Office of the High Commissioner for Human Rights

Submission from the Global Respectful Maternity Care Council

On the Implementation of the Technical Guidance on the Application of a Human Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality, (A/HRC/21/22)

Introduction

The aim of this report is to highlight program possibilities and challenges Respectful Maternity Care Council member organizations and other peer organizations encounter in operationalizing certain aspects of A/HRC/21/22. We seek to contribute to understanding on maternal mortality and morbidity in humanitarian settings and the challenges faced by women and providers in healthcare settings during times of crisis and emergencies. The report focuses on how explicit research, policy, and program engagement of respectful maternity care can advance the elimination of maternal mortality and morbidity in humanitarian settings and the provision of quality, person-centered care.

Respectful Maternity Care

Respectful maternity care (RMC) is a universal human right that is due to every childbearing woman in every health system around the world. It expands the notion of safe motherhood beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including recognition of and support for women's autonomy, dignity, feelings, choices, and preferences, such as choice of companionship wherever possible. In 2011, the White Ribbon Alliance (WRA) convened a global and multi-sectoral community of concern to launch a global campaign to promote a clear standard for 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 (WRA, 2011). The initial community of concern formed the Global Respectful Maternity Care Council (GRMCC).

Today, GRMCC is a growing multi-sectoral group of 100 organizations, representing over 340 members from around the world, including researchers, clinicians, technical advisors, program managers, advocates, professional associations, UN agencies, and donors. The GRMCC has two active subcommittees, one devoted to advocacy and another focused on research and practice, and is dedicated to identifying, implementing, and advocating for strategies to promote respectful maternity care and tackle the problem of disrespect and abuse during childbirth in order to improve the quality of reproductive, maternal, and newborn health. This submission represents the consolidated input of the GRMCC Advocacy Subcommittee.

The Challenge

Women's experiences with maternity providers can empower and comfort them, or inflict lasting damage and emotional trauma. Disrespect and abuse (D&A) can be defined generally as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or

conditions that are experienced as or intended to be humiliating or undignified" (Freedman et al., 2014). D&A has many manifestations, both individual (specific provider behaviors experienced or intended as disrespectful or humiliating) and structural (systemic deficiencies that create a disrespectful or abusive environment). Mistreatment can occur in both low- and high-income settings, but may manifest in different forms depending on the context (Schroll et al., 2013). While D&A is perpetuated and experienced by individuals, the practice is a manifestation of structural violence and gender inequality that has become normalized in societies around the world (Sadler et al., 2016; Jewkes & Penn-Kekana, 2015).

Mistreatment in humanitarian settings

By the end of 2016, there were 32 million new cases of internal displacement, of which 24.2 million people were displaced by natural disasters and 6.9 million were displaced by conflict. The United Nations (UN) and partners are working to provide humanitarian assistance to nearly 96.2 million people living in 40 countries (United Nations Secretary-General, n.d.). With concerns that humanitarian emergencies will only increase, it is critical that humanitarian agencies, especially those implementing maternal health programs and protection communities identify effective strategies for ensuring safe, timely, respectful, and culturally appropriate maternity care in crises.

Maternity care is one aspect of sexual and reproductive health (SRH) that deserves special attention in humanitarian settings (Austin et al., 2008). According to a United Nations Population Fund (UNFPA) report on SRH in emergencies, one in five women of childbearing age in crisis settings is likely to be pregnant, and pregnancy and childbirth complications that would be treatable in other contexts can become fatal due to the destruction or disruption of health care services. Approximately 60 percent of maternal deaths occur in countries affected by humanitarian crises and fragility, with more than 500 women in these environments dying each day from complications of pregnancy and childbirth (UNFPA, 2017). With concerns that humanitarian emergencies will only increase (UNSG, n.d.), it becomes even more critical that maternal health professionals identify effective strategies for ensuring safe and secure delivery in crises. Mistreatment towards women giving birth within the context of an emergency, such as a natural disaster or warzone, has not been well researched, yet remains a large concern given that the heightened resource and security challenges and vulnerability of women in emergency settings may exacerbate the systematic causes of D&A outlined above.

There has been some documentation of D&A in humanitarian and emergency settings. For example, Krause et al.'s study of reproductive health services in Zaatri Refugee Camp in Jordan revealed that Syrian refugee women living in the camp had low utilization of facility-assisted birth. The main reason for this low utilization of services was the lack of respect women received from camp health providers. Despite the fact that the UN provided free maternal and reproductive health services, many women in Zaatri were reluctant to use them due to poor quality and lack of female providers and privacy. In addition, women described the facilities as being attended by unqualified providers and lacking basic resources (Krause et al., 2015). There have also been examples of mistreatment against refugee women in the media, such as refugee women in Greece denied information, pain medication, female providers, translators, and other basic accommodations and subjected to interventions – cesarean section, episiotomy, even hysterectomy – without their consent (Ahmetasevic, 2016; Gill, 2016a; Gill, 2016b),

and refugees in Lebanon and Iran turned away or prevented from taking their baby home due to inability to pay (Karas, 2017; Nawa, 2017).

However, there is a need for more research into mistreatment in humanitarian settings and efforts to ensure proper documentation and measurement of such disrespect, especially among displaced people who may be excluded under current indicators.

Drivers of Mistreatment in humanitarian settings

Weak, fragmented, and under-resourced health systems underlie disrespect and abuse. The negative attributes of such systems are often exacerbated in humanitarian emergencies. Researchers reviewing hospitals and clinics in twelve conflict-affected settings found them to have "inadequate infrastructure, including electricity and clean running water; shortages of essential medicines, equipment and supplies; gaps in communication and emergency transport systems; shortages of qualified staff; lack of infection prevention; and low utilization of services and insufficient data collection" (Krause et al., 2006, p.209). Lack of protocols and resources creates a challenging environment for health providers to navigate, opening space for D&A in times of stress and frustration.

Demoralization within the workforce stems from, and contributes to, weak health systems. This demoralization is a known contributor to mistreatment (Filby et al., 2016). In conflict settings, health workers are at heightened risk of burnout/compassion fatigue, secondary trauma, and depression (Tyson, 2007). Further, many frontline workers, such as midwives, experience disrespect, discrimination, and/or violence themselves in the workforce (Filby et al., 2016; World Health Organization et al., 2016). Paradoxically, while frontline providers may need increased technical and emotional support during an emergency, such support may be less available than normal. Moreover, cultural differences, language barriers, and the stigmatization of refugees may exacerbate hierarchies between providers and patients in humanitarian settings.

Finally, mistreatment may be increasingly normalized in an emergency, as stress and poor infrastructure, inputs, and lack of support become the norm. In a state of urgency, for instance, providers could skip important childbirth guidelines such as post-birth follow up, transfer their stress onto their patients through verbal abuse during labor and delivery, and/or conduct deliveries in a manner so as to make the providers' job easier but that may not be in the woman's best interest (e.g., restricting delivery to the bed, unindicated episiotomies or caesarean sections) ("Are You Syrious?," 2016; Ahmetasevic, 2016).

Types of violations that are more likely in humanitarian settings:

- *Lack of information*: In an emergency scenario, providers may lack the time or resources to fully explain procedures or interventions. However, for women who are delivering in a hospital or in a Western health care setting for the first time, have fears surrounding childbirth or interventions, or have limited education, efforts to educate, counsel, and when possible, accommodate women's desires may help to alleviate women's concerns (Fink et al., 2014).

- *Lack of privacy*: Issues of privacy can be of particular concern in camp settings, where there is very little space and one-room tents are often used as clinics (Women's Commission, 2004; Krause et al., 2015). During the earthquakes in Haiti and Pakistan, women hesitated to access care because of the lack of privacy that facilities provided (Bloem & Miller, 2010).
- *Lack of consent*: Emergencies can cause migration, leading to groups of people living in places where they do not speak the language, are not familiar with the norms, or are unwelcome. Language and cultural barriers, compounded by discrimination, lack of education, and health personnel short on time, can lead to non-consensual health intervention. In Namibia in the 1980s, for example, women in SWAPO refugee camps were sterilized during cesarean sections without their knowledge in order to limit their reproduction (Lindsay, 1986). In Greece, many Syrian refugee women describe undergoing cesareans and even hysterectomies without their knowledge or consent (Ahmetasevic, 2016; Gill, 2016a).
- *Denial or delay of care*: Interviews with women in the West Bank and Gaza found that restricted mobility and lack of funding lead to limited functioning of facilities and an increase in deliveries at home and at military checkpoints. Military checkpoints have been found to block ambulances and women in labor, and there exist reports of women dying at military checkpoints because they were denied passage to reach the hospital (Aswad, 2007; Bosmans et al., 2008). When camp health facilities close at night, Syrian refugees in Greece have to rely on the Greek healthcare system, which prioritizes the needs of its citizens; it can take up to twelve hours for an ambulance to arrive (Ahmetasevic, 2016). At facilities, lack of medicine, equipment, personnel, or skill can also cause delays in care (Hynes et al., 2012). Even when resources are available, care may be delayed or denied if patients do not have the funds to pay for them (Women's Commission, 2004). In Malaysia, for example, Rohingya who do not possess a valid UNHCR registration card cannot access government and private hospitals, even in emergencies when by law these hospitals are required to treat them; even with the cards, which allow for subsidized healthcare, costs – especially those for pregnancy-related and childbirth services – are often out of reach and families must look to outside sources to cover fees (Sullivan, 2016).
- *Neglect and abandonment*: The risk of neglect and abandonment is likely higher in emergencies due to severe human and material resource shortages and discrimination. In one study, Palestinian women described being left alone in the hospital for long periods during labor, without even family to provide support, because midwives and nurses were overwhelmed with patients; in addition, the women would often leave the hospital within hours of delivery and be lost to follow-up (Wick, 2002).
- *Issues relating to the presence of short-term, foreign aid health workers*: In some cases, short-term mission staff working in emergency response may lack cultural competency or lack the time and resources to provide culturally appropriate care. Although not necessarily intended as D&A, laboring women may perceive care as disrespectful if providers do not share or adhere to their cultural norms (e.g. around gender, language, power), and consequently, be deterred from utilizing services. For example, in certain contexts, the presence of male providers or ancillary personnel, such as interpreters, may also be seen as disrespectful and prevent women from seeking care (Women's Commission, 2004; Bloem & Miller, 2010; Krause et al., 2015).

The Solution

Campaigners have called for respectful care and protection of all childbearing women, especially the marginalized and vulnerable, such as adolescents, minorities, women with disabilities, women in remote areas, and women with severely constrained financial circumstances (Amnesty International, 2010; WRA, 2011; WHO, 2015). The **RMC Charter**, a normative document that was developed collaboratively by researchers, clinicians, program implementers, and advocates, outlines a rights-based approach to maternity care. The Charter is based on universally recognized international human rights instruments to which many countries are signatories, such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social, and Cultural Rights; and the Convention on the Elimination of all Forms of Discrimination against Women. The Charter is being integrated into new standards of care, promoting the respect, protection, and fulfillment of human rights (WHO, 2016).

In 2018 the Inter-Agency Working Group for Reproductive Health in Crises (IAWG) will publish an updated **Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM).** The manual incorporates respectful maternity care as a non-negotiable component of sexual and reproductive health care that is due to women, babies and their families, including in humanitarian settings. It is critical that governments, international and UN organizations, and implementing partners join forces in operationalizing the manual and ensuring that human rights in maternity care are respected, protected, and fulfilled, especially for the most vulnerable women and children. Engaging the health sector/cluster in humanitarian settings to advocate for full implementation of the Minimum Initial Service Package (MISP) and transition to comprehensive sexual and reproductive health services as soon as is feasible is important.

Moreover, **accountability for the provision of quality maternity services** needs to be strengthened in humanitarian settings, with the continued commitment of all stakeholders to the Core Standard on Quality and Accountability (CHS Alliance et al., 2016) and adoption of the main components of the Independent Accountability Panel (IAP): monitor, review, and act/remedy (IAP, 2016). From the onset of a humanitarian crisis, accountability mechanisms should be put into place, using innovative approaches and adapting social accountability models such as citizen monitoring. In conflict-affected Democratic Republic of Congo, Ho et al. (2015) found that community scorecards increased transparency and community participation in facility management and improved quality of care by "facilitating flows of information, increasing collaboration, and supporting user demands regarding their entitlements" (p.8). If implemented early on, such mechanisms could improve the functioning of health systems in fragile settings. An independent framework needs to be established for oversight on how well accountability mechanisms are implemented in crisis settings. It should be led by the IAP with links to human rights bodies and country mechanisms, such as independent monitoring bodies (IAP, 2016).

Respectful maternity care (RMC) in humanitarian settings is a woman's right, not a luxury. Childbirth should not be another manifestation of the alienation, lack of dignity, and stigma that women in humanitarian settings may experience. Instead, it could be an empowering experience that gives hope for the future and builds resilient societies and responsive states.

Signed:

White Ribbon Alliance

Averting Maternal Death and Disability – Columbia University

American Refugee Committee

Regroupement Naissance-Renaissance – Canada

Citizen, Democracy and Accountability (CDA) – Slovakia

Ženské kruhy (Women's circles) – Slovakia

Goodbirth Network

Emory University, United States

International MotherBaby Childbirth Organization

Roda - Parents in Action, Croatia

Maternity Foundation, United Kingdom

The Center for Health and Gender Equity (CHANGE)

ReHuNa – The Brazilian Network for the Humanization of Childbirth (Rede pela Humanização do Parto e Nascimento)

Maternal Health Taskforce

El Parto es Nuestro, Spain

El Parto es Nuestro, Ecuador

Every Mother Counts

Canadian Association of Midwives

HOPE Foundation for Women and Children of Bangladesh

CARE

Management Sciences for Health

Maternal Health Systems and Implementation Research Group, King's College London, UK

International Confederation of Midwives

Save the Children

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