**United Nations Special Rapporteur on violence against women**

**Call for submissions: Mistreatment and violence against women during reproductive health care with a focus on childbirth**

**15 May 2019**

**Background**

UNFPA operates in over 150 countries to strengthen sexual and reproductive health systems and care, including access to contraception, maternal health services, HIV prevention, and sexuality education. We also work to advance gender equality and to empower women to decide freely on their fertility and sexuality free from coercion, discrimination and violence, including by preventing and addressing gender-based violence (GBV), female genital mutilation (FGM) and child, early, and forced marriage (CEFM).

Disrespect and abuse during childbirth can occur in many ways. For example, in the form abusive care practices (scolding, shouting, conducting or suturing of an episiotomy without anesthesia), physical abuse (hitting, slapping, pushing, pinching), lack of privacy (discussing and disclosing confidential health information in public), abuse of power (threatening to withhold treatment or care), neglect (no attendant at delivery), absence of informed consent (for several procedures), as well as inappropriate demands for payment.[[1]](#footnote-1) Abuse at facility level has been well documented and is a recognized quality of care issue. Women are frequently denied their right to make informed decisions about care and may be punished for attempting to assert their right to refusal. Mistreatment is not uncommon and persists because of factors inherent to socio-economic discriminatory structures, hospital social culture, lack of proper education and training, but also lack of respect for women’s equal status and rights.[[2]](#footnote-2)

The harmful, disrespectful and abusive treatment of women before, during and after childbirth in health facilities by healthcare personnel is receiving increasing global attention. Respectful Maternity Care (RMC) is a universal human right owed to every childbearing woman in every health system around the world.[[3]](#footnote-3) RMC is increasingly recognized as central to quality maternal and newborn health care and outcomes, and is defined as an approach centered on the individual and based on principles of ethics that recognizes and promotes women’s rights, including respect for their autonomy, dignity, emotions , choices, and preferences. While many activities are promoting RMC globally, there is a need for greater support and programmatic interventions to further RMC implementation and the use of consistent methods to measure changes.

UNFPA has recognized these human rights violations and has started to implement RMC interventions. For instance, the concept of RMC is now a firm part of the curriculum for midwives in most UNFPA supported midwifery schools. Furthermore, the UNFPA Maternal Health Trust Fund (MHTF) present in 32 countries is currently working on an evaluation and country surveys to identify the bottlenecks of respectful maternity care in Emergency Obstetric and Newborn Care (EmONC) facilities. In parallel, to address this issue at the global level, UNFPA in 2018 co-organized a policy dialogue at the Woodrow Wilson Centre titled ‘*Too much too soon’[[4]](#footnote-4)*, highlighting the emerging epidemic of harmful and unnecessary clinical interventions (i.e. over-medicalization) women are experiencing during childbirth[[5]](#footnote-5). Verbal and physical abuse in health facilities was also identified not only as a huge quality of care problem, but also as one of the barriers to facility-based delivery. There is evidence to suggest that women are choosing not to give birth in health facilities because they are aware of the level of violence and disrespect they could endure. At the global level, there is a lack of global level consensus on how violence against women during facility-based childbirth is defined and measured.

In responding to this call for submission, UNFPA asked for inputs from its country and regional offices worldwide. We received two regional level inputs from the Eastern and Southern Africa Regional Office (UNFPA ESARO) and the Asia and the Pacific Regional Office (UNFPA APRO). UNFPA also received inputs from over 35 countries from Latin American and the Caribbean (LAC) and Asia and the Pacific.

1. **Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country’s response and any good practices, including protection of human rights;**

UNFPA at the global level identified common examples of over-interventions:

* The chronic cesarean section (C/S) rates in some regions. A medical justification that is given often refers to the protection of the well-being of the unborn child. In many legal contexts, including the USA, the rights of the unborn fetus override the rights of the mother. This can lead to situations where women purposefully are not involved in the decision to deliver the baby via C/S (which in some situations is indeed safer than a vaginal birth). There is also evidence to suggest that women are becoming victims of failing health systems where services are planned and managed with a focus on time/cost-efficiency. The argument here is that normal childbirth is unplannable and can occur at any point during the day and night, whereas C/S can be scheduled.
* The incorrect use of uterotonics in the attempt to shorten the birth process. A uterotonic, or ecbolic, is an agent used to induce contraction or greater tonicity of the uterus (i.e. oxytocin). Uterotonics are used both to induce labor, and to reduce postpartum hemorrhage. Managed improperly, the use of oxytocin, can cause fetal distress, stillbirths, uterine rupture and is hugely painful without appropriate pain relief.[[6]](#footnote-6)
* The overuse of episiotomies. An episiotomy is a deep cut in a women’s perineum into the pelvic floor muscle. Obstetricians in the tropics continue to instruct health staff to apply a policy of “avoid tears-do episiotomies” routinely. They may be acting in good faith, but the evidence shows that they are wrong.[[7]](#footnote-7) Aiming surgically to cut all women delivering vaginally has no demonstrable benefit for the infant or mother but causes the woman unnecessary pain and adverse psychological effects and may cause death.[[8]](#footnote-8)
* The manual removal of the placenta without administration of sedative or pain relief. The placenta is normally expelled without intervention and when this does not happen, it can lead to post-partum hemorrhage and sepsis (excessive blood loss and infection of the blood system/blood poisoning-the most frequent causes of maternal death). In this process, a practitioner inserts one hand into the women’s womb in order to extract the placenta, or parts of it without administrating a sedative or pain relief.

**Eastern and Southern Africa**

The current global movement for RMC is calling for respectful care and protection of all childbearing women, especially the marginalized and vulnerable, such as adolescents, ethnic minorities, and women with disabilities. However, there is still limited documented evidence in Africa on disrespect and abuse during childbirth. A study done in six countries (Ethiopia, Kenya, Madagascar, Rwanda, Tanzania and Zambia) indicated that the most frequent form of disrespect and abuse were abandonment and neglect during labour. In the report of State of Midwifery 2017, which covers 21 countries in Eastern and Southern Africa, most countries identified at least one reason why a woman might be uncomfortable seeking care from a midwife or nurse. Among these reasons were a fear of disrespect or abuse.

**Latin America and the Caribbean**

Maternal and neonatal mortality rates have decreased in Latin America and the Caribbean (LAC) but access to quality care is still not guaranteed for many pregnant women and newborns. Evidence demonstrates that disrespect and abuse remains common, contributing to underutilization of services and poor health outcomes in the region. Several countries in the region have taken steps to address the issue of mistreatment and violence during childbirth by issuing respectful maternity care policies or regulations, such as Nicaragua, Uruguay, Paraguay, Panama, Peru and El Salvador, but these same countries and many others have no formal mechanisms for monitoring cases of mistreatment and violence. There is also anecdotal evidence and trends supporting generalized mistreatment of teenage mothers and women from ethnic minorities and women of lower socioeconomic status, as is the case in Antigua and Barbuda, Barbados, Belize, St Lucia, Dominica, Grenada and Haiti.

Some countries in the region are also addressing chronic rates of caesarian sections as part of their respectful maternity care interventions, such as Chile and Paraguay, while the Dominican Republic still has to take steps to address its 58% C-section rate. Good practices are also documented in the region with inquiries, research and surveys being carried out to address the issue, usually conceptualized as obstetric violence. In Chile, for instance, research conducted by the School of Obstetrics of the University of Chile (Binfa and al., 2016) documents that 90% of women are medically induced in labor using oxytocin, while nearly 60% of them have their membranes artificially ruptured.

In Costa Rica, the Ombudsman investigated several complaints and issued conclusions documenting the causes of obstetric violence including overcrowding in maternity wards, the lack of trained professionals in obstetrics, perinatology and surgery, and transfers of pregnant women at full term for delivery to city hospitals in dangerous conditions, etc.

In Mexico and Bolivia, both conceptualizing the issue as obstetric violence, data has been collected through surveys. In Mexico in 2016, the National Survey on the Dynamics of Household Relations for the first included a section on obstetric violence. According to the results, 33.4% of women experienced obstetric violence in their last childbirth. This included:

* being forced to remain in an uncomfortable or painful position (9.2%);
* being yelled at or scolded (11.2%);
* being told offensive or humiliating things (7%);
* being ignored when asking about labor or baby (9.9%);
* a long delay in care, because she was screaming or complaining a lot (10.3%);
* being pressured to accept an IUD or an operation to prevent further pregnancies (9.3%);
* not being informed on a comprehensible manner why a C-section was required (10.3%);
* and not giving permission for a C-section (9.7%).

As for procedures not recommended during labor, such as amniotomy, enema, trichotomy and episiotomy, it was found that at least one of these was performed in all the facilities studied.[[9]](#footnote-9) In Bolivia, the results of the Prevalence and Characteristics of Violence Against Women Survey (EPCVcM) by the National Statistics Office in 2016 concluded that 63.5% of women underwent obstetric violence. Most women reported not being able to be accompanied by a trusted relationship (67%), not being properly informed (55%), being mocked or criticized for expressing feelings (43%) and not being able to choose their method of delivery (36%). Both in Mexico and Bolivia, the national human rights institution was pivotal in pushing for a national policy dialogue on this issue. Ecuador plans to implement a similar survey in 2019.

**Asia and the Pacific**

Anecdotal evidence indicates that there are many forms of mistreatment and violence during reproductive health care, including childbirth, in India, Bangladesh, Nepal, the Solomon Islands and Timor Leste. In Bangladesh and Iraq, it was specifically mentioned that violence and mistreatment were commonplace in public facilities. Countries like India and Nepal have issued guidelines and adopted legislation to address this issue. The government of India, for instance, has recently launched an initiative called “LaQshya”, which provides guidelines to providers on RMC, including on privacy, birth companion, allowing a position of choice during labour, and avoiding verbal/physical abuse, lithotomy position, unnecessary induction/augmentation and out of pocket expenditures.[[10]](#footnote-10) The country has also gathered data on the issue. Indeed, a recent study in the state of Uttar Pradesh[[11]](#footnote-11) has shown that the prevalence of mistreatment in public health facilities is as follows:

* Physical abuse: 9.5%
* Verbal abuse: 15.2%
* No privacy: 35.5%
* No position of choice for labour and delivery: 91%
* Birth companion not allowed: 6.2%
* Process of labor not explained: 38.9%
* Reasons for augmentation not explained: 14.7%
* Restriction of food and water: 7.1%
* Enema: 28.9% Fundal pressure: 31.3%
* Episiotomy: 21.8%

Other studies also confirm the evidence of disrespect and abuse during childbirth in India.[[12]](#footnote-12) To address this, a new category of midwives are being trained in accordance with ICM standards. This will include skills on respectful and human rights based care, cultural sensitivity, and evidence based care.[[13]](#footnote-13) In other countries like the Philippines, the national human rights institution flagged delays or outright refusal of medical services to women for various reasons, such as lack of records or lack of capacity to pay. The Commission on Human Rights also highlighted the issue of the proliferation of ordinances criminalizing and penalizing traditional and indigenous home births, ultimately discriminating against Muslim and indigenous women and women who live in geographically inaccessible and disadvantaged areas.

1. **Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;**

Linked to informed consent are the chronic cesarean section (C/S) rates in some regions, including Latin America and the Caribbean (<40%).[[14]](#footnote-14) There have been reports when women’s requests for a spontaneous (normal) birth were denied.

**Latin America and the Caribbean**

Most countries in the region like Nicaragua, Panama, Chile, Costa Rica, Honduras, Belize and Haiti have documented regulations or legislations around informed consent for healthcare. But they have different levels of implementation, with most countries requiring consent only in the case of surgeries, including C-sections. Implementing informed consent is still a challenge for several Latin American and Caribbean countries. In Mexico, for instance, the Executive Commission for Attention to Victims, developed in 2016 a Diagnosis on Victimization as result of Obstetric Violence in México with an emphasis on cases in 7 states (Chiapas, Chihuahua, Guanajuato, Mexico, CDMX, Oaxaca and Veracruz). Some of the findings of the diagnosis were that one third (33%) of women were not informed on the birth process, 43% on the cesarean section procedure and more than a quarter (26%) on the type of delivery that would happen.

Several countries require parental or guardian consent for any type of reproductive health care provided to adolescents. This is the case in Antigua and Barbuda, Barbados, Dominica, Grenada, Guyana, St Lucia, Trinidad and Tobago and Suriname. In countries like the Dominican Republic and Uruguay, informed consent is the exception rather than the rule in practice. There is still a gap between laws and regulations and professional practice. In Colombia, despite existing guidelines, decisions are made mainly based on the authoritative knowledge of the health professionals and. For instance, in several hospital settings, routine episiotomy, Kristeller maneuver, enemas and routine shaving are still performed -without consent. Care during pregnancy, childbirth and postpartum is obstetric-led as professional midwives are not recognized, which leads to a high-level of interventions. In some areas, caesarian sections account for 90% of births.

**Asia and the Pacific**

Most countries in the region apply informed consent in the case of surgical procedures, including C-sections. In rare cases, informed consent is required for all types of reproductive health care, such as in India, Pakistan, the Fiji Islands and Nepal. Yet implementing this requirement remains challenging; for example, a study in India found that 30.8% women did not give their informed consent prior to a vaginal examination.[[15]](#footnote-15) Countries like Bangladesh, Afghanistan and Iraq, similarly, were found to have a weak implementation of the requirement for informed consent.

1. **Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations;**

Putting in place user-centric accountability frameworks in health facilities whereby women can provide their feedback on how they have been treated is central to identifying where challenges lie and what issues need addressing[[16]](#footnote-16). It is also a first step towards ensuring accountability and remedy for victims where their rights have been violated.

**Latin America and the Caribbean**

For many countries in the region, complaints are administered at the level of the chief medical officer in the health facility. This is the practice in Dominica, Grenada, Guyana, St Lucia and Antigua and Barbuda. Yet, accountability has been found to be weak for many of these cases, with compensation to victims rarely provided. Where the health facilities manage the complaints in-house through their human resources department, transparency and independence can also be an issue -as was documented in Honduras and St Vincent.

In some countries where there is a law that regulates quality of care, complaints can be dealt with at the central level by a specialized unit within the Ministry of Health; Uruguay and El Salvador have adopted this model whereas Honduras, Costa Rica, Haiti and Peru have an ombudsperson mandated to deal with these issues. In some cases, there is a co-existence of medical arbitration bodies and human rights institution/ombudsperson, as is the case in Belize and Mexico.

Good practices are to be noted, including in Barbados where the ministry of health has adopted a continuous quality improvement approach and is planning to institute a national quality council to review implementation of the approach, in Venezuela where the law on obstetric violence provides for reparation and compensation, and in Bolivia where UNICEF and the Ministry of Health have developed a baby-friendly label to support accountability at facility level. Costa Rica has even issued a circular to provide for the opening of disciplinary and administrative procedures when reports of abuse are substantiated. Yet, in all cases, gaps in the implementation of accountability mechanisms has been noted. Integral reparation of human rights violations, including financial compensation, remains a rarity.

**Asia and the Pacific**

There were only a few cases of facility-based complaints mechanisms documented for this region. When there is no facility based accountability mechanism, cases can only be investigated through a national human rights commission, if there is one in the country. Timor Leste, Afghanistan and the Fiji Islands have documented the existence of complaints mechanisms and dedicated human resources/bodies for the review of cases.

Good practices of facility based mechanisms were noted in India and Cambodia. In the former, there are general grievance redress mechanisms in public and private health care establishments[[17]](#footnote-17), a patient welfare committee called “Rogi Kalyan Samiti” whose objective is to operationalize the grievance redress systems, as well as Quality Assurance Committees. The functioning of these redress mechanisms has been analyzed in a study, which noted that it needed to be strengthened.[[18]](#footnote-18) In Cambodia, a Hospital Management Committee or a Health Centre Management Committee, consisting of local representatives, local authorities and healthcare representatives, and chaired by the Head of the District or the Head of Commune, sits in each health facility to address any complaint by patients.

Both in the Philippines and in Bangladesh, the national human rights institution is mandated to address these violations, while in the Solomon Islands, the Nursing Council has investigated cases and provided redress in the form of administrative sanctions and compensation to the victims. Accountability mechanisms are still not prevalent or fully functional in the region however,, though innovative and promising practices do exist.

1. **Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue**

**Eastern and Southern Africa**

A few countries in the region are taking action to ensure respectful care; DR Congo and South Africa have revised their medical education curricula to emphasize its importance, and midwifery associations in Zambia and Zimbabwe have provided in-service training on respectful care.[[19]](#footnote-19) Regulated codes of ethics would help to define and frame a mandate for respectful care. 16 countries in the region said that at least one national policy document specifically addresses how the country will deliver Sexual, Reproductive, Maternal, Newborn and Adolescent Health care that is sensitive to social, cultural and traditional needs. Examples provided by countries include: Botswana’s Patient Charter and Policy which states that services should be sensitive to culture and tradition, Ethiopia’s health service delivery guidelines which recommend the establishment of a “youth-friendly corner” in all health centres, and Zambia’s Scale up Family Planning 2020 plan which emphasizes that family planning services should be socially and culturally sensitive.

**Latin America and the Caribbean**

UNFPA in Latin America and the Carribean has been doing RMC work complementary to the activities of the Regional Interagency Task Force for Maternal Mortality Reduction (GTR in Spanish) of which UNFPA LACRO is currently the technical secretariat. The GTR has worked effectively to promote an enabling policy framework and inter-agency synergy for maternal mortality reduction across the region in areas including RMC, intercultural maternal health care, maternal deaths surveillance and response (MDSR), and the provision of the latest evidence-based guidelines and selected practices to countries. To guide action, the LAC Regional Interagency Task Force for Maternal Mortality Reduction (GTR in Spanish) facilitated sub regional consultations focusing on human rights and the quality of care in Panama (2016) and in Trinidad and Tobago (2017).

The 91 meeting participants from 18 LAC countries identified the following main challenges and drivers of disrespect and abuse: insufficient political will, poor accountability systems, limited financial resources, inadequate infrastructure, lack of respect for cultural difference and women’s perspectives, gender inequality, poor working environment for health personnel, overworked health staff with limited capacity, weak supervision and implementation of quality standards, insufficient data on vulnerable populations and poor RMC monitoring and evaluation systems. The key priorities to accelerate action on RMC in LAC identified were: high-level inter-sectoral advocacy to foster political and financial commitments, dissemination of best available evidence, documentation and dissemination of best practices, incorporation of key RMC elements into regulatory frameworks, educational curricula and training courses, empowering midwives at all levels, strengthening monitoring and evaluation systems including RMC relevant indicators, developing behavior change and communication strategies to reach vulnerable groups and improving infrastructure.

Many countries in the region, such as Nicaragua, Honduras, El Salvador, Ecuador have guidelines and standards applicable to respectful maternity care which are updated periodically. While others, such as Bolivia, Costa Rica and Chile have attempted to issue comprehensive legislation to protect women’s rights before, during and after pregnancy. Countries in the region address violence and mistreatment during childbirth through a myriad of focus, ranging from issuing regulations, guidelines and protocols on sexual and reproductive health (Barbados, Grenada, Belize) or violence against women and gender-based violence (Antigua and Barbuda, Dominica, Haiti, St Lucia, Peru, Paraguay). These are usually in line with WHO guidelines and the countries have worked with UNFPA and/or WHO to align to international standards. Countries like Panama, Cuba, and Guyana are currently working with relevant UN organizations, including UNFPA, to adopt and implement standards applicable to health sector response to violence against women in general, and respectful maternity care in particular. Good practices have been shared by Uruguay and Bolivia that have aimed to ensure respectful maternity care through legal provisions and operational guidelines.

Still, efforts need to be scaled up to devise integrated and comprehensive responses addressing VAW, in general, and mistreatment and violence during childbirth, in particular. Several response systems are narrowly focusing on sexual violence and intimate partner violence. This is the case in Colombia, for instance, where the health system response, though integrated, is yet to be broadened and implemented in remote and conflict-stricken areas.

**Asia and the Pacific**

Many countries developed guidelines, namely collaborating with UNFPA or other international partners, to implement health sector responses to gender-based violence or violence against women which are compliant with WHO standards. This is the case in Pakistan, Bangladesh, Cambodia, the Fiji Islands, the Solomon Islands, Nepal, and Afghanistan. Other countries, like India, Kiribati and Timor Leste are working to do the same, sometimes with the aim of broadening existing legislation limited to clinical management of sexual violence.

The Philippines has shared good practices with the establishment of Women and Children Protection Units (WCPU) in hospitals (typically staffed by a trained physician, a registered social worker and police officer). These units aim to institutionalize and standardize quality health services for all women and children.

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2. [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920649/*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920649/) [↑](#footnote-ref-2)
3. [*https://www.who.int/reproductivehealth/topics/maternal\_perinatal/statement-childbirth-rights/en/*](https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-rights/en/) [↑](#footnote-ref-3)
4. [*https://www.sciencedirect.com/science/article/pii/S0140673616314726?via%3Dihub*](https://www.sciencedirect.com/science/article/pii/S0140673616314726?via%3Dihub) [↑](#footnote-ref-4)
5. [*https://www.wilsoncenter.org/sites/default/files/myriam\_vuckovic\_tltl\_and\_tmts\_in\_india.pdf*](https://www.wilsoncenter.org/sites/default/files/myriam_vuckovic_tltl_and_tmts_in_india.pdf) [↑](#footnote-ref-5)
6. [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4982443/*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4982443/) [↑](#footnote-ref-6)
7. [*https://www.mhtf.org/2017/05/30/advancing-an-evidence-based-approach-to-episiotomy/*](https://www.mhtf.org/2017/05/30/advancing-an-evidence-based-approach-to-episiotomy/) [↑](#footnote-ref-7)
8. [*https://www.bmj.com/content/316/7139/1179#ref-4*](https://www.bmj.com/content/316/7139/1179#ref-4) [↑](#footnote-ref-8)
9. Diagnosis on Victimization as result of Obstetric Violence in México (Chiapas, Chihuahua, Guanajuato, Mexico, CDMX, Oaxaca and Veracruz), Executive Commission for Attention to Victims, 2016 [↑](#footnote-ref-9)
10. *Ibid* [↑](#footnote-ref-10)
11. *An investigation into mistreatment of women during labor and childbirth in maternity care facilities in Uttar Pradesh, India: a mixed methods study; available:* [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345007/*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345007/) [↑](#footnote-ref-11)
12. [*https://nhm.gov.in/New\_Updates\_2018/NHM\_Components/RMNCH\_MH\_Guidelines/LaQshya-Guidelines.pdfhttps://www.researchgate.net/publication/327124233\_Silent\_voices\_Institutional\_disrespect\_and\_abuse\_during\_delivery\_among\_women\_of\_Varanasi\_district\_northern\_India*](https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/LaQshya-Guidelines.pdfhttps://www.researchgate.net/publication/327124233_Silent_voices_Institutional_disrespect_and_abuse_during_delivery_among_women_of_Varanasi_district_northern_India)*)* [↑](#footnote-ref-12)
13. [*https://nhm.gov.in/New\_Updates\_2018/NHM\_Components/RMNCHA/MH/Guidelines/MIDWIFERY\_GUIDELINE.pdf*](https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/MIDWIFERY_GUIDELINE.pdf) [↑](#footnote-ref-13)
14. [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4743929/*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4743929/) [↑](#footnote-ref-14)
15. [*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345007\*](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345007\) [↑](#footnote-ref-15)
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19. *UNFPA. The State of Midwifery 2017: Analysis of the Sexual Reproductive, maternal, Newborn and Adolescent Health Workforce in east and Southern Africa. United Nations Population Fund East and Southern Africa region; 2017. Available from:* [*https://esaro.unfpa.org/en/publications/state-worlds-midwifery-analysis-sexual-reproductive-maternal-newborn-and-adolescent*](https://esaro.unfpa.org/en/publications/state-worlds-midwifery-analysis-sexual-reproductive-maternal-newborn-and-adolescent)*)* [↑](#footnote-ref-19)