**UN Special Rapporteur on Violence against Women**

**Submission from the White Ribbon Alliance**

*On mistreatment and violence against women during reproductive healthcare with a focus on childbirth*

1. **Introduction**

Founded in 1999, White Ribbon Alliance’s (WRA) vision is a world where all women and girls realize their right to quality health and well-being. This vision is achieved through our mission to activate a people-led movement for reproductive, maternal and newborn health and rights. Each of WRA’s 14 National Alliances seeks to elevate citizen voices, particularly women’s and adolescent girls’, as the centerpiece of their efforts to influence policies, programs and practices; harness resources; and enhance accountability. WRA is recognized as a leader in citizen-led accountability and reproductive, maternal, newborn health advocacy around the world. Comprised of both individual and organizational members in the tens of thousands, members represent civil society and community-based organizations, private businesses, health professional associations, academia, media, politicians, faith-based groups, traditional leaders, and local government officials.

In 2011, the White Ribbon Alliance (WRA) convened a multi-sectoral group to launch a global campaign to promote clear standards for Respectful Maternity Care (RMC) rooted in international human rights. Together, the members of this community of concern produced a groundbreaking consensus document, the *Respectful Maternity Care Charter: The Universal Rights of Childbearing Women* (hereafter referred to as the RMC Charter), which demonstrates how fundamental human rights apply in the context of maternity care.[[1]](#footnote-1)

1. **The Challenge**

In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families and represent a time of intense vulnerability. The concept of “safe motherhood” is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Women’s experiences with caregivers at this time have the impact to empower and comfort or to inflict lasting damage and emotional trauma. While many organizations and interventions aim to improve access to skilled birth care, the quality of relationships with caregivers has received less attention.

Disrespect and abuse (D&A) is a continuum and many categories can overlap or take different forms depending on the context. Most forms of D&A occur in the countries where WRA works. A 2010 landscape analysis conducted by Bowser and Hill identified seven major categories of D&A, which include: physical abuse; non-consented care; non-confidential care; non-dignified care (including verbal abuse); discrimination based on specific attributes; abandonment or denial of care; detention in facilities.[[2]](#footnote-2)

**Physical abuse** can include a range of violations, such as pinching, hitting and other severe forms of physical abuse as reported by WRA National Alliances in India, Nigeria, Nepal and Kenya. At times providers may try to explain or justify physical abuse as being for the benefit of the patient, for example slapping a woman who is being uncooperative or tying a woman’s legs to the stretcher during labor as described in our assessments in Nigeria and Pakistan. Physical and verbal abuse violate women’s basic human rights and autonomy and can traumatize women who are already in a vulnerable position during childbirth and deter them from utilizing skilled care and returning to a facility to deliver.

**Non-consented care:** When women deliver in facilities informed consent is not always acquired or respected. Often, processes and procedures are not fully explained to women, as evidenced in our work in India, Nigeria, Nepal and Malawi. Some women also report that procedures, such as episiotomies, were performed against their wishes, as for example, in Nepal and Nigeria. In India women were reporting that procedures, such as insertion of post-partum long-acting contraceptive methods were performed without their consent. Women’s choice of birth companion and birth position are not always respected, as reported by our colleagues in India and Tanzania.

**Non-confidential care:** occurs frequently in under resourced health facilities. In crowded labor wards it is hard to talk about privacy when women have to physically share a bed as evidenced in India and Tanzania, and Pakistan. Very often screens or curtains that are meant to divide beds are not available or not used as evidenced in India and Malawi.

**Verbal abuse:** Verbal abuse is one of the most frequent types of disrespect and abuse women experience during childbirth. Several WRA National Alliances reported women are shouted at or scolded, insulted, or blamed for negative pregnancy outcomes during facility-based childbirth - e.g. India, Nigeria, Nepal and Pakistan.

**Discrimination & Abandonment/Denial of Care:** Acts of omission are also forms of disrespect and abuse and failure to recognize, protect and fulfill a patient’s rights is a form of mistreatment. Abandonment or denial of care is a prevalent form of disrespect and abuse globally and it occurs for different causes. Many women report discrimination due to various patient attributions, including socioeconomic status reported in India, Nigeria, Pakistan and Nepal, and ethnicity in India, which can be a cause of denial or abandonment of care. An inadequate number of healthcare providers is a larger driving cause of abandonment or denial of care than discrimination. In many low- and middle-income countries the healthcare workforce is not large enough to serve their communities and healthcare centers are dangerously understaffed in India, Tanzania, Malawi and Nigeria. In Malawi, our census-style survey discovered that more than 20,000 additional midwives are needed to reach World Health Organization standard ratio of one midwife to 175 women of reproductive age. In 2016, Malawi had only 3420 midwives for a population of more than 18 million.[[3]](#footnote-3)

**Detention:** detention in facilities is a grave violation that negatively impacts a woman, her baby, and her entire family. The threat of detention can deter women from accessing skilled care in a facility. In Nigeria, several women who gave birth in mission homes or with traditional birth attendants, instead of in a facility, mentioned cost as one of the main factors in their decision. A recent investigation by the BBC in Nigeria discovered that there were many cases of detention in facilities, impacting especially women and babies after childbirth.[[4]](#footnote-4) In Kenya it is illegal to detain women in hospitals due to an inability to pay, and maternal healthcare has been free since 2013.[[5]](#footnote-5) But this harmful practice continues and in 2019 twenty women were being detained at Kenyatta National Hospital, some for close to a year, due to an inability to pay hospital bills.[[6]](#footnote-6) An investigation by the Associated Press highlighted the problems at Kenyatta National Hospital and other facilities in the country.[[7]](#footnote-7)

**Healthcare providers** are also subject to disrespect and abuse at the facilities where they are employed and in the larger community. Many healthcare providers, including midwives, are predominately women and face societal discrimination and violence against women. In a global survey of midwives from 93 countries, 20-30 percent reported being treated poorly because of gender discrimination.[[8]](#footnote-8) Part of this discrimination is the lower social and financial value assigned to midwifery and nursing compared to other professions within the medical field. Midwives also experience harassment in the facilities where they work. Thirty-seven percent of midwives surveyed said they experience harassment at work and many fear for their security. A significant number of respondents, particularly in Africa, said that the disrespect in their workplace extends to verbal harassment and at times physical and sexual abuse Midwives in Nigeria, and Tanzania reported being afraid to introduce themselves as midwives because of negative community attitudes to the profession, as reported by our colleagues there. Many midwives join the profession out of a motivation to save lives and passion for providing care. However, their working conditions are not motivating, their facilities are often understaffed, midwives are underpaid, and many rely on a second source of income to survive.

1. **Participatory Accountability as a Solution**

Participatory accountability and feedback mechanisms where women’s voices and experiences are central are crucial for ensuring respectful maternity care. There mechanisms must be integrated within the system and used continuously to improve and monitor respectful care. Social accountability tools that have been successfully used–often together– in ensuring the participation of women in demanding accountability for quality respectful maternal healthcare:

*Community monitoring:* Community monitoring is a form of public oversight to increase the accountability and quality of social services. WRA India joined with partners to develop the Mobile Monitor for Quality of Maternal Care (MoM-QC).[[9]](#footnote-9) This program used a toll-free number and basic mobile phone technology to inform expecting mothers of existing health services and give them an opportunity to provide feedback on the quality of the services they received. The program targeted underserved and rural populations and almost all members of the cohort were able to use the mobile phone as a tool for learning and feedback, despite socioeconomic, literacy, and connectivity barriers. The feedback received was used to encourage providers and health officials (both public and private) who want to be responsive to women’s needs to improve care in response to quality ratings. This is a low-cost mechanism that can be scaled in order to collect objective, balanced and direct feedback from women that can be used to address quality of care concerns in public and private health facilities.

*Public Hearings and Community Meetings:* Public hearings and community meetings provide a platform for government officials, stakeholders, and community members to gather together and discuss concerns regarding health services and, together, develop solutions and plans for action. They serve a double purpose of empowering citizens to know their rights and to hold their leaders to account on commitments made to end the preventable deaths of women and newborns.[[10]](#footnote-10) WRA Malawi has successfully used “citizen hearings” to draw attention to the needs of both women and providers and thus support the community to design mutually beneficial outcomes that have improved respectful care for women.[[11]](#footnote-11) WRA India has created forums and reported high levels of participation from elected leaders, health workers, health providers, and women in the community.WRA Nigeria organized “Family Health Days” in Kwara State to allow families and health workers to come together to discuss quality of care and for community members to learn about their rights to services at the health facilities, the chain of command and how they could lodge complaints with the leadership of the health facility whenever they felt they had experienced disrespect or abuse.

*Other client feedback mechanisms:* Ensuring that opportunities exist for community members to voice their concerns and provide feedback about the health programs designed to serve them creates the basis for identifying and addressing key issues and developing action plans. WRA India’s Citizens’ Voice Reporter provides a platform for citizens to hold leaders, politicians and governments accountable for their commitments to women and children by conducting and publishing interviews that document government follow-through on obligations regarding safe pregnancy and childbirth.[[12]](#footnote-12)

*Policy changes and legal redress mechanisms* also play a large role in ensuring respectful, people-centered care. For example, the new Safe Motherhood and Reproductive Health Rights Act in Nepal codifies basic human rights such as consent, privacy and confidentiality, which are the key to delivering respectful care.[[13]](#footnote-13) In addition, strategic human rights litigation has played an important role in bringing attention to the most horrific violations of human dignity– as for example, cases of detention of mothers and babies after delivery in Kenya.[[14]](#footnote-14) In India, the Human Rights Law Network (HRLN), a collective of lawyers and social activists, has filed 150 cases in 14 states over the past 16 years regarding the violation of reproductive rights. The violations HRLN covers include denial of services based on class, caste, or religion, lack of privacy, maternal or infant death, and medical procedures – including removal of uterus or insertion of PP-IUD without consent.

1. **Recommendations**

It is the responsibility of every government to ensure that everyone’s human rights are respected, protected and fulfilled. This is especially important in childbirth when both the woman and her newborn are especially vulnerable and extra measures might be needed to ensure their rights are realized.

1. Governments should report periodically on the steps they are taking to address disrespect and abuse in childbirth. Existing reporting mechanisms that can be utilized include: UPR, CEDAW, CRC, and any other relevant reporting mechanisms such as CRPD, ICERD, UNCAT, etc.
2. Governments need to be supported and held accountable for regulating public and private provision of health services and ensure that human rights are respected, protected and fulfilled no matter the setting.
3. Governments should institute mechanisms to continuously collect and aggregate feedback information from girls and women and use this information to design and monitor services. Girls and women should participate in the design, monitoring and evaluation of services that are presumed to benefit them.
4. Governments should institutionalize accountability mechanisms at the national and sub-national level. Promising practices in social accountability should be adopted and scaled by governments.
5. Governments should ensure that providers are prepared and supported to provide high-quality, respectful care. Governments need to invest in training providers to international standards and ensuring support supervision so that providers can continue to grow.
6. Governments need to ensure adequate number of providers to meet minimum international standards. Government should ensure the availability of feedback mechanisms for providers, so they can raise concerns and ensure accountability in healthcare settings.
7. The international community and donors have an important role to play to support governments with technical assistance and ensure that promising practices are disseminated within the framework of international cooperation.

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3. White Ribbon Alliance, Summary of a Count of Bedside Midwives in Malawi, February 2017, *available at* <https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Summary-of-a-Count-of-Bedside-Midwives-in-Malawi.pdf>. [↑](#footnote-ref-3)
4. BBC Radio 4, Nigeria’s Patient “Prisoners,” 26 Nov. 2018, *available at* <https://www.bbc.co.uk/programmes/m00017vv> [↑](#footnote-ref-4)
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