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Respectful Maternity Care interventions. What has been done?

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ABSTRACT

For the last decade, there has been emerging evidence on experiences of mistreatment, disrespect and abuse (D&A) during facility-based childbirth all around the world. Women suffering any of these negative experiences during labour are at 50-60% increased odds of developing severe postpartum depression, and these have also been proven to create a barrier for seeking both facility-based childbirth and postnatal health care. This is not only a quality of care issue, but a major violation of human rights. However, only a few studies have tried specifically designed interventions to reduce them. The aim of this scoping review is to synthetise all the evidence available to that respect, identifying successful initiatives that have been taken to eradicate the mistreatment, D&A women suffer during childbirth in health facilities. Published literature was searched in PubMed, and every original study assessing the effectiveness of any kind of intervention specifically designed to reduce these negative experiences was selected. Ten articles were included in this review. The publication years ranged from 2015 to 2022, and all were located in Africa except for two, whose settings took place in Mexico and the U.S. Five did a before-and-after intervention study, 3 used mixed-methods, one was a comparative study between birth centers, and another one, a quasi-experimental study. The most common feature was including some sort of Respectful Maternity Care (RMC) training for providers at the intervention center. Every study that did so, concluded that it resulted in an improvement of the care received by the delivering women. Physical abuse was the most consistently reduced. Other strategies that only a few articles explored were open maternity days, clinical checklists, wall posters and constant user feedback. The articles reviewed indicate that there are effective interventions to reduce D&A and promote RMC for women during facility-based childbirth. Specific types of training and

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different initiatives complementing them should be assessed by further scientific research, and RMC interventions applying these strategies should be implemented by health institutions to assure a human rights based maternity care for women giving birth in health facilities all around the world.

INTRODUCTION

For the last decade, there has been emerging evidence on experiences of mistreatment, disrespect and abuse (D&A) during facility-based childbirth all around the world (1). Women suffering any of these negative experiences during labour are at 50-60% increased odds of developing severe postpartum depression, and these have also been proven to create a barrier for seeking both facility-based childbirth and postnatal health care (2).

This mistreatment of women during childbirth, is not only a quality of care issue, but also constitutes a major violation of human rights. Every woman attains the right to the highest reachable level of health, including the right to respectful health care during pregnancy and labour, as stated by the Universal Rights of Childbearing Women charter (3).

It is important to note that these negative practices by health care providers are not intentional by definition and may coincide with other respectful care conducts. Nevertheless, women's experiences of D&A should be considered as such, in spite of intent. Besides, healthcare system features may explain some of these negative experiences but should not be used as justification for this mistreatment of women (4).

Many of the evaluations of D&A during childbirth were initially done in low-resource settings. Systematic reviews in Africa and India described prevalence rates ranging from 15% to 98%

(4–7). However, childbearing women from high and middle resource countries have also reported mistreatment, D&A during labour. Research conducted in the US, Switzerland, the Netherlands, Italy, and Spain has reported prevalence rates on a similar range (17%-67%) (8–10). Nevertheless, all these prevalence studies lack of comparison standards, given the different ways used to assess D&A in each of them.

The need for standardised typology and operational definitions of this phenomenon impedes greater research in this area (4). In 2010, Bowser and Hill recounted seven types of disrespectful and abusive practices during childbirth (11): physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in health facilities.

In 2014, Freedman and Kruk (12) further differentiated between the practices that arise from individual behaviours and the ones that do so from health system deficiencies. In 2015, Bohren et al. (4) suggested the term “mistreatment of women”, since they believed it to be broader and more inclusive for the complete range of negative experiences described in the literature. In their systematic review, they also proposed a new categorisation system: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints.

Within Latin America, discussions have not focused on D&A, but on terminology referring to “obstetric violence” as a sort of abuse that corresponds to other forms of violence against women. Gender inequalities have been fundamental to the conceptualisation of this term. In this regard, Nagle et al. observed a significant positive relationship between structural sexism and C-section rates in the U.S. (controlling for age, race and ethnicity, education level, and

payment type) (13). This finding fits with the theoretical framing of it being a symptom of structural violence and sexism towards women.

One of the reasons why obstetric violence as a term is not more spread out is the resistance by healthcare providers to the use of the concept of violence. Focusing the debate on individual malpractices can give rise to unproductive hostility towards the discussion of D&A in childbirth, especially among health workers, which is why avoiding to blame the health professionals as a group should be considered a priority (14). With this in mind, we will refer to these negative experiences of childbirth as the terms noted before (mistreatment, D&A) and avoid using the obstetric violence typology not to build resistance of clinical practitioners.

Based on the principle that the mere absence of D&A is not enough by itself, respectful maternity care (RMC) has appeared as an approach to care that showcases the basic rights of women, promoting equitable access to evidence-based practices while assuming their unique needs and preferences (15). Shakibazadeh et al. described some of the concepts that constitute RMC. Jolivet et al. operationalised these concepts into seven human rights-based categories of RMC: right to be free from harm and ill treatment; right to dignity and respect; right to information, informed consent and respect for choices and preferences, including the right to companionship of choice where ever possible; right to privacy and confidentiality; right to non-discrimination, equality and equitable care; right to timely healthcare and to the highest attainable level of health; and right to liberty, autonomy, self-determination and freedom from coercion (16).

With this in mind, both should be considered, respectful and disrespectful care, given that some practices may not appear exceedingly disrespectful but still should not be considered as respectful maternity care. Women's medical care should be based on the best available

scientific evidence subject to systematic review and adapted to each patient's preferences, respecting their rights and principles.

Finding successful interventions that have addressed these negative experiences during childbirth may help to showcase best practice for other maternity services and countries to implement. The aim of this study is to summarise all the evidence available to that respect, making for a comprehensive review of all the effective initiatives that have been taken to eradicate the mistreatment, D&A women suffer during childbirth in health facilities all around the world.

METHODS

Study Design

This study consists on a descriptive scoping review based on available peer-reviewed literature and following the Arksey and O'Malley's five-stage framework (17). Research was conducted to answer the following question: What interventions have been proven as effective to reduce mistreatment, D&A during facility-based childbirth?

Search Strategy

To identify relevant articles, published literature was searched in PubMed using Mesh and free-text terms referring to two main concepts: mistreatment of women and obstetrics.

The search formula was: *"Obstetric violence" OR ("Violence"[Mesh] OR "Gender-Based Violence"[Mesh] OR "Dehumanization"[Mesh] OR "Human Rights"[Mesh] OR "Human Rights Abuses"[Mesh] OR "Physical Abuse"[Mesh] OR "Emotional Abuse"[Mesh] OR*

"Malpractice"[Mesh] OR "Health Services Misuse"[Mesh] OR "Disrespect" OR "Disrespectful" OR "Respectful" OR "Mistreatment" OR "Abuse" OR "Medicalization" OR "Industrialization") AND ("Delivery, Obstetric"[Mesh] OR "Parturition"[Mesh] OR "Obstetrics"[Mesh]).

The "Abstract" search filter was used (see "Eligibility Criteria").

The search was conducted on June 7, 2022.

Eligibility Criteria

Every original study assessing the effectiveness of any kind of initiative or intervention specifically designed to reduce experiences of mistreatment, D&A among women during facility-based childbirth was selected. These included from clinical interventions to institutional initiatives.

The languages considered were English, Spanish, French, Portuguese and Italian.

The exclusion criteria discarded any article that did not have an abstract. Articles that did not derive from scientific research or those whose methodology was not explicitly detailed (study protocols, commentaries and conferences) were also excluded.

According to the definition stated before, these negative experiences of care also involve medicalization of childbirth. This includes unnecessary C-sections and similar procedures. However, the problem on these avoidable medical interventions was recognised decades before research started to focus on mistreatment and D&A as a continuum. Consequently, a large body of literature has been published to this respect, requiring systematic reviews focusing only on interventions reducing these medical procedures. Furthermore, the majority of studies regarding this specific topic lack the mistreatment lens when analyzing this

phenomenon. Because of this reason, articles that only evaluated initiatives planned to diminish unnecessary C-sections and similar medical interventions were excluded too.

Similarly, studies analyzing programs exclusively designed for facilitating the presence of a companion of choice during labour were also discarded. Since these articles only evaluated the change on one concrete first-order theme, they were excluded not to interfere with the general scope of the review.

Study Selection

The three authors participated on the study selection. Each abstract was screened for inclusion by two different researchers. The same procedure was followed for the full-text evaluation, every article was selected by two researchers independently. Discrepancies during these two stages were discussed with the third author until consensus was reached. Mendeley Reference software was used to manage the studies during this process.

Data Extraction

Data were extracted using a standardised Excel form assessing the following domains: study type; target and objectives of the intervention (reducing mistreatment, D&A or increasing RMC); approach (quality of care, human rights, gender violence); description and scope of the intervention; evaluation methods; obtained results; limitations and conclusion of the articles. As for study selection, every article was analysed by two different researchers. Each of the two authors extracted the data independently, then the information was compared, and any discrepancies were resolved by consensus.

RESULTS

The initial search yielded 2.279 citations. After analyzing their titles and abstract, 40 studies remained, out of which 4 involved discrepancies between the two researchers that had screened them, making for a concordance of 90% (36/40).

Once discussed with the third researcher, 2 of these studies were directly removed, with 38 remaining. Of these 38, 20 were considered ambiguous by one of the two authors. After discussion, 13 of these articles were excluded. When the slightest doubt, the studies were selected for full-text analysis.

Once this procedure took place, 25 articles out of the initial 40 remained. After their full texts were analysed, 10 studies out of these 25 were finally included. No article was excluded for language. This whole process is represented on figure 1.

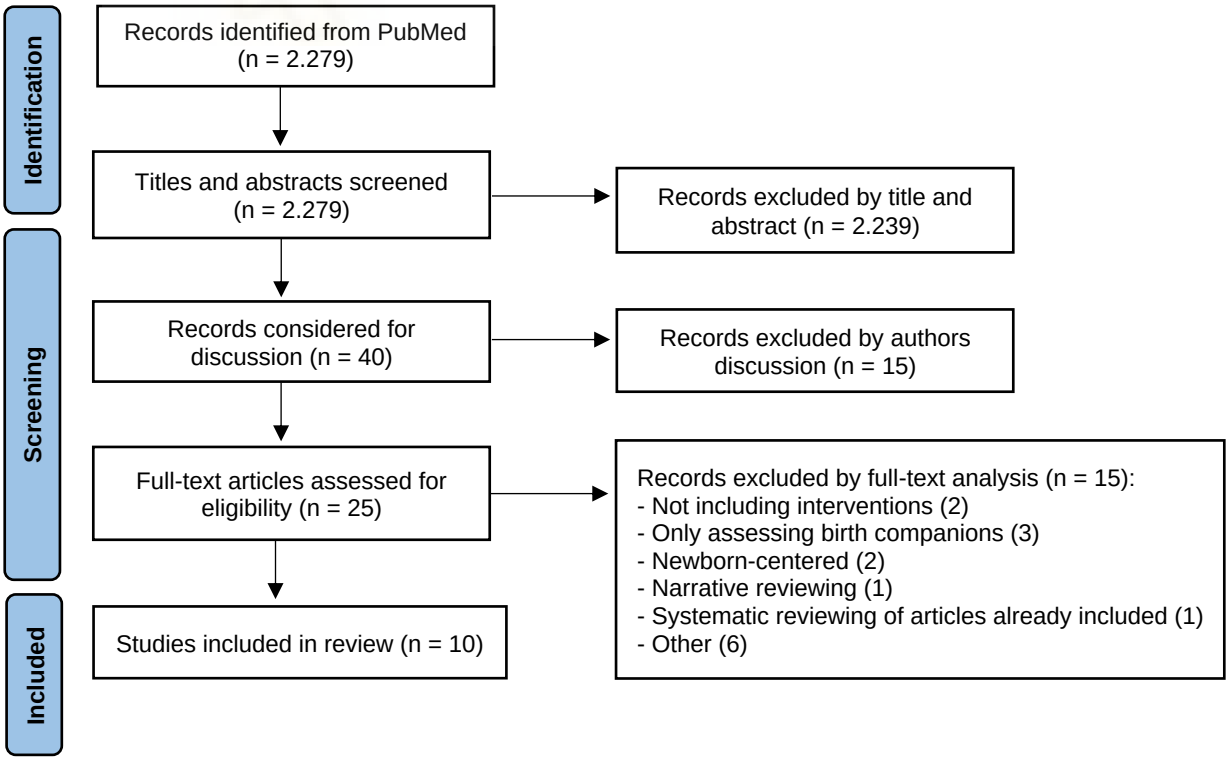

Figure 1. PRISMA flowchart of search and study inclusion process.

The publication years ranged from 2015 to 2022, and all were located in Africa except for two, whose settings took place in Mexico (18) and the United States (19).

Of these 10 articles that were included, 5 did a before-and-after intervention study (20–24), 3 used mixed-methods (18,25,26), one was a comparative study between birth centers (19), and another one, a quasi-experimental study (27). Three of them focused on reducing D&A and 5 on increasing RMC. One sought birth racial equity (19) and another aimed at humanised childbirth (25). Every study approached this phenomenon as a quality of care issue, but only 5 of them used a human rights lens to address this topic (apart from the one approaching it as an ethnic disparity). Table 1 summarises the main characteristics of these articles that were analysed.

The majority of interventions were conducted at facility level: none of the articles was specifically designed either as a policy or as a community-level intervention, but every one included initiatives taken at health centers, most of them being composed by different action plans.

For these initiatives, the most common feature was including some sort of RMC training for providers at the intervention center (18,20–22,24–27). Four of them considered implementing D&A continuous feedback (20,23,24,27), and another 3 also aimed at improving the infrastructure and/or available equipment (18,23,25). Two of them proposed Maternity Open Days (20,26), and another two, counselling for providers (20,23). One of them also used wall posters (22), another one, RMC checklists (18), and other, a provider-patient document on agreed behaviours during labour and delivery (27).

The article by Almanza et al. did not assess a concrete intervention but a comparison between Roots (a Black-owned culturally centered birth clinic) and other centers (19). More detailed information about the studied interventions and the way they were evaluated is presented at Table 2.

Table 1. Summary characteristics of the studies that described RMC interventions.			
Reference	Study design	Objectives	Approach
Authors: Abuya et al. (20) Year: 2015 Setting: Kenya	Before-and-after	Reduce D&A	Human rights and quality of care issue
Authors: Afulani et al. (21) Year: 2019 Setting: Ghana	Before-and-after	Increase RMC	Quality of care issue
Authors: Almanza et al. (19) Year: 2022 Setting: United States	Comparative study between birth centers	Birth equity	Reducing ethnic disparities
Authors: Asefa et al. (22) Year: 2020 Setting: Ethiopia	Before-and-after	Increase RMC	Quality of care issue
Authors: Gélinas et al. (25) Year: 2022 Setting: Senegal	Mixed methods	Humanised childbirth	Human rights and quality of care issue
Authors: Kujawski et al. (23) Year: 2017 Setting: Tanzania	Before-and-after	Reduce D&A	Human rights and quality of care issue
Authors: Molina et al. (18) Year: 2019 Setting: Mexico	Mixed methods	Increase RMC	Quality of care issue
Authors: Oosthuizen et al. (24) Year: 2020 Setting: South Africa	Before-and-after	Increase RMC	Human rights and quality of care issue
Authors: Ratcliffe et al. (26) Year: 2016 Setting: Tanzania	Mixed methods	Reduce D&A	Human rights and quality of care issue
Authors: Smith et al. (27) Year: 2022 Setting: Zambia	Quasi-experimental	Increase RMC	Quality of care issue
RMC, respectful maternity care; D&A, disrespect and abuse.			

Table 2. Interventions and results of the studies that described RMC interventions.			
Reference	Interventions	Evaluation	Results
Abuya et al. (20) 2015 Kenya	Policy level: continuous dialogue in technical meetings with government, civil society and professional knowledge network. Community level: training on RMC, community dialogue and counseling and resolution of reported cases by a mediator. Facility level: training in RMC (including values clarification and attitude transformation), counselling for providers (supporting them with coping mechanisms to overcome experiences related to high workload, trauma or critic incidents), mentorship, Quality Improvement teams, Maternity Open Days and D&A monitoring.	Interviews pre- and post-intervention (n = 641 and 728) and observations of provider-patient interactions during labour and delivery (n = 677 and 523, respectively).	Interviews: feelings of humiliation or disrespect decreased from 20% to 13% (p=0.0004), physical abuse was reduced from 4% to 2% (p=0.024); verbal abuse, from 18% to 11% (p=0.01); violations of confidentiality, from 4% to 2% (p=0.021); violations of privacy, from 7% to 6% (p=0.101); and detainment, from 8% to 1% (p<0.0001). Observations: physical abuse decreased from 3.8% to 0.4% (p=0.003); violations of privacy during examination, from 34% to 13% p<0.0001); and violations of privacy during delivery, from 92% to 79% p<0.0001).
Afulani et al. (21) 2019 Ghana	Provider trainings based on methodology developed by PRONTO International: low-tech, highly realistic simulation and team training with facilitated debriefing, to improve identification and management of obstetric and neonatal emergencies and team functioning.	Interviews pre- and post-intervention (n = 215 and 318).	At baseline, 12% felt they were treated respectfully and 8% reported to be treated in a friendly manner, compared to 64% and 65% at endline (p<0.01 for both differences). A relative increase of the full-scale score on person-centered maternity care of 43%, with relative increases of 15% in dignity and respect, 87% in communication and autonomy and 45% in supportive care (all statistically significant, p < 0.001) .

Almanza et al. (19) 2022 United States	Roots, where care is delivered by acknowledging the client's cultural community as a strength, providing racially concordant care as able. It includes 13-15 prenatal visits (for no less than 30 minutes each) and 4 group classes. Postpartum care includes lactation support with 3 home visits in the first week, and clinic visits at week 2, 4, and 6.	Comparing Roots (n = 80) to other BIPOC centers, using the sample of the GVtM (n = 2700).	Autonomy and respect scores were statistically higher for clients receiving culturally centered care at Roots. No statistical significance was found in scores between BIPOC and white clients, however there was a tighter range among BIPOC individuals, showing less variance in their experience of care.
Asefa et al. (22) 2020 Ethiopia	Interactive training of service providers deploying various teaching methods (presentations, role plays, demonstrations, case studies, individual readings, video shows and a hospital visit). Placement of wall posters in labour rooms listing universal rights, describing manifestations of mistreatment and presenting guidelines on RMC.	Post-partum interviews (n pre- and post-intervention = 198 and 190, respectively).	99.5% and 99% of women reported suffering at least one negative experience. The number of mistreatment components experienced by women was reduced by 18% when the post-intervention group was compared with the pre-intervention group, adjusting for several clinical and sociodemographic variables ($p<0.05$). Components: physical abuse, from 16.7% to 8.9% ($p=0.02$); non-consented care, from 83.3% to 65.3% ($p=<0.001$); refusal of preference, from 67.7% to 54.7% ($p=0.01$). No significant difference was detected for verbal abuse, lack of information, privacy and confidentiality, and neglect and discrimination.

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Gélinas et al. (25) 2022 Senegal	Communication with communities, sharing the concept in health facilities, improving the working environment, evidence-based care practices and support development activities. Redesign of health facilities to provide natural birthing rooms with accessories (tatami mats, balls, cushions, swings, stepladders and screens) and essential technical equipment. Staff training: 5S/Kaizen approach and evidence-based medicine with WHO's standards for normal childbirth.	Interviews (n = 20) and direct labour observations (average duration = 5 days/facility, n = 20).	Women who gave birth post-intervention appreciated their experience due to changes such as the opportunity to eat and drink, to be accompanied by a trusted person and to choose their position during childbirth. It was the way in which women were received at the health facility and the attitude of health professionals that were decisive in their level of satisfaction with care.
Kujawski et al. (23) 2017 Tanzania	Maternity ward improvements, including moving the admissions area to a private room, using curtains for delivery and for physical examinations, posting supply stock outs to ensure transparency and build trust, and continuous customer satisfaction exit surveys. At facility management level, counseling of staff who continued to exhibit disrespectful behaviours and best practice sharing with other wards and the regional hospital.	Interviews (n = 2983) before and after in two different facilities (the intervention and control group).	The intervention was associated with a 66% reduced odds of a woman experiencing D&A ($p<0.0001$). The biggest reductions were for physical abuse (adjusted OR: 0.22, 0.05-0.97, p=0.003) and neglect (0.36, 0.19-0.71, p=0.045).

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Molina et al. (18) 2019 Mexico	Implementation of an adapted version of the WHO Safe Childbirth Checklist with a mobile application to incorporate RMC (allowing birth companions, asking women about their preferred delivery position and emphasizing clear communication regarding the care plan). Monthly clinical training courses for clinicians. Budget to fill supply gaps for essential medications and equipment, funds for gasoline to facilitate travel for women in need of referral and lodging in an existing patient hostel with food vouchers for pregnant women and their birth companion.	Synchronised data of the mobile application (n = 384), and surveys (n = 221) and semi-structured interviews with birthing women (n = 28) and companions (n = 13).	384 (85.9%) women were attended by staff that used the adapted SCC during delivery. Adherence with offering a birth companion (OR: 3.06, 1.40–6.68, p<0.01), free choice of birth position (2.75, 1.21–6.26, p=0.02), and immediate skin-to-skin contact (4.53, 1.97–10.39, p<0.01) improved 6-8 months after implementation. The 221 respondents of the survey were highly satisfied with their experience at the hospital, with a median satisfaction score of 10/10 versus 9/10 for the previous delivery. The prevalent narrative was that quality of care at the hospital had improved over time, and women were satisfied.
Oosthuizen et al. (24) 2020 South Africa	CLEVER package: Clinical care and obstetric triage, Labour ward management to resolve the withholding of care, Elimination of barriers to meet basic human needs, Verification of care (monitoring, evaluation and feedback), Emergency obstetric simulation training, and RMC to improve birthing women's experiences; implemented with a period for creating awareness and a core group of activities aimed at behavioural change.	Interviews before (n = 653) and after (n = 679) in 10 different facilities (5 intervention sites and 5 control comparisons).	For consent to examination, being spoken nicely and treated respectfully during labour, and being satisfied with the treatment received, there were significant positive changes from baseline to end-line regarding the intervention group units (OR: 2.3, 3.2, 4.3 and 4; p = 0.0018, 0.0009, <0.0001 and <0.0001, respectively).

Ratcliffe et al. (26) 2016 Tanzania	Open Birth Days for pregnant women (complementing the antenatal care sessions) and RMC Workshops for providers (adapting the WHO Health Workers for Change curriculum).	Pre- and post-tests with participants in Open Birth Days (n = 362) and with attendants to the RMC Workshop (n = 76), direct labour observations (n = 459), structured community follow-up interviews (n = 149) and structured interviews with providers (n = 55).	During community follow-up interviews, 75.8% of women reported being very satisfied with their delivery experience compared to only 12.9% at baseline. At baseline, quality of care was rated as "excellent" (0%) or "very good" (2.9%), with an increase to 22.8% and 40.3% respectively at evaluation. Patient satisfaction with provision of health care improved, from 10% of women reporting "very satisfied" to 76.5%.
Smith et al. (27) 2022 Zambia	BETTER pain management toolkit (Breathe, Encourage, Turn, Think, and Rub), including pain management technique posters, massage balls and a pain management manual with a partograph guide. Feedback box to empower clients to regularly assess clinic performance. Provider–client promise document on agreed behaviours during labour and delivery. Reflection workshop for providers to build an intention to change care as a facility introducing solutions. Fresh start funds to generate a sense of agency in changing the experience of care.	Surveys with health providers (n = 33 and 35) and women (n = 60 and 92) before and after intervention, endline interviews (n = 5) and labour observations (n = 10). Each intervention site was matched to a similar comparison facility.	Clients at implementation facilities were 15% less likely to experience any form of D&A compared to clients at comparison facilities (p=0.01). Providers at intervention facilities reported greater use of more evidence-based pain management techniques at endline relative to baseline (p=0.003). Though not statistically significant, findings suggested that providers in intervention facilities were more likely to be more empathetic towards clients (p=0.07). Both clients and providers at intervention facilities found utility in the feedback box.
RMC, respectful maternity care. D&A, disrespect and abuse. OR, odds ratio. Roots, black-owned culturally centered birth clinic. BIPOC, black, indigenous and people of colour. GVtM, giving voice to mothers study.			

All of the selected studies concluded that the implemented intervention resulted in an improvement of the care received by delivering women. Kujawski et al. and Smith et al. reported 66% and 15% reduced odds of suffering D&A, respectively (23,27). For Abuya et al., this supposed a D&A decrease from 20% to 13% (20), and for Afulani et al., a RMC increase from 12% to 64% (21). Asefa et al. found an 18% reduction in the number of components of mistreatment experienced (22), while Oosthuizen et al. documented that different RMC components improved with the intervention (24). Molina et al. reported that satisfaction and the perceived quality of care improved (18), and for Gélinas et al., it was the way in which women were received at the health facility and the attitude of health professionals that were decisive for this level of satisfaction with care (25).

Ratcliffe et al. found that there was an increase in patient and provider knowledge of user rights, as well as women's knowledge of the labour and delivery process and provider's empathy for the women they served, with improved communication and user reports of satisfaction and perceptions of care quality (26). For Almanza et al., autonomy and respect scores were statistically higher for clients receiving culturally centered care at Roots, but no statistical significance was found in scores between black, indigenous and people of colour (BIPOC) and white clients (19). More detailed results are presented at Table 2.

DISCUSSION

This scoping review synthetised 10 articles testing any kind of initiative specifically designed to reduce D&A or to promote RMC for women seeking care during childbirth in health facilities all around the world.

Our results indicate that there are effective interventions to tackle this phenomenon. Even though it was a small sample of articles and in some cases the improvements were not extraordinary, they were significant enough to encourage the implementation of programs adapted to each context, to make the step from explanatory research to intervention and implementability.

Most of the effort so far, is being directed towards determining D&A prevalence and debating its terminology. This is especially relevant in high-income countries, which can be illustrated by the fact that, within these 10 initiatives, all were located in Africa except for two, whose settings took place in Mexico (18) and the United States (19) (the latter centering on ethnic disparities).

As noted before, childbearing women from high- and middle-resource countries have also reported mistreatment, D&A during hospital births (8–10,28). This reveals the urge for starting to implement similar initiatives to the described in this study, but in high- and middle-income settings.

Most of the articles reviewed included training as a relevant part of the intervention. It should be highlighted that every study that did so, concluded that it resulted in an improvement of the care received by the delivering women (18,20–22,24–27). Physical abuse was the most consistently reduced (20,22,23). These results suggest that provider education should include a form of RMC training, starting at Medical school and being encouraged by Gynecology and Obstetrics services.

For Asefa et al., even though physical abuse was indeed reduced, they found no changes in the level of verbal abuse and neglect and discrimination, pointing to the fact that ingrained

negative and normalised behaviours require time to change and are highly associated with age and experience of service providers (22).

In the case of Afulani et al., their results differed from the other studies in that verbal and physical abuse paradoxically increased (despite the increase in reports of being treated with respect). A potential reason they found was that, while treating women with dignity and respect was emphasised in the training, verbal and physical abuse never actually occurred in their simulations, not giving a chance for improving (21). On this note, it would be useful to investigate more about which specific type of provider training does the greatest effect.

Not only that, but effort should also be headed towards finding any other kind of tools that could either complement or top these trainings when implemented. Other strategies that only a few articles explored were open maternity days (Abuya et al., Ratcliffe et al.), clinical checklists (Molina et al), wall posters (Asefa et al.) and constant user feedback (Abuya et al., Oosthuizen et al., Kujawski et al., Smith et al.). While only tested by 1-4 studies each, every one of them seemed to complement the training effectively.

However, every intervention was at facility level, not tackling directly gender-discrimination structural health determinants at policy level, which, although hard to accomplish, could potentially be the most effective (13,29). Apart from this, efforts headed towards designing community level interventions should also be made.

Research conducted by Downe et al. showed similar results. In their systematic review (30), they analysed the articles by Abuya et al. (20), Kujawski et al. (23) and Ratcliffe et al. (26) (already covered in this review), and two other studies (one placed in South Africa only assessing birth companions, and another one in Sudan, testing a communication-building

package with staff). They found that moderate certainty evidence suggested that RMC interventions increase women's experiences of respectful care by almost four times and reduce D&A by about two-thirds, also supported by the observational studies. In terms of specific attitudes and behaviours, moderate certainty evidence suggested that RMC policies probably reduce physical abuse, with evidence on other components of D&A being graded low certainty. These results agree with the ones presented in our study.

Nevertheless, all the studies included in our review shared similar limitations. Most of them lacked a control group (see Table 1, Study design), which removed the ability to properly distinguish the intervention's effect from other contextual factors during the implementation period.

In addition, the majority of the initiatives were short (the one studied by Abuya et al. (20) took place during around a year and a half, but the rest only lasted for a few months). Added to the fact noted before, that that ingrained negative and normalised behaviours require time to change, this could have underestimated the potential interventions' effects, but it also made it impossible to assess their long-term sustainability.

Finally, for the studies that interviewed women as a mean of evaluation, social desirability and recall bias could have altered the result, as could have also done the Hawtorne effect for the ones that included direct labour observations (the providers being observed could have acted more self-consciously).

This study also has its own limitations. Being a scoping review, it lacked the degree of control that a systematic review could have offered. However, we reckon that it made it possible to explore more findings, serving as a useful landscape analysis. PubMed was the only search

engine screened and we only considered articles that had an abstract. Furthermore, given the altering terminology regarding this phenomenon, a standardised search formula could not be used, potentially leaving some other studies out of our scope. Nevertheless, we think that the majority of available evidence was reviewed within this article, giving a broad approach regarding the interventions analysed.

CONCLUSION

The 10 articles reviewed in this study indicate that there are effective interventions to reduce D&A and promote RMC for women during facility-based childbirth. Provider training is the most tried strategy, and physical abuse, the most consistently reduced. Specific types of training and different initiatives complementing them should be assessed by further scientific research, and RMC interventions applying these strategies should be implemented by health institutions. Beyond the need for new research and the implementation of actions already examined, there is an urgent need to establish and evaluate interventions and policies of a more structural nature in order to modify the social and health contexts that impede full RMC, to assure a human rights based maternity care for women giving birth in health facilities all around the world.

REFERENCES

1. WHO. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. World Heal Organ. 2015; 4.
2. Minckas N, Gram L, Smith C, Mannell J. Disrespect and abuse as a predictor of postnatal care utilisation and maternal-newborn well-being: a mixed-methods systematic

review. BMJ Glob Heal. 2021/04/23. 2021; 6 (4).

3. United Nations General Assembly. A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. United Nations. 2019; 11859 (July): 23.

4. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. PLoS Med. 2015/07/01. 2015; 12 (6): e1001847; discussion e1001847.

5. Sando D, Ratcliffe H, McDonald K, Spiegelman D, Lyatuu G, Mwanyika-Sando M, et al. The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. BMC Pregnancy Childbirth. 2016/08/21. 2016; 16: 236.

6. Jungari S, Sharma B, Wagh D. Beyond Maternal Mortality: A Systematic Review of Evidences on Mistreatment and Disrespect During Childbirth in Health Facilities in India. Trauma Violence Abus. 2019/10/22. 2021; 22 (4): 739–51.

7. Ansari H, Yeravdekar R. Respectful maternity care during childbirth in India: A systematic review and meta-analysis. J Postgr Med. 2020/07/18. 2020; 66 (3): 133–40.

8. Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, et al. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reprod Heal. 2019/06/12. 2019; 16 (1): 77.

9. Mena-Tudela D, Iglesias-Casás S, González-Chordá VM, Cervera-Gasch Á, Andreu-Pejó L, Valero-Chilleron MJ. Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences. Int J Env Res Public Heal. 2020/10/28. 2020; 17 (21).

10. Martínez-Galiano JM, Martinez-Vazquez S, Rodríguez-Almagro J, Hernández-Martinez A. The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study. Women Birth. 2020/10/22. 2021; 34 (5): e526–36.

11. Bowser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis. Usaid. 2010; 2: 1–57.

12. Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth: Challenging the global quality and accountability agendas. Lancet. 2014; 384 (9948): e42–4.

13. Nagle A, Samari G. State-level structural sexism and cesarean sections in the United States. Soc Sci Med. 2021/09/22. 2021; 289: 114406.

14. Jewkes R, Penn-Kekana L. Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women. PLoS Med. 2015; 12 (6): 10–4.

15. Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Nogueira Pileggi V, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. Bjog. 2017/11/09. 2018; 125 (8): 932–42.

16. Jolivet RR, Gausman J, Kapoor N, Langer A, Sharma J, Semrau KEA. Operationalizing respectful maternity care at the healthcare provider level: a systematic scoping review. Reprod Health. 2021 Oct; 18 (1): 194.

17. Arksey H, O'Malley L. Scoping studies: Towards a methodological framework. Int J Soc Res Methodol Theory Pract. 2005; 8 (1): 19–32.

18. Molina RL, Villar J, Reyes A, Elliott J, Begley M, Johnson M, et al. Delivery practices and care experience during implementation of an adapted safe childbirth checklist and respectful care program in Chiapas, Mexico. Int J Gynaecol Obstet Off organ Int Fed Gynaecol Obstet. 2019 Apr; 145 (1): 101–9.

19. Almanza JI, Karbeah J 'Mag, Tessier KM, Neerland C, Stoll K, Hardeman RR, et al. The Impact of Culturally-Centered Care on Peripartum Experiences of Autonomy and Respect in Community Birth Centers: A Comparative Study. Matern Child Health J. 2022 Apr; 26 (4): 895–904.

20. Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N, et al. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. BMC Pregnancy Childbirth. 2015/09/24. 2015; 15: 224.

21. Afulani PA, Aborigo RA, Walker D, Moyer CA, Cohen S, Williams J. Can an integrated obstetric emergency simulation training improve respectful maternity care? Results from a pilot study in Ghana. Birth. 2019/01/27. 2019; 46 (3): 523–32.

22. Asefa A, Morgan A, Gebremedhin S, Tekle E, Abebe S, Magge H, et al. Mitigating the mistreatment of childbearing women: evaluation of respectful maternity care intervention in Ethiopian hospitals. BMJ Open. 2020 Sep; 10 (9): e038871.

23. Kujawski SA, Freedman LP, Ramsey K, Mbaruku G, Mbuyita S, Moyo W, et al. Community and health system intervention to reduce disrespect and abuse during childbirth in Tanga Region, Tanzania: A comparative before-and-after study. PLoS Med. 2017/07/13. 2017; 14 (7): e1002341.

24. Oosthuizen SJ, Bergh A-M, Grimbeek J, Pattinson RC. CLEVER maternity care: A before-and-after study of women's experience of childbirth in Tshwane, South Africa. African J Prim Heal care Fam Med. 2020 Oct; 12 (1): e1–8.

25. Gélinas É, Mallé Samb O. L'impact d'une intervention d'humanisation des accouchements sur l'expérience de soins des femmes au Sénégal. Sante Publique. 2022; 33 (5): 695–704.

26. Ratcliffe HL, Sando D, Lyatuu GW, Emil F, Mwanyika-Sando M, Chalamilla G, et al. Mitigating disrespect and abuse during childbirth in Tanzania: an exploratory study of the effects of two facility-based interventions in a large public hospital. Reprod Health. 2016 Jul; 13 (1): 79.

27. Smith J, Schachter A, Banay R, Zimmerman E, Vargas A, Sellman A, et al. Promoting

respectful maternity care using a behavioral design approach in Zambia: results from a mixed-methods evaluation. Reprod Health. 2022 Jun; 19 (1): 141.

28. Vargas E, Marshall RA, Mahalingam R. Capturing women's voices: lived experiences of incivility during childbirth in the United States. Women Heal. 2021/07/27. 2021; 61 (7): 689–99.

29. Diaz-Tello F. Invisible wounds: obstetric violence in the United States. Reprod Heal Matters. 2016/09/01. 2016; 24 (47): 56–64.

30. Downe S, Lawrie TA, Finlayson K, Oladapo OT. Effectiveness of respectful care policies for women using routine intrapartum services: a systematic review. Reprod Health. 2018 Feb; 15 (1): 23.

Biblioteca
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