How Women Are Treated During Facility-Based Childbirth in Four Countries: A Cross-sectional Study With Labour Observations and Community-Based Surveys

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ABSTRACT

Women around the world experience mistreatment during childbirth. This includes, but is not limited to, physical abuse, verbal abuse, discrimination, and procedures performed without consent. To address this issue, a recommendation was provided to the World Health Organization (WHO) to develop tools to evaluate the ill-treatment of women in labor. The aim of this study was to develop evidence-based, validated tools to measure the mistreatment of women during childbirth in low- and middle-income countries.

This multisite study prospectively recruited pregnant women, at least 15 years of age, who were admitted for childbirth at 12 health facilities in Nigeria, Ghana, Guinea, and Myanmar. Data were collected between September 19, 2016, and January 18, 2018, using 2 approaches: continuous labor observation and community-based surveys.

A total of 2016 women were included in the continuous labor observation cohort and observed from admission to 2 hours postpartum. Among the key findings, 41.6% (838) experienced physical abuse, verbal abuse, or discrimination. Physical abuse was observed in 14.0% (282) of women, most commonly in the form of being slapped, hit, or punched; subject to forceful downward abdominal pressure; or forcefully held down to the bed (9.3% [n = 188], 3.1% [n = 63], 1.9% [n = 38], respectively). Verbal abuse was observed in 37.8% (n = 762) of women, most commonly in the form of being shouted at and scolded (27.2% [n = 158] and 3.9% [n = 104], respectively). Physical and verbal abuse occurred most often 30 minutes before birth until 15 minutes after birth and were most highly concentrated during the 15 minutes before birth. Racial and ethnic discrimination was observed in 0.6% (n = 11) of cases. Additionally, women who had episiotomy or cesarean delivery did not give their consent for the procedure (75.1% [n = 190] of 253 women who had episiotomy; 13.4% [n = 35] of 261 who had cesarean delivery).

A total of 2672 women were included in the community-based surveys cohort and interviewed up to 8 weeks postpartum. Among the key findings, 35.4% (945/2675) of women reported physical abuse, verbal abuse, or discrimination. Physical abuse was reported in 14.0% (282) of women, most commonly in the form of being slapped, hit, or punched; subject to forceful downward abdominal pressure; or forcefully held down to the bed (9.3% [n = 188], 3.1% [n = 63], 1.9% [n = 38], respectively). Verbal abuse was reported in 37.8% (n = 762) of women, most commonly in the form of being shouted at and scolded (27.2% [n = 158] and 3.9% [n = 104], respectively). Physical and verbal abuse occurred most often 30 minutes before birth until 15 minutes after birth and were most highly concentrated during the 15 minutes before birth. Racial and ethnic discrimination was observed in 0.6% (n = 11) of cases. Additionally, women who had episiotomy or cesarean delivery did not give their consent for the procedure (75.1% [n = 190] of 253 women who had episiotomy; 13.4% [n = 35] of 261 who had cesarean delivery).

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women who had cesarean deliveries, 10.8% (n = 52) did not consent to the procedure, nor did the 24.1% of the 536 women who had episiotomy or the 13.1% of the 349 women who were induced. Of the 2445 women who reported having at least 1 vaginal examination, 49.7% (n = 1214) said that the examination was performed without their consent. Age played a major role in the mistreatment of surveyed women. Physical abuse, verbal abuse, or discrimination was more likely to be reported by younger women, aged 15 to 19 years (odds ratio [OR], 1.9; 95% confidence interval [CI], 1.4–2.6). Compared with women who were 30 years or older, younger women with no education (OR, 3.6; 95% CI, 1.6–8.0) or some education (OR, 1.6; 95% CI, 1.1–2.3) were more likely to experience verbal abuse.

In conclusion, the mistreatment of women during childbirth is a serious issue. The measurement tools used in this analysis—continuous labor observation and community-based surveys—may be considered for future studies and used to develop quality-of-care initiatives.

EDITORIAL COMMENT

(Quality health measures and indicators have most often focused on availability of medical procedures and clinical outcomes. In low-resource settings, this often involves outcomes such as the proportion of births with skilled birth attendants present and in all settings involves outcomes such as maternal mortality. In high-resource settings, it is increasingly recognized that these indicators do not completely reflect quality. Rather, patients’ experiences of care and measures of respect and communication are now considered important quality measures as well. But while this is true in high-resource settings, in low-resource settings, the focus has largely been on clinical and medical procedures and outcomes, and women’s experiences of maternity care have not often been measured. This gap is recognized by the WHO, which recommends respectful maternity care for all women, including and defined as care that includes “dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth” (Geneva: WHO; 2018).

Given this gap, the WHO undertook to develop and validate tools to measure the mistreatment of women during childbirth in different contexts in primarily low-resource settings. This abstracted article reports on a prospective study in 12 health facilities in Ghana, Guinea, Myanmar, and Nigeria. The investigators measured treatment of women in childbirth using 2 different strategies—they undertook direct observations of 2016 women in throughout labor and the first 2 hours postpartum, and they also administered surveys to a separate cohort of 2672 women postpartum. The direct labor observations reported that 41.6% of women experienced physical abuse, verbal abuse, or stigma or discrimination, including such as being slapped, hit, or punched. The rate reported in the survey group was similar, 35.4%. Physical and verbal abuse peaked 30 minutes before birth until 15 minutes after birth and was more common in younger women and women with lower levels of education. Most women did not have a companion present, and lack of consent for cesarean, episiotomy, and vaginal examinations was common. In addition, in the observed group, 7% of women requested pain relief, but 34% did not receive any. Finally, providers suggested or asked 3.1% of women for a bribe or informal payment, and some women had discharge delayed because they were not able to pay their bill. The authors concluded addressing these issues involves understanding the drivers and structural dimensions of mistreatment, including gender and social inequalities.

While reading these data are distressing, likely many of us feel that this is not reflective or necessarily relevant to the care that we provide in the United States. While physical abuse is certainly rare, it was not so long ago that we likewise did not consider patient-centered outcomes in discussion of quality measurements. If similar measures were collected in the United States, it is likely that we would also identify concerns regarding mistreatment of some patients. In this report, the mistreatment most commonly occurred during the birth itself, and this may be due to the stressors that happen during the often intense time when the delivery is occurring. In this study, 3.3% of women were admitted to intensive care, and 0.2% died. With such a high-risk population and relatively high morbidity and mortality, it is no wonder providers are stressed (although that certainly does not justify mistreatment of patients).
In a setting with limited resources, and if the providers are not skilled in management of obstetrical complications, this would further increase stress and anxiety. The increased risk during this period might also just be because providers are more likely to be present around the time of birth.

It is not surprising that the highest rate of mistreatment was in women who were young and had lower education. It is unfortunately often the case that such women are more likely to be disrespected. There are also cultural factors, such as judgment of adolescents made by health care providers about their age and engagement in sexual activity. Such judgment undoubtedly occurs in high-resource settings as well. Even in our hospital and unit, there are patients who are judged as difficult, noncompliant, and otherwise problematic. Especially during stressful events, it is difficult to care for patients who are not quietly obedient.

In this study, the midwives and doctors often described women as “uncooperative” during delivery. Speaking for myself, I could certainly have been described as uncooperative when in the final throes of an unmedicated labor!

So how is this article relevant to our US high-resource settings, and how can these data help us provide better care here and work toward better and more patient-centered care in other settings? It is a daunting task when the underlying factors are often cultural and social inequities that are difficult to address. The authors note that understanding drivers and structural dimensions of mistreatment during childbirth include factors such as historical biases, power inequalities, normalization of poor treatment, and communication barriers and that it is essential to ensure that any interventions account for such societal context.

For obstetrical providers, interventions to increase provider confidence could be helpful in decreasing stress that leads to patient mistreatment. Addressing some structural components of mistreatment, such as a lack of privacy, companionship in labor, and pain relief, may be more readily addressed than major cultural issues. Some structural changes, such as curtains to allow privacy in labor, and allowing or encouraging companionship, are inexpensive. Changing societal treatment of women is obviously more difficult and complex, but society and community groups should continue to advocate for respectful care for all women and empower people to hold health systems accountable. Ultimately, to achieve respectful maternity care, the balance of power must shift from systems to people, and to women themselves. And in any setting, we should follow the advice of Kruk and colleagues (Lancet Glob Health 2018; 6:e1196–e1252) and “measure and report what matters most to people.”—MEN)