

**PREVENTION AND ELIMINATION
OF MISTREATMENT OF WOMEN
DURING CHILDBIRTH IN HEALTH FACILITIES**

Project submitted in partial fulfilment of
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Abstract

Emerging evidence clearly shows that women worldwide experience disrespect and abuse during facility-based childbirth. Until recently disrespect and abuse of women during facility-based childbirth was not clearly defined and often even not recognized in different contexts and cultures. Nowadays mistreatment, disrespect and abuse or neglectful treatment have been identified by the WHO as factors preventing women from seeking and using maternal health care services. While most of the available literature focused on the identification of cases of mistreatment and quantification of prevalence in different settings, several studies provided revealing examples of implemented interventions to prevent and eliminate disrespect and abuse during facility-based childbirth. This capstone project serves as a starting point for a discussion on interventions focused specifically on prevention and elimination of disrespect and abuse of women during childbirth in health facilities. This paper will review the emerging evidence on the international and the national levels, identifying promising practices to lessen disrespect and abuse of women during childbirth in health facilities. The purpose of the capstone project is (1) to explore D&A definitions, (2) describe existing international guidelines and frameworks that inform environment to prevent D&A and (3) then to describe interventions explicitly focused on reducing incidence of D & A within particular health sites.

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Introduction

Maternal mortality: achievements, failures and further steps

Approximately 830 women die every day primarily in middle- and low-income countries as a result of pregnancy, delivery and post-delivery complications that could have been prevented (WHO, 2016a). To reduce maternal mortality, the Millennium Development Goal 5 (MDG 5) was established in 2000 with the goal of providing a framework for improvement of maternal health as well as achieving universal access to sexual and reproductive health. Since then, the global maternal mortality ratio has significantly decreased; however, only nine countries were able to achieve the MDG target, a 75% reduction in maternal mortality (Koblinsky et al., 2016).

The revision of MDG achievements and establishment of new targets for the Sustainable Development Goals brought forward an important discussion on the quality of maternity services globally. The number of skilled maternity services around the world increased substantially during the new millennium. Nevertheless, a crucial gap in quality maternity care has meant millions of women currently suffer from services that are “neglectful, abusive, and disrespectful” (Bohren et al., 2015, p. 1). To achieve progress in the subsequent target set in the Sustainable Development Goals – the reduction of the maternal mortality ratio to less than 70 per 100,000 live births globally – there is an urgent need to promote “respectful, evidence-based maternal care” (Miller et al., 2016, p. 1).

Disrespect and abuse of women during child delivery in health facilities

Mistreatment, disrespect, abuse or neglectful treatment have been identified by the WHO as factors preventing women from seeking and using maternal health care services (WHO, 2015). Building discussions on growing body of D&A research by Bowser and Hill (2010), Freedman et al (2014), and Bohren et al (2014), the WHO

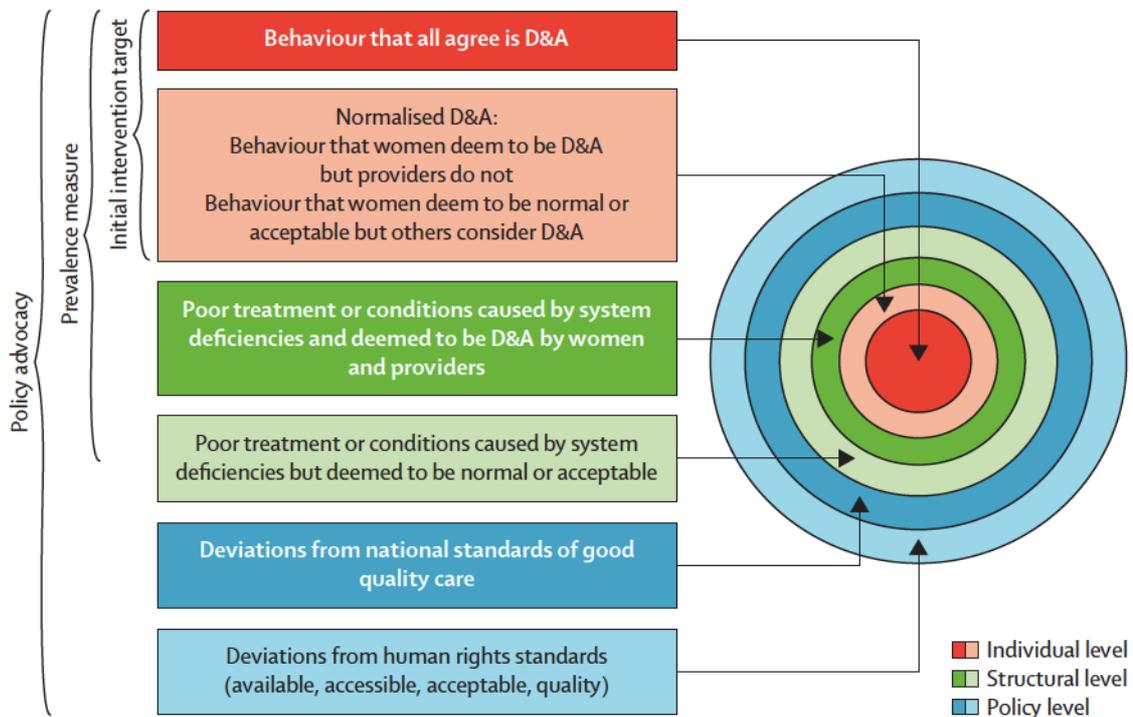
highlights the right of every woman to dignified and respectful care (WHO, 2015). The WHO brought attention of governments, UN agencies, national, international organizations, and research institutions working in maternal health to the gap in understanding the issue of respectful maternal care as well as the need to find effective strategies that can prevent and eliminate disrespect and abuse (WHO, 2015). Importantly, the WHO statement (2015) has become an entry point for a broad discussions of respectful maternal care globally and has catalyzed efforts directed towards the prevention of mistreatment of women during childbirth.

Emerging evidence clearly shows that women worldwide experience disrespect and abuse during facility-based childbirth (Bohren et al, 2014; Silal et al., 2012; d'Oliveira et al., 2002; Small et al., 2002, Sando et al., 2016, Vocaflor, 2016; Pittman et al., 2011). While the global D&A prevalence is not clear, research shows that for example, in selected hospitals in Kenya, 20% of women have experienced at least one form of disrespect and abuse, and in Tanzania - as much as 70% of women have been mistreated (Abuya et al., 2015b). Moreover, the disrespect and abuse phenomenon is not restricted to low- and middle-income countries only, but is also seen in countries like Canada and the United States of America (Bohren at al., 2014; Diaz-Tello, 2016).

Until recently disrespect and abuse of women during childbirth was not clearly defined and often even not recognized in different contexts and cultures. Discussion on potential contributors to mistreatment started in a landscape analysis done Bowser and Hill (2010). Although Bowser and Hill (2010) played an important role in developing D&A as a substantive area by describing phenomenon and categorize different forms of D&A, this early work did not clearly define D&A. Importantly, a definition of D&A identifies criteria that conditions or situations should meet in order to

be identified as disrespectful and/or abusive. A strong definition plays a critical role in being able to collect evidence of D & A across different cultures and contexts, enabling consistent measurement of D&A crucial for measuring D&A prevalence. Freedman et al (2014) defined disrespect and abuse as “interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified” (Freedman et. al., 2014: p. 916). Freedman et al’s work (2014) resulted in definitional framework identifying several building blocks of D&A (refer to Figure 1). Each building blocks help us to understand different dimensions of D&A. The first addresses D & A at the individual level and covers a list of observable actions and behaviors that everyone in society considers to be D&A as well as actions that are experienced by women, but not always recognized as D&A due to cultural or legal reasons. Another building block identifies contributions to D&A at a structural level including system deficiencies that cause intentional inflictions of mistreatment by commission or omission, and policies that address facility conditions and services yet do not meet standards set by human rights and national laws and policies. The definition developed by Freedman et al (2014) help us to understand the main drivers of D&A by identifying situations and behavior that result in mistreatment. The definition also set up different levels identifying intervention to decrease the incidence of D&A, to measures the D&A prevalence, and advocate for policy change.

Figure 1. Definition of disrespectful and abusive treatment (D&A) of women in childbirth. Source: Freedman & Kruk, 2014



In addition to finding a shared definition of D & A, other teams have been working on creating typologies. Bowser and Hill (2010) presented an early attempt to typologize categories of disrespect and abuse through interviews and a scoping review of the literature, but had some limitations in its research methods with no systematic searches and synthesis methodology employed. According to Bohren et al (2015) several measurements studied that have been based on Bowser and Hill typology used different definitions and those variations “may have contributed to the substantial differences in estimates of prevalence, preventing meaningful meta-analysis” Bohren et al., 2015 p.

To develop an evidence-based typology of the D&A, Bohren et al (2015) conducted a systematic literature review. Ultimately, they identified 7 types of D & A including physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and poor health system conditions and constraints. A more thorough description of

this typology is provided in Appendix 1. The development of an evidence-based typology is important to measure and document D&A, as well as for development, implementation and evaluation of intervention directed to prevention and eliminating of D&A

Project purpose and objectives.

This capstone project serves as a starting point for a discussion on interventions focused specifically on prevention and elimination of disrespect and abuse of women during childbirth in health facilities. The purpose of the capstone project is (1) to explore D&A definitions, (2) describe existing international guidelines and frameworks that inform environment to prevent D&A and (3) then to describe interventions explicitly focused on reducing incidence of D & A within particular health sites.

The specific objectives are as follows:

1. To explore the definitions of disrespect and abuse presented in the literature
2. To review published evidence on existing international guidelines and frameworks for D&A prevention and elimination
3. To review interventions and develop further recommendations for different levels on prevention and elimination of mistreatment of women during childbirth.

Methods

The primary method for this capstone project is a literature review focused on peer-reviewed articles published in academic journals between 2000 to 2017. However, taking into account that the issue is relatively new and lacking academic research, gray literature including governmental reports, reports of international organizations and NGO's was used to augment the literature review. The aim of the

review was to find emerging evidence that embraces interventions specifically aimed at preventing and eliminating D&A during facility-based childbirth.

A comprehensive search strategy was employed in consultation with the SFU Health Sciences Liaison Librarian. The search was undertaken in Medline (EBSCOhost) and Medline (Pubmed), Web of Science, Cochrane Database of Systematic Reviews, and Global Health to identify qualitative and quantitative research studies and implementation reports published from 2000 to 2017, which addressed prevention and elimination of mistreatment of women during childbirth worldwide. The initial search used general search terms (“mistreatment of women during childbirth in health facilities”), followed by a search using the MeSH terms “mistreatment,” “Delivery, Obstetric” AND “Violence,” “Disrespect” AND “Abuse.” A modified search was implemented with the words “disrespect” and abuse” AND “childbirth” AND “health facilities.” Only English language documents were reviewed. Studies were included as relevant if they reported on the definition of D&A, implemented activities and prevention strategies, evaluation of prevention activities on different levels, or provided recommendations, policies, or strategies on respectful maternal care. To identify relevant gray literature, the exact phrase “disrespect and abuse of women during childbirth” as searched in Google Scholar. These strategies resulted in 143 peer-reviewed articles and 38 grey literature documents. All titles and abstracts were screened and 85 articles and documents appeared to meet inclusion criteria. A full text review of these 85 documents resulted in 29 meeting inclusion criteria for analysis.

As D&A is a relatively new area it was important for this capstone project to arrive at a concrete understanding of the phenomenon and study existing definitions and typologies. Thus a major subset of included documents established a broad

definition and categorization of D&A, while the remainder of the documents concerned guidelines and frameworks and interventions employed to reduce and eliminate mistreatment. It is important to mention that there is lack of published studies on implemented interventions that specifically have targeted D&A. In fact, this capstone discuss two case studies that have been specifically tried to intervene D&A on different levels. The case studies are presented in this capstone paper in as much details as possible taking into account that those two case studies are fundamental for D&A interventions.

In order to organize interventions, the multi-level approach utilized was based on the definition developed by Freedman et al. (2014) who identifies three main levels – policy, structural and individual. Yet a review of the literature showed that initiatives were more neatly divided into the categories: “international” that covers the policy level, includes human rights and quality standards, and concerns interventions developed on international levels or guided by international documents; and “national” that pertains to poor treatment and conditions caused by the national health system and behavior of women and providers on an individual level. These two categories will subsequently be used to discuss results of the review.

Results: opportunities and strategies for prevention and elimination of D&A

While many articles examined for this capstone project focused on the identification of cases of mistreatment and quantification of prevalence in different settings, several studies provided revealing examples of implemented interventions to prevent and eliminate disrespect and abuse during facility-based childbirth. This section will review the emerging evidence on the international and the national level, identifying promising practices to lessen disrespect and abuse of women during

childbirth in health facilities. The section on the international level explores the possibilities in prevention and elimination of disrespect and abuse set by key international documents that were developed to provide guidance on quality of maternal care and frame respectful maternal care as a universal human right. The national level section analyses the results of interventions implemented specifically to address disrespect and abuse in health facilities in countries

International level – human rights, quality framework and guidelines

While there is emerging evidence on the prevalence and growing awareness of disrespect and abuse in many countries around the world, there is limited research on effective measures on prevention and elimination of mistreatment of women during childbirth in health facilities. Nevertheless, several fundamental documents have been recently developed that open so-called “window of opportunities” in this area. Firstly, the United Nations Technical Guidance on right-based approaches to maternal mortality and morbidity set policy frameworks to help policy makers on the application of a rights-based approach at every step of development and implementation of laws and regulations on maternal health (Yamin, 2013). Further, the World Health Organization Standards for improving the quality of maternal and newborn care in health facilities put respect and preservation of dignity of women and newborns as one of the standards of quality care (WHO, 2016). Lastly, the Guidelines for mother–baby friendly birthing facilities developed by the Safe Motherhood and Newborn Health (SMNH) Committee of the International Federation of Gynecology and Obstetrics (FIGO) promote multi-stakeholders involvement to improve quality of care and provide respectful maternal care in health facilities.

[Human rights-based approach to maternal mortality and morbidity to ensure respectful maternal care](#)

Several documents introduce a human right-based approach to health, and among others, the Technical Guidance of the UN Human Rights Council plays a critical role in supporting human rights of childbearing women. It provides guidance to a variety of stakeholders on practical implementation of protective measures at different levels of policies and programs (Yamin, 2013). The Technical Guidance emphasizes the responsibilities of states “to enable women to survive pregnancy and childbirth” (UN Human Rights Council, 2014, p.8). In addition to offering Guiding Principles, this document assists in the understanding of a human rights-based approach at every stage of policy and program making, and proposes addressing maternal mortality and morbidity problems “within the current societal framework” (UN Human Rights Council, 2014, p.8). First, a national health plan is a core obligation of the state. This plan remains critical to ensuring that populations have access to essential inputs needed to meet their right to health, for example, appropriate medicines and services available for delivery care (Yamin, 2013) In fact, in many countries, national policy and program planning processes often do not address women’s rights to high-quality and respectful services pertaining to sexual and reproductive health. HRC highlights the necessity of rights-based planning that examines the dominant assumptions underlying the “structural determinants of women’s health, and ... includes strategies to address those factors, to reshape the possibility frontier for advancing maternal health” (Human Rights Council, 2012, p.7).

Second, the Technical Guidance concerns the importance of health workers' rights and states while “any form of abuse, neglect or disrespect of health system users undermines their rights ... it is also true that health workers are rights-holders as much as duty-bearers” (Human Rights Council, 2012, p.14). This is key to understanding the institutional level of mistreatment where women may suffer a lack

of attention or poor treatment due to poor infrastructure or poor working conditions of medical providers. The document calls on states to ensure “adequate working conditions and treatment of health workers, including salary and benefits, disciplinary processes and voice, are necessary to respect their rights and, in turn, to promote health system effectiveness in addressing maternal mortality and morbidity” (Human Rights Council, 2012 p.14). Stressing the need of the workers’ rights is an important dimension that calls to address the root of the problem of mistreatment.

The Technical Guidance on right-based approaches to maternal mortality and morbidity creates a high-level policy framework addressing disrespect and abuse of women during childbirth in health facilities. The Guide clearly states that when women are not bestowed access to respectful care their human rights are violated. The human rights-based approach makes a significant difference for advocacy work and frames the possibility to urge governments around the world to set laws, policies, and programs accordingly and create necessary conditions for women to receive high-quality maternal care.

[World Health Organization standards of care](#)

WHO Standards for Improving Quality of Maternal and Newborn Care in Health Facilities not only clearly identify respectful maternal care as an essential part of quality services, but provide clear guidance for healthcare managers and medical providers on prevention of disrespect and abuse of women during childbirth. Unlike previous guidance and frameworks on maternal health (for example, Effective Perinatal Care, Making Pregnancy Safer) WHO Standards of Care include respect and preservation of dignity, in addition to emotional support and effective communication as experience of care, as a part of the framework of maternal and newborn healthcare. The WHO’s Standard 5 outlines the prevention and elimination

of disrespect and abuse during facility-based childbirth, and incorporates current D&A definitions and typologies. Standard 5 specifically discusses respect and abuse and observes that “any mistreatment, such as physical, sexual or verbal abuse, discrimination at all times, and, neglect, detainment, extortion or denial of services, should be avoided” (WHO, 2016, p 22).

The WHO’s Standard 5 is crucial both at the international level as a technical framework on disrespect and abuse, but also for setting a clear framework for health systems and health facilities in their defining of quality measures and outcomes. Clear quality measures create an enabling environment for provision of respectful maternal care in health faculties. Defined indicators provide a solid bases for facility-level changes to prevent and eliminate abusive and disrespectful care during childbirth.

[FIGO Guidelines for mother–baby friendly birthing facilities](#)

Another opportunity to address disrespect and abuse is the Initiative of the International Federation of Gynecology and Obstetrics (FIGO) on mother-baby friendly facilities that was approved by FIGO Board in 2014 to improve the quality of care and reduce abuse, neglect of women in health facilities (Lalonde & Miller, 2015). FIGO guidelines set ten criteria and ten sets of indicators to ensure that health facilities treat women with respect and dignity and provide evidence-based maternity care (Lalonde & Miller, 2015). Unlike WHO standards, the FIGO Initiative specifically targets health facilities and delves further into the identification of specific criteria for respectful maternal care. FIGO proposes an audit process to help health providers and managers identify weaknesses and to find ways to improve on those weaknesses. To contribute to continuous quality improvement the FIGO proposes an annual certification that includes a criterion-based audit of health facilities that provide maternal services. A certificate of “Mother and baby friendly facility” is granted to

clinical facilities that adhere to high-quality and rights-based maternal services. The annual audit and certification process is a powerful instrument of accountability that contributes to sustainable quality improvement. The FIGO certification not only will hold health managers and providers accountable but will support them in quality improvements. Undoubtedly, these improved conditions in health facilities will lead to better coverage of women by skilled birth attendance, reduction of health access inequities and improvement of delivery outcomes.

National level: policy, facility, community interventions

There are few studies that evaluate the effectiveness of interventions aimed to identify and mitigate main drivers of mistreatment of women. This part of the paper will focus on emerging evidence on prevention and elimination of disrespect and abuse in Kenya and Tanzania. There are several reasons to focus on these two cases from Africa. Firstly, these two identified interventions were implemented recently and specifically targeted the decreasing of disrespect and abuse during facility-based childbirth. As noted earlier, given the recentness of this topic, few interventions have been guided by the goal of decreasing D & A. Both of the case studies use the terms 'disrespect' and 'abuse' in accordance with recent research, which is presented at the beginning of this paper. Secondly, the packages of interventions have been developed and implemented to target different levels and covered all main stakeholders involved in maternal health and responsible for the quality of maternal services at the level of country. Both of the case studies are worthy examples of targeted interventions and provide evidence on the effectiveness of specific actions to prevent and eliminate disrespect and abuse of women during facility-based childbirth.

Case study 1. Kenya

As a response to the growing public concern and awareness at a policy level concerning the quality of maternal services and the need to address maternal mortality, the Heshima project was implemented from 2011 – 2014 in 13 health facilities in both rural and urban areas of Kenya. According to the Kenya Demographic and Health Survey (KDHS), maternal mortality in 2010 in Kenya was estimated at 488 deaths per 100 000 live births, and less than half of deliveries (43%) occurred in health facilities between 2005 and 2010 (Abuya et al., 2015). Despite the commitment of Kenya to increase skilled birth attendance as a part of MDG 5, from 2008 - 2009 there was a decrease reported (Warren et al., 2013). The overall goal of the Heshima project was “to conduct implementation research aimed at designing, testing, and evaluating novel approaches with the potential to significantly reduce disrespectful and abusive care of women during labor and delivery in facilities” (Warren et al., 2013, p.1). The project developed and implemented activities on the policy, facility and community levels.

At the policy level the Heshima project initiated dialogues that included engagement of government, civil society, and professional organizations in a critical discussion of D&A as a key component of quality of care. These dialogues linked the main actors involved in maternal health services and built “rapport and ownership” to reflect on disrespect and abuse (Abuya et al, 2015, p.2). The Heshima project was able to raise awareness on high political and decision making levels, among the country’s population, and also on the international level (Population Council, 2017). The project received significant press coverage and was presented at a number of international fora and conferences (Population Council, 2017).

Training on key aspects of respectful maternal care at the facility level, targeting both healthcare personnel and facility managers, was critical for forwarding

understandings of the issue (Abuya et al., 2015). D&A frequently reflects the poor conditions under which medical providers work every day, which are often related to poor management at the facility level. The involvement of health facilities management is critical to fomenting changes to the working environment that create increased dignity and respect for healthcare providers themselves. Another important element for orientation and training is addressing not only knowledge and skills but also individual attitudes toward disrespect and abuse – a difficult factor to change.

Abuya et al (2015) report on important steps taken to link health facilities with communities to strengthen accountability and governance of maternal services. Importantly, community members were trained on key respectful maternal health issues, as well as on communication techniques, as well as basic counseling. Along with facility and community level interventions, the Heshima project developed instruments that facilitated dialogue and conflict resolution among involved parties (Abuya et al., 2015). This particular mechanism encouraged women with negative experiences in deliveries to report abuse or disrespect. Enfranchising this process meant that a woman knew that she would be heard and that a meaningful effort would be undertaken to examine her case. It is important to note that resolution between a woman and a facility provider was achieved with the help of a “mutually-agreed mediator” (Abuya et al., 2015, p.2) who would respect a woman’s rights and not diminish her role in the process.

As a result of the interventions, the Heshima project reported improvements in disrespect and abuse prevalence at project sites. An overall 7% “absolute reduction in the prevalence of any feelings of humiliation or disrespect” was reported by women at their discharge with most sub-categories of D&A declining 40-50% (Abuya et al., 2015). According to Abuya unadjusted results for D&A typologies clearly

demonstrated the impact of the project in awareness raising and creating a safe environments, as women were less significantly less likely to report during the baseline on physical and verbal abuse, violation of confidentiality and detainment comparing to the same women participated in endline survey. Table 1 presented below demonstrates detailed results on prevalence that have been reported during baseline and endline surveys.

Table 1. Prevalence of reported disrespect and abuse during labor and delivery of maternity patients participating in baseline (2012) and endline (2014) surveys of the Heshima project in 13 facilities in Kenya, N = 1,369 (Source: Abuya et al., 2015)

	Baseline (N = 641)	Endline (N = 728)	OR (95 % CI) ^a	p-value ^b
	% (n)	% (n)		
Feeling humiliated or disrespected	20.1 (129)	13.2 (96)	0.58 (0.43 – 0.79)	0.0004
Physical abuse	4.2 (27)	2.1 (15)	0.47 (0.25 – 0.90)	0.024
Privacy violated	7.4 (47)	5.7 (41)	0.69 (0.44 – 1.08)	0.101
Confidentiality violated ^c	3.9 (25)	1.8 (13)	0.45 (0.23 – 0.89)	0.021
Verbal abuse	18.0 (115)	11.3 (82)	0.58 (0.42 – 0.80)	0.001
Detention	8.0 (51)	0.8 (6)	0.09 (0.04 – 0.22)	< .0001
Abandonment	12.7 (81)	16.9 (122)	1.28 (0.93 – 1.76)	0.124

The results suggest that comprehensive intervention strategies are needed on policy, facility, and community levels, with a particular focus not only on knowledge and skills, but also attitude, as the main drivers of disrespect and abuse. Importantly, the project demonstrates a comprehensive strategy that includes linkages between levels has the potential to reduce the number of D&A incidence in health facilities and influence the quality of maternal services (Abuya et al., 2015)

Case study 2. Tanzania

In 2013 – 2014 Tanzania introduced interventions directed at the reduction of disrespect and abuse in health facilities: such strategies included antenatal education for women and their families; training of healthcare providers with regard to patients' rights and birth preparedness; as well as measures to “increase and improve patient-provider and provider-administrator communication and improve women’s experience and provider attitudes” (Ratcliffe et al., 2016 p.1). Organized in three phases, the main

activities involved different level stakeholders and included a baseline study, implementation of selected interventions, Open Birth Days for women and Respectful Maternity Care Workshops for health providers, and evaluation of all activities (Ratcliffe et al., 2016). The project utilized a participatory approach in the intervention selection process undertaken by a multi-stakeholder working group that identified interventions that “would have a positive cumulative impact on the knowledge and attitudes of and communication between patients and providers,” which were “feasible, acceptable and sustainable in the existing resource-constrained health system” (Ratcliffe et al., 2016, p.3).

Open Birth Days (OBD) is a prenatal course designed to address the concern often heard from medical providers that women lack of knowledge about pregnancy, delivery and postpartum, and rudimentary necessities: “where to go, what to bring, what to expect, or... their rights and responsibilities” during the delivery. (Ratcliffe et al, 2016, p.3). OBDs simultaneously met women’s own demands for basic information concerning birth preparation. The course covered covered 100% of pregnant women attending antenatal care, included a participatory health education session and a facility tour that replicated a woman’s path when she is admitted to maternity services (Ratcliffe et al., 2016).

It is not a surprise that activities on birth preparedness were successful, as this tool has proven effective in other mother and child health programs all over the world (Ratcliffe et al., 2016). Knowledge about “what to expect during the delivery” (Ratcliffe et al., 2016, p 3.) empowers a woman and raises her confidence, transmits the ability to advocate for her rights, build relationships with providers and holds them accountable to quality standards. The course addressed and facilitated communication between a woman and a medical provider. Strengthened

communication skills is another effective and often critical tool that contributes significantly to patient satisfaction, better quality of maternal services and ultimately better delivery outcomes.

The World Health Organization's Health Workers for Change curriculum was adapted to address the request of medical providers and managers to improve their knowledge on respectful maternal care (Ratcliffe et al., 2016). The goal of the workshops for providers was "to revisit their professional codes of conduct, assess their current practice in relation to these ethical principles, reflect on the personal situations of patients ... and openly and honestly reflect on interpersonal and structural barriers that prevent the provision of RMC at the study facility" (Ratcliffe et al, 2016, p. 4). This approach to provider training has proven to be successful in other contexts (Fonn et al., 2001; Onyango-Ouma et al, 2001; Pittman et al, 2001).

As a result of implemented activities the research team reported "substantial positive changes in providers and patients" with increased awareness in women about their rights (Ratcliffe et al., 2016, p.10). Women reported feeling empowered during labor and delivery and commented on their ability to report D&A cases to hospital administration. Similarly, medical providers reported increased knowledge on women's rights, improved communication skills with "a greater capacity to empathize with the women they serve," as well as improved job satisfaction (Ratcliffe et al., 2016, p.11). Among other results was the important ability of medical providers to "realistically and honestly" evaluate their services, assess patients' levels of satisfaction, and demonstrate a desire to change the situation in their facilities and instill confidence in such changes (Ratcliffe et al., 2016, p.11).

While the limitation of this research does not present a clear picture of the prevalence of D&A in this hospital, the interventions results do offer a clear picture on

successful interventions affecting the main drivers of D&A in a large public hospital setting in Tanzania. This research suggests that the work on mitigation of D&A could be performed utilizing feasible and low-cost interventions such as engaging hospital staff in discussions of their professional code of conduct, improving their communication skills, and increasing awareness about patients' rights, while empowering women by increasing knowledge on pregnancy and delivery, and their rights.

Discussion: Guidance, standards and strategies for ensuring respectful maternal care

Adoption of a comprehensive approach to prevention and elimination of mistreatment and institutionalize of respectful maternal care principles are central to improve the quality of maternal care and decrease inequities in access to sexual and reproductive services (WHO, 2015; WRA, 2015). The institutionalization of a comprehensive approach to respectful maternal care is important to ensure that sustainable changes are implemented not only on a facility level but also on a national policy level, grounded in clearly delineated responsibilities and involvement of the different stakeholders. In fact, international frameworks, such as the UNHRC Technical Guidance, emphasize the responsibility of the state to address the structural causes of abuse, the health systems' conditions and constraints, as well as meeting professional standards of care and making the states accountable for the various forms of abuse of women in health facilities. Taking into account the high status of the Human Rights Council, Technical Guidance posits a significant influence on recognition of fundamental women's rights to respectful maternal care, introduces a rights-based approach to high level regulations, policies on maternal health as well as

sets clear responsibilities for stakeholders in sexual and reproductive health and rights.

While international human rights frameworks operate on a high policy level, it is critical to have D&A prevention approaches embedded in national maternal health policies and programs with technical support from the international level. The World Health Organization plays a leading role in maternal and child health globally and could contribute significantly to the technical process of adaptation and devising quality standards at the country level. Importantly, WHO standards of care provide clear measures of quality and respectful maternal services and help health systems to evaluate the conditions of maternity care for a country and the world.

Likewise, the International Federation of Gynecology and Obstetrics, that join professional associations around the world, could play an import role, not only in strengthening the quality control system on facility and country levels, but it could also provide a change of attitude and improve professionalism among healthcare providers. While certification of “mother and baby friendly” facilities plays an important role in the implementation of a comprehensive approach to respectful maternal care, in itself it will not change the situation dramatically for several reasons. As previously stated, to sustain the desired level of quality of services, the process of certification should be embedded in national legislation and regulations on maternal healthcare to ensure that newly implemented changes are in accordance with local legislation, policies and programs and, ideally, are supported by financial and human resources. Countries should identify a governmental or non-governmental body (for example, a professional union) to be responsible for the regular process of certification and to oversee the implementation of the recommendations received during the certification process. In many countries, this would entail a revision of quality control processes in

maternal and child health and would integrate prevention of disrespect and abuse into regular quality control activities to meet certification standards on mother-baby friendly facilities. Ultimately, all involved parties should harness a clear understanding of why it is important to address the issue of friendliness to mothers and babies in their facility, the importance for the health and wellbeing of women and children for the communities. In reality this entails involvement of many different stakeholders and implementation of complex interventions.

Complex interventions in respectful maternal health mean implementation on different levels – community, facility, national policy and decision making level – in addition to the involvement of different stakeholders. Both the Kenya and Tanzania case studies in this capstone contributed immensely to understanding the complex interventions and comprehensive approach to prevention and elimination of mistreatment and the importance of multi-stakeholder involvement. Both case studies have shown that not only health providers, managers and decision makers should be a part of the interventions, but pregnant women, their families and communities are also integral participants.

Conclusion and recommendations

Combatting disrespect and abuse as a health system issue requires systemic and complex interventions. The interventions studied in this paper offer a range of possibilities from high-level international human rights frameworks to small-scale birth preparedness courses and visits to maternity wards for pregnant women. To make sustainable progress in maternal care, there is a need for coordinated efforts and a comprehensive approach to D&A prevention that involves all actors working together to improve the quality of maternal health services. The literature reviewed for this capstone supports the idea that recommendations on prevention of disrespect and

abuse of women during facility-based childbirth are required on several levels, international and national, in addition to the facility and community levels.

International level

The human rights-based approach gives an opportunity to develop human rights-based policy and programs and claim the responsibilities of the states, governments, policy makers and practitioners to ensure the rights of women are fulfilled. The human rights-based approach is fundamental for framing the work related to maternal and child health, in particular specific interventions on the promotion of respectful maternal services. Technical Guidance promises not only to establish a human rights framework for maternal care but offers “tools to support its implementation ... with respect to the meaningful operationalization of a human rights frameworks in the context of maternal health” (Yamin, 2013, p. 193). It is also important to ensure that an accountability mechanism on human rights-based approach implementation is in place on the international and country levels to ensure that countries report regularly to the United Nations Human-Rights Council.

The quality of maternal care is recognized internationally as a critical aspect of effective maternal care, and both WHO standards and the FIGO mother-baby friendly initiative provide guidance to ensure quality and respectful maternal services that promote and protect maternal health (WHO, 2016). The WHO quality standards and FIGO certification process should be introduced on an international level by WHO Headquarters and Regional Offices and the FIGO Secretariat and Member Associations in countries, and followed by national level commitments to join efforts to improve maternal health. The introduction of FIGO and WHO documents on international and country levels will contribute to outlining the significant responsibilities of governments to the provision of respectful maternal care, to realize

“meaningful community mobilization and social change” (Mane, 2015, p.1). It is important to institutionalize the certification process of Mother–Baby Friendly Birthing Facilities on a national level, including mechanisms of annual audit and constant technical support of those facilities.

National level

The interventions examined in this project demonstrated that targeted actions can render significant changes and influence the prevalence of mistreatment in health facilities. The case of Tanzania provides an apt example of a strategy that can be implemented at the hospital level and does not require significant financial resources nor does it involve significant policy changes. The knowledge on pregnancy, delivery, and, importantly, about patients’ rights during facility-based deliveries made women feel prepared for birth, more supported by medical providers, who received additional training on rights as well (Ratcliffe, 2016). It is necessary to develop and introduce specialized national programs for pre- and post- diploma education of healthcare providers and managers on professional communications in health facilities that include respectful maternal care. It is also important to ensure access to all pregnant women and their families to appropriate birth preparedness courses that include knowledge on women’s rights (RMC Charter) and a visit to a health facility. Such interventions are feasible to implement in the short term and could form a core for maternal health programs.

The case study from Kenya offers a comprehensive approach to D&A prevention involving many actors, bringing policy change and strengthening the linkages between levels. The evidence provided by this case study suggests that a “multi-component intervention may have the potential to reduce the frequency of D & A” (Abuya et al., 2015, p. 13). Thus, it is important to initiate policy dialogue on a

country level with involvement of all stakeholders on prevention and elimination of disrespect and abuse of women during childbirth in health facilities. Professional associations, such as FIGO Member Associations, are well positioned to initiate a discussion on the country level that involves healthcare providers and decision makers, in addition to NGO's and community-based organizations. Both cases demonstrate the need for not only training of medical providers but the development of a professional Code of Conduct (Ethics Code) at the country level guided by a professional association.

Conclusion

The evidence presented in this paper indicates that there is growing awareness on respectful maternal care among research, health experts, and human rights advocates, national governments and local authorities, as well among health professionals working with pregnant women their families and communities. While this capstone provided evidence that there are targeted interventions directed at prevention and elimination of disrespect and abuse during child birth in health facilities, there is a gap in evidence regarding the effectiveness of particular interventions. More efforts should be put to bringing research driven interventions into practice on different levels to guide evidence-based policy and future programming. The evidence suggests that disrespect and abuse of women during childbirth could be prevented by joint efforts implementing acceptable, feasible and low-cost interventions that have significant influence on main drivers of disrespect and abuse.

Reflection

SFU MPH Program for me is a unique combination of challenging and rewarding experience. I entered the program with lots of experience, but no solid academic

training in public health, that made my journey so exciting. Today I can see growth and development of myself as an emerging public health and global health practitioner, bringing the knowledge gained from motivating instructors and sound MPH curriculum, and professional skills from practicum.

My capstone project became a logic culmination of my MPH program, built not only on my knowledge and skills, but on my commitment to equity, equality, and human rights, and my passion for women's health. The work on capstone project allowed me to apply research methodologies and global health concepts that I learned during studies and my practicum. I was working on the steps that should be done to promote respectful maternal care with full knowledge and understanding of ethical, structural, economic and social determinant that serve as a significant barrier and influence health outcomes around the world. My MPH program gave me a better understanding of the global health concepts, stakeholders, relations, and essential conditions of sustainable changes that I applied for my capstone project.

I was happy to work on disrespect and abuse of women during childbirth and feel that I'm able to find opportunities for prevention and elimination of this phenomenon. Now I feel more confident in articulating the critical steps needed to improve maternal health and look forward to serving as an agent of change to ensure that women around have access to quality, equitable and respectful healthcare.

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Annex 1. *Typology of the mistreatment of women during childbirth.* Source: Bohren et al, 2015

Third-Order Themes	Second-Order Themes	First-Order Themes
Physical abuse	Use of force Physical restraint	Women beaten, slapped, kicked, or pinched during delivery Women physically restrained to the bed or gagged during delivery
Sexual abuse	Sexual abuse	Sexual abuse or rape
Verbal abuse	Harsh language	Harsh or rude language Judgmental or accusatory comments Threats of withholding treatment or poor outcomes Blaming for poor outcomes
Stigma and discrimination	Discrimination based on socio-demographic characteristics Discrimination based on medical conditions	Discrimination based on ethnicity/race/religion Discrimination based on age Discrimination based on socioeconomic status Discrimination based on HIV status
Failure to meet professional standards of care	Lack of informed consent and confidentiality Physical examinations and procedures Neglect and abandonment	Lack of informed consent process Breaches of confidentiality Painful vaginal exams Refusal to provide pain relief Performance of unconsented surgical operations Neglect, abandonment, or long delays Skilled attendant absent at time of delivery
Poor rapport between women and providers	Ineffective communication Lack of supportive care Loss of autonomy	Poor communication Dismissal of women's concerns Language and interpretation issues Poor staff attitudes Lack of supportive care from health workers Denial or lack of birth companions Women treated as passive participants during childbirth Denial of food, fluids, or mobility

		<ul style="list-style-type: none"> Lack of respect for women's preferred birth positions Denial of safe traditional practices Objectification of women Detainment in facilities
Health system conditions and constraints	<ul style="list-style-type: none"> Lack of resources Lack of policies Facility culture 	<ul style="list-style-type: none"> Physical condition of facilities Staffing constraints Staffing shortages Supply constraints Lack of privacy Lack of redress Bribery and extortion Unclear fee structures Unreasonable requests of women by health workers