Health Care

Improvement project and the bilateral PISAF program were able to demonstrate improved quality of maternal health counseling in maternity facilities in Benin as part of a maternal newborn health improvement collaborative. Specific interventions included a standards-based training and supervision curriculum supplemented by ongoing testing of changes to improve quality of counseling care by facility-based QI teams to achieve defined standards. Pre and post direct observation of interpersonal dimensions of provider counseling care demonstrated improved post-intervention compliance with interpersonal standards of counseling care (e.g. personal introduction by the provider, eye contact, ascertaining and answering patient questions). Likewise, pre and post-intervention assessment of client's satisfaction with maternal health counseling demonstrated improved client satisfaction and knowledge post intervention (Jennings, 2009). (www.hciproject.org)

The World Health Organization Department of Making Pregnancy Safer (MPS) has recently published a handbook for building skills for counseling for maternal and newborn healthcare. (http://www.who.int/making_pregnancy_safer/documents/9789241547628/en/index.html.)

Caring Behavior Interventions

As part of its five-year Skilled Care Initiative in Kenya, Burkina Faso and Tanzania, Family Care International implemented a "caring behavior" intervention to improve the interpersonal skills of maternal care providers. A community baseline qualitative assessment conducted in Kenya by FCI in collaboration with the CHANGE project demonstrated widespread user dissatisfaction with the interpersonal dimension of maternal care and helped to inform the caring behavior intervention. Based on those findings, FCI developed a Caring Behavior Module, which was integrated into the in-service training curriculum on Emergency Obstetric Care (EMOC) skills. This intervention was carried out in coordination with a broader set of interventions focused on upgrading infrastructure and supplies, strengthening communication and referral systems, promoting skilled care service utilization and improving clinical quality of maternal health care as part of the multi-country Skilled Care Initiative. The Caring Behavior Module "guides providers in assessing the 'caring' dimensions of the care provided to maternity clients. Providers used these observations to modify their daily practices so as to better accommodate maternity clients' preferences, while upholding clinical standards. The module emphasizes the benefits of compassionate care for both clients and providers (Family Care International, The Skilled Care Initiative, 2005).

The caring behavior training intervention is specifically aimed to improve providers' interpersonal skills to deliver compassionate childbirth care and to supplement a traditional focus on clinical care competence with a concomitant focus on interpersonal care competence. Competence-based interpersonal care training was integrated into ongoing clinical training using a multi-part training module developed by FCI that included four parts: 1. participatory provider exploration of the key dimensions of "caring behaviors"; 2. direct observation by providers of interpersonal dimensions of care in their service delivery setting; 3. participatory reflection on observed caring behaviors (or lack there-of) and consideration of action that could be undertaken to improve caring behaviors in their service setting, associated with practical exercises and role-plays; and 4. consideration of how providers might introduce proposed changes and action plan to colleagues (including supervisors) who had not participated in training.

While there was no formal assessment of the impact of the caring behavior intervention within the Skilled Care Initiative (see FCI website for a detailed evaluation of the broader initiative), the caring behavior training module was reportedly positively received by maternity

care providers (Family Care International, The Skilled Care Initiative, 2005). Maternity patients also noticed a difference in compassionate care at training sites and it was reported that in Kenya "maternity clients began to complain when the trainees were scheduled to go off duty at night because they perceived an appreciable difference in the way the trainees treated them, as compared to the regular hospital staff" (Family Care International, The Skilled Care Initiative, 2005). Efforts by FCI to integrate the caring behavior intervention into the national MOH maternal care clinical training program have not yet been successful for a variety of reasons.

Another intervention that was included in FCI's Skilled Care Initiative in Kenya, Burkina Faso and Tanzania, was the introduction of an adapted version of EngenderHealth's COPE for Maternal Health Services, a quality improvement approach, to include an added focus on the right to caring, compassionate care. This revised version COPE was introduced at district hospitals and mid-level health facilities (health centers and sub-district hospitals). The COPE process involved all staff in identifying gaps in the quality of care, as well as in identifying simple, low-cost measures that could be implemented at the health facility to strengthen attention to clients' rights and to improve the quality of care (Family Care International, The Skilled Care Initiative, 2005). The effect of the COPE intervention on compassionate care was not formally assessed.

A caring-based training program was implemented through the CARE project in Ayacuhco, Peru. The program was called FEMME (Foundations to Enhance Management of Maternal Emergencies) and was implemented with the assistance of AMDD. This training took place at a regional training office and lasted 15 days with on-call competence based training. Training was mostly clinical, focusing on the causes of maternal death, the treatment and prevention of postpartum hemorrhage but led to improved relationships between staff at different facilities. This in turn led to a better referral system and a more receptive, rather than hostile, environment for referrals (Kayongo et al., 2006).

Humanization of Childbirth/Cultural Adaptation of Childbirth

Humanization of Childbirth and Cultural Adaptation of Childbirth interventions may be viewed in the context of a broader maternal health and social movement in Latin America and the Caribbean over the past decade and a half. In the mid-1990's humanization of childbirth movements sprouted in multiple countries throughout the LAC region. The term "humanization", often used by activists in the region around issues of social justice, including by the Brazilian educator Paulo Freire, has been used in the context of childbirth to refer to a "woman-centered, nature-centered, appropriate technology approach to childbirth." Part of the impetus behind the humanization of childbirth movement in Latin America and the Caribbean has been the widespread reaction to the well-documented "medicalization of childbirth," illustrated by soaring rates of cesarean sections in the region.

Cultural adaptation of childbirth interventions have often been implemented as part of Humanization of Childbirth interventions, but have tended to focus in particular on adapting maternal care to the needs and preferences of indigenous women in the LAC region who have traditionally been the object of significant stigma and discrimination in the institutional birth setting. In November 2002, the International Conference on the Humanization of childbirth was held in Brazil, supported by the *"Projeto Luz",* a five year humanization of childbirth project implemented in collaboration with the Japanese International Collaborative Agency (JICA). As a result of a workshop held at the International Conference on Humanization of Childbirth held in Brazil in 2000, the Latin American and Caribbean network for Humanization of Childbirth

was formed (Onuki, 2002). Through this organization, people and groups are able to exchange information and experiences in order to promote humanization of childbirth (http://www.relacahupan.com).

Misago et al. define humanization of childbirth care as having the following attributes: "is fulfilling and empowering both to women and their care providers; promotes the active participation of women in all aspects of their own care; is provided by physicians and non-physicians working together as equals; is evidence-based, including use of evidence-based technology; is located with a decentralized system of birth attendees and institutions with high priority to community-based primary care; is financially feasible as indicated by a cost-benefit analysis" (Misago et al., 2001). Empathetic support by providers, women's choice of birth companion and birthing position, freedom to move about and drink during labor are often cited as criteria of humanization of childbirth.

One of the earliest humanization of childbirth projects was implemented in five municipalities in the State of Ceara, Brazil, from 1997 to 2000, culminating in the International Conference on Humanization of Childbirth Care (mentioned above). A Rapid Anthropological Assessment was used to assess different aspects of childbirth before and after the intervention. Community and facility based data gathering using ten different instruments included interviews of mothers, men, birth attendants, physicians and other health professionals as well as independent observers. The intervention itself included seminars, workshops, in-service training and training of trainers focused on "humanization of childbirth" defined as a "safe and satisfied birthing experience". The results of the project were positive. Although there was no quantitative reporting of results, the authors state that after the intervention, health professionals showed greater self-esteem, commitment and team work. Women did not deliver alone anymore as they were encouraged to bring a family member or friend to the birthing area. Women were encouraged to use their preferred birthing position and there were less reported vaginal exams, and more monitoring of uterine contractions and fetal heartbeat. Women in general thought the labor room was more comfortable after the intervention, reporting "quiet ambience, relaxing music, adequate air conditioning and curtains that separated each bed". To our knowledge, the intervention did not directly assess women's perceptions of the interpersonal dimensions of care or formally assess "disrespectful care at birth" as a separate construct (Misago et al., 2001).

The 2007 UNICEF maternal health program in Peru focused on the cultural adaptation of maternity services to eliminate cultural barriers between the health care providers and other staff at health facilities and mothers who have deeply rooted cultural traditions with respect to childbirth (UNICEF, 2007). Results have shown that taking this type of intercultural approach to obstetric care increases the coverage of institutional obstetric services, reduces maternal and perinatal mortality, and establishes a more gratifying relationship between the service provider and the user.

Both FCI and URC (Quality Assurance Project/Health Care Improvement Project & Ecuador Child Survival Project) have been implementing cultural adaptation of childbirth interventions in the LAC region. In Ecuador, FCI and HCI have collaborated with the MOH, UNFPA, and the indigenous organization CONAMU to adapt cultural responsiveness of maternal health services in Ecuador. The cultural adaptation intervention has included participatory workshops with health workers, traditional birth attendants, users of the maternal health services and community members to develop recommendations about specific changes to improve cultural responsiveness of facility maternal care services. In some regions, quality improvement teams consisting of users and providers have worked collaboratively to make

changes to facility-based maternal care services, such as choice of birthing position, choice of birth companion, consumption of traditional foods during childbirth, etc. The positive results of the Ecuador adaptation of cultural care collaborative intervention have been expanded throughout Ecuador and have been summarized in a document on humanization and cultural adaption of childbirth issued by the Ecuador MOH (Ministerio de Salud Pública del Ecuador, 2007). A report published by URC on a formal evaluation of the "Humanization and Cultural Competence of Delivery Services in Ecuador" (URC, 2008) demonstrated an increase in client satisfaction for many measures. Assessment of the effect of the intervention on interpersonal dimensions of provider-client interactions was more difficult to assess and less positive. In collaboration with local civil society organizations, FCI is currently adapting these tools and methodology to use in indigenous communities in two Bolivian districts (Pando and Beni).

A recent publication from Japan that assesses barriers and facilitators of "humanization of childbirth" in Japan found that "restricting the presence of a birth companion was one of the most important barriers to a humanized birth while the main facilitators were the women's own cultural values and beliefs in a natural birth, and institutional strategies designed to prevent unnecessary medical interventions" (Behruzi et al., 2010). Although Japan has been rated as one of the best places to deliver a baby and has one of the lowest infant mortality rates in the world, the Japanese government is highly supportive of initiatives to improve the maternal health care system by lowering the number of cesarean sections and implementing the "humanization of birth practice" (Behruzi et al., 2010). The Japanese government has been collaborating with other countries to implement the humanization of birth practice (i.e. Brazil) and also offers training for midwives from developing countries to undergo training in Japanese birthing facilities.

Health Workers as Change Agents

The literature includes descriptions of two participatory approaches that targeted maternal health providers as change agents for achieving higher levels of respectful care at birth.

Health Workers for Change was a project developed in the mid 1990's by the UNDP, the World Bank, the WHO Special Program for Research and Training in Tropical Diseases and the Women's Health Project Department of Community Health, University of the Witwatersrand. It is based on a participatory continuous training methodology for health workers that take health workers through a process of identifying and analyzing problems that providers and patients face and proposing provider-led solutions and action plans to address identified problems. The focus of the training workshops is on women health care workers. The workshops focus on some of the main health system drivers of abusive maternal care described in earlier sections of this report: poor management and referral systems, badly trained and demoralized staff, too little equipment and too few supplies. The first workshop was conducted in a health center in the rural part of South Africa (S. Fonn & Xaba, 1995). The main methodology of this approach is "problem posing" which focuses on presenting back to the health care worker what is going on at the health facility and having them analyze it (S. Fonn & Xaba, 2001). Each workshop focuses on a separate topic such as: choice of occupation, health workers' perceptions of their clients' perceptions, health workers' perceptions of women and women's health problems, work organization, identifying and ranking helps and hindrances in doing their jobs (S. Fonn & Xaba, 2001) (S. Fonn et al., 2001). An assessment of the Health Worker for Change project in seven settings (six sites in Africa: two in Nigeria, two in Tanzania, one in Ghana, one in Kenya, and

one site in Argentina) indicated that the workshops improved provider–client relations, facility level functioning and aspects of staff interrelationships, and had some impact at the system level (Onyango-Ouma et al., 2001).

The 5-day FIGO ALARM emergency obstetrical care training curriculum, developed by the Canada Society of Obstetrics and Gynecology, and implemented in numerous countries includes a one-day training component devoted to Sexual and Reproductive Health Rights (SRHR). In Ukraine, the ALARM training intervention was implemented under the leadership of Dr. Irina Magilevkina with Ukrainian mid-wives and obstetricians-gynecologists. The Ukrainian team adapted the traditional 5-day training to integrate a focus on SRHR throughout the 5-day training, so that essential service components of an SRHR framework such as a patient's right to privacy, informed consent, decision-making, confidentiality, and a companion in labor were actively integrated into all aspects of clinical training. Providers actively participated in a self-assessment of compliance with SRHR standards in their service setting, and then participated in numerous role-plays in which they took turns playing the role of patient and provider. Finally, participants developed an implementation plan that prioritized changes they could test and introduce in their facilities to achieve better compliance with SRHR standards such as informed consent and decision-making. The results of this training intervention will be published in a forthcoming WHO publication (Mogilevkina et al., forthcoming 2010). In a region in which providers traditionally hold significant power for all decision-making with extremely limited legal liability mechanisms, the training intervention represented a promising approach for raising awareness among providers of patient rights and of practical changes that they could make to introduce change. A follow-on implementation phase is hoped for to reinforce the impact of the ALARM training intervention in Ukraine.

Accountability Mechanisms

A central factor at the core of addressing disrespectful care at birth is the unequal relationship between the skilled provider and the woman giving birth. Beyond the inherent biological vulnerability for women at the time of childbirth, the differences in provider and client access to power and decision-making at this vulnerable moment for women giving birth are often greatly accentuated by the different status of provider and patient with regard to educational, wealth, ethnic/racial status and other social constructs. Many would argue that it is impossible to effectively address maternal health care abuses without directly assessing the inequities in power between the maternal health provider and the woman giving birth.

Accountability measures have been explored as an approach for promoting more respectful care at birth and for reducing abusive care. Asha George (2003) defines accountability as "a moderator or referee of the dynamics in two-way relationships, e.g. between service providers and patients…….accountability measures typically mediate relationships between unequal partners with the aim of redressing the imbalances between them" (George, 2003).

Based on the literature, accountability approaches or oversight in the health care sector can be grouped into several categories. Administrative and bureaucratic approaches are those in which public agencies impose rules that are legally enforced (e.g. medical councils, penal codes, tort laws). The challenge is that often such laws are ineffectively implemented and enforced. Patient oriented approaches may focus on mechanisms that help patients to choose their own providers and voice opinions on quality of services. A consumer forum, for example, can be

created to handle patient/physician disputes. Collaborative approaches in which services and regulation of these services are shared and organized among government and civil society structures represent another accountability implementation approach (Peters & Muraleedharan, 2008). In India, for example, a group of women called the Self-Employed Women's Association (SEWA) provides health insurance schemes for its own members. Some of the most effective accountability approaches involve civil society organizations, the media and provider organizations that can most effectively inform the public on the quality of health services (G. Bloom & Standing, 2008).

Other accountability approaches stipulate and enforce desired standards of care, describing what doctors, hospitals, and health providers ought to offer patients. This type of accountability might include for example posting a bill of rights on the wall of a health facility, using suggestion boxes, or allowing for concrete mechanisms to file complaints on the part of the patient. Performance-based contracts and mechanisms through which providers can report non-compliance with standards on the part of peer providers represent another approach to promoting accountability.

A project in Andhra Pradesh, India used communication between providers and lower caste women to improve the accountability of the system. Mahila arogya sanghas (women's health groups) were trained in empowerment, self-esteem and bargaining skills with a specific focus on health. Each sangha was identified by the local government doctor and the community when they finished the training with an identification badge. The sangha women then became responsible for accompanying women with obstructed labor to the government hospital in the middle of the night. With the use of their badges they were allowed to pass after initially being forbidden from entering the hospital grounds. After the nurse examined the badge, the nurse went looking for the doctor after she initially told the sangha and the woman that the doctor was not available. Sanghas in other areas of India have reported that "when they accompany poor women to the health centre, their collective presence inhibits health workers from asking for informal payment" (George, 2003).

Other accountability approaches focus on promoting improved monitoring and surveillance of maternal mortality and morbidity in conjunction with interventions such as audits. In India, although registration of births and deaths is mandatory, only 48% of deaths are registered (Human Rights Watch, 2010). Audits of maternal deaths are being used to monitor the causes of death and to hold health services accountable. In Indonesia, for example, maternal-perinatal audits of difficult cases have been introduced at the district level. This was intended to be used as a learning tool and not as a "corrective activity". In some cases, improved monitoring linked to audits may generate resistance among providers who fear reprisal (George, 2003, Geefhuysen, 1999). In Brazil, for example, in conducting a study on humanization of childbirth, the team found a number of deaths that had been reported at the community level but not to the Municipality (Misago et al., 2001). One of the primary recommendations of Amnesty's International's report on the maternal health care crisis in the US is to establish a national maternal mortality surveillance system in the US (Amnesty International, 2010).

Human Rights Framework Interventions

The FEMME project in Peru, implemented through CARE and Averting Maternal Death and Disability (AMDD), used a rights-based framework to support quality improvements and increased access to services. This approach focused on initiatives to provide non-discriminatory

services to local cultures. Signs were posted at health facilities, in different languages, on availability of services. Other services provided based on women's preferences were birthing chairs that allowed for different birthing positions, curtains to ensure privacy, availability of food served cold or warm, and name tags on each bed so that the provider referred to each woman by name. This rights based approach made the services more "client-centered" and "empowered the community to demand that the health system be accountable to the people it serves" (Kayongo et al., 2006).

During the Skilled Care Initiative, FCI modified the COPE tool to include a section on patient rights to compassionate care.

The WHO's Department of Reproductive Health and Research and the Harvard School of Public Health's Program on International Health and Human Rights has developed a tool that assesses a country's human rights commitments alongside legal/policy and public health data to reveal discrepancies and gaps between their commitments and their health outcomes. This tool has been field tested in a number of countries and adapted to conduct analyses related to maternal and newborn health, sexual and reproductive health as well as adolescent sexual and reproductive health (Cottingham et al., 2010). The tool helps the analyst first assess which international and regional human rights treaties the country has ratified, along with relevant reports, human rights consensus documents, and concluding observations or comments by treaty monitoring bodies. Next, relevant human rights principles related to the specific topic are identified and assessed in terms of the country's national laws and policies. Finally, data related to the core health issues associated with the topic are gathered to assess how the country is meeting health outcomes related to human rights commitments.

The recently launched International Initiative on Maternal Mortality and Human Rights (IIMMHR) (http://righttomaternalhealth.org/) has funded several modest human rights maternal health interventions in India, Kenya, and Peru. This is a first civil society human rights effort to reduce maternal mortality. It is a partnership of international, regional, and national civil society organizations committed to a comprehensive human rights approach to reduce maternal mortality. The effort is governed by a steering committee that includes membership from the Averting Maternal Death and Disability Program at Columbia University, Family Care International, and Center for Reproductive Rights to name a few. Final reports of the human rights maternal health country interventions supported by IIMMHR may yield lessons and examples of promising approaches for further consideration, including a recently completed intervention by FCI in Kenya and an ongoing intervention by CARE in Peru.

The project in Kenya was called the "Right to Care" and used a human rights approach to increase accountability to inform and engage rights holders in ensuring maternal survival. In order to better understand the relationship between national policy and international human rights documents, FCI through the IIMMHR project in Kenya, developed a "Rights Matrix". The matrix creates a link between the Kenya Ministry of Health Service Charter and the international and regional human rights instruments in order to promote acceptance of human rights within the health system. The matrix has also increased accountability of health workers in terms of human rights related to maternal health (Family Care International, 2010).

The project in Peru was called "No Woman Behind" and also used a human rights approach to strengthen the capacities of local civil society networks in order to improve maternal health and increase the knowledge and understanding of women's health rights, specifically for poor, rural women.

IMMHR organized a one day event in Geneva in September 2010, titled "Maternal Mortality, Human Rights and Accountability." Also in September 2010, CRR is organizing a one-day meeting in Geneva, funded by UNFPA, on maternal mortality for regional and global human rights treaty-body experts.

Two of the most recent fact finding interventions/missions by Center for Reproductive Rights are included under Human Rights Interventions, although they also could be included under accountability. These two reports focus on violations of abuses of HIV positive women in Chile and legal and accountability strategies for maternal health in India.

Legal Interventions/Approaches

FCI has begun several initiatives in Ecuador focused on legal approaches to ensuring health services for women. First, FCI and the National Council of Women (CONAMU) created a document that is meant to serve as a guide to guarantee the maternal and child rights that are outlined in the law (Benavides Llerena et al., 2007). Second, FCI and the CONAMU also developed a guide to strengthen the User Committees in order to help raise awareness within communities about legal rights and to provide the community with tools to monitor maternal health care services. Third, FCI recently completed a set of guidelines to explain the procedures for filing claims in the case that a woman's right to quality health care has been violated. http://www.familycareintl.org/en/places/13

An interesting example of how certain health facilities are bridging legal services and health services are health facilities that have lawyer on their staff. This allows patients of the health facility to receive regular health services and then if they and/or their provider feel they need legal services as well they can be referred directly to the lawyer on staff. This new service has been used in the United States and is being attempted in some health facilities internationally and is addressing issues of domestic violence and other claims. This model could also be utilized to deal with disrespectful care at birth.

Several recent legal interventions/activities by the Center for Reproductive Rights are included under Legal Interventions/Approaches, although they also could be classified under Human Rights Interventions. These legal approaches describe cases that have been filed before human rights bodies and the Kenyan Court for violations against women in health care facilities in Chile, Brazil and Kenya. Public interest or strategic litigation can be used to raise awareness of and hold governments accountable for widespread, systemic violations in healthcare facilities.

HIV/AIDS Stigma Reduction

There have been several successful interventions to reduce stigma from HIV/AIDS. For example, Uys et al. (2009) use a case study approach, combined with pre and post intervention measurement of HIV stigma, to explore HIV/AIDS stigma interventions in five African health care facilities. The intervention consisted of bringing together a team of approximately 10 nurses and 10 people living with HIV or AIDS (PLHA) in each setting and facilitating a process in which they planned and implemented a stigma reduction intervention, involving both information giving and empowerment. Questionnaires were completed by nurses and patients before and after each intervention. The results showed that the intervention was well received in each country and created momentum for continued activities among both PLHA communities, and nurses. Positive results in terms of decreased feelings of stigma were demonstrated with

PLHA. However, there was not much change observed in nurse stigma, measured as nurse's stigmatizing behavior to patients as well as community stigmatizing behavior to nurses.

Another study conducted an in depth assessment of HIV/AIDS stigma in Nigeria (Reis et al., 2005). The main purpose of the study was to describe health-care professional practices and attitudes towards people with HIV/AIDS. The study was conducted in four cities of Nigeria. The sample included doctors, nurses, and midwives from tertiary facilities, public and private secondary and primary health-care facilities, with a sample size of about 1000 in each location. They used a 104-item health-care professional survey that included questions on respondent demographics; practices regarding informed consent, testing, and disclosure; treatment and care of patients with HIV/AIDS; and attitudes and beliefs about treatment and care of patients with HIV/AIDS including informed consent, testing, and disclosure. The study also surveyed patients. The main results showed that there is a high level of stigma of HIV/AIDS patients in Nigeria. They found that 9% of professionals had refused care for an HIV/AIDS patient; 59% agreed that people with HIV/AIDS should be on a separate ward; 40% believed a person's HIV status could be determined by his or her appearance; 20% agreed that many with HIV/AIDS behaved immorally and deserve the disease.

The World Bank just published a report that reviews the level of success of 26 interventions addressing HIV/AIDS stigma and discrimination in South Asia. Although none of the interventions focus specifically on women in a health care delivery setting, the lessons learned from the interventions focusing on other stigmatized groups (men having sex with men, female sex workers etc.) can be used in planning interventions to eliminate stigma from HIV/AIDS in the birth setting (World Bank, 2010).

Another study in Nigeria conducted a longitudinal randomized controlled trial examining how training of health professionals impacts stigma against patients with HIV/AIDS. Training took place in health care facilities in intervention and control states in Nigeria and the training included clinical management, health education, as well as training on changing attitudes toward people with HIV. The results were positive post intervention showing more willingness to treat HIV, less fear and discrimination, and increased understanding of clinical, psychosocial, and human rights issues in intervention as opposed to control areas (Ezedinachi et al., 2002).

UNAID conducted a qualitative, information-gathering study in India and Uganda on the topic of determinants of HIV/AIDS related stigmatization, discrimination and denial. They found that the type of stigma was related to culture, perceived stigma, finances and gender (UNAIDS, 2000).

Tools for Measurement of Respectful Care at Birth

The CHANGE Project (AED, Manoff Group) developed a number of tools that were used in Kenya, Guinea and Bangladesh to assess behaviors of midwives and other skilled providers during labor and delivery in the health facility setting. Tools were developed and adapted to each country setting to understand provider-client behaviors, provider-provider behaviors, and provider-community behaviors. The provider-client tool, for example, assesses provider-client behaviors based on seven different dimensions of caring behavior including: attend to physical needs; be accessible to clients; attend to emotional needs; respect human dignity/ rights; inform/explain/instruct; involve family; incorporate cultural context. Data collection methods include an observational instrument, a provider self-assessment, a provider focus group discussion guide and a patient exit interview guide. As mentioned in the Providing Skilled Care Summary (CHANGE Project, 2005) these tools could be used to design strategies and interventions to improve the behaviors of health care providers during labor and delivery, to design pre-service and in-service training curricula for midwives and other health care providers, and to assess the extent of disrespectful care at birth.

Indeed, Family Care International in their Gates-funded Skilled Care Initiative in Burkina Faso, Tanzania and Kenya used and adapted the CHANGE tools as part of an intervention to improve caring behavior among providers (Family Care International, The Skilled Care Initiative, 2005). FCI adapted the tools for the development of a multi-part training module (described in greater detail under the Caring Behavior intervention).

These assessment and training tools, developed by the Change Team and FCI, could be re-examined to determine their relevance for future interventions in this area.

A team in Norway, the Nordic research network NorVold, constructed a questionnaire, NorAQ, to measure several constructs, one of which was abuse in health care (AHC). The questionnaire was tested and validated in five Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden). The sample population was women aged 18-64 years old. The questions related to abuse are the following: 1) Mild abuse: Have you ever felt offended or grossly degraded while visiting health services, felt that someone exercised blackmail against you or did not show respect for your opinion – in such a way that you were later disturbed by or suffered from the experience? 2) Moderate abuse: Have you ever experienced that a 'normal' event, while visiting health services, suddenly became a really terrible and insulting experience, without you fully knowing how this could happen? and 3) Severe abuse: Have you experienced anybody in health service purposely – as you understood – hurting you physically or mentally, grossly violating you or using your body to your disadvantage for his/her own purpose? Using this survey, rates of abuse in health care in the five Nordic countries ranged from 13-28%.

Population-based and facility-based patient exit interviews are another type of measurement method that can be used to assess disrespect and abuse in childbirth. Exit interviews have been used in a number of health care settings to measure the patient's perception of the content of care received, including interpersonal and cultural dimensions of care. There are several examples of exit interviews used with women to assess their experiences during labor and delivery. The Change Project used exit interviews to interview both the patient and her family as they left labor and delivery units in both Bangladesh and Kenya. The tools used for the exit interviews in each of these countries are available, however the results of these exit interviews could not be found. Exit interviews have been used in the USAID/URC maternal newborn collaborative to evaluate and inform interventions to improve maternal and newborn

care counseling in Benin (2009). The results show that quality of counseling with skilled care providers improved after the intervention as well as maternal knowledge about the birthing process. Maternal knowledge was measured through patient exit interviews across topic areas relating to maternal and newborn care. The proportion of women recalling at least three messages on birth preparedness, danger sign recognition, and healthy home practices increased (Jennings, 2009). Family Health Options Kenya (FHOK), an NGO, also uses exit interviews with patients in its own facility where they select one out of 15 patients to measure satisfaction with the services received (Center for Reproductive Rights & Federation of Women Lawyers-- Kenya (FIDA), 2007). The Reproductive Health Response in Conflict Consortium provides an overview of patient exit interviews and some sample surveys for exit interviews that may be useful to reference (Reproductive Health Response in Conflict Consortium, 2004).

Gaps in the Evidence

The final section of this report reviews several identified gaps in the evidence around respectful care at birth.

Lack of an operational definition, validated measurement method(s) and prevalence estimate

The report reviews a large number of studies from a wide range of countries. The evidence reviewed, however, does not include a validated measurement method for assessing disrespect in facility-based childbirth and does not provide a prevalence estimate. The one study that attempted to measure the level of abuse in health facilities measured prevalence levels of 13-28%, but did not focus on childbirth and was conducted in a high-resource setting, making the results poorly generalizable to disrespect in childbirth in resource-poor settings (Swahnberg et al., 2007).

Contributors to disrespect and abuse in childbirth

Several categories of likely contributors to disrespect and abuse in childbirth based on a review of the evidence are highlighted in the schematic in Table 2. However, to our knowledge there has been no published systematic evaluation and analysis of the relative contribution and specific mechanisms by which different drivers may contribute to the problem, including the interaction between specific types of drivers.

For example, most interviewees asserted that the effects of provider training and provider demoralization due to working in highly constrained health systems act as important contributor to disrespect perpetrated by providers. But there has been little formal investigation of this complex area to highlight how and to what degree different types of training, supervision and health service delivery constraints may drive disrespect in facility-based childbirth.

Another driver category for which there are important gaps in the evidence concerns the effect of a lack of accountability interventions such as legal redress, patient charters, etc. on the incidence of disrespect in childbirth. An in-depth review of the literature on accountability mechanisms in middle and high income countries, such as patient charters and provider professional regulatory mechanisms (e.g. licensure maintenance protocols) might yield useful insights, although the generalizability of such mechanisms might be constrained by context specific health care, legal and political factors.

Impact of disrespect and abuse in facility-based childbirth on skilled birth care utilization

While there is increasing evidence to support the importance of disrespect as a deterrent to skilled care utilization, the specific ways in which disrespect may act as a deterrent to skilled care utilization and the relative contribution of different categories of disrespect to lack of skilled care utilization represents an important gap in the evidence that has direct implications for the global strategy for increasing skilled maternal care coverage to achieve MDG-5.

Impact of intervention approaches on promotion of respectful and non-abusive birth care

There is a general lack of studies that rigorously evaluate the impact of interventions designed to reduce disrespect and abuse or promote respectful birth care. While this report extrapolates from impact studies in related areas such as HIV stigma reduction studies, impact studies that rigorously evaluate interventions to improve respect or reduce disrespect and abuse in childbirth are relatively rare in the literature. There is an urgent need in light of the evidence presented in this report for impact studies that can build the evidence base for effective interventions to promote respectful care at birth and reduce disrespect and abuse in facility-based childbirth. It is unlikely that the global community can achieve MDG 5 goals for skilled care coverage if it does not address the impact of disrespect and abuse in facility-based childbirth.

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Annexes

Annex A. List of individuals interviewed

Informants interviewed:
1.   Lynn Freedman, J.D., M.P.H., Director of Averting Maternal Death and Disability (AMDD), Columbia University (Human Rights/Maternal Health expert)

2. Asha George,   UNICEF, NYC (Accountability and Maternal Health; extensively published)

3. Kathleen McFarland, M.S., Senior Progam Officer, Anglophone Africa Program, Family Care International

4. Iryna Mogilevkina, Professor, Department of Obstetrics, Gynaecology and Perinatology, Donetsk National Medical University, Ukraine,(Ukraine and SOGC ALARM project; combined human rights/emergengcy obstetric care training program implemented in Ukraine)

5. Alma Camacho, MD, MPH. Medical Officer, Sexual and Reproductive Health, CAH/ADH, WHO, Geneval (LAC region "Humanization of Childbirth")

6. Lamia Mehmood, Federal Ministry of Health of Sudan, Head of the National Reproductive Health Program in the North (FGD Women Deliver)

7. Angela Mutunga, FCI Kenya (FGD Women Deliver)

8. Sofia Gruskin, Associate Professor of Health and Human Rights, Director of the Program on International Health and Human Rights, Department of Global Health and Population, Harvard School of Public Health (informal information gathering with Diana Bowser specifically on human rights)

9. Jorge Hermida, M.D. Director LAC region Health Care Improvement project (Humanization of Childbirth Care/Cultural adaptation of care in Ecuador.)