“If I did not slap you, you would not have given birth to your baby”:
The mistreatment of women during childbirth

by
Meghan A. Bohren

A dissertation submitted to Johns Hopkins University in conformity with the requirements for the
degree of Doctor of Philosophy.

Baltimore, Maryland, USA

February 2016

© 2016 Meghan A. Bohren
All Rights Reserved
Intended to be blank.
Dissertation abstract

Background

Evidence suggests that women experience mistreatment during childbirth in facilities across the world, including physical and verbal abuse, discrimination and neglect. However, there is no agreed-upon definition of mistreatment, hampering measurement and preventative measures. This study aims to address this by systematically reviewing existing evidence and conducting a qualitative study in Abuja, Nigeria.

Methods

A mixed-methods systematic review was conducted to contribute to the development of a global evidence-informed definition of mistreatment during childbirth. PubMed, CINAHL, Embase and grey literature were searched. Thematic synthesis was used for qualitative evidence and the CERQual approach was used to assess confidence in qualitative review findings. Due to heterogeneity of quantitative data, only descriptions of study characteristics, outcome measures, and results are presented. A qualitative study using focus group discussions and in-depth interviews was conducted in Abuja, Nigeria, among women, midwives, doctors and administrators. Thematic synthesis was used to identify key themes and patterns.

Results

In the systematic review, 65 studies were included from 34 countries. Qualitative findings were organized under seven domains: 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. The first qualitative analysis showed that women experience and providers acknowledge mistreatment during childbirth, including physical
and verbal abuse, being tied to a delivery bed, and detainment in the hospital. The second qualitative analysis showed that women and providers are accepting of mistreatment, including slapping, shouting, neglect and physical restraint, when used to gain compliance or ensure a good outcome.

**Conclusion**

Mistreatment of women during childbirth occurs on labor wards across the world, and has serious public health and human rights implications. This dissertation provides three contributions: (1) evidence-informed typology of mistreatment; (2) contextual analysis of experiences and perceptions of mistreatment during childbirth in Abuja; and (3) analysis of the parallels between acceptability of mistreatment during childbirth and violence against women more broadly. These results can be used to develop measurement tools to quantify the burden of mistreatment, and to inform future research and interventions to prevent mistreatment and promote respectful care.
Committee of final thesis readers

Committee Members:

Michelle Hindin, PhD, MHS, MA
Professor and Thesis Advisor
Department of Population, Family and Reproductive Health
Johns Hopkins Bloomberg School of Public Health

Susan Sherman, PhD, MPH
Professor and Dissertation Committee Chair
Department of Epidemiology
Johns Hopkins Bloomberg School of Public Health

Kristin Mmari, DrPH, MA
Assistant Professor
Department of Population, Family and Reproductive Health
Johns Hopkins Bloomberg School of Public Health

Nicole Warren, PhD, MPH, CNM
Assistant Professor
Department of Community-Public Health
Johns Hopkins School of Nursing

Alternate Committee Members:

Saifuddin Ahmed, PhD, MBBS
Associate Professor
Department of Population, Family and Reproductive Health
Johns Hopkins Bloomberg School of Public Health

Andrea Ruff, MD
Associate Professor
Department of International Health
Johns Hopkins Bloomberg School of Public Health
Acknowledgements

This dissertation is the culmination of years of work conducted across several countries, with many individuals providing support, insight and collaboration in their own special ways.

My sincere appreciation and thanks my advisor, Michelle Hindin, for her unwavering support, encouragement and advice throughout the PhD process. Thank you for always listening to my ideas (and reigning them in when necessary), troubleshooting a truly astonishing number of exceptional circumstances, and for being a motivating and enthusiastic teacher, mentor, colleague and friend.

I am honored to have completed my studies in such a supportive department – Population, Family and Reproductive Health. Thank you in particular to Lauren Feretti Black for making all of the students’ lives easier, and to all of the professors who have taught, mentored and provided support over the years, especially Bob Blum and Gilbert Burnham.

A freak snowstorm led to the unique circumstance of my final defense being conducted remotely via videoconference. My sincere thank you to my final defense committee for their flexibility, enthusiasm and thoughtful feedback: Michelle Hindin, Susan Sherman, Kristin Mmari and Nicole Warren. This arrangement would have been possible without the determination of Laura Morlock, and the patient and helpful support from the JHSPH Information Technology team, especially Sukon Kanchanaraksa, Dominic DeLauney, Kenneth Herron, and Brian Klaas. For helping to shape the early stages of this research, thank you to my preliminary oral examination committee: Kristin Mmari, Nicole Warren, Donna Strobino, Amy Tsui, Saifuddin Ahmed, Stephan Ehrhardt, Andrea Geilen, and alternates M.E. Hughes and Jackie Agnew.

For the past four years, I have had the privilege of working with the motivated and diligent Maternal and Perinatal Health and Preventing Unsafe Abortion team in the Department of
Reproductive Health and Research, World Health Organization, who have helped me to develop
as a researcher and who have become part of my Geneva family. Thank you in particular to João
Paulo Souza, Metin Gülmezoglu, Özge Tunçalp, Emma Allanson, Anisa Assifi, Ana Pilar Betran,
Qian Long and Femi Oladapo. Thank you to Mary Ellen Stanton from USAID for her tireless
support of our team, and particularly for her support for our work on mistreatment of women
during childbirth. Thank you to my collaborators, whose guidance and friendship make this
“work” more like a hobby, especially: Claire Glenton, Simon Lewin, Heather Munthe-Kaas,
Kidza Mugerwa, Richard Adanu, Kwame Adu-Bonsaffoh, Ernest Maya, Mamadou Balde and
Thae Maung Maung.

To the University of Ibadan research team – I could not imagine working with a more enthusiastic,
hard-working and dedicated team: Bukola Fawole, Lanre Olutayo, Musibau Titiloye, Agnes
Oyeniran, Modupe Ogunlade, Olubunmi Osunsan, Loveth Metiboba, Hadiza Idris and Francis
Alu. Thank you also to Olubunmi Ojelade and Adebimpe Olalere for the insightful discussions on
research and being a woman in Nigeria.

This study would not have been a reality without the women, midwives and doctors who devoted
their valuable time as participants. Thank you for always being a source of inspiration.

Many friends have supported and enriched my graduate school endeavor, through sharing stories
about being women, challenging my positions, and intellectual debates and many laughs over a
bottle of wine. Thank you for always being there: Marissa Hiruma, Katie Seitz Evans, Heather
Stevenson Tiscia, Suprita Kudesia Makh, Vikram Saxena, Colleen Murray, Emily Gousen,
Melissa Stillman, Melissa Sherry, Nina Sun, Helena Ardura Garcia, Dena Javadi, Kara Durski,
Rachel Frans Najjar, Shannon Mitch, Fernanda Almeida, Lauren Megaw, Joel Earley and John
Zorbas.
To my family: Mom, Dad, Aislinn and Granny, for their endless faith in my abilities. Thank you for supporting me through yet another (and perhaps the last?) degree, the fly-in and drive-in visits, keeping me well-fed, being my #1 cheerleaders, and everything else in between. Thank you to Aislinn for being a stellar PhD role model. Thank you to Dad for always staying on top of life administrative matters. Thank you to Mom for the patience and dedication that it takes to teach someone how to write clearly, cogently and passionately – writing this dissertation would have been far more painful without your ongoing editorial support!

And last, but certainly not least, to my partner Josh, who knows better than anyone the mundane, day-to-day stresses, insecurities and challenges faced throughout the PhD process. Your steadfast confidence and unwavering optimism, patience and reassurance has been integral to the completion of this journey, especially when I was not feeling it myself. Thank you for the love, hugs and compassion that got me through this, and all things.

Thank you.
**Table of Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title page</td>
<td>i</td>
</tr>
<tr>
<td>Dissertation abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Committee of final thesis readers</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
<tr>
<td>Table of contents</td>
<td>ix</td>
</tr>
<tr>
<td>List of tables</td>
<td>xii</td>
</tr>
<tr>
<td>List of figures</td>
<td>xiii</td>
</tr>
</tbody>
</table>

**CHAPTER ONE: INTRODUCTION**

- **Background and significance**
  - Concept and terminology of mistreatment of women during childbirth | 3 |
- **Study setting**
  - Overview of the Nigerian health system | 6 |
  - Women’s health in Nigeria | 8 |
- **Theory and conceptual framework**
- **Study aims**
- **Dissertation overview** | 16 |
- **Chapter One References** | 18 |

**Appendix 1.1 Violence against women: an integrated ecological framework** | 24 |
**Appendix 1.2 WHO quality of care framework for maternal and newborn health** | 25 |

**CHAPTER TWO: MANUSCRIPT ONE**

*The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review*

- **Introduction** | 28 |
- **Methods**
  - Search strategy | 30 |
  - Study selection | 30 |
  - Quality assessment | 31 |
  - Data extraction | 31 |
  - Synthesis | 32 |
  - Reporting | 33 |
- **Findings**
  - General overview | 33 |
  - Quantitative synthesis | 34 |
  - Qualitative synthesis | 36 |
- **Discussion**
  - Limitations and strengths of the review | 52 |
  - Implications for future research | 53 |
  - Conclusions | 53 |
- **Chapter Two References** | 55 |
- **Appendix 2.1: PubMed search strategy** | 75 |
- **Appendix 2.2: CINAHL search strategy** | 77 |
- **Appendix 2.3: Embase search strategy** | 79 |
- **Appendix 2.4: Title and abstract screening criteria** | 81 |
- **Appendix 2.5: Full text screening form** | 84 |
- **Appendix 2.6: Quality appraisal form templates** | 85 |
CHAPTER THREE: MANUSCRIPT TWO
Mistreatment of women during childbirth in Abuja, Nigeria: perceptions and experiences of women and healthcare providers

Introduction
Methods
Study sites
Study participants, recruitment and sampling
Study instruments
Data collection and management
Data analysis
Results
Preferences for childbirth in Abuja
Context of mistreatment in Abuja
Impact of mistreatment on care-seeking
Participants’ suggestions for improving the treatment of women during childbirth
Discussion
Chapter Three References

CHAPTER FOUR: MANUSCRIPT THREE
“By slapping their laps, the patient will know that you truly care for her”: A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria

Introduction
Gender inequality, patient inferiority and violence against women
Social norms and attitudes towards mistreatment during childbirth
Maternal health services in Nigeria
Methods
Study sites
Study participants, recruitment and sampling
Study instruments
Data collection and management
Data analysis
Results
Acceptability of a provider pinching or slapping a woman
Acceptability of a provider shouting at a woman
Acceptability of a provider refusing to help a woman
Acceptability of physically restraining a woman
Discussion
Challenges with defining mistreatment during childbirth
Limitations and future research
Conclusions
Chapter Four References
List of Tables

Table 2.1 Typology of the mistreatment of women during childbirth
Table 2.2 Selected measures of how women are mistreated during childbirth from three measurement studies
Table 2.3 Summary of qualitative findings
Table 3.1 Facility characteristics
Table 3.2 Sociodemographic characteristics of participants: women of reproductive age
Table 3.3 Sociodemographic characteristics of participants: healthcare providers and administrators
Table 4.2 Sociodemographic characteristics of participants: women of reproductive age
Table 4.3 Sociodemographic characteristics of participants: healthcare providers and administrators
List of Figures

Figure 1.1 Map of Nigeria
Figure 1.2 Quality of care framework for mistreatment of women during childbirth in facilities
Figure 2.1 Flow diagram of search and study inclusion process.
Intended to be blank.
Chapter One: Introduction
Background and significance

Worldwide, an estimated 303,000 maternal deaths occurred in 2015, of which 99% occurred in low- and middle-income countries (LMICs) [1]. While the maternal mortality ratio (MMR) has declined by 44% in the past 25 years, global progress towards the Millennium Development Goal (MDG) 5 target of a 75% reduction in the MMR was not reached by 2015 [1]. Sub-Saharan Africa has the highest regional MMR at approximately 546 maternal deaths per 100,000 live births, accounting for 66% of the global burden [1]. At a country level, Nigeria accounts for 19 percent of maternal deaths worldwide, with approximately 58,000 maternal deaths in 2015 [1].

One of the key components of the strategy to avert and reduce maternal morbidity and mortality has been to increase rates of skilled birth attendance and facility-based childbirth worldwide. Increasing the proportion of women attended at delivery is challenging, as it requires a comprehensive effort to overcome a range of economic, geographical and infrastructural obstacles to women reaching facility-based care [2]. Furthermore, it requires efforts to improve both the coverage and quality of care provided for women at facilities. Improvements in quality of care must not only ensure access to timely, safe and effective care, but should also be delivered in a manner that protects and promotes women’s rights to dignified and respectful care [3]. While global efforts have increased skilled birth attendance rates by 11% in developing regions over the past two decades, 34% of women in these regions deliver without a skilled birth attendant [4].

Given the importance of improving attendance at facilities for delivery, it is concerning that a number of recent studies on women’s experiences during childbirth suggest that many women experience disrespectful, abusive or neglectful treatment from healthcare providers in facilities [5-14]. A recently published systematic review also highlighted that perceived low quality of care and fear of discrimination during childbirth are key barriers to women giving birth in facilities and is a potent disincentive for women to attend facilities for childbirth [2].
Concept and terminology of mistreatment of women during childbirth

In 2010, Bowser and Hill published a landscape analysis that explored the evidence for “disrespect and abuse” during facility-based childbirth, and proposed a seven-category model including physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in facilities [15]. This analysis is the first known synthesis and proposed definition of the concept of disrespect and abuse during childbirth. Among others, adolescents, unmarried women, women of different ethnicities, the poor, migrant women and women who are HIV positive appear to be particularly vulnerable to disrespectful and abusive treatment by healthcare providers [15]. Most significantly, this report found that there was a lack of primary research activities on this important topic, including a lack of validated measurement tools and reliable estimates of prevalence.

Since the publication of the Bowser and Hill report, four primary research studies have been initiated in Tanzania, Kenya, Ethiopia, and Nigeria on the measurement of disrespect and abuse during facility-based childbirth. Using the categories proposed by Bowser and Hill, these studies developed operational definitions of disrespect and abuse that encompass a list of identification criteria to define specific behaviors or events that constitute disrespect and abuse. For example, according to the Kenya study “physical abuse” constitutes “pinching, slapping, pushing, beating, stitching episiotomy without anesthesia, female genital mutilation (FGM) during labor, re-stitching a FGM scar, rape, inappropriate touching during examination of genitals or thighs” [16]. Based on these categories and identification criteria, each study developed separate tools for measuring disrespect and abuse through direct observation of labor, facility exit interview, community interview, and/or postnatal visit interview [17-19]. Analysis of data from the three studies is ongoing, but preliminary findings were published in 2015 [17-20].
Despite the growing recognition of the importance of disrespect and abuse in facility-based childbirth, several critical hurdles remain. First, no effort has yet been made at a global level to systematically define what constitutes mistreatment during childbirth [21], and the terminology used in different parts of the world to describe the poor treatment of women during childbirth is variable. For example, in Venezuela and Brazil, the term “obstetric violence” has been used in public health [22, 23] and law [24], whereas “disrespect and abuse” [17, 19, 20, 25-27] and “dehumanized care” [28, 29] have been used elsewhere. The variable terms and definitions are partially due to linguistic and cultural differences, different fields of study (e.g.: legal or public health), and different research methods used to document these experiences [21]. For the purposes of this study, “mistreatment of women during childbirth” will be used as a more inclusive term that “better captures the full range of experiences women and healthcare providers” have described [30]. For example, this would include intentional abuse, unintentional or passive abuse, and mistreatment resulting from both individual behaviors and health system conditions [30]. Despite the deliberateness of the event and the different levels (e.g.: intrapersonal or health system) in which mistreatment occurs, these experiences can impact a woman’s childbirth experience, her health, and her right to respectful, humane and dignified care at birth. A consistent and agreed-upon definition is a necessary first step to providing accurate and comparable data at a community, national and international level.

Another critical hurdle is the lack of reliable and validated measurement tools. Population-based research using consistent definitions, methods and tools will provide more accurate measures of the true prevalence of mistreatment during childbirth, as well as help key stakeholders to understand the problem, inform the design of interventions and strengthen advocacy efforts. Finally, interventions should be developed to prevent mistreatment during childbirth and promote respectful maternity care. Such efforts are needed not only to protect women’s fundamental
human rights, but also as part of broader efforts to improve the quality of care available to women during childbirth in order to reduce maternal and perinatal morbidity and mortality.

There are, however, several limitations to the adoption and application of existing tools to measure the prevalence of mistreatment. First, all four studies used the categories of disrespect and abuse proposed by Bowser and Hill, but each study operationalized the definition and identification criteria for disrespect and abuse differently, thus preventing reliable comparisons. Moreover, none of the tools has been independently validated. Further work is therefore needed to develop and validate tools that can be adopted and used globally. These studies have also identified the need for deeper exploration of institutional and health system factors (such as lack of staffing, resources, medications and other barriers to the provision of quality care).

**Study setting**

Nigeria is located in West Africa and shares land borders with Chad and Cameroon to the east, Niger to the north, Benin to the west and the Atlantic Ocean to the south. The total population of Nigeria is 177,155,754, with 49.6% living in urban areas [31]. Nigeria is comprised of 36 states and the Federal Capital Territory (FCT). States are further sub-divided into 774 Local Government Areas (LGAs). Nigeria has over 250 ethnic groups that are geographically divided, with the Hausa and Fulani (29%) located in the north, the Yoruba (21%) located in the southwest and the Igbo (18%) located in the southeast [31]. The official language is English, but hundreds of languages are spoken in Nigeria, the most common being Yoruba, Hausa, Igbo and Fulani. Fifty percent of the population is Muslim, located primarily in the north, and 40 percent is Christian, located primarily in the south. Nigeria gained independence from the United Kingdom in 1960, but plunged into a series of coups as parties from Nigeria’s culturally and politically
diverse ethnic groups (Hausa northerners, Igbo easterners and Yoruba westerners) struggled to gain power.

Overview of the Nigerian health system

The responsibilities of the health system in Nigeria fall under the federal government, state government and LGAs. As such, the federal government is primarily responsible for coordinating efforts between Federal Medical Centers (tertiary-level) and university teaching hospitals, while state governments are responsible for general hospitals (secondary- and district-level facilities) and LGAs are responsible for primary health care facilities. The Federal Ministry of Health Nigeria coordinates 20 federal teaching hospitals and 22 federal medical centers. Most districts have state government-run district hospitals, which provide free or subsidized antenatal and delivery care.

The National Health Insurance Scheme (NHIS) was launched by the federal government in 2005 to provide affordable access to healthcare through prepayment systems, with a primary aim of developing universal health insurance coverage for all Nigerians [32]. The NHIS offers eight programs designed to cover different segments of society, including rural community social health, children under-five social health and formal sector social health [32]. However, enrollment has been slow – to date, only four million Nigerians have registered with NHIS [32]. In 2011, the National Primary Healthcare Development Agency (NPHDA) launched the Community Based Health Insurance Scheme (CBHIS), designed to allow communities to organize pooled funds to finance their health care needs [33]. Facility-based childbirth costs are low or free for those registered with the NHIS.

In recognition of the impact of a weak health system on morbidity and mortality rates, national efforts to strengthen the Nigerian health system across the federal, state and LGA levels
commenced in 2007 [34]. The National Strategic Health Development Plan (NSHDP) was developed from 2008 to 2010 in order to define national health priorities and areas of immediate need for the period of 2010 to 2015, as well as strategic plans at both the state- and LGA-levels [34]. Priority areas identified in maternal, sexual and reproductive health include the following: improved service delivery for health services (commodities, consumables and equipment), human resource capacity building, increased health financing using a mixed approach (public financing, social health insurance and pro-poor interventions), a national health management information system, and research for health and community empowerment to drive demand for quality services [34]. The NPHDA also developed a strategic plan in 2011 to improve health and save lives in Nigeria through improved access to primary health care and quality of facility-based care, strengthened health institutions, strengthened partnerships and engaged communities [33].

The Nigerian government has implemented several interventions to address widespread health disparities, including the Midwives Service Scheme (MSS); the Subsidy Reinvestment and Empowerment Program, Maternal and Child Health (SURE-P-MCH); and systematic primary health care infrastructural upgrades [35]. In the MSS program, newly qualified and retired midwives provide maternal health services at primary health care centers in underserved communities. As of 2012, 4000 midwives and 1000 community health extension workers had been deployed to 1000 primary health care facilities, thereby improving access to skilled birth attendants. Similarly, the SURE-P-MCH program aims to improve supply- and demand-side components of maternal and child health through an extension of the MSS program. As of 2012, 3,072 village health workers were trained and deployed, and a maternal health conditional cash transfer scheme was launched [35].
Women’s health in Nigeria

According to DHS estimates, the total fertility rate (TFR) in 2013 was 5.5, which dropped only slightly from 6.4 in 1960 [35-37]. Nigeria fell short of the MDG5 target for reducing MMR by 75% between 1990 and 2015, as estimates suggest that MMR reduction was 39.6 percent during this period [1]. However, the 80 percent uncertainty interval (UI) for the estimated reduction ranges from (-5.0 to 56.3 percent), implying that there is a chance that no reduction in Nigeria’s MMR occurred between 1990 and 2015 [1]. In 2015, Nigeria had the fourth worst maternal mortality ratio in the world with 814 (UI 596 to 1180) maternal deaths per 100,000 live births, and women in Nigeria have a 1 in 22 lifetime risk of maternal death [1]. There are vast geographical health disparities across the nation, with very poor health indicators in the northern region of Nigeria compared to the southern region, including an almost ten-fold difference in maternal mortality between the northeast and southwest regions [36].

Approximately 60.6 percent of women have at least one antenatal care visit and 51.1 percent have at least four visits [35]. In 2013, 35.8 percent of births took place in a health facility, with no change from 2008 [35]. Women in Nigeria often prefer the services of traditional birth attendants (TBAs), and 22.0 percent of births occurred with a TBA in 2013 [35]. In southern Nigeria, 43.4 percent of women reported that TBAs provided more compassionate care than formal health workers and 34.0 percent of women reported that the care received from TBAs was more culturally acceptable [38].

Poor use of maternal health services in Nigeria is a key factor contributing to high levels of maternal morbidity and mortality. In addition to problems related to availability and access, poor perceived quality of care provided at facilities was a critical barrier for use of services [39-43]. In one study in northwestern Nigeria, 23.7 percent of women interviewed who did not deliver in a health facility cited negative provider attitudes as the primary reason for not using delivery
services, and 52.0 percent of women suggested that improvements in provider attitudes are necessary to increase demand for facility-based deliveries [39]. Another study in rural southern Nigeria indicated that women viewed government owned health facilities as providing poor quality intrapartum services and had poor availability of trained staff during the time of delivery [41]. Health workers’ attitudes were one of the most critical factors that affected the woman’s choice of visiting a health facility or traditional provider [41-43]. A randomized control trial in Ibadan assessed the effect of psychosocial support in the form of companionship of choice during labor and found that women with birth companions had more satisfying labor experiences and better labor outcomes, including fewer cesarean sections, shorter duration of active labor and lower pain scores, compared to women without birth companions [44]. Another study in Ibadan reported that 75 percent of women at an antenatal clinic desired companionship of choice during labor [45]. Given the structural and human resources constraints present in maternity wards in Nigeria, allowing women to have a birth companion of their choice who can provide social and emotional support during labor may help to achieve positive childbirth experiences for more women. Positive childbirth experiences in facilities may also contribute to an increased demand for facility-based childbirth and more positive perceptions of facility-based maternity services.

Violence affects women across all cultural and socioeconomic backgrounds in Nigeria. According to the 2013 DHS, 28 percent of women aged 15 to 49 years have ever experienced physical violence, and 11 percent of women aged 15 to 49 years have experienced physical violence in the previous 12 months [35]. In the North Central Zone, 30.5 percent of women aged 15 to 49 reported experiencing physical violence, and 47.6 percent never sought help or told anyone about the violence [35]. Women provided several justifications for wife beating, including burning the food, arguing with her husband, going out without telling her husband, neglecting the children, and refusing to have sexual intercourse, with a total of 35 percent of women agreeing with at least one reason for abuse [35].
Although violence against women is widely acknowledged as a problem in Nigeria, the culture of silence and lack of trustworthy accountability mechanisms have affected the reporting of violent encounters and hindered efforts to reduce violence against women. A study conducted in Ibadan concluded that there is an “urgent need for education of…women on their rights, sensitization of…men on gender-based violence and punishment for perpetrators” [46]. Furthermore, there are clear links between violence against women and mistreatment of women during childbirth, as both issues are underpinned by structural gender inequality that places women at a lower status compared to men. Societal devaluation of women, hierarchical power dynamics and lack of accountability mechanisms often render women powerless to act when faced with abusive experiences, and violence against women may also be linked to poor reproductive health practices and care-seeking behaviors.

**Theory and conceptual framework**

As the proportion of women delivering in a health facility rises, a higher proportion of avoidable maternal and perinatal morbidity and mortality has occurred in health facilities compared to in communities [47]. Therefore, it is imperative that efforts to end preventable morbidity and mortality include improving the quality of care provided in health facilities. No single factor can explain why some individuals behave abusively toward others, or why it is more prevalent in some communities than in others. The mistreatment of women during childbirth is likely the result of a complex interplay of individual, relationship, social, cultural and environmental factors, as has been depicted in an ecological framework for violence against women (Appendix 1.1) [48].

Understanding how these factors are related to abusive or neglectful practices is an important step in the public health approach to preventing its occurrence. The World Health Organization’s
quality of care framework for pregnant women and newborns is useful for assessing the quality of care across many settings and situations [47]. WHO has defined quality of care as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes [47]. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people centered” [47]. The WHO framework (Appendix 1.2) builds on the Donabedian [49] and Hulton [50] frameworks to show how the health system provides the structure in which care is provided; the provision and experience of care are both important components of the process of care, and the outcome is comprised of both individual and facility-level outcomes. The different domains that fall within the framework provide targets to assess, improve and monitor the care provided within the context of the health system. The conceptual framework for this study (Figure 1.2) is an adaptation of the WHO quality of care framework [47], modified to include consideration of the macro and exosystem social structures that influence how women are treated during childbirth.

**Structure of society and health system**

Given the complex interplay of personal, situational and sociocultural factors contributing to the mistreatment of women during childbirth [48], the structure of society must be addressed when considering the structure of care. The personal history that an individual brings to their behavior, the immediate context where mistreatment occurs (health facility), institutional and social structures and more general perceptions and norms in society must be included [48]. This includes factors at the macrosystem level that influence cultural beliefs and values, such as gender roles, acceptance of intrapersonal violence and women’s empowerment. The exosystem level refers to social structures that influence the “immediate settings in which a person is found” [48], and includes the socioeconomic status of women, isolation of woman on the labor ward, hierarchy of providers, and patient-provider relationship. Such an encompassing approach has
been useful in the study of violence against women, where findings from different fields were integrated to theorize the causes of abuse.

The structure of the health system refers to the physical and organizational characteristics of the health system in which care occurs. There are six building blocks used to describe health systems strengthening, which provide a structure in which health systems can effectively operate: (1) service delivery; (2) health workforce; (3) information; (4) medical products, vaccines and technologies; (5) financing; and (6) leadership or governance [51]. Improvements to access, coverage, quality and safety of these building blocks are essential to improve health, responsiveness, social and financial risk protection, and efficiency of the health system [51].

**Process of care**

The process of care occurs within the structure of the health system and health facility and is comprised of two intertwined dimensions: provision and experience of care. Provision of care refers to: (1) evidence based practices for routine care and management of complications; (2) actionable information systems; and (3) functional referral systems. The experience of care refers to: (1) effective communication; (2) respect and dignity; and (3) emotional support. Cross-cutting the provision and experience of care dimensions are a competent and motivated human resources and essential physical resources. When care is experienced by women as disrespectful, undignified or unsupportive, or her provider has not effectively communicated with her, the link between the mistreatment of women and the “experience of care” domains is clear. However, poor quality care across the “provision of care” domains can also contribute to the poor treatment of women. For example, the absence of “actionable information systems”, particularly in low- and middle-income settings, may leave women unattended during labor and result in her delivering on her own in a health facility.
While different types of mistreatment can occur at the level of interaction between the woman and the health worker, a complex range of systemic failures at the levels of the health facility and the health system contribute to its occurrence. For example, an “overt” action of mistreatment, such as hitting, slapping and physical restraint, occurs directly in the interaction between a provider and a woman. But more “covert” actions of mistreatment, such as neglect or poor communication, may occur in the absence of provider-woman interactions. At a health facility and health systems level, poor supervisory structures, insufficient staffing, inadequate supply chains, poor physical conditions, and policies, culture and power dynamics that systematically disempower women also contribute to how women are mistreated.

**Outcome**

Both individual- and facility-level outcomes should be reflected, including health outcomes, the coverage of key practices, and woman-centered outcomes. These outcomes are aligned with the provision and experience of care dimensions. Too often, woman-centered outcomes, or how women experience their care, are ignored when assessing the quality of care. The incorporation of women’s perspectives, as well as their families’ and communities’ perspectives, is crucial to identifying the needs and preferences of the end users, generating demand for good quality care, and promoting positive childbirth experiences.

The adapted WHO’s quality of care framework is a useful to guide this study to explore how structural and societal factors influence the facility environment, in which poor processes of care occur and ultimately lead to poor health outcomes. Using systematic review methodologies, the first paper of this dissertation aims to explore how women and healthcare providers globally conceive and experience the outcome of mistreatment during childbirth, in order to develop a typology of mistreatment. This includes both intrapersonal experiences of abuse (e.g.: slapping, pinching, verbal abuse) and systemic failures of the health system (e.g.: insufficient number of beds causing women to deliver on the floor). The second paper of this dissertation uses qualitative
methods to explore how women and healthcare providers perceive and experience mistreatment during childbirth in Abuja, Nigeria, in order to provide contextually-specific evidence. The third paper of this dissertation uses qualitative methods to delve into the exosystem and macrosystem to explore how social norms and acceptance of violence, gender roles, clinical hierarchy and patient inferiority influence perceptions and experiences of mistreatment during childbirth in Abuja, Nigeria.


**Study aims**

This study will explore how women are mistreated during childbirth using multiple methods. The first part of this thesis explores mistreatment globally, while the second part is an in-depth exploration in Abuja, Nigeria.

There are three specific aims of the proposed study, to:

1. **Develop an evidence-based typology of the mistreatment of women during childbirth in facilities globally by conducting a mixed-methods systematic review;**

2. **Use qualitative methods to explore women’s, healthcare providers’ and healthcare administrators’ perspectives and experiences of mistreatment during childbirth in facilities in Abuja, Nigeria; and**

3. **Use qualitative methods to explore social norms and acceptability of the mistreatment of women during childbirth in facilities, among women and healthcare providers in Abuja, Nigeria.**
Dissertation overview

This dissertation includes three manuscripts focused on the mistreatment of women during childbirth, as well as an introductory chapter and a concluding chapter. Detailed descriptions of the methodology employed in the study are found in the respective manuscript chapters. Each of these chapters is described below:

Chapter One provides an introduction to the dissertation, the concept of mistreatment during childbirth, description of the study context and study aims.

Chapter Two contains the first of three manuscripts and is titled “The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review.” Systematic review methods were used to synthesize data on how women are mistreated during childbirth from 65 studies conducted in 34 countries. A thematic synthesis approach was used to synthesize the qualitative evidence and assessed the confidence in the qualitative review findings using the CERQual approach.

Chapter Three contains the second of three manuscripts and is titled “Mistreatment of women during childbirth in Abuja, Nigeria: perceptions and experiences of women and healthcare providers”. This study used qualitative methods to explore the experiences and perceptions of mistreatment during childbirth from two study sites in Abuja, Nigeria. In-depth interviews (IDIs) and focus group discussions (FGDs) were conducted with women of reproductive age who delivered at a healthcare facility in the previous twelve months. IDIs were conducted with midwives, doctors and administrators from an urban and peri-urban hospital.

Chapter Four contains the third and final manuscript and is titled “By slapping their laps, the patient will know that you truly care for her”: Social norms and the acceptability of the mistreatment of women during childbirth in Abuja, Nigeria”. This analysis focuses on four
scenarios of mistreatment during childbirth presented through IDIs and FGDs with women, midwives and doctors: (1) pinching or slapping a woman; (2) shouting at a woman; (3) refusing to help a woman; and (4) physically restraining a woman. Participants were asked whether each scenario was acceptable, under what conditions (if any) the scenario would be acceptable, and how they would feel if it happened to them or their partners.

Chapter Five contains the conclusions drawn from the study, limitations and strengths of the study, the public health implications of the findings and recommendations for future research.
Chapter One References


38. Ebuehi OM, Akintujoye I. Perception and utilization of traditional birth attendants by pregnant women attending primary health care clinics in a rural Local Government Area in Ogun State, Nigeria. (1179-1411 (Electronic)).

39. Idris S, Sambo M, Ibrahim M. Barriers to utilisation of maternal health services in a semi-urban community in northern Nigeria: The clients' perspective. (0300-1652 (Print)).


41. Osubor KM, Fatusi Ao Fau - Chiwuzie JC, Chiwuzie JC. Maternal health-seeking behavior and associated factors in a rural Nigerian community. (1092-7875 (Print)).


43. Uzochukwu BS, Onwujekwe Oe Fau - Akpala CO, Akpala CO. Community satisfaction with the quality of maternal and child health services in southeast Nigeria. (0012-835X (Print)).

44. Morhason-Bello IO, Adedokun Bo Fau - Ojengbede OA, Ojengbede Oa Fau - Olayemi O, Olayemi O Fau - Oladokun A, Oladokun A Fau - Fabamwo AO, Fabamwo AO. Assessment of the effect of psychosocial support during childbirth in Ibadan, south-west Nigeria: a randomised controlled trial. (1479-828X (Electronic)).
45. Morhason-Bello IO, Olayemi O Fau - Ojengbede OA, Ojengbede Oa Fau - Adedokun BO, Adedokun Bo Fau - Okuyemi OO, Okuyemi Oo Fau - Orji B, Orji B. Attitude and preferences of nigerian antenatal women to social support during labour. (1469-7599 (Electronic)).


Figure 1.1: Map of Nigeria.

Source: CIA World Factbook
Figure 1.2: Quality of care framework for mistreatment of women during childbirth in facilities, adapted from the WHO quality of care framework for pregnant women and newborns [47] and Heise’s ecological framework for violence against women [48].
Appendix 1.1 Violence against women: an integrated ecological framework

Heise (1998) ecological framework to depict factors related to violence against women across different levels of the social ecology [48].
Appendix 1.2 WHO quality of care framework for maternal and newborn health [47].
Intended to be blank.
Chapter two: Manuscript One

The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review
Introduction

An estimated 289,000 maternal deaths occurred in 2010, of which 99% occurred in low- and middle-income countries (LMICs) [1]. While maternal mortality has declined globally by 45% since 1990, progress towards Millennium Development Goal (MDG) 5, a 75% reduction in the maternal mortality ratio, has been slow and many LMICs will not reach this target [2]. Ensuring universal access to safe, acceptable, good quality sexual and reproductive health care, particularly contraceptive access and maternal health care, can dramatically reduce global burden of maternal morbidity and mortality. A key component of the strategy to reduce maternal morbidity and mortality has been to increase rates of skilled birth attendance and facility-based childbirth. While global skilled birth attendance rates rose by 12% in developing regions over the past two decades, almost one-third of women in these countries still deliver without a skilled birth attendant [3]. Increasing the proportion of women delivering in a health facility is challenging, as it requires comprehensive efforts to overcome sociocultural, economic, geographical and infrastructural obstacles to reach facility-based care [4]. Furthermore, it requires efforts to improve both the coverage and quality of care provided to women at health facilities, including women’s rights to dignified and respectful care [5].

A recent qualitative evidence synthesis [4] and several recent studies [6-11] and reports [12, 13] clearly indicate that many women globally experience poor treatment during childbirth, including abusive, neglectful or disrespectful care. Every woman has the right to dignified, respectful sexual and reproductive health care, including during childbirth [14-16], as highlighted by the “Universal Rights of Childbearing Women” (http://whiteribbonalliance.org). Therefore, this mistreatment can represent a violation of women’s fundamental human rights [17-20] and can serve as a powerful disincentive for women to seek care in facilities for their subsequent deliveries [4, 6, 10, 21]. In September 2014, a World Health Organization statement called for greater research, action, advocacy
and dialogue on this important public health issue, in order to ensure safe, timely, respectful care during childbirth for all women [5]. Likewise, respectful care is a key component of both the Mother-baby friendly birthing facilities initiative [22] and the WHO vision for quality of care for childbearing women and newborns [23].

In a 2010 landscape analysis, Bowser and Hill described seven categories of disrespectful and abusive care during childbirth: physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment and detention in health facilities [12] which has been a building block of recent work on this topic [24-27]. Freedman et al build on the Bowser and Hill categories to propose a definition (e.g.: to articulate criteria for determining when an interaction or condition should be considered abusive or disrespectful) and conceptual model illustrating how the definition of disrespectful and abusive care during childbirth can vary across individual, structural and policy levels [28, 29]. In their projects, Freedman et al defined disrespect and abuse during childbirth 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” [28].

The Bowser and Hill classification has some limitations. The authors integrated findings from a literature review and key stakeholder interviews to develop the seven categories; however, it appears that systematic searching and synthesis methodologies were not employed. Furthermore, three recent measurement studies based on the Bowser and Hill categories have used different operational definitions and study designs [25-27]. These variations may have contributed to the substantial differences in estimates of prevalence, preventing meaningful meta-analysis. The lack of a standardized, comprehensive and agreed typology, identification criteria and operational definitions of the mistreatment of women during facility-based childbirth thus complicates further research in this important area.

Developing an evidence-based typology is therefore a critical step, in order to inform the development and application of measurement tools and to permit the development and
evaluation of interventions to reduce mistreatment and promote respectful maternity care. Such efforts are necessary to improve quality of maternity care, increase demand for facility-based childbirth and more broadly to protect women’s fundamental human rights. This systematic review aims to contribute to the development of a global evidence-based typology of the mistreatment of women during childbirth in health facilities.

Methods

Search strategy

The published literature was systematically searched in PubMed (Appendix 2.1), CINAHL (Appendix 2.2) and Embase (Appendix 2.3) using controlled vocabulary and free-text terms combing two main components: (a) maternal health, perinatal health and childbirth; and (b) mistreatment of women. Searches were conducted on 4 September 2013, and updated on 3 September 2014 and 11 February 2015, with no date or language restrictions. WHO Global Health Library, Cochrane Library, DARE, Google Scholar, CRD, OpenGrey, and EThOs were searched for grey literature and unpublished reports, and researchers in relevant fields were contacted for assistance in identifying studies. Reference lists of all included studies were hand-searched to identify additional studies.

Study selection

Each title and abstract was screened for inclusion by two independent reviewers using a standardized form (Appendix 2.4). Each full text article was reviewed by two independent reviewers using standardized inclusion criteria: (a) primary data analysis; (b) qualitative studies must use a qualitative method of data collection and analysis; (c) discusses poor treatment of women during childbirth; (d) childbirth occurring in health facilities; and (e) English, French, Spanish or Portuguese language (Appendix 2.5). Discrepancies during title
and abstract and full text screening were resolved by discussion until consensus with a third reviewer.

Quality assessment

The quality of the qualitative studies was assessed using an adaptation of the Critical Appraisal Skills Programme (CASP) quality-assessment tool (http://www.casp-uk.net), and included the following domains: aims, methodology, design, recruitment, data collection, data analysis, reflexivity, ethical considerations, findings and research contribution (Appendix 2.6). The quality of the quantitative studies was assessed using an adaptation of the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement [30], and included the following domains: eligibility criteria, method of variable assessment, participant characteristics, reporting of summary measures/outcome events and discussion of sources of bias and/or imprecision. The overall quality assessment of “high”, “medium” or “low” was based on independent evaluation by two reviewers and discussion until consensus in the case of discrepancies. No studies were excluded as a result of the quality assessment; rather, the methodological rigor of each contributing study contributed to the confidence assessments of each review finding.

Data extraction

Data were extracted using a standardized form including the following domains: study setting, sample characteristics, objectives, design, data collection and analysis methods and conclusions (Appendix 2.7). Themes, findings and participant quotations were extracted from qualitative studies. Data source, outcome measures and results were extracted from quantitative studies.
Synthesis

Quantitative. We planned to present prevalence estimates of the mistreatment of women. However, meta-analysis was not possible due to high heterogeneity in the quantitative studies, including inconsistent identification criteria and operational definitions. Therefore, descriptions of study characteristics, outcome measures and key findings are presented.

Qualitative. A thematic synthesis approach was used to analyze and synthesize the qualitative data [31]. A spreadsheet was created of all qualitative data extracted from the studies’ findings sections and thematic analysis methods were used to conduct initial open coding on each relevant text unit [32]. Based on the initial coding, fourteen broad themes were developed and all text units were iteratively classified into one of the broad themes. Each theme was further analyzed to inductively develop the axial coding scheme and to disaggregate core themes [33, 34]. Axial codes were then systematically applied by hand-sorting the text units into first-, second- and third-order themes. First order themes represent text units grouped together based on common, descriptive themes. Second order themes represent first order themes grouped together based on higher-level analytic themes. Third order themes represent overarching high-level analytic themes comprising of the first and second level themes [35].

Each qualitative review finding was assessed using the CERQual (Confidence in the Evidence from Reviews of Qualitative Research) approach. CERQual is a method to transparently assess and describe how much confidence to place in findings from systematic reviews of qualitative evidence [36, 37]. Our “confidence” is an assessment of the extent to which the review finding is a reasonable representation of the phenomenon of interest, such that the phenomenon of interest is unlikely to be substantially different from the research finding [36, 37]. The CERQual approach is under development and currently includes four elements: (1) methodological limitations of the individual studies; (2) relevance to the review question; (3) coherence; and (4) adequacy of data, which we operationalized in the following manner [4,
The methodological limitations of the individual studies contributing to each review finding were assessed using the modified CASP tool. Relevance to the review question of the individual studies contributing to the review finding was assessed based on the extent to which the review finding is applicable to the context (perspective, population, phenomenon of interest, setting) specified in the review question. Coherence of each review finding was assessed by exploring to what extent clear patterns could be identified across the data contributed by each study, or that plausible explanations are provided if variation across studies exists [4]. Adequacy of the data (thickness of data, number of studies, stratification of countries/regions and stratification of country income-level of studies) that support a review finding was assessed. We assessed each of these four components as having minor, moderate or substantial concerns regarding the specific component. Based on an overall assessment of methodological quality, relevance, sufficiency and coherence, the confidence in the evidence for each review finding was assessed as high, moderate or low.

**Reporting**

This systematic review is reported following the ENTREQ statement guidelines to enhance transparency in reporting qualitative evidence synthesis (Appendix 2.8) [42].

**Findings**

**General overview**

The initial PubMed, CINAHL and Embase searches yielded 5,733 articles and the updated searches yielded an additional 1,524 articles, for a total of 7,257 articles. Full texts were retrieved for 250 potentially eligible studies. After exclusions, 65 studies were included (Figure 2.1). The analysis synthesizes findings from primary research conducted across 34
countries, with eleven in sub-Saharan Africa, five in Asia, two in Oceania, four in Europe, five in the Middle East and North Africa, two in North America and five in Latin America. Study summaries are presented in Appendix 2.9.

Table 2.1 presents the typology of the mistreatment of women during childbirth developed from the synthesis of the qualitative and quantitative evidence. First, the qualitative evidence was synthesized into first-order descriptive themes and second- and third-order analytic themes (discussed in detail in the qualitative synthesis below). Then, these themes were compared to the quantitative findings. Most of the quantitative findings fit into the themes constructed from the qualitative synthesis. However, two themes emerged from only the quantitative synthesis, which were then integrated into the typology: sexual abuse and the performance of unconsented surgical operations. These two themes are therefore presented in Table 2.1 and Table 2.2: Selected measures of how women are mistreated during childbirth from three measurement studies, but are not discussed in the qualitative synthesis section below.

**Quantitative synthesis**

In total, twelve studies had relevant quantitative data [25-27, 43-51]. However, only three of these studies explored the experience of the mistreatment of women during childbirth in health facilities as a primary objective [25-27]. Table 2.2 presents selected quantitative measures of how women are mistreated during childbirth from these three studies. All three studies operationalized the domains of disrespect and abuse during childbirth from the Bowser and Hill landscape analysis [12]; however, the operationalization of these domains varied substantially by study. We present detailed findings below from the three studies that directly measured the mistreatment of women.
Kruk et al. (2014) explored mistreatment among women in rural Tanzania and is based on women’s self-reported experiences during a facility exit survey and follow-up survey with a sub-sample of the same women five to ten weeks postpartum [25]. Women reported experiencing any mistreatment during childbirth in both the facility exit survey (19.5%) and the follow-up survey (28.2%) [25]. Common specific experiences included “non-dignified care” [facility exit survey: 12.9%, follow-up survey: 18.9%], “shouting or scolding” [facility exit survey: 8.7%, follow-up survey: 13.8%], “neglect” [facility exit survey: 8.5%, follow-up survey: 15.5%] and “physical abuse” [facility exit survey: 2.9%, follow-up survey: 5.1%] [25].

Sando et al. (2014) explored whether women living with HIV were more vulnerable to mistreatment during childbirth in Dar es Salaam, Tanzania, and is based on interviews with women at three to six hours postpartum and direct observations of labor [27]. Women reported experiencing any form of mistreatment [HIV-positive women: 12.2%, HIV-negative women: 15.0%]; however, women living with HIV were no more or less likely to report mistreatment [p<0.37] [27]. The direct observations of labor suggest that “partitions did not provide privacy” to women during childbirth [HIV-positive women: 94.4%, HIV-negative women: 91.3%], “women were not asked for consent during vaginal examination” [HIV-positive women: 100.0%, HIV-negative women: 79.8%], and “women’s legs tied” during delivery was rarely noted [HIV-positive women: 0.0%, HIV-negative women: 3.3%] [27].

Okafor et al. (2014) explored mistreatment in a teaching hospital in southeastern Nigeria, and is based on interviews conducted with a convenience sample of women accessing newborn services at an immunization clinic [26]. Almost all women reported at least one kind of mistreatment during childbirth [98.0%] [26]. Women commonly reported physical abuse during childbirth [35.7%], including being “restrained or tied down during labor” [17.3%], being “beaten, slapped or pinched” [7.2%], and “sexually abused by the health worker” [2.0%].
The other nine studies with relevant quantitative data were indirectly relevant to this review, limited in scope and varied in their operational definition of the mistreatment of women [43-51]. However, these studies reported on indicators that can be classified under the domains of mistreatment of women during childbirth, as defined by the qualitative evidence synthesis. For example, a pilot randomized control trial in South Africa reported that 84.5% of women were not allowed companions during childbirth and 4.3% of women were slapped or struck [43]. A cross-sectional study from Brazil showed that companions were often not allowed on the labor ward (41.8%) or delivery ward (98.6%) and that 9.0% of women were shouted at or slapped during delivery [49]. Appendix 2.10 presents the quantitative measures of mistreatment of women during childbirth from all twelve studies.

Qualitative synthesis

The majority of the studies included in this review used qualitative methods only, or a mixed-methods approach where only the qualitative data were relevant [6-11, 13, 21, 27, 52-96]. Most studies detailed the experiences of women, but some studies also explored the experiences of healthcare providers, medical administrators or policy-makers. Table 2.3 presents the summary of qualitative findings and confidence assessments. Many themes were homogenous across geographical and country income-levels; regional and income-level sub-analysis are presented where appropriate. Below we highlight key findings across themes constructed from the qualitative evidence synthesis.

Physical abuse

Physical abuse during childbirth [9, 10, 13, 21, 60, 66, 67, 72, 74, 76, 79, 83, 85, 86, 90, 96] was perpetrated by nurses [10, 13, 66, 79, 83, 85], midwives [60, 72, 74, 76, 86, 90], and
doctors [83, 90]. Women sometimes reported specific acts of violence, but often referred to these experiences more generally, describing beatings, aggression, physical abuse, a “rough touch” and the use of extreme force [9, 10, 13, 21, 60, 72, 79, 83, 86]. Hitting and slapping, with an open hand or an instrument, were the most commonly reported specific acts of physical violence [10, 13, 66, 74, 76, 86, 90]. Women also reported being pinched, particularly on the thighs [13, 85] and kicked [10]. Some women were physically restrained during labor with bed restraints [96] and mouth gags [85].

Verbal abuse

Verbal abuse of women by health providers during childbirth was commonly reported across all regions and country income-level strata [6, 7, 9, 10, 13, 47, 50-54, 57, 58, 60, 62, 63, 66, 67, 69, 72, 74, 76, 79, 80, 82, 84, 86, 87, 89, 90, 92]. Verbal abuse included the use of harsh or rude language [6, 7, 9, 10, 13, 47, 50-54, 57, 58, 62, 63, 66, 72, 74, 76, 79, 80, 82, 84, 86, 87, 89, 92], judgmental or accusatory comments [9, 13, 53, 54, 57, 58, 62, 67, 72, 76, 79, 86] and threats of poor outcomes or withholding treatment [58, 62, 74, 76, 90]. Where the cadre of health worker perpetrating the verbal abuse was specified, nurses and midwives (with whom women have the most contact) were most commonly mentioned [6, 7, 9, 10, 13, 47, 50-52, 57, 58, 62, 66, 67, 69, 72, 74, 76, 79, 80, 82, 86, 89, 92], followed by doctors [57, 58, 80] and administrative staff [51, 66, 76]. Women who were from a lower socioeconomic status, migrants or an ethnic minority were sometimes called derogatory slurs during delivery [13, 51, 52, 57, 76, 79]. Women felt shamed by health workers who made inappropriate comments to them regarding their sexual activity [10, 13, 53, 54, 57, 58, 72, 76, 79, 86, 90], and particularly to adolescent or unmarried women [54, 76, 79]. Health workers also ridiculed and admonished women for certain behaviors such as their inability to breastfeed, their failure to attend antenatal care and the absence of their partner during childbirth [13, 57, 62, 67, 76]. In Canada, refugee women who had experienced female genital cutting reported judgmental
remarks from their health providers regarding the appearance of their genitalia [57]. Some women were threatened with poor quality of care, withholding treatment or poor outcomes for their babies as a result of their behavior during childbirth [13, 57, 58, 62, 67, 76], including threats of beatings if the woman was non-compliant [76], threats of withholding services [58] and blame for their baby’s or their own poor health outcomes [74, 76].

Women’s childbirth experiences were negatively impacted by these abusive encounters with health workers. Box 1 provides a list of the many words women used to describe the types of verbal abuse perpetrated by health workers. Some women believed that their treatment by health workers was contingent on their ability or inability to remain silent throughout labor and delivery [52, 79], or because of their disobedience on the antenatal or delivery ward, such as pushing before instructed to do so [7, 9, 10, 52, 62, 76, 79, 80].

<table>
<thead>
<tr>
<th>Box 1. Types of verbal abuse from health workers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rude [6, 13, 51, 52, 57, 62, 66, 74, 76, 79, 84, 96]</td>
</tr>
<tr>
<td>Harsh language [10, 76, 79]</td>
</tr>
<tr>
<td>Sarcasm [76]</td>
</tr>
<tr>
<td>Swear [62]</td>
</tr>
<tr>
<td>Snap at [76]</td>
</tr>
<tr>
<td>Mock [13, 50, 72]</td>
</tr>
<tr>
<td>Threaten [13, 54, 62, 76]</td>
</tr>
<tr>
<td>Scold [9, 58, 66, 76, 79, 80]</td>
</tr>
</tbody>
</table>

**Stigma and discrimination**

Stigma and discrimination during facility-based childbirth occurred across four main categories: (1) ethnicity/race/religion; (2) age; (3) socioeconomic status; and (4) medical conditions. Women commonly reported feeling discriminated against due to their ethnic or racial backgrounds [8, 13, 48, 51, 52, 57, 61, 62, 66, 71, 77, 79, 94]. Differential treatment by health workers influenced the quality of care they received and alienated them from their providers [13, 57, 62, 77]. Women felt that some biomedical models of maternity care disrespected cultural preferences, and propagated racial stereotyping [8, 62, 64, 66, 77].
Both unmarried adolescents [54, 62, 66, 76, 79] and older women of high parity [9, 66, 87] reported discrimination. Adolescents were criticized and ridiculed for engaging in sexual activity before marriage [54, 76, 79] and some felt that their confidentiality was breached due to their age [54].

Women from a lower socioeconomic status group believed that they received poorer treatment as they were unable to pay for services or bribes [8-10, 57, 61, 66, 74, 75, 78, 89, 90, 92]. They felt health workers humiliated them for their poverty, inability to read or write, for residing in rural or slum areas or for being “dirty” or unkempt [8-10, 75, 78]. Fear of such discrimination was considered a powerful disincentive to deliver in health facilities in Ghana, Sierra Leone and Tanzania [10, 78, 89]. Health workers confirmed that women of lower socioeconomic status were more likely to receive poorer treatment [90].

Women believed that their positive HIV status contributed to the provision of substandard care, including delays in essential interventions, avoidance of patient contact and fewer vaginal examinations [11, 13, 27]. However, some health workers in Kenya stated that there was no discrimination against or segregation of HIV-positive women on the labor ward, although they reported being “anxious” if they suspected a woman to be HIV-positive and might handle them with “extra care” [11, 27].

**Failure to meet professional standards of care**

Health workers often failed to meet professional standards of care intended to address the basic needs of women during childbirth, particularly regarding (1) lack of informed consent and confidentiality; (2) improper conduct of physical examinations and medical procedures; and (3) neglect and abandonment of women.

*Lack of informed consent and confidentiality*
Women complained that they did not provide consent for medical procedures such as cesarean section [13, 91]. When women were asked to provide consent prior to a procedure, they were not always adequately informed of the risks and benefits and felt that the health worker went through the motions of obtaining consent [13]. Some women in South Africa avoided or feared facility-based delivery due to anxiety about HIV tests given without consent [11].

Women complained that health workers did not maintain doctor-patient confidentiality and disclosed private information to male partners or other patients [11, 13, 27, 54, 58]. For some HIV-positive women, the lack of trust in the confidentiality of treatment at health facilities was so great [27] that they chose to deliver at home where their HIV status would not be disclosed to other community members or health workers [11].

**Physical examinations and procedures**

Many women reported frequent and painful vaginal examinations during labor [57, 73, 79, 82, 85, 88, 94], which they viewed as excessive [57, 73, 82, 85] and dehumanizing [57, 73, 82, 88]. Vaginal examinations were sometimes conducted in a non-private setting [73] and women may not have consented to examinations [73, 88]. Health workers sometimes withheld pain relief or pain medication was not available for women during labor, often due to stock outs or insufficient patient payment [13, 21, 57, 67, 74, 76, 79, 80, 89, 91, 92].

**Neglect and abandonment**

Women frequently referred to long delays in receiving care and inattentive health workers who neglected women during labor and delivery [6, 8-10, 13, 21, 47, 50, 58, 61-63, 65-67, 69, 70, 74-77, 79, 80, 83, 85-87, 91-94, 96]. Women reported feeling alone, ignored and abandoned during their stay at the facility, and felt that their request for help or attention from health workers was an imposition [6, 8-10, 47, 62, 63, 65, 70, 74-77, 79, 80, 83, 85-87, 91, 92, 96]. Interactions with health workers were “rushed” and women felt like a “burden,”
“nuisance,” and were “bothering” the health workers or “putting them out.”[76, 77, 91]. As such, women did not feel that consideration for their well-being was a central component of their care. Many women reported long wait times before seeing a health worker or receiving an intervention [10, 13, 76, 80, 85, 86, 91, 93]. Long wait times were exacerbated when women did not book prior to delivery, because their antenatal care information was not in the system, and some health workers “punished” women with longer wait times if they did not book [76]. Other women waited for many hours or days before receiving referrals to higher-level health facilities [13, 85]. In some cases, women who were in labor were refused care at a facility without an exam [13, 50, 76, 80]. Turning women away from health facilities during labor is particularly troublesome for those who live far away from the facility or cannot afford transportation costs [13, 50].

Some women reported that neglect directly increased the physical risks women faced during delivery [13, 21, 47, 66, 76, 80, 85, 86]. In some extreme cases of neglect, women delivered at facilities without the presence of skilled birth attendants who were preoccupied with other tasks [6, 9, 13, 21, 47, 58, 66, 76, 80, 83, 85, 86, 92]. In Tanzania, several women reported that they sent escorts to find traditional birth attendants (TBAs) to assist in the delivery in a facility because of the neglect by the facility-based providers [9].

**Poor rapport between women and providers**

Women commonly described communication issues with health workers that left women feeling “in the dark” about their care [8, 11, 13, 21, 47, 49, 51, 52, 56, 57, 59, 61, 63, 65, 66, 69, 72, 74, 77, 83, 85, 87, 91, 93, 96]. Women often made general statements about poor staff attitudes, without detailing specific interactions [10, 13, 47, 52, 62, 63, 65, 74, 76, 77, 85, 86, 90, 92]. Some referred to providers as disrespectful [65], unwelcoming [62], misbehaving [90], having negative attitudes [10, 13, 47, 63, 77, 86], unsupportive [86, 92], judgmental
42

[10], unfriendly [10, 74, 90, 92], unhelpful [52], rude [74], impolite [74], sarcastic [76],
discouraging [62], unprofessional [90] and unkind [90].

Ineffective communication

Women were often dissatisfied with explanations from health workers regarding their care
and believed health workers were more interested in their compliance than answering
questions or clarifying proposed procedures [6, 13, 21, 47, 52, 60, 61, 63, 72, 85, 87, 91-93].
Health workers actively dismissed women’s concerns and anxieties regarding potential
complications or impending delivery [6, 21, 47, 59, 61, 72, 77, 87, 91, 93]. When faced with
labor complications, women believed that adequate explanations from health workers were
imperative to fully comprehend the situation, but these explanations were often rushed, if
provided at all [6, 13, 56, 60, 63, 66, 72, 85, 87, 91-93].

In some cases, risks of procedures were not properly communicated to women, which in some
cases increased women’s fear of the procedure, such as Caesarean section [13, 60, 63, 72, 91-
93]. Women who refused Caesarean sections felt that the rationale for the surgery was not
adequately described [63, 72, 93] and where communication between providers and women
did take place, it was inadequate [83]. Women also reported that they were not “heard” or
respected by their providers [21, 47, 52, 56, 59, 63, 65, 91, 93].

Women often reported language barriers and interpretation challenges when attempting to
communicate with health workers [8, 13, 51, 57, 61, 77], and this was particularly an issue for
migrant and refugee women in high-income settings [51, 57, 61, 77]. In some cases, women
were given medication or procedures without knowing their purpose [13, 51]. Sometimes, if
interpreters were unavailable, family members or other patients were used as interpreters,
which made the women uncomfortable [61]. Some women tried to bring companions as
interpreters, but their companions were unable to gain access to the antenatal and labor wards
[13, 61].
**Lack of supportive care**

Women commonly reported a lack of supportive care, including a perception that the care provided by health workers was mechanical, lacked comfort or courtesy [6, 7, 21, 47-49, 51, 56, 57, 59, 62, 64, 65, 70-72, 74, 77, 80, 81, 89, 91, 92, 94]. Women often felt that they did not receive the time and attention from health workers to feel supported and adequately cared for, [7, 21, 47, 48, 51, 56, 57, 59, 62, 64, 70, 72, 77, 80, 91, 92] which made women feel anxious and alone [21, 51, 56, 57, 59, 62, 91]. Many women believed that delivering in a health facility would ensure positive health outcomes for themselves and their babies. Despite receiving technically sound care, their experiences were marred by a lack of emotional support and their care experiences were therefore incongruous with their expectations.

While women often desired the presence of a birth companion, such as a family member, husband or friend [6, 9, 21, 47-49, 53, 65, 71, 74, 77, 89] many were prohibited from having a companion of choice with them during delivery [21, 47-49, 53, 65, 71, 74]. Although not always clearly explained, hospital policy often banned birth companions, as the administration deemed them an unnecessary hindrance [47-49, 53, 74]. The lack of companionship left women feeling disempowered, frightened and alone during their delivery.

**Loss of autonomy**

Women commonly reported feeling a loss of autonomy, including objectification and disrespect of safe traditional practices and birthing positions, which rendered them passive participants [6, 7, 10, 13, 21, 47, 49, 52, 56, 59, 62, 64-67, 69, 71, 72, 78, 81, 83, 88, 96]. Women overwhelmingly felt “removed” from decisions about their childbirth, and that health workers were coercive and rushed through their deliveries in an attempt to reduce them to dependent, disempowered and passive patients [6, 47, 49, 56, 59, 62, 65, 66, 81, 96]. Women reported feeling stripped of their dignity during childbirth due to the health workers’ objectification of their bodies [13, 21, 47, 56, 83]. They resented being forced to be on all fours and exposing their bodies to numerous health workers [21, 56, 83]. Women felt that
they were “processed technically” and did not receive humanized or compassionate care [21, 47, 56]. After delivery, some women were left alone in their own blood, urine and feces with no support from the health workers to clean up [83]. Women were sometimes denied food and water during labor [47] and confined to recumbent positions (lying down) rather than upright positions (walking, standing) [21].

Some women preferred to deliver in a squatting or kneeling position, rather than the supine position, and resented feeling forced to deliver in undesirable or humiliating positions that rendered them passive [6, 9, 21, 52, 69, 71, 81, 88]. Some health workers explained that they had not been trained to deliver women in positions other than lying down and felt uncomfortable letting a woman choose her own birth position [52, 71, 81].

Maintaining safe traditional practices, such as retaining the placenta for burial, were important to women and the denial of these practices may be an important barrier to seeking facility-based delivery or experiencing quality supportive care [10, 77].

Select studies from Benin, Tanzania and Sierra Leone suggest that either the mother or baby may be detained in the health facility, unable to leave until they pay the hospital bills [9, 72, 89]. However, this phenomenon was not richly described in the primary studies.

**Health system conditions and constraints**

While women and providers most often discussed individual-level experiences and factors contributing to the mistreatment of women during childbirth in health facilities, they also discussed greater health systems factors that contributed to an abusive environment and culture within a facility [10, 11, 13, 21, 48, 50, 52, 57, 58, 66, 73, 74, 76, 77, 83, 86, 89, 90]. Most women and providers who discussed health systems factors believed that health workers were doing the best that they could in constrained environments, particularly in low- and middle-income countries.
Lack of resources

Both women and health workers illustrated how staffing constraints affected the provision of care [13, 50, 53, 60, 69, 77, 83, 86, 89, 90, 92]. Staffing shortages were of particular concern and led to longer wait times, neglectful and poor quality care [13, 50, 60, 69, 77, 83, 86, 89, 90]. Providers of all cadres were described as “overworked,” “too busy,” “stretched” and “underpaid” by both women and other providers [13, 50, 77, 86, 90, 92]. Where health facilities were understaffed, women were triaged, which may contribute to women who are experiencing normal labor to feel neglected [69, 83, 86]. Furthermore, inexperienced or poorly trained health workers were often responsible for inappropriate levels of care without adequate supervision [52, 83, 86]. In lower-level health facilities, qualified doctors may be rare, leaving unskilled nurses or inexperienced medical officers to attend to labor management, complications and decisions regarding intervention and referral [52, 83, 86]. Staffing constraints also play a critical factor in experiences of neglect as there are often not enough health workers available to engage with women. Women and health workers both purported that staffing constraints not only directly affected provision of care, but also contributed to the health workers’ negative attitudes and poor motivation [77, 86, 90].

Women and health workers also reported a lack of privacy on the antenatal and labor wards, particularly during vaginal and abdominal exams, with problems including no curtains to separate them from other patients [11, 21, 48, 52, 53, 57, 60, 69, 73, 74, 83, 94]. In low- and middle-income settings, the antenatal and labor/delivery wards were sometimes located in common or public areas and some women were forced to share beds with other parturient women [11, 21, 48, 69]. Women expressed their desire to be shielded from other patients, male visitors and staff who were not attending them while they were in labor and particularly during physical exams [11, 21, 48, 52, 57, 69, 73, 74, 83]. They felt that such exposure was undignified, inhumane and shameful [21, 48, 52, 73, 74].
Health workers explained having inadequate medical supplies, such as medication, gloves and blood, which caused unnecessary danger and stress in their work environment [9, 27, 53, 60, 66, 69, 86, 92].

Both women and health workers described the antenatal and delivery wards as “dirty,” “noisy,” “disorderly” and “overcrowded”, where needles, biomedical waste and dirt were strewn on the floor [6, 27, 52, 58, 60, 66, 69, 83, 94]. In some facilities, women in labor lay on bare mattresses that were soiled with urine, feces, blood, vomit and amniotic fluid [6, 83].

*Lack of policies*

Women lamented their inability to express their opinions about the treatment and services rendered during childbirth [8, 9, 13, 66, 76]. Several reasons for this were posited, including women not wanting to get a health worker in trouble [66], women fearing unfair treatment or discrimination if they complained [9, 13, 66], health workers being perceived as unapproachable [66], women unaware of their rights as patients [8, 13, 66], fear of facility closure [9] and a lack of redress or accountability mechanism for lodging complaints [8, 9, 13, 66]. Even in settings where health policies dictated the creation of a formal complaint registration system, these systems were not always implemented [13]. When complaints were launched through informal mechanisms, facility-level responses were seldom received, thus discouraging future complaints [13].

The lack of accountability and sanctioning within the health system left women feeling powerless to seek justice for their mistreatment.

*Facility culture*

Women reported the need to pay bribes in health facilities [8, 9, 13, 55, 70, 74, 75, 92], including for doctors [8, 70], nurses [8, 13, 55], midwives [13, 74], receptionists [13], and guards [13]. Bribes took the form of money [8, 13, 55, 70, 74], food or drinks [13, 55], jewelry [8] and other gifts [8, 13]. Women believed that paying bribes could ensure the
receipt of timely care, adequate attention from health providers and medication [8, 9, 13, 55, 70, 75, 92]. Health workers were perceived to ignore women on the maternity ward until they paid a bribe [8, 13, 55, 70, 75, 92]. Women in Tanzania reported that an unclear fee structure for services and supplies rendered during childbirth led to frustration, confusion and a fear of detainment in the facility [9].

Some women were angry with health workers for making unreasonable demands of them, such as being forced to clean up the “mess” they made on the floor or bed after vaginal deliveries and Caesarean sections [6, 7, 13, 66, 76]. Some women were told to walk to a different room to retrieve supplies or to dispose of medical waste during advanced labor or immediately after delivery without a wheelchair or support [7, 13, 66, 76].

Exploring the influences of the mistreatment of women

Potential drivers of the mistreatment of women

Both women and health workers posited potential drivers for the mistreatment of women during facility-based childbirth [10, 13, 21, 58, 66, 71, 72, 74, 76, 79, 83, 86, 90, 92]. Women referred to health workers as impatient and hurried [21, 72, 74, 83, 90], and that they used force to gain compliance [10, 13, 21, 72, 76, 86]. Some women believed that health workers sought to ensure good health outcomes and women were therefore yelled at due to their disobedience on the antenatal or delivery ward, such as pushing before instructed to do so, or because of the health workers being “overstretched,” “tired” and “overworked” [7, 9, 10, 52, 62, 66, 76, 79, 80, 92].

Health workers described how hierarchical authority in the health system legitimizes the control health workers have over women during childbirth [10, 13, 53, 58, 76, 90]. Some providers believed that they could use extreme or coercive measures to gain compliance from women [76] and some providers did not feel obligated to provide care when women were
non-compliant [76]. Furthermore, the lack of provider supervision contributed to feelings of
demoralization and negative attitudes [13], leading to both health workers and patients
expecting and accepting the poor treatment of women as the norm [13, 90].

Some health workers blamed health system issues, such as understaffing, high patient volume,
low salaries, long hours and lack of infrastructure, for creating stressful environments that
facilitated unprofessional behavior [13, 69, 90, 92]. Some midwives felt that poor health
outcomes were inevitable in their work environment as women arrived at the facilities with
complications, and that they were unfairly blamed for mistreatment that occurred [76]. Nurse-
midwives justified their mistreatment of women by claiming that they were attempting to
ensure safe outcomes for mothers and babies [13, 58, 76, 86], and excused the perpetration of
physical abuse as a “necessity” to ensure compliance and safe birth outcomes, believing that
they were “forced by circumstance” [13, 53, 58, 76, 86]. Nurses and midwives from South
Africa and Cambodia confirmed the urge to use physical aggression to deal with anger or
frustration at a noncompliant woman [74, 76, 79]. Obstetricians from Brazil emphasized that
some parturient women are aggressive, non-compliant and arrive primed for confrontations,
which contributed to misinterpretation of interactions between women and health workers
[53]. Some nurses believed that they were caught up in providing clinical care and forgot to
communicate with the woman to explain what they were doing [79] or that communicating to
women about every procedure or exam was repetitive [71]. Midwives in Turkey and South
Africa suggested that some health workers are “caught in a superiority complex” and enjoyed
exerting control over patients [58, 76]. Finally, some health workers believed that abuses
perpetrated to women were “ritualized” and “punitive” but only occurred with a few “rotten
apples” rather than with all providers [13, 53, 76].

Consequences of the mistreatment of women

Experiences of mistreatment during childbirth have far-reaching consequences for women and
communities outside of the direct woman-provider interaction. Prior experiences and

48
perceptions of mistreatment, low expectations of care provided at facilities and poor reputations of facilities in the community eroded many women’s trust in the health system and impacted their decision to deliver in health facilities in the future, particularly in low- and middle-income countries [6, 8, 10, 13, 21, 51, 52, 60, 63, 69, 70, 76-78, 81, 84, 89, 93, 95]. Some women may consider childbirth in facilities as a last resort, prioritizing the culturally appropriate and supportive care received by traditional providers in their homes over medical intervention [69, 81]. These women desired home births where they could deliver in a preferred position, were able to cry out without fear of punishment, received no surgical intervention and were not physically restrained [81, 84].

Discussion

This systematic review illustrates how, in many settings worldwide, women’s childbirth experiences are marred by instances of mistreatment, including physical and verbal abuse, a lack of supportive care, neglect, discrimination and denial of autonomy. Our findings indicate that while these various forms of mistreatment can occur at the level of interaction between the woman and provider, a complex range of systemic failures at the levels of the health facility and health system contribute to its occurrence, including poor supervisory structures, insufficient staffing, inadequate supply chains, poor physical conditions, as well as policies, facility culture and power dynamics that systematically disempower women.

Bowser and Hill published a landscape analysis exploring evidence for disrespect and abuse in facility-based childbirth and proposed a seven-category model [12]. This analysis was designed to stimulate dialogue and an implementation research agenda, rather than provide a comprehensive review of global evidence. As such, this systematic review builds upon the work of Bowser and Hill to present a comprehensive typology to describe and understand the
mistreatment of women during childbirth. We envisage that as more research on this important topic is conducted, this typology will continue to evolve.

While different countries, organizations and authors have adopted different terminology (such as “obstetric violence”, “dehumanized care” and “disrespect and abuse”) to describe this phenomenon, we have proposed “mistreatment of women” as a broader, more inclusive term that better captures the full range of experiences women and healthcare providers have described in the literature. These experiences can be active (such as intentional or deliberate physical abuse), passive (such as unintentional neglect due to lack of staffing or overcrowding), related to the behavior of individuals (verbal abuse by healthcare providers against women), or health systems conditions (such as lack of beds compromising basic privacy and confidentiality). However, they can all impact on a woman’s health, childbirth experiences and her rights to respectful, dignified and humane care at birth.

Health systems factors can be experienced directly by women as mistreatment. For example, a woman may feel that her privacy was violated in a labor ward without curtains or partitions available to allow healthcare providers and women the necessary privacy during vaginal examinations. Similarly, staffing shortages may mean that healthcare providers are unable to attend to all women during childbirth, which can be experienced directly by women as neglect. However, health systems constraints may also have more indirect effects as contributing factors to the behaviors of individuals. For example, staffing shortages, poor infrastructure or lack of medications can create stressful working environments, which may predispose healthcare providers to behave poorly (or even abusively) towards women. It is important to note that mistreatment or abusive conduct by healthcare providers is not necessarily intentional, and may coexist with other compassionate and respectful care practices. However, women’s experiences of mistreatment must be viewed as such, regardless of intent. Health systems factors may provide contextual explanations for negative experiences, but should not be considered as justification of the continued mistreatment of women. The conceptual model proposed by Freedman et al illustrates the need to engage
stakeholders at local, national and international levels to participate in the discourse on the drivers of the mistreatment of women [28].

The emphasis placed on increasing the proportion of women attended by skilled birth attendants requires substantial efforts to improve quality of care. However, research has largely concentrated on issues related to the provision of clinical aspects of care; we have not been able to identify any existing systematic reviews of interventions or strategies that improve women’s experiences of care during childbirth. Improvements to quality of care need to not only ensure access to timely, safe and effective clinical care, but must also protect and promote women’s rights to dignified and respectful care [20]. The WHO Quality of Care framework for mothers and newborns makes explicit the need for more evidence and action on good communication, respect, dignity and emotional support in efforts to improve quality of care [23]. This approach can empower women, promote positive childbirth experiences and increase satisfaction, but could also increase demand for and utilization of maternal health services [97-99].

The mistreatment of women during childbirth is not only a quality of care issue, but is also demonstrative of larger human rights violations. Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination. Mistreatment, neglect, abuse or disrespect during childbirth can amount to a violation of a woman’s fundamental human rights, as described in internationally adopted human rights standards and principles. In particular, women have the right to be “equal in dignity, to be free to seek, receive and impart information, to be free from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health” [20, 100].
Limitations and strengths of the review. We were unable to differentiate between different levels of health facilities, as most primary studies did not specify the type of facility described in the analysis. Different levels of health facilities have different environments that may facilitate or mitigate the mistreatment of women during childbirth. Furthermore, we did not include studies that explored mistreatment during home birth experiences as we viewed this as conceptually different from facility-based birth experiences. The scope of this review was to synthesize research evidence (both published and from grey literature); given the interdisciplinary scope of this topic across medicine, public health, law and human rights domains it is therefore possible that relevant human rights reports or legal documentation did not meet the inclusion criteria of this review. Moreover, given the large scope of this phenomenon, it is possible that we have missed some articles which may have been relevant. Although no language filters were used in the search, it is possible that the searches did not yield articles published in non-Latin alphabets, and four studies were excluded because they were not published in English, French, Spanish or Portuguese. However, it is unlikely that the exclusion of these studies will impact the model generated by this review or limit its global applicability.

There are several important strengths to this review. To our knowledge, this is the first systematic review of the mistreatment of women during childbirth in facilities. Second, the typology presented in this review is designed to inform an evidence-based classification system and definition of how women are mistreated during childbirth, based on the findings of systematic mixed-methods evidence syntheses. Third, using the rigorous CERQual approach to assess the confidence in the review findings affords more credibility, reliability and transparency to the analysis [36, 37, 39]. Finally, with the help of an international team of researchers, we included 65 studies published in four languages, which allowed us to conduct a comprehensive global synthesis across diverse settings.
Implications for future research. This review found there is limited availability of quantitative evidence regarding the burden of the mistreatment of women. Furthermore, the complex relationships between health system constraints, healthcare provider behavior and women’s experiences of mistreatment need greater exploration in order to improve quality of maternity care. Moving forward, the typology presented in this review can be used in the development and validation of indicators and tools to measure the prevalence of the mistreatment of women during childbirth, to identify interventions to reduce this mistreatment, and to inform efforts to develop global consensus on the definition of the mistreatment of women during childbirth. Such efforts are necessary not only to protect women’s fundamental human rights, but also to promote a women-centered approach to the provision and experience of quality care. Similar efforts should be undertaken to explore the mistreatment of women during other maternal health services, such as antenatal and abortion care.

Conclusions

This systematic review presents a comprehensive, evidence-based typology of the mistreatment of women during childbirth in health facilities. Moving forward, we propose this typology of the phenomenon be used to develop measurement tools and to inform the discourse and further research on policies and programs to prevent its occurrence.

We must seek to find a process by which women and healthcare providers engage to promote and protect women’s participation in safe and positive childbirth experiences. A woman’s autonomy and dignity during childbirth must be respected and her healthcare providers should promote positive birth experiences through respectful, dignified, supportive care, as well as ensuring high quality clinical care. The development of validated and reliable tools to measure the mistreatment of women during childbirth, as well as interventions to prevent mistreatment and promote respectful care are critical next steps. Future research and
interventions addressing quality care during childbirth must emphasize that high quality of care is respectful, humanized care [5].
Chapter Two References


31. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC medical research methodology. 2008;8:45.


37. Assessing How Much Confidence to Place in the Evidence from Reviews of Qualitative Research. The Campbell Collaboration Colloquium; 16-19 June 2014; Queen's University, Belfast.


42. Tong A; Flemming K, McInnes E, Oliver S, Craig J. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. (1471-2288 (Electronic)).


50. Silal SP, Penn-Kekana L, Harris B, Birch S, McIntyre D. Exploring inequalities in access to and use of maternal health services in South Africa. BMC Health Serv Res. 2012;12:120.


53. Aguiar J, d'Oliveira A, Schraiber L. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde / [Institutional violence, medical authority, and power relations in maternity hospitals from the perspective of health workers]. 2013(1678-4464 (Electronic)).


100. Office of the United Nations High Commissioner for Human Rights. 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. UN General Assembly; 2012.
Figure 2.1. Flow diagram of search and study inclusion process.

[Diagram showing the flow of records identification, title/abstract screening, full text screening, and final included studies with reasons for exclusion.

* Note: The four articles excluded based on their language were in Norwegian, Polish, Greek and German.]
Table 2.1. Typology of the mistreatment of women during childbirth.
The typology presented in this table is an evidence-based classification system of how women are mistreated during childbirth, based on the findings of the evidence syntheses. The first order themes are identification criteria describing specific events or instances of mistreatment. The second and third order themes further classify these first-order themes into meaningful groups based on common attributes. The third-order themes are ordered from the level of interpersonal relations through the level of the health system.

<table>
<thead>
<tr>
<th>Third order</th>
<th>Second order</th>
<th>First order</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical abuse</strong></td>
<td>Use of force</td>
<td>Women beaten, slapped, kicked, and pinched during delivery</td>
</tr>
<tr>
<td></td>
<td>Physical restraint</td>
<td>Physically restrained to the bed or gagged during delivery</td>
</tr>
<tr>
<td><strong>Sexual abuse</strong></td>
<td>Sexual abuse</td>
<td>Sexual abuse or rape</td>
</tr>
<tr>
<td><strong>Verbal abuse</strong></td>
<td>Harsh language</td>
<td>Harsh or rude language</td>
</tr>
<tr>
<td></td>
<td>Threats and blaming</td>
<td>Threats of withholding treatment or poor outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blaming for poor outcomes</td>
</tr>
<tr>
<td><strong>Stigma and discrimination</strong></td>
<td>Discrimination based on sociodemographic characteristics</td>
<td>Discrimination based on ethnicity/race/religion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discrimination based on age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discrimination based on socioeconomic status</td>
</tr>
<tr>
<td><strong>Failure to meet professional standards of care</strong></td>
<td>Lack of informed consent and confidentiality</td>
<td>Lack of informed consent process</td>
</tr>
<tr>
<td></td>
<td>Breaches of confidentiality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical examinations and procedures</td>
<td>Painful vaginal exams</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refusal to provide pain relief</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performance of unconsented surgical operations</td>
</tr>
<tr>
<td></td>
<td>Neglect and abandonment</td>
<td>Neglect, abandonment and long delays</td>
</tr>
<tr>
<td></td>
<td>Skilled attendant absent at time of delivery</td>
<td></td>
</tr>
<tr>
<td><strong>Poor rapport between women and providers</strong></td>
<td>Ineffective communication</td>
<td>Poor communication</td>
</tr>
<tr>
<td></td>
<td>Dismissal of women’s concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Language and interpretation issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poor staff attitudes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of supportive care</td>
<td>Lack of supportive care from health workers</td>
</tr>
<tr>
<td></td>
<td>Denial or lack of birth companions</td>
<td></td>
</tr>
<tr>
<td><strong>Loss of autonomy</strong></td>
<td></td>
<td>Women treated as passive participants during childbirth</td>
</tr>
<tr>
<td></td>
<td>Denial of food, fluids and mobility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of respect for women’s preferred birth positions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denial of safe traditional practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objectification of women</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detainment in facilities</td>
<td></td>
</tr>
<tr>
<td><strong>Health systems conditions and constraints</strong></td>
<td>Lack of resources</td>
<td>Physical condition of facilities</td>
</tr>
<tr>
<td></td>
<td>Staffing constraints</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supply constraints</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of privacy</td>
<td></td>
</tr>
<tr>
<td><strong>Lack of policies</strong></td>
<td>Lack of redress</td>
<td></td>
</tr>
<tr>
<td><strong>Facility culture</strong></td>
<td>Bribery and extortion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unclear fee structures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unreasonable requests of women by health workers</td>
<td></td>
</tr>
</tbody>
</table>
Table 2.2. Selected measures of how women are mistreated during childbirth from three measurement studies.

This table presents selected measures of how women are mistreated during childbirth from three measurement studies conducted in Tanzania and Nigeria [25-27]. These selected measures are reported by study and data collection method and are reorganized according to the domains of the mistreatment of women during childbirth presented in the typology in Table 3.2. Due to similarities in some terminology across studies, some measures below have been aggregated for ease of reporting and interpretation and are noted as such (*); however, it is unclear whether the operationalization of the measure was consistent across studies. Sando et al stratified findings by HIV-status and data collection method; this table presents aggregated measures by data collection method for all women. Appendix 3.10 presents all relevant quantitative findings from the twelve included quantitative and mixed-methods studies.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Kruk et al 2014</th>
<th>Sando et al 2014</th>
<th>Okafor et al 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-report at exit (women) (n=1779)</td>
<td>Self-report at home follow-up (women) (n=593)</td>
<td>Self-report at discharge 3-6 hours postpartum (women) (n=1954)</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Any experience of mistreatment</td>
<td>343</td>
<td>19.48%</td>
<td>167</td>
</tr>
<tr>
<td>Lack of privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-confidential care</td>
<td>77</td>
<td>4.39%</td>
<td>36</td>
</tr>
<tr>
<td>Lack of [physical] privacy / provision of care without privacy*</td>
<td>77</td>
<td>4.39%</td>
<td>36</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shouting/scolding/called stupid*</td>
<td>153</td>
<td>8.71%</td>
<td>78</td>
</tr>
<tr>
<td>Threatening or negative comments</td>
<td>93</td>
<td>5.28%</td>
<td>68</td>
</tr>
<tr>
<td>Threat of withholding treatment</td>
<td>73</td>
<td>4.16%</td>
<td>35</td>
</tr>
<tr>
<td>Stigma and discrimination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination [based on] specific patient attributes</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Neglect and abandonment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect/abandonment*</td>
<td>150</td>
<td>8.53%</td>
<td>92</td>
</tr>
<tr>
<td>Delivery without attendant</td>
<td>68</td>
<td>3.91%</td>
<td>31</td>
</tr>
<tr>
<td>Lack of supportive care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denied companionship by the husband or relatives</td>
<td>-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical abuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>51 2.90%</td>
</tr>
<tr>
<td>Physical abuse (slapping, pinching, etc)</td>
<td>47 2.68%</td>
</tr>
<tr>
<td>Beaten, slapped or pinched</td>
<td>34 1.94%</td>
</tr>
<tr>
<td>Restrained or tied down during labor</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual abuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td>4 0.23%</td>
</tr>
<tr>
<td>Sexually abused by health worker</td>
<td>3 0.17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lack of informed consent and confidentiality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-consented care</td>
<td>1 0.06%</td>
</tr>
<tr>
<td>Woman not asked for consent for vaginal examination in antenatal ward</td>
<td>-</td>
</tr>
<tr>
<td>Shaving of pubic hair [without consent]</td>
<td>-</td>
</tr>
<tr>
<td>Disclosure of HIV status without consent</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical examinations and procedures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-consent for tubal ligation, sterilization, or hysterectomy*</td>
<td>1 0.06%</td>
</tr>
<tr>
<td>Episiotomy [without consent]</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loss of autonomy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Detention in the health facility</td>
<td>-</td>
</tr>
<tr>
<td>Detention in facility for failure to pay*</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lack of resources</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed in postnatal ward was not clean</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility culture</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for bribe or inappropriate demands for payment*</td>
<td>31 1.78%</td>
</tr>
</tbody>
</table>
Table 2.3. Summary of qualitative findings.
A summary of the review findings from the qualitative synthesis are presented here, with the relevant papers contributing to each review finding. The “confidence in the evidence” refers to the overall CERQual assessment of the methodological limitations of included studies, relevance, sufficiency and coherence, and are rated as high, moderate or low confidence. The “explanation of confidence in the evidence assessment” provides a brief assessment of each CERQual domain to support the overall CERQual assessment.

<table>
<thead>
<tr>
<th>#</th>
<th>Review finding</th>
<th>Relevant papers</th>
<th>Confidence in the evidence</th>
<th>Explanation of confidence in the evidence assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use of force</td>
<td>[6, 9, 10, 13, 21, 60, 66, 67, 72, 74, 76, 79, 83, 85, 86, 90, 95, 96]</td>
<td>High confidence</td>
<td>15 studies with minor to significant methodological limitations. Thick data from 10 countries across all geographical regions, but predominantly sub-Saharan Africa. High coherence.</td>
</tr>
<tr>
<td>2</td>
<td>Physical restraint</td>
<td>[85, 96]</td>
<td>Low confidence</td>
<td>2 studies (Tanzania and Brazil) with minor to significant methodological limitations. Limited, thin data from 2 countries. Extent of coherence unclear due to limited data.</td>
</tr>
</tbody>
</table>
**Verbal abuse**

| 3 | **Harsh or rude language** | Across high, middle and low income countries, verbal abuse of women by health providers during childbirth was a commonly reported event, particularly the use of harsh or rude language. Women’s perceptions of their facility-based childbirth experiences were often shaped by negative encounters with health workers in which they were verbally abused. | [6, 7, 9, 10, 13, 47, 50-54, 57, 58, 60, 62, 63, 66, 67, 69, 72, 74, 76, 79, 80, 82, 84, 86, 87, 89, 90, 92] | High confidence | 30 studies with minor to significant methodological limitations. Thick data from 18 countries across all geographical regions, but predominantly sub-Saharan Africa. High coherence. |
| 4 | **Judgmental and accusatory comments** | Women reported feeling shamed by health workers who made inappropriate comments to them regarding their sexual activity. Insensitive comments may be experienced more frequently by adolescent or unmarried women, since many communities view pregnancy and childbirth as appropriate only in the context of marital relationships. Intentionally lewd comments humiliated the women while they were in an already vulnerable position during childbirth and in need of supportive care. As a result, women often felt that their health provider was disrespectful, uncaring, and rude. | [10, 13, 54, 57, 58, 72, 76, 79, 86, 90] | Moderate confidence | 10 studies with minor to significant methodological limitations. Fairly thick data from 8 countries, predominantly low-income countries. High coherence. |
| 5 | **Threats and blaming** | Some women were threatened with poor quality of care or poor outcomes for their babies as a result of their behavior during childbirth. This included threats of a beating if the woman did not comply with a health worker’s request and threats of withholding health services. Other women were blamed for their baby’s or their own poor health outcomes. | [13, 57, 58, 62, 67, 76] | Moderate confidence | 6 studies with minor to significant methodological limitations. Adequate data from 5 countries, predominantly middle- and high-income countries. High coherence. |
### Stigma and discrimination

<table>
<thead>
<tr>
<th>6</th>
<th><strong>Discrimination based on ethnicity/race/religion</strong></th>
<th>Women commonly reported feeling discriminated against due to their ethnic or racial backgrounds. Differential treatment by health workers often pervaded their experiences during childbirth and influenced the quality of care they received. This type of treatment tended to make women feel alienated from their healthcare providers. In some settings, migrants and refugees received particularly disrespectful care and may be expected to pay higher rates for services or bribes. This includes Somali women with female genital cutting in Canada, Roma women in the Balkans and refugee women in South Africa.</th>
<th>[8, 13, 48, 51, 52, 57, 61, 62, 66, 71, 77, 79, 94]</th>
<th>High confidence</th>
<th>12 studies with minor to significant methodological limitations. Thick data across 9 countries across all geographical regions and country income-levels. High coherence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td><strong>Discrimination based on age</strong></td>
<td>Women felt discriminated against based on their age, for both being pregnant as an unmarried adolescent and as an older woman of high parity. Adolescents were criticized and ridiculed for engaging in sexual activity before marriage and some felt that their confidentiality was breached due to their age. Adolescents in South Africa reported that mistreatment that they or their friends experienced during facility-based childbirth directly facilitated them to deliver at home in the future.</td>
<td>[9, 54, 62, 66, 76, 79, 87]</td>
<td>Moderate confidence</td>
<td>6 studies with minor to significant methodological limitations. Fairly thick data across 4 countries, but particularly in South Africa. High coherence.</td>
</tr>
<tr>
<td>8</td>
<td><strong>Discrimination based on socioeconomic status</strong></td>
<td>Across the world, women who were of lower socioeconomic status reported feeling discriminated against due to their social class or income level. They believe that they received poorer treatment or were neglected because they were poor and often unable to pay for services or bribes. They often felt that health workers humiliated them for their poverty, inability to read or write or for residing in rural or slum areas. Fear of such discrimination was considered a powerful disincentive to deliver at in health facilities in Ghana, Sierra Leone and Tanzania.</td>
<td>[8-10, 57, 61, 66, 74, 75, 78, 89, 90, 92]</td>
<td>High confidence</td>
<td>10 studies with minor to significant methodological limitations. Thick data across 11 countries [1 multi-country study], but predominantly in sub-Saharan Africa. High coherence.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Discrimination based on medical conditions</strong></td>
<td>Some women in Kenya and South Africa believed that their positive HIV status contributed to the provision of substandard care, including delays in receiving essential interventions, avoidance of patient contact and fewer vaginal examinations. However, some health workers in Kenya stated that there was no discrimination against or segregation of HIV-positive women on the labor ward, although they reported being “anxious” if they suspected a woman to be HIV-positive and might handle them with “extra care”.</td>
<td>[11, 13, 27]</td>
<td>Low confidence</td>
<td>3 studies with minor to significant methodological limitations. Adequate data from 3 countries (South Africa, Kenya and Tanzania). Reasonable level of coherence; may have higher confidence in settings with similar HIV epidemics or there may be discrimination based on other medical conditions.</td>
</tr>
</tbody>
</table>
## Failure to meet professional standards of care

<table>
<thead>
<tr>
<th></th>
<th>Painful vaginal examinations</th>
<th>Refusal to provide pain relief</th>
<th>Lack of informed consent</th>
<th>Breaches of confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Some women reported frequent and painful vaginal examinations during labor. They viewed the number of vaginal examinations they received during labor as excessive and dehumanizing. In some cases, vaginal examinations were conducted in non-private settings and women may not have consented to the procedure or the procedure may not have been communicated to them.</td>
<td>Across multiple settings, women described the health workers' refusal to provide pain relief or that pain medication was not available for them during labor. Surgical procedures, such as episiotomy, were sometimes carried out without any pain relief. In lower resource settings, this was often due to stock outs or lack of sufficient patient payment. In higher resource settings, women reported that they were not offered pain relief or were denied pain relief requested.</td>
<td>Women complained that they were not always asked to provide consent for medical procedures such as cesarean section. When women were asked to provide consent prior to a procedure, they were not always adequately informed of the risks and benefits of the procedure and felt that the health worker went through the motions of obtaining consent. Some women in Kenya also avoided or feared facility-based delivery due to anxiety about being tested for HIV without their consent.</td>
<td>Some women complained that the health workers did not maintain doctor-patient confidentiality and disclosed private information either to their male partners or to other patients. For some HIV-positive women in Kenya, the lack of trust in the confidentiality of treatment at health facilities was so great that they chose to deliver at home where their HIV status would not be disclosed to other community members or health workers.</td>
</tr>
<tr>
<td></td>
<td>[53, 57, 73, 79, 82, 85, 88, 94]</td>
<td>[13, 21, 57, 67, 74, 76, 79, 80, 89, 91, 92]</td>
<td>[11, 13, 91]</td>
<td>[11, 13, 27, 54, 58]</td>
</tr>
<tr>
<td></td>
<td>Moderate confidence</td>
<td>High confidence</td>
<td>Moderate confidence</td>
<td>Moderate confidence</td>
</tr>
<tr>
<td></td>
<td>6 studies with minor to significant methodological limitations. Fairly thick data in 5 countries across multiple geographical regions and country income-levels. High coherence.</td>
<td>11 studies with minor to moderate methodological limitations. Thick data in 9 countries across multiple geographical regions and country income-levels. High coherence.</td>
<td>3 studies with minor to moderate methodological limitations. Fairly thick data in 3 (Kenya, South Africa and United Kingdom). High coherence.</td>
<td>5 studies with minor to significant methodological limitations. Fairly thick data across 5 countries, particularly in sub-Saharan Africa. High coherence.</td>
</tr>
</tbody>
</table>
### Neglect, abandonment and long delays
Women frequently referred to long delays in receiving care and inattentive health workers who neglected women during labor and delivery. Women commonly reported feeling alone, ignored and abandoned during their stay at the facility, and felt as if their request for help or attention from health workers was an imposition. Many women reported long wait times before seeing a health worker or before receiving an intervention. Long wait times may be exacerbated when women do not book prior to delivery, as their information may not be in the system and they perceive that health workers punish women who do not book with longer wait times. These experiences of neglect and abandonment by health workers in facilities were direct barriers to seeking future deliveries in facilities in Ghana, Bolivia and Tanzania, as some women prioritized the need for supportive childbirth care which they could receive from traditional providers.

|---|---|---|---|---|

### Skilled attendant absent at time of delivery
Some women reported that health worker shortages and negligence directly increased the physical risks women faced during delivery. In some extreme cases of neglect, women delivered at facilities without the presence of skilled birth attendants who were preoccupied with other tasks.

<table>
<thead>
<tr>
<th>15</th>
<th><strong>Skilled attendant absent at time of delivery</strong></th>
<th>[9, 13, 21, 47, 58, 66, 76, 80, 83, 85, 86, 92]</th>
<th>High confidence</th>
<th>11 studies with minor to significant methodological limitations. Thick data across 7 countries, particularly in the Middle East and sub-Saharan Africa. High coherence.</th>
</tr>
</thead>
</table>

### Poor communication
Women commonly referred to communication issues between their health workers and themselves that left women feeling “in the dark” about their childbirth care. Many women felt dissatisfied with the information and explanations provided to them by their health workers regarding their care and believed that the health workers were more interested in having them comply with their demands rather than allowing the women to ask questions to clarify the proposed procedures. These experiences made women feel distanced from their health workers, fearful of procedures and like they were not active participants in their childbirth experience. Some women in the United Kingdom, Dominican Republic and Brazil went so far as to believe that health workers intentionally avoided exchanging information with patients and described them as unresponsive to patient needs.

| 16 | **Poor communication** | [6, 8, 11, 13, 21, 47, 49, 51, 52, 56, 57, 59, 61, 63, 65, 66, 69, 72, 74, 77, 83, 85, 87, 91-93, 95, 96] | High confidence | 27 studies with minor to significant methodological limitations. Thick data from 21 countries across all geographical regions. High coherence. |
| 17 | **Language and interpretation issues**  
Women often suffered from language and interpretation barriers when attempting to communicate with their health workers, and this was particularly a burden for migrant and refugee women in high income settings. | [8, 13, 51, 57, 61, 77] | Moderate confidence | 6 studies with minor to moderate methodological limitations. Fairly thick data from 6 middle- and high-income countries. High coherence. |
| 18 | **Lack of supportive care from health workers**  
Women commonly reported a lack of supportive care during childbirth in facilities, including the perception that the care provided by health workers was mechanical and lacked comfort and courtesy. During their deliveries, women often felt that they did not receive the time and attention from health workers to make them feel supported and adequately cared for. Women felt that staff were insensitive to their needs, which made women feel unconfident, anxious and alone. Many women believed that delivering in a health facility would ensure positive health outcomes for themselves and their babies. However, while they often felt that they received technically sound care, their experiences at the facility were marred by feelings of being emotionally unsupported. Women felt that they were provided with systemized, mechanistic care that focused solely on technical outcomes rather than supportive care that incorporated sensitive communication and a comforting touch. Women from Sierra Leone, Uganda and rural China stated that when expectations for a supportive environment during a facility-based childbirth were not met, they may be less inclined to deliver at a facility in future births. | [6, 7, 9, 21, 47-49, 51, 56, 57, 59, 60, 62, 64, 65, 70-72, 74, 77, 80, 81, 87, 89, 91, 92] | High confidence | 26 studies with minor to significant methodological limitations. Thick data from 20 countries across all geographical regions, but predominantly in sub-Saharan Africa. High coherence, but lack of supportive care in lower income settings may impact future childbirth care-seeking behaviors. |
| 19 | **Denial or lack of birth companions**  
Women desired the supportive attention and presence of a birth companion, who may be a family member, husband or a friend. However, women across the world were often prohibited from having a companion of their choice during delivery. Although not always clearly explained to clients, it was often official hospital policy to ban birth companions, as they were deemed unnecessary by the administration. The lack of companionship left women feeling disempowered, frightened and alone during childbirth as they yearned for the comfort provided by familiar faces. | [6, 9, 21, 47-49, 53, 65, 71, 74, 77, 89] | Moderate confidence | 11 studies with minor to significant methodological limitations. Fairly thick data from 9 countries across many regions, but predominantly middle-income settings. High coherence. |
| 20 | **Lack of respect for women’s preferred birth positions**  
Some women preferred to deliver in positions other than the supine position, such as by squatting or kneeling, and resented that health workers forced them to deliver in undesirable or humiliating positions. Women felt that adopting an undesirable birth position at the demand of the health worker made them passive participants in their childbirth process. Restricting the childbirth position to lying down acted as a barrier for some women to access facility-based deliveries in Bangladesh. Health workers in Bangladesh, Cuba and Uganda explained that they had not been trained to deliver women in positions other than lying down and felt uncomfortable letting a woman choose her own birth position. | [6, 9, 21, 52, 69, 71, 81, 88] | Moderate confidence | 6 studies with minor to significant methodological limitations. Adequate data from 6 countries, predominantly middle-income countries. Reasonable level of coherence. |
| 21 | **Denial of safe traditional practices**  
Some women in Ghana and the United Kingdom referred to the denial of safe traditional religious or cultural practices related to childbirth. Maintaining these traditional practices, such as retaining the placenta for burial, were important to women and the denial of these practices may be an important barrier to seeking facility-based delivery or experiencing quality supportive care. | [10, 77] | Low confidence | 2 studies with minor to moderate methodological limitations. Fairly thin data from 2 countries (United Kingdom and Ghana). Extent of coherence unclear due to limited data, but findings were similar across the studies. |
| 22 | **Objectification of women**  
In several settings, women reported feeling stripped of their dignity during childbirth due to the health workers’ objectification of their bodies. They resented being forced to be on all fours and exposing their bodies to numerous health workers, sometimes including large group of students. | [13, 21, 47, 56, 83] | Moderate confidence | 5 studies with minor to significant methodological limitations. Adequate data from 8 countries [1 multi-country study], but only in middle- and high-income settings. Reasonable level of coherence for middle- and high-income settings. |
| 23 | **Detainment in facilities**  
Studies from Benin and Sierra Leone suggest that either the mother or baby may be detained in the health facility, unable to leave until they pay the hospital bills. | [72, 89] | Low confidence | 2 studies with moderate methodological limitations. Fairly thin data from 2 countries (Benin and Sierra Leone). Extent of coherence unclear due to limited data, but findings were similar across the studies. |
### Health systems conditions and constraints

<table>
<thead>
<tr>
<th></th>
<th><strong>Physical condition of facilities</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Both women and health workers described the physical conditions of health facilities that contributed to the mistreatment of women. Antenatal and delivery wards were described as &quot;dirty,&quot; &quot;noisy,&quot; &quot;disorderly&quot; and &quot;overcrowded&quot; where needles, biomedical waste and dirt were strewn on the floor.</td>
<td>[27, 52, 58, 66, 69, 83, 94, 95]</td>
</tr>
<tr>
<td></td>
<td>Moderate confidence 9 studies with minor to significant methodological limitations. Fairly thick data from 8 low- and middle-income countries. High coherence.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Staffing shortages</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>Both women and health workers illustrated how staffing constraints affect the quality of care provided. Staffing shortages were of particular concern in low- and middle-income countries and often led to longer wait times for women and their families, as well as neglectful or poor quality care. Women and health workers both purported that staffing constraints affected not only direct provision of care, but also contributed to the health workers’ negative attitudes or lack of motivation. In low- and middle-income countries, providers of all cadres were described as &quot;overworked,&quot; &quot;too busy,&quot; &quot;stretched&quot; and “underpaid” by both women and other providers.</td>
<td>[13, 50, 77, 83, 86, 89, 90, 92]</td>
</tr>
<tr>
<td></td>
<td>Moderate confidence 87 studies with minor to significant methodological limitations. Fairly thick data from 7 countries, particularly in sub-Saharan Africa. High coherence.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Staffing constraints</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>In addition to the understaffing of health workers, inexperienced or poorly trained health workers were often responsible for inappropriate levels of care without supportive supervision. In lower-level facilities, qualified physicians may be a rarity, leaving unskilled nurses to attend to labor management, complications and decisions regarding referrals.</td>
<td>[52, 53, 83, 86, 95]</td>
</tr>
<tr>
<td></td>
<td>Low confidence 6 studies with minor to significant methodological limitations. Adequate data from 6 countries. High coherence.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Supply constraints</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Health workers and male partners in low and middle-income countries explained that they do not have adequate medical supplies, including medication, gloves and blood, which are critical for executing their duties. In some cases, this shortage lead to the requirement of patients to bring their own supplies, such as gloves, gauze, and pads. This may cause health workers to attend first to women who brought their own supplies, or for women to think that the health workers are withholding supplies from them for malicious reasons. Health workers believed that the shortage of supplies, particularly gloves, caused unnecessary danger and stress in the work environment.</td>
<td>[9, 27, 53, 60, 66, 69, 86, 92, 95]</td>
</tr>
<tr>
<td></td>
<td>Moderate confidence 9 studies with minor to significant methodological limitations. Thick data from 7 low- and middle-income countries. High coherence for low- and middle-income settings.</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td><strong>Lack of privacy</strong></td>
<td>Women across many settings reported a general lack of privacy on the antenatal and labor wards and specifically during vaginal and abdominal exams. Women were exposed to other patients, their families and health workers due to the lack of curtains to separate them from other patients, the lack of curtains on the outside windows and doors that were left open. In low- and middle-income countries, the antenatal and labor/delivery wards were sometimes common or public areas and women were sometimes forced to share beds with other parturient women who may be strangers. Not surprisingly, women expressed their desire to be shielded from other patients, male visitors and staff who were not attending them while they were in labor and particularly during physical exams. They felt that such exposure, particularly during this vulnerable time, was undignified, inhumane and shameful.</td>
</tr>
<tr>
<td>29</td>
<td><strong>Lack of redress</strong></td>
<td>Women lamented the inability to express their opinions about the treatment and services rendered during childbirth. Several reasons for this were posited, including women fearing unfair treatment or discrimination if they complained, women unaware of their rights as patients, fear of facility closure and a lack of redress or accountability mechanism for lodging complaints. Even in settings where health policies dictated the creation of a formal complaint registration system, these systems may not have been implemented at a facility level. The lack of accountability and sanctioning within the health system left women feeling vulnerable and powerless to seek justice for their mistreatment.</td>
</tr>
<tr>
<td>30</td>
<td><strong>Bribery and extortion</strong></td>
<td>In several settings, women reported the need to pay bribes to different workers throughout health facilities, including to doctors, nurses, midwives, receptionists, and guards. Bribes took the form of money, food or drinks and other gifts. Women believed that paying bribes positively influenced the quality of services provided to them in health facilities. For instance, bribery could ensure that women received timely care, adequate attention from health providers and any necessary drugs or medications. Health workers were perceived to ignore women on the maternity ward until the patients paid the bribe, at which point, the health workers would become attentive to their needs. One study from the Balkans explicitly stated that Roma women avoid facility-based deliveries because they know that bribes are required to receive sufficient care.</td>
</tr>
<tr>
<td>31</td>
<td><strong>Unclear fee structures</strong></td>
<td>Women in Tanzania reported that an unclear fee structure for services and supplies rendered during childbirth led to frustration, confusion and a fear of detainment in the facility.</td>
</tr>
</tbody>
</table>
| 32 | Unreasonable requests of women by health workers  
In South Africa and Ghana, women were angry at health workers for making unreasonable demands of them during their stay at health facilities. In particular, women were forced to clean up the “mess” they made on the floor or bed immediately after both vaginal deliveries and caesarean sections, when women were feeling particularly weak and vulnerable. Some women were told to walk to a different room, to retrieve supplies or to dispose of medical waste during the second stage of labor or immediately after delivery without a wheelchair or support from birth attendants. | [6, 7, 13, 66, 76] | Moderate confidence | 5 studies with minor to significant methodological limitations. Fairly thick data across 2 countries (South Africa and Ghana). High coherence. |

**Impact on utilization of maternal health services**

| 33 | Power dynamics and systemized abuse  
Health workers discussed how the hierarchical authority in the health system legitimizes the control that health workers have over their patients and contributes to the detrimental treatment of women during childbirth. These power differentials place women at the bottom of the hierarchy, where their needs and concerns are often ignored or deemed as unnecessary by health workers. Furthermore, the lack of supportive supervision for health workers from their superiors contributes to feelings of demoralization and negative attitudes, thus perpetuating the mistreatment of women. As a result of past negative experiences, both health workers and patients may have come to expect and accept the poor treatment of women as the norm. | [10, 13, 58, 76, 90] | Moderate confidence | 5 studies with minor to significant methodological limitations. Fairly thick data across 4 low- and middle-income countries. High coherence. |

| 34 | Impact on future care-seeking behaviors, late attendance to facilities and desire for home birth  
Experiences of mistreatment during childbirth may have far reaching consequences for women and communities outside of the direct patient-provider interaction. Prior experiences and perceptions of mistreatment, low expectations of care provided at facilities and poor reputations of facilities in the community eroded many women’s trust in the health system and may impact their decision to deliver in a health facility in the future, particularly in low- and middle-income countries. | [6, 8-10, 13, 21, 51, 52, 60, 63, 70, 76-78, 81, 84, 89, 93, 95] | High confidence | 20 studies with minor to significant methodological limitations. Thick data across 16 countries, but particularly in low- and middle-income countries and sub-Saharan Africa. High coherence. |
Appendix 2.1: PubMed search strategy

4 September 2013
Developed by Meghan Bohren & Lori Rosman
Mistreatment of women during childbirth in facilities systematic review

<table>
<thead>
<tr>
<th>#</th>
<th>Searches</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“obstetric delivery”[tiab] OR &quot;obstetric deliveries”[tiab] OR &quot;delivery, obstetric&quot;[Mesh]</td>
<td>59290</td>
</tr>
<tr>
<td>3</td>
<td>“maternal health services”[mesh]</td>
<td>33049</td>
</tr>
<tr>
<td>5</td>
<td>#1 OR #2 OR #3 OR #4</td>
<td>90527</td>
</tr>
<tr>
<td>8</td>
<td>#5 OR #6 OR #7</td>
<td>92023</td>
</tr>
</tbody>
</table>
```
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>“confidentiality”[mesh] or “informed consent”[mesh] or &quot;women's rights&quot;[mesh] or &quot;violence&quot;[mesh] or &quot;social stigma&quot;[mesh] or &quot;health services/ethics&quot;[mesh] or &quot;health care quality, access, and evaluation/ethics&quot;[mesh]</td>
</tr>
<tr>
<td>11</td>
<td>#8 AND (#9 OR #10)</td>
</tr>
</tbody>
</table>
```
# Appendix 2.2: CINAHL search strategy

2 September 2013  
Developed by Meghan Bohren & Lori Rosman  
Mistreatment of women during childbirth in facilities systematic review

<table>
<thead>
<tr>
<th>#</th>
<th>Searches</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>(MH &quot;Maternal-Child Care&quot;) OR (MH “Obstetric Patients”) OR (MH “Rooming In”) OR (MH “Obstetric Service”) OR (MH “Childbirth”) OR (MH &quot;Women's Health Services/EL&quot;) OR (MH &quot;Obstetric Care&quot;) OR TI “perinatal care” OR TI “perinatal service” OR TI “perinatal services” OR TI “perinatal care” OR TI “peri natal service” OR TI “peri natal services” OR TI “maternal care” OR TI “maternal service” OR TI “maternal services” OR TI childbirth OR TI childbirths OR AB “perinatal care” OR AB “perinatal service” OR AB “perinatal services” OR AB “peri natal care” OR AB “peri natal service” OR AB “peri natal services” OR AB “ante natal care” OR AB “ante natal service” OR AB “ante natal services” OR AB “maternal care” OR AB “maternal service” OR AB “maternal services” OR AB childbirth OR AB childbirths</td>
<td>44,301</td>
</tr>
<tr>
<td>S2</td>
<td>(MH &quot;Health Facilities&quot;) OR TI “Health Facility” OR TI “Health Facilities” OR TI “Medical Center” OR TI “Medical Centers” OR TI “Ambulatory Care Facility” “Ambulatory Care Facilities” OR TI “Health Center” OR TI “Health Centers” OR TI “Midwifery Service” OR TI “Midwifery Services” OR TI “Nurse-Midwifery Service” OR TI “Nurse-Midwifery Services” OR TI “Nursing Service” OR TI “Nursing Services” OR TI “Obstetric Service” OR TI “Obstetric Services” OR TI “Delivery Room” OR TI “Delivery Rooms” OR TI “Nursing Unit” OR TI “Nursing Units” OR TI “Self-Care Unit” OR TI “Self-Care Units” OR TI “Health Care Facility” OR TI “Health Care Facilities” OR TI “Hospital” OR TI “Hospitals” OR TI “Patients' Room” OR TI “Patients' Rooms” OR TI “Regional Center” OR TI “Regional Centers” OR TI “facility based” OR AB “Health Facility” OR AB “Health Facilities” OR AB “Medical Center” OR AB “Medical Centers” OR AB “Ambulatory Care Facility” OR AB “Ambulatory Care Facilities” OR AB “Health Center” OR AB “Health Centers” OR AB “Midwifery Service” OR AB “Midwifery Services” OR AB “Nurse-Midwifery Service” OR AB “Nurse-Midwifery Services” OR AB “Nursing Service” OR AB “Nursing Services” OR AB “Obstetric Service” OR AB “Obstetric Services” OR AB “Delivery Room” OR AB “Delivery Rooms” OR AB “Nursing Unit” OR AB “Nursing Units” OR AB “Self-Care Unit” OR AB “Self-Care Units” OR AB “Health Care Facility” OR AB “Health Care Facilities” OR AB “Hospital” OR AB “Hospitals” OR AB “Patients' Room” OR AB “Patients' Rooms” OR AB “Regional Center” OR AB “Regional Centers” OR AB “facility based”</td>
<td>378,340</td>
</tr>
<tr>
<td>S3</td>
<td>TI “facility based delivery” OR TI “facility based deliveries” OR TI “facility delivery” OR TI “facility deliveries” OR TI “facility based birth” OR TI “facility births” OR TI “birth” OR TI “births” OR TI “clinic delivery” OR TI “clinic deliveries” OR TI “clinic births” OR TI “clinic birth” OR TI “hospital delivery” OR TI “hospital deliveries” OR TI “hospital birth” OR TI “hospital births” OR TI “hospital childbirth” OR TI “hospital childbirths” OR TI “hospital based deliveries” OR TI “hospital based delivery” OR TI “hospital based births” OR TI “institutional birth” OR TI “institutional births” OR TI “institutional childbirth” OR TI “institutional childbirths” OR TI “institutional delivery” OR TI “institutional deliveries” OR AB “facility based delivery” OR</td>
<td>471</td>
</tr>
<tr>
<td>S4</td>
<td>(S1 AND S2) OR S3</td>
<td>9,002</td>
</tr>
<tr>
<td>----</td>
<td>------------------</td>
<td>-------</td>
</tr>
<tr>
<td>S5</td>
<td>TI “disrespect” OR TI “disrespects” OR TI “disrespectful” OR TI “disrespected” OR TI “disrespect” OR TI “respectful” OR TI “abuse” OR TI “abused” OR TI “abusive” OR TI “abus” OR TI “neglect” OR TI “neglected” OR TI “neglects” OR TI “confidentiality” OR TI “confidential” OR TI “non-confidential” OR TI “informed consent” OR TI “violence” OR TI “violent” OR TI “violence” OR TI “violent” OR TI “humiliation” OR TI “humiliate” OR TI “condescend” OR TI “condescending” OR TI “condescension” OR TI “intimidation” OR TI “intimidate” OR TI “yelling” OR TI “yell” OR TI “non dignified” OR TI “non-dignified” OR TI “undignified” OR TI “discrimination” OR TI “discriminate” OR TI “abandon” OR TI “abandonment” OR TI “detention” OR TI “human rights” OR TI “maltreatment” OR TI “mistreatment” OR TI “humanization” OR TI “humanized” OR TI “dehumanized” OR TI “dehumanization” OR TI “dignified” OR TI “undignified” OR TI “stigma” OR TI “dignity” OR TI “bullying” OR TI “bully” OR AB “disrespect” OR AB “disrespects” OR AB “disrespectful” OR AB “disrespected” OR AB “disrespect” OR AB “respectful” OR AB “abuse” OR AB “abused” OR AB “abusive” OR AB “abus” OR AB “neglect” OR AB “neglected” OR AB “neglects” OR AB “confidential” OR AB “confidential” OR AB “non-confidential” OR AB “informed consent” OR AB “violence” OR AB “violent” OR AB “violence” OR AB “violence” OR AB “humiliation” OR AB “humiliate” OR AB “condescend” OR AB “condescending” OR AB “condescension” OR AB “intimidation” OR AB “intimidate” OR AB “yelling” OR AB “yell” OR AB “non dignified” OR AB “non-dignified” OR AB “undignified” OR AB “discrimination” OR AB “discriminate” OR AB “abandon” OR AB “abandonment” OR AB “detention” OR AB “human rights” OR AB “maltreatment” OR AB “mistreatment” OR AB “humanization” OR AB “humanized” OR AB “dehumanized” OR AB “dehumanization” OR AB “dignified” OR AB “undignified” OR AB “stigma” OR AB “dignity” OR AB “bullying” OR AB “bully”</td>
<td></td>
</tr>
<tr>
<td>S6</td>
<td>(MH &quot;Patient Rights/EI/ST&quot;) OR (MH &quot;Women's Rights/EI&quot;) OR (MH &quot;Violence&quot;) OR (MH &quot;Stigma/EI&quot;) OR (MH &quot;Quality of Health Care/EI/TD&quot;) OR (MH &quot;Patient Attitudes&quot;) OR (MH &quot;Patient Centered Care&quot;)</td>
<td></td>
</tr>
<tr>
<td>S7</td>
<td>S4 AND (S5 OR S6)</td>
<td>649</td>
</tr>
</tbody>
</table>
**Appendix 2.3: Embase search strategy**

2 September 2013  
Developed by Meghan Bohren & Lori Rosman  
Mistreatment of women during childbirth in facilities systematic review

<table>
<thead>
<tr>
<th>#</th>
<th>Searches</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>'obstetric delivery':ab,ti OR 'obstetric deliveries':ab,ti OR 'delivery'/de</td>
<td>33,963</td>
</tr>
<tr>
<td>2</td>
<td>‘perinatal care’,:ti,ab OR ‘peri natal care’,:ti,ab OR ‘perinatal healthcare’,:ti,ab OR ‘peri natal health care’,:ti,ab OR ‘perinatal health care’,:ti,ab OR ‘peri natal health care’,:ti,ab OR ‘delivery’:ti,ab OR ‘peri natal care’/de</td>
<td>9877</td>
</tr>
<tr>
<td>3</td>
<td>'maternal care'/de</td>
<td>11,677</td>
</tr>
<tr>
<td>4</td>
<td>('perinatal service':ti,ab OR ‘peri natal service’,:ti,ab OR ‘perinatal services’,:ti,ab OR ‘peri natal service’,:ti,ab OR ‘perinatal health service’,:ti,ab OR ‘peri natal health service’,:ti,ab OR ‘maternal care’,:ti,ab OR ‘maternal care’/ti,ab OR ‘maternal health care’,:ti,ab OR ‘maternal healthcare’,:ti,ab OR ‘maternal service’,:ti,ab OR ‘maternal health service’,:ti,ab OR ‘maternal health services’,:ti,ab) AND (‘birth’,:ti,ab OR ‘births’,:ti,ab OR ‘childbirth’:ti,ab OR ‘child birth’:ti,ab OR ‘childbirths’,:ti,ab OR ‘child births’,:ti,ab OR ‘delivery’:ti,ab OR ‘deliveries’:ti,ab)</td>
<td>941</td>
</tr>
<tr>
<td>5</td>
<td>#1 OR #2 OR #3 OR #4</td>
<td>54,258</td>
</tr>
<tr>
<td>6</td>
<td>‘birthing centers’,:ti,ab OR ‘maternal-child health centers’,:ti,ab OR ‘delivery rooms’,:ti,ab OR ‘maternity hospitals’,:ti,ab OR ‘delivery room’/de</td>
<td>3008</td>
</tr>
<tr>
<td>7</td>
<td>‘facility based delivery’,:ti,ab OR ‘facility based deliveries’,:ti,ab OR ‘facility delivery’,:ti,ab OR ‘facility deliveries’,:ti,ab OR ‘facility based births’,:ti,ab OR ‘facility based birth’,:ti,ab OR ‘facility-based childbirth’,:ti,ab OR ‘facility-based birth’,:ti,ab OR ‘facility birth’,:ti,ab OR ‘facility births’,:ti,ab OR ‘clinic delivery’,:ti,ab OR ‘clinic deliveries’,:ti,ab OR ‘clinic births’,:ti,ab OR ‘clinic birth’,:ti,ab OR ‘hospital delivery’,:ti,ab OR ‘hospital deliveries’,:ti,ab OR ‘hospital birth’,:ti,ab OR ‘hospital births’,:ti,ab OR ‘hospital childbirth’,:ti,ab OR ‘hospital child births’,:ti,ab OR ‘hospital based deliveries’,:ti,ab OR ‘hospital based delivery’,:ti,ab OR ‘hospital based births’,:ti,ab OR ‘institutional birth’,:ti,ab OR ‘institutional births’,:ti,ab OR ‘institutional childbirth’,:ti,ab OR ‘institutional child births’,:ti,ab OR ‘institutional delivery’,:ti,ab OR ‘institutional deliveries’,:ti,ab</td>
<td>1455</td>
</tr>
<tr>
<td>8</td>
<td>#5 OR #6 OR #7</td>
<td>57,601</td>
</tr>
<tr>
<td>9</td>
<td>‘disrespect’:ti,ab OR ‘disrespects’:ti,ab OR ‘disrespectful’:ti,ab OR ‘disrespected’:ti,ab OR ‘respectful’:ti,ab OR ‘abuse’:ti,ab OR ‘abused’:ti,ab OR ‘abusive’:ti,ab OR ‘abuses’:ti,ab OR ‘neglect’:ti,ab OR ‘neglected’:ti,ab OR ‘neglects’:ti,ab OR ‘confidentiality’:ti,ab OR ‘confidential’:ti,ab OR ‘non-confidential’:ti,ab OR ‘informed consent’:ti,ab OR ‘violence’:ti,ab OR ‘violent’:ti,ab OR ‘humiliation’:ti,ab OR ‘humiliate’:ti,ab OR ‘condescend’:ti,ab OR ‘condescending’:ti,ab OR ‘condescension’:ti,ab OR ‘intimidation’:ti,ab OR ‘intimidate’:ti,ab OR ‘yelling’:ti,ab OR ‘yell’:ti,ab OR ‘non dignified’:ti,ab OR ‘non-dignified’:ti,ab OR ‘undignified’:ti,ab OR ‘discrimination’:ti,ab OR</td>
<td>385,282</td>
</tr>
<tr>
<td></td>
<td><code>discriminate</code>:ti,ab OR <code>abandon</code>:ti,ab OR <code>abandonment</code>:ti,ab OR <code>detention</code>:ti,ab OR <code>human rights</code>:ti,ab OR <code>maltreatment</code>:ti,ab OR <code>mistreatment</code>:ti,ab OR <code>humanization</code>:ti,ab OR <code>humanized</code>:ti,ab OR <code>dehumanized</code>:ti,ab OR <code>dehumanization</code>:ti,ab OR <code>dignified</code>:ti,ab OR <code>undignified</code>:ti,ab OR <code>stigma</code>:ti,ab OR <code>dignity</code>:ti,ab OR <code>bullying</code>:ti,ab OR <code>bully</code>:ti,ab</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>10</td>
<td><code>confidentiality</code>:de OR <code>informed consent</code>:de OR <code>women’s rights</code>:de OR <code>violence</code>:de OR <code>stigma</code>:de OR <code>social stigma</code>:de OR <code>medical ethics</code>:de OR <code>nurse attitude</code>:de OR <code>physician attitude</code>:de OR <code>patient abuse</code>:de OR <code>physical abuse</code>:de OR <code>sexual abuse</code>:de OR <code>emotional abuse</code>:de</td>
<td>270,845</td>
</tr>
<tr>
<td>11</td>
<td>#8 AND (#9 OR #10)</td>
<td>2955</td>
</tr>
</tbody>
</table>
Appendix 2.4: Title and abstract screening criteria

1. Is it a study?

2. Is the study population appropriate?
   a. Women
      i. Women who are planning for childbirth
      ii. Women who have ever experienced childbirth
      iii. Women of reproductive age 15-49
   b. Men
      i. Men who are planning for childbirth
      ii. Men who have ever experienced childbirth
      iii. Men of reproductive age
   c. Health workers
      i. Physicians
      ii. Nurses, nurse-midwives
      iii. Midwives
      iv. Doulas or TBAs
      v. Lay health workers
      vi. Other health workers

3. Is the phenomenon of interest appropriate?
   a. Disrespectful or abusive care during facility-based delivery
   b. Poor quality of care during facility-based delivery
   c. Poor birth experiences during facility-based delivery
4. Are the reported experiences appropriate? For example, but not limited to:

   a. Physical abuse, including hitting, slapping, forcefully held down, and tying woman to the bed
   b. Verbal abuse, including yelling, rudeness, hostile personality
   c. Neglect, including long wait times, lack of birth attendant, and untimely care
   d. Non-consented care, including caesarean section without consent or episiotomy without consent
   e. Non-dignified care, including exposing a woman’s “private parts” or treating the woman like an inferior person
   f. Discrimination, including discrimination based on race, ethnicity, SES, age, HIV-status or marital status
   g. Detention in facilities, including holding a woman without her consent due to lack of payment

Level 1: Title / abstract screening

1) Is disrespect and abuse during facility-based childbirth a primary emphasis of the paper?

   □ Yes (= promote to next level)
   □ Can't tell (= promote to next level)
   □ No (= exclude, do not promote to next level)
2) Is the sample/population of the paper:

   i) Women who are planning for childbirth
   ii) Women who have ever experienced childbirth
   iii) Women of reproductive age 15-49
   iv) Men who are planning for childbirth
   v) Men who have ever experienced childbirth
   vi) Men of reproductive age

□ Yes (= promote to next level)
□ Can't tell (= promote to next level)
□ No (= exclude, do not promote to next level)

Two reviewers scan the titles and, if available, abstract of each reference. Each reviewer score either "yes/promote to next level", "no/exclude" or "can't tell". The reference is excluded, without discussion, only when both reviewers score one or more of the questions "no/exclude." If at least one reviewer scores "can't tell" or "include", will the reference be promoted to level 2 screening (full text screening).
### Appendix 2.5: Full text screening form

<table>
<thead>
<tr>
<th>RefID:</th>
<th>First author/year/title:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1.</th>
<th>Is the article in English, French, Spanish, or Portuguese?</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.</th>
<th>Is it a primary study? (Note: exclude if the article is a commentary, response, news article, etc.)</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.</th>
<th>Does the article explain the study methods, including the data collection and data analysis methods?</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.</th>
<th>Does the article discuss disrespect and abuse* occurring during delivery/childbirth? (Note: exclude if it discusses D&amp;A during ANC or prenatal care visits ONLY).</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.</th>
<th>Does the article refer to births occurring at a health facility? (Note: health facility at any level – community through tertiary – are included. Studies exploring ONLY births occurring at home are excluded.)</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6.</th>
<th>Does the study include one of the following perspectives?</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>User perspective (female/male)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider perspective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy-maker perspective</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7.</th>
<th>Does the article contain a prevalence estimate of D &amp; A or some quantitative measure? (Note: do not exclude if no prevalence estimate – just as a FYI at this point)</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.</th>
<th>Should the study be included? (Note: if don’t know, provide explanation)</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Disrespect and abuse terminology may include, but is not limited to:
- Physical abuse
- Discrimination
- Intimidation
- Abandonment
- Stigma
- Verbal abuse
- Condescension
- Yelling
- Detention at facility
- Bullying
- Neglect
- Humiliation
- Non-dignified care
- Human rights abuse
- Physical restraint
- Breaches of confidentiality
- Lack of informed consent
- Non-confidential care
- Dehumanized care
### Qualitative quality appraisal form template

*To be completed with a detailed response, not yes/no response.*

<table>
<thead>
<tr>
<th>Screening Questions</th>
<th>Detailed Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clear statement of research aims?</td>
</tr>
<tr>
<td>2</td>
<td>Qualitative methodology appropriate?</td>
</tr>
<tr>
<td>3</td>
<td>Appropriate research design to meet aims?</td>
</tr>
<tr>
<td>4</td>
<td>Appropriate recruitment strategy?</td>
</tr>
<tr>
<td>5</td>
<td>Data collected in a way that addressed the research issue?</td>
</tr>
<tr>
<td>6</td>
<td>Reflexivity adequately considered?</td>
</tr>
<tr>
<td>7</td>
<td>Ethical issues adequately considered?</td>
</tr>
<tr>
<td>8</td>
<td>Data analysis sufficiently rigorous?</td>
</tr>
<tr>
<td>9</td>
<td>Clear statement of findings?</td>
</tr>
<tr>
<td>10</td>
<td>Value of research?</td>
</tr>
<tr>
<td>Overall assessment (low, medium, high)</td>
<td></td>
</tr>
</tbody>
</table>

### Quantitative quality appraisal form template

*To be completed with a detailed response, not yes/no response.*

<table>
<thead>
<tr>
<th>Screening Question</th>
<th>Detailed questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Was there a clear statement of the aims of the research</td>
</tr>
<tr>
<td>2</td>
<td>Is the eligibility criteria for the participants provided?</td>
</tr>
<tr>
<td>3</td>
<td>Are the methods of assessment (measurement) for each variable of interest provided?</td>
</tr>
<tr>
<td>4</td>
<td>Are the characteristics of study participants (demographic, clinical, social) provided?</td>
</tr>
<tr>
<td>5</td>
<td>Are the numbers of all outcome events/summary measures reported?</td>
</tr>
<tr>
<td>6</td>
<td>Are sources of potential bias/imprecision discussed?</td>
</tr>
<tr>
<td>Overall assessment (low, medium, high)</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2.7: Data extraction form templates

<table>
<thead>
<tr>
<th>Reviewer</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

#### 1. IDENTIFICATION

<table>
<thead>
<tr>
<th>RefID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Authors</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
</tbody>
</table>

#### 2. ELIGIBILITY

<table>
<thead>
<tr>
<th>Is the study eligible for inclusion?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for exclusion</td>
<td></td>
</tr>
</tbody>
</table>

#### 3. SETTING & DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Location of study (city, district, state, country)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban or rural?</td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td></td>
</tr>
<tr>
<td># of participants (total; specify how many per FGD/how many IDI)</td>
<td></td>
</tr>
<tr>
<td>Perspective</td>
<td></td>
</tr>
<tr>
<td>Participant characteristics</td>
<td></td>
</tr>
</tbody>
</table>

#### 4. STUDY DESIGN & DATA COLLECTION

<table>
<thead>
<tr>
<th>Aims or objectives</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Study design</td>
<td></td>
</tr>
<tr>
<td>Study duration</td>
<td></td>
</tr>
<tr>
<td>How was the sample formed?</td>
<td></td>
</tr>
<tr>
<td>Concerns about bias (indicate if own concerns or author’s concerns)</td>
<td></td>
</tr>
<tr>
<td>How many sites included in the study?</td>
<td></td>
</tr>
<tr>
<td>What data collection method was used? (i.e.: focus group, in-depth interview, survey)</td>
<td></td>
</tr>
<tr>
<td>Description of data collection</td>
<td></td>
</tr>
</tbody>
</table>

#### 5. ETHICS

| How were ethical issues addressed? |     |

#### 6. DATA ANALYSIS

| What data analysis method was used (i.e.: grounded theory, thematic analysis, description of quantitative analysis) |     |

---

86
If there is a qualitative component, complete section 7. If there is no qualitative component, skip to section 8.

7. QUALITATIVE DATA - KEY THEMES ***insert more rows as necessary

<table>
<thead>
<tr>
<th>Theme (author interpretation)</th>
<th>Author's interpretation (i.e.: author text) **include page numbers</th>
<th>Participant quotation **include page numbers</th>
<th>Reviewer comments</th>
</tr>
</thead>
</table>

If there is no quantitative component, skip to section 9.

8. QUANTITATIVE DATA EXTRACTION (note: the quantitative studies have a broad range on outcomes collected/reported. Contact MB if you are unsure of how to extract) ***Insert more rows as necessary

<table>
<thead>
<tr>
<th>Data source</th>
<th>If other or multiple - specify source here</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments on study design</td>
<td></td>
</tr>
<tr>
<td>1-Describe in words the first D&amp;A outcome measure</td>
<td></td>
</tr>
<tr>
<td>1-What outcome measurement is used (i.e.: percentage, prevalence, OR)</td>
<td></td>
</tr>
<tr>
<td>1-Describe # of cases, denominator, percentages and any other relevant outcome measures IN DETAIL</td>
<td></td>
</tr>
</tbody>
</table>

9. CONCLUSIONS

What are the author's main conclusions?

10. COMMENTS

Reviewer comments
### Appendix 2.8: ENTREQ statement to enhance transparency in reporting qualitative evidence synthesis [42]

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Guide and description</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aim</td>
<td>State the research question the synthesis addresses.</td>
<td>29</td>
</tr>
<tr>
<td>2</td>
<td>Synthesis methodology</td>
<td>Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).</td>
<td>29-32</td>
</tr>
<tr>
<td>3</td>
<td>Approach to searching</td>
<td>Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved).</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appendix 2.1-2.3</td>
</tr>
<tr>
<td>4</td>
<td>Inclusion criteria</td>
<td>Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).</td>
<td>29-30</td>
</tr>
<tr>
<td>5</td>
<td>Data sources</td>
<td>Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organizational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources.</td>
<td>29</td>
</tr>
<tr>
<td>6</td>
<td>Electronic Search strategy</td>
<td>Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appendix 2.1-2.3</td>
</tr>
<tr>
<td>7</td>
<td>Study screening methods</td>
<td>Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies).</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Figure 2.1</td>
</tr>
<tr>
<td>8</td>
<td>Study characteristics</td>
<td>Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).</td>
<td>32-35</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appendix 2.9</td>
</tr>
<tr>
<td>9</td>
<td>Study selection results</td>
<td>Identify the number of studies screened and provide reasons for study exclusion (E.g., for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development).</td>
<td>32, 34</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Figure 2.1</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>10</strong></td>
<td>Rationale for appraisal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), and assessment of content and utility of the findings).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>11</strong></td>
<td>Appraisal items</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>12</strong></td>
<td>Appraisal process</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>Appraisal results</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>14</strong></td>
<td>Data extraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicate which sections of the primary studies were analyzed and how were the data extracted from the primary studies? (E.g. all text under the headings “results /conclusions” were extracted electronically and entered into a computer software).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>15</strong></td>
<td>Software</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>State the computer software used, if any.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>16</strong></td>
<td>Number of reviewers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify who was involved in coding and analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>17</strong></td>
<td>Coding</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Describe the process for coding of data (e.g. line by line coding to search for concepts).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>18</strong></td>
<td>Study comparison</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>19</strong></td>
<td>Derivation of themes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explain whether the process of deriving the themes or constructs was inductive or deductive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>20</strong></td>
<td>Quotations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author’s interpretation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>21</strong></td>
<td>Synthesis output</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2.9: Summaries of included studies

Note: summaries of included studies that utilized both quantitative and qualitative research methodologies only specify the qualitative components as the quantitative data was not extracted for the purposes of this review. Abbreviations: Traditional birth attendant (TBA), community health worker (CHW). (*) Study number does not refer to the number on the reference list.

<table>
<thead>
<tr>
<th>#</th>
<th>Study (author/year)</th>
<th>Location</th>
<th>Sample characteristics</th>
<th>Data collection &amp; analysis</th>
<th>Findings * relevant sections regarding disrespectful and abusive care summarized by the reviewer</th>
<th>Quality assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fujita N, Perrin X, Vodounon J, et al (2012)</td>
<td>Porto-Novo, Benin</td>
<td>16 hospital staff (midwives, nurse assistants, specialist doctors and hospital staff)</td>
<td>In-depth interviews, Grounded theory, thematic analysis</td>
<td>Humanized care was originally seen as a foreign concept and staff were initially hesitant to change their practices. However, through training and practice, midwives became comfortable with assisting deliveries in non-supine positions. Providers felt more actively involved in supporting women during pregnancy, labor and delivery. Women were now able to have a birth companion of their choice, as well as eat, drink and move around during labor. Communication between the providers and women was improved. Providing humanized care made providers feel more confident, trusted and proud.</td>
<td>Medium quality</td>
</tr>
<tr>
<td>2</td>
<td>Enderle CF, Kerber NPC, Susin LRO, &amp; Concalves BG (2012)</td>
<td>Porto Alegre, Rio Grande do Sul, Brazil</td>
<td>269 adolescents who recently delivered at a university hospital</td>
<td>Semi-structured interviews, Thematic analysis</td>
<td>Adolescents viewed appropriate delivery care as care that was provided with guidance and respect from the health workers. Open dialogue and active participation during labor and childbirth were critical. Adolescents desired timely attention from health workers, clear explanations of procedures and examinations. Overall, adolescents sought to be active participants in the labor and delivery process and positive interactions with health workers.</td>
<td>Medium quality</td>
</tr>
<tr>
<td>3</td>
<td>Redshaw M &amp; Hockley C (2010)</td>
<td>England</td>
<td>2,960 women who were 3 months postpartum, as identified by birth registration records</td>
<td>Mailed survey including open ended questions, Thematic analysis of open ended questions</td>
<td>Women reported that providers dismissed their concerns during labor, including those with pre-existing health conditions. Ineffective communication continued as providers did not communicate the need for intervention or surgery to the women. Women felt that they were passive participants who only had the illusion of choice during labor and delivery. Women felt alone and neglected during their deliveries, like they were “just another new mother” to the providers.</td>
<td>Medium quality</td>
</tr>
<tr>
<td>4</td>
<td>Kruger L &amp; Schoombee C (2010)</td>
<td>Semi-rural community in South Africa</td>
<td>93 women, 8 maternity ward nurses</td>
<td>In-depth interviews, Grounded theory, thematic analysis</td>
<td>Abusive maternity care was a prominent theme and both women and providers suggested that such abuse has become “ritualised, sanctioned, normalised and ultimately institutionalised”. Nurses were systematically disempowered by the hierarchical health system while patients were referred to as “docile passive bodies” on the maternity wards. As nurses struggled to stay in control of the maternity wards, the environment and their behavior led both the nurses and their patients to feel disappointed, frustrated and resentful. In order for disrespectful and abusive treatment on maternity wards to end, nurses and patients must be empowered as critical players in the health system.</td>
<td>High quality</td>
</tr>
<tr>
<td></td>
<td>Authors and Location</td>
<td>Sample Size</td>
<td>Methods</td>
<td>Key Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------</td>
<td>-------------</td>
<td>---------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Turan J, Miller S, Bukusi E, Sande J, Cohen C (2008)</td>
<td>Kisumu, Kenya</td>
<td>17 maternity workers, 14 women, 4 male partners, 2 TBAs</td>
<td>HIV-related fears play an important role in where women deliver and difficulties facing maternity workers in caring for HIV positive women. Women feared being forced to test for HIV or tested for HIV without their consent, as a positive HIV test was viewed as a death sentence. Women also feared unwanted disclosure of HIV status by providers during maternity care to other patients or a male partner. Maternity workers confirmed that protecting confidentiality of HIV status was difficult on crowded maternity wards. Health workers did not report segregating HIV-positive women during care or other discriminatory practices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Busanello J, da Costa P, Mendoza-Sassi R, Souza O, Gonsalves B (2011)</td>
<td>Porto Alegre, Rio Grande do Sul, Brazil</td>
<td>23 health workers (nurse, nurse assistant, doctors, students)</td>
<td>Health workers tended to believe that privacy and autonomy of women was preserved during childbirth. However, many women believed that health workers did not maintain privacy (30.4%) and were not involved in the type of delivery selected (87.0%). Furthermore, women were often not allowed choices regarding their care, including routine deliveries in lithotomy position (95.6%), routine trichotomy (69.6%), and routine episiotomy (78.3%). Some women were required to fast during labor (21.7%).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Dzomeku M (2011)</td>
<td>Sekyere-West district, Ghana</td>
<td>12 women delivering at the district maternity unit</td>
<td>Women reported that negative provider attitudes influenced their usage or non-usage of the facility, as well as late arrival to the facility. Women reported not receiving explanations about procedures, being yelled at and neglect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Gao Y, Barclay L, Kildea S, Hao M, &amp; Belton S (2010)</td>
<td>Rural Shanxi Province, China</td>
<td>30 women aged 21-39 years</td>
<td>Women feared the hospitals due to their dissatisfaction with previous experiences of facility-based delivery. They felt that staff had negative attitudes, neglected on the wards, were unable to have birth companions and feared unnecessary medical intervention. Women preferred delivering at home, where traditional birth attendants provided continuous supportive care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Small R, Yelland J, Lumley J, Brown S, Liamputtong P (2002)</td>
<td>Vietnams e, Turkish and Filipino immigrant s in Australia</td>
<td>318 women</td>
<td>Women expected to receive care that was kind, safe, supportive and respectful, and when care did not meet these standards, women were distressed. Women were dissatisfied with their overall experience when they perceived staff as unhelpful and uncaring and when they were removed from the decision-making process. Many women felt that they were not actively involved in decision-making (28.9%) and that their labor was taken over by strangers or machines (20.2%). Women also felt that staff were inconsiderate, rude, cold, not gentle, uncaring and hostile (29.5%).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Teixeira N, Pereira W (2006)</td>
<td>Suburbs of Cuiaba, Mato Grosso, Brazil</td>
<td>10 women</td>
<td>Institutional culture promotes violence and disrespect on the obstetric wards. Providers were viewed as hostile and impatient during vaginal deliveries and often did not provide effective communications. Women were called derogatory names and in one case, a woman was physically tied to the bed during labor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study ID</td>
<td>Authors</td>
<td>Country</td>
<td>Sample Size</td>
<td>Research Methods</td>
<td>Findings</td>
<td>Study Quality</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>-------------</td>
<td>------------------</td>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>11</td>
<td>Hulton L, Matthews Z, &amp; Stones R (2007)</td>
<td>Urban India</td>
<td>14 providers, 70 women</td>
<td>Exit interviews, participant observation and in-depth interviews</td>
<td>Women reported experiencing unnecessary procedures and lack of privacy during facility-based deliveries, as they often labored in public places. They felt that their care was hurried and neglectful. Women reported being shouted at and slapped during labor (9%). Women were not allowed birth companions, and felt that they lacked supportive care.</td>
<td>Low quality</td>
</tr>
<tr>
<td>12</td>
<td>El-Nemer A, Downe S, &amp; Small N (2006)</td>
<td>Egypt</td>
<td>21 women</td>
<td>In-depth interviews</td>
<td>Women favored home birth compared to facility birth, and desired care from providers who were “helping from the heart”. They felt that childbirth in hospitals was systemized, including lack of choice of delivery position, provision of unwanted drugs and lack of privacy. Health workers did not communicate effectively with women and were described as having a “technical touch”. They felt disempowered from their childbirth process, neglected and alone. Such experiences made some women claim that they would not return to that hospital again.</td>
<td>High quality</td>
</tr>
<tr>
<td>13</td>
<td>Oliveira Z, Madeira A (2002)</td>
<td>Belo Horizonte, Minas Gerais, Brazil</td>
<td>8 women</td>
<td>In-depth interviews</td>
<td>Adolescents felt that their bodies were controlled by providers during their childbirth. They were not allowed to cry out in pain. Vaginal examinations were not clearly explained by the providers and not understood by the patients, who found them to be painful. They were not allowed to choose their own delivery position.</td>
<td>Low quality</td>
</tr>
<tr>
<td>14</td>
<td>Afsana K, Rashid S (2001)</td>
<td>Rural Bangladesh</td>
<td>41 women, 5 TBAs, 4 physicians, 7 paramedics</td>
<td>In-depth interviews, FGDs, birth observations</td>
<td>Women felt that providers in the health facilities did not communicate as effectively as TBAs. Women were not allowed to choose their delivery position, which was a key barrier to accessing facility-based care. Government staff were perceived as rude, unhelpful and slow. Privacy was not maintained in the facilities, which made women feel shameful. Health workers often shouted at women during delivery.</td>
<td>High quality</td>
</tr>
<tr>
<td>15</td>
<td>Coyle K, Hauck Y, Percival P, Kristjanson L (2001)</td>
<td>Western Australia, Australia</td>
<td>17 women</td>
<td>In-depth interviews</td>
<td>Women felt that they could not build a rapport with their providers and felt that this had a negative impact on their perceptions of care. They felt that care was systemized and providers did not provide individualized care and did not communicate effectively.</td>
<td>Medium quality</td>
</tr>
<tr>
<td>Study ID</td>
<td>Authors</td>
<td>Country</td>
<td>Sample Description</td>
<td>Methodology</td>
<td>Quality</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>---------</td>
<td>-------------------</td>
<td>-------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>88 providers of maternity services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Kyomuhendo G (2003)</td>
<td>Hoima district, Uganda</td>
<td>Qualitative: 240 women and men Quantitative: 808 women (not relevant to D&amp;A)</td>
<td>Focus group discussions and survey Does not specify analysis methods</td>
<td>Low quality</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Richard F, Filali H, Lardi M, De Brouwere V (2003)</td>
<td>Tetouan and Sidi Kacem, Morocco</td>
<td>94 women who had a severe maternal morbidity, 91 family members, 53 health staff</td>
<td>Semi-structured interviews, focus group discussions Thematic analysis</td>
<td>High quality</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Chalmers B, Omer-Hasi K (2002)</td>
<td>Ontario, Canada</td>
<td>432 Somali women who had given birth to a baby in Canada</td>
<td>Quantitative survey Thematic analysis of the open ended survey questions</td>
<td>Medium quality</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Esposito NW (1999)</td>
<td>New York City, USA</td>
<td>29 women, 5 midwives, 6 staff members at a birthing center</td>
<td>Ethnography, interviews and observation Thematic analysis</td>
<td>Medium quality</td>
<td></td>
</tr>
</tbody>
</table>

The facilities included in the observations were overcrowded and understaffed. Staff were dangerously inexperienced and higher-level providers were not seen caring for patients. Women shared beds while they were in labor and were exposed to other patients during this time. There was no privacy on the wards and women’s dignity was not maintained. Facilities were filthy with trash, bodily fluids, needles and glass visible on the beds and floor. Women were made to walk barefoot across the floor for examination. Providers had poor communication with women. Women felt neglected and abandoned during labor.

The use of facilities for childbirth was considered as a last resort, due to lack of skilled staff, abuse, neglect and poor treatment. Women had to deliver in a supine position but preferred the traditional kneeling position. Health workers rushed through the delivery of care and did not support or communicate effectively with women. Women felt abandoned during critical moments of their labor and were often asked to pay bribes.

Overall, women reported satisfaction with their care, which they viewed as life-saving. However, many women and their families reported mistreatment during their deliveries in the health facility. This mistreatment included poor staff attitudes, verbal abuse, having to pay bribes, lack of empathy and discrimination against women of low socioeconomic status.

Women with prior experience of female genital cutting (FGC) who had childbirth experiences in Canada were faced with culturally insensitive and harsh treatment from their health providers. In the facility-setting, they did not receive confidential or private care. Providers frequently made judgmental comments regarding their Muslim faith, sexual experiences and the experience of FGC. Women received ineffective communication regarding procedures and examinations.

Women frequently experienced hurtful comments made by their caregivers regarding their circumcision (87.5%). Women were touched roughly during delivery (20.1%) and were often exposed to others (33.1%). Most women were not engaged in a discussion regarding possible procedures or options before delivery (79.9%).

Women’s contrasting experiences of childbirth in a hospital compared to a birthing center in New York City are presented. Marginalized women experienced gender, race and class-power inequities in the hospital settings, which did not meet their needs for respect and autonomy during childbirth. Women did not play an active role in their childbirth experience and did not receive supportive delivery care. They were often faced with racism and prejudice.
<table>
<thead>
<tr>
<th></th>
<th>Author(s)</th>
<th>Location and Sample Size</th>
<th>Methodology</th>
<th>Key Findings</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Brown H, Hofmeyr GJ, Nikodem VC, Smith H, Garner P (2007)</td>
<td>Facilities within a 200 km radius of Johannesburg, South Africa, 10 health facilities (Baseline: 2090 women, Endline: 2058 women)</td>
<td>Quantitative survey</td>
<td>Women were often not allowed to have a companion (84.5%) and felt that they were left alone during labor and delivery (16.2%). Women were usually not allowed food (77.4%) or drinks (83.6%) during labor, and were often not allowed to move around during the first (46.6%) or second (97.1%) stage of labor. Some women were shouted at (17.7%) and slapped or struck (4.3%) by their providers.</td>
<td>High quality</td>
</tr>
<tr>
<td>23</td>
<td>Beck CT (2004)</td>
<td>Global (Internet-based recruitment), 40 women from New Zealand (23), the United States (8), Australia (6) and the United Kingdom (3)</td>
<td>Birth trauma stories written by participants</td>
<td>Four main themes were reported in the analysis: (1) to care for me: was that too much to ask? (2) to communicate with me: why was this neglected? (3) to provide safe care: you betrayed my trust and I felt powerless; and (4) the end justifies the means: at whose expense? at what price?</td>
<td>Medium quality</td>
</tr>
<tr>
<td>24</td>
<td>Janevic T, Sripad P, Bradley E, Dimitrievska V (2011)</td>
<td>Belgrade, Serbia and Skopje, Macedonia and two rural areas in each country, 71 women who delivered in the past year and lived in a Romani settlement, 8 gynecologists, 11 key informants</td>
<td>Focus group discussions and in-depth interviews</td>
<td>Romani women perceived racism and discrimination to play a critical role in the inequalities in access to and utilization of the maternal health care system. Three types of racism (institutional, personally-mediated, and internalized) interacted with the emergent themes. Six main domains emerged in the analysis: social environment and resources, health system accountability, financial issues, education, perceptions and interactions with the health system and psychological factors.</td>
<td>High quality</td>
</tr>
<tr>
<td>25</td>
<td>Mselle LT, Kohi TW, Mvungi A, Evjen-Olsen B, Moland KM (2011)</td>
<td>Dar es Salaam and Mwanza, Tanzania, 16 women of reproductive age who were affected by obstetric fistula</td>
<td>Mixed-methods: in-depth interview and quantitative survey (not relevant) Thematic analysis</td>
<td>Women with obstetric fistula experienced delays before arriving at the facility for childbirth and after arriving at the facility. Upon arrival at the facility, women faced serious delays as they were neglected, left to labor unsupervised, received inadequate labor monitoring and a lack of supportive care from providers. When faced with labor complications, women also faced significant delays in referral to higher level facilities.</td>
<td>High quality</td>
</tr>
<tr>
<td>26</td>
<td>Jomeen &amp; Redshaw (2013)</td>
<td>United Kingdom, 219 ethnic minority women who recently delivered in the United Kingdom</td>
<td>Open-ended responses of a quantitative survey Thematic analysis</td>
<td>In general, women’s expectations of receiving high quality compassionate care were not met, as they were faced with a lack of supportive care and neglect during childbirth. Women felt that they were left alone for inappropriately long periods during their labor. Providers often failed to explain procedures and claimed that they were too busy to communicate with women. Women felt that they were not provided choice in their care and sometimes did not provide informed consent.</td>
<td>Medium quality</td>
</tr>
<tr>
<td></td>
<td>Authors</td>
<td>Location</td>
<td>Participants</td>
<td>Methods</td>
<td>Findings</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>27</td>
<td>Bangser M, Mehta M, Singer J, Daly C, Kamugumya C, Mwangomale A (2011)</td>
<td>3 districts in Tanzania and 4 districts in Uganda</td>
<td>137 women of reproductive age who were affected by obstetric fistula</td>
<td>In-depth interviews, Thematic analysis</td>
<td>Delays in seeking and accessing care, combined with health system delays and failures contributed to fistula experiences. Abuse and neglect by health workers, including verbal abuse, neglect and blame for their health condition, were identified as negative care experiences. In Tanzania, nurses requested bribes prior to providing care.</td>
</tr>
<tr>
<td>28</td>
<td>Cindoglu D &amp; Sayan-Cengiz F (2010)</td>
<td>Ankara, Istanbul and Izmir, Turkey</td>
<td>9 groups of women who ever visited health facilities for reproductive problems, 4 groups of physicians, 1 group of midwives</td>
<td>Focus group discussions, Thematic analysis</td>
<td>Although most Turkish women use hospital-based care during childbirth, many have unpleasant experiences of medicalization and patriarchy during their deliveries. Women reported nurses scolding them during labor, making condescending comments, neglect during labor, and a lack of privacy during examinations. Providers indicated that they felt that they preferred patients who fully submitted to them and felt that they were at the top of the hierarchy.</td>
</tr>
<tr>
<td>29</td>
<td>Roost M, Jonsson C, Liljestrand J, Essen B (2009)</td>
<td>La Paz district, Bolivia</td>
<td>30 women who experienced near miss event upon arrival at hospital</td>
<td>Semi-structured interviews, Modified analytic induction (thematic analysis)</td>
<td>Women who experienced near miss events perceived themselves as being fundamentally different from women who utilized health care. These women were distrustful of the healthcare system, feared mistreatment by staff and believed that they would not receive proper communication from their provider about their condition, including providing informed consent.</td>
</tr>
<tr>
<td>30</td>
<td>Nagahama EEI &amp; Santiago SM (2008)</td>
<td>Maringa, Parana, Brazil</td>
<td>569 women</td>
<td>Cross-sectional survey, Exploratory and descriptive analysis</td>
<td>Women reported that health staff had authoritarian attitudes towards their patients, which subjected women to losing autonomy over their childbirth experiences. Women found it difficult to communicate with their providers. Health staff were resistant to allowing women a male birth companion. In total, 41.8% of women had no companion on the antenatal ward and 98.6% of women had no companion on the delivery ward.</td>
</tr>
<tr>
<td>31</td>
<td>Mselle LT, Moland KM, Mvungi A, Evjen-Olsen B, Kohi TW (2013)</td>
<td>Dar es Salaam, Temeke &amp; Mwapwa districts, Tanzania</td>
<td>16 women who experienced obstetric fistula, 5 nurse-midwives, 1 group of community members, 1 group of husbands</td>
<td>In-depth interviews and focus group discussions, Thematic analysis</td>
<td>Both women and their husbands and health providers experienced poor quality of care during childbirth and challenging working conditions. In particular, women reported experience of neglect, physical abuse, verbal abuse and lack of supportive care. Nurse-midwives struggled to provide quality care as they lacked supportive supervision, motivation and critical medical supplies.</td>
</tr>
<tr>
<td>32</td>
<td>Rahmani Z and Brekke M (2013)</td>
<td>Kabul and Ghazni provinces, Afghanistan</td>
<td>12 women, 7 doctors, 5 midwives, 3 TBAs</td>
<td>In-depth interviews, Phenomenological analysis</td>
<td>Women reported dissatisfaction with childbirth services, particularly the poor attitudes and behavior of health workers, including discrimination, neglect, and verbal and physical abuse. Despite negative experiences with the health services, women appreciated having any access to health services. Health workers reported that low salaries, high stress and poor working conditions contributed to the poor quality of care.</td>
</tr>
<tr>
<td>Study ID</td>
<td>Authors</td>
<td>Location</td>
<td>Sample Size</td>
<td>Methods</td>
<td>Findings</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>----------</td>
<td>-------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>33</td>
<td>Hatamleh R, Shaban IA, Homer C (2013)</td>
<td>Jordan</td>
<td>460 women of reproductive age</td>
<td>Exit interviews, Descriptive and thematic analysis</td>
<td>Women reported that providers ignored and neglected them during labor and delivery, which in some cases led to women delivering in a facility without skilled attendance. Health workers did not communicate processes or procedures to women and verbally abused women. Women were not allowed to have birth companions and felt that they delivered without any human support.</td>
</tr>
<tr>
<td>34</td>
<td>Ith P, Dawson A, Homer CSE (2013)</td>
<td>Cambodia</td>
<td>30 women who delivered in health facilities</td>
<td>In-depth interviews, Thematic analysis</td>
<td>Women reported that their perception of staff attitudes and safety influenced their choice of health facility for delivery. Negative staff attitudes and lack of supportive care during labor impacted the utilization of public maternity hospitals. Women felt that they were abandoned during labor by midwives who were rude and judgmental. Health providers did not effectively communicate procedures to women and facilities were unable to provide privacy for women.</td>
</tr>
<tr>
<td>35</td>
<td>Kumbani LC, Chirwa E, Malata A, Odland JO, Bjune G (2012)</td>
<td>Chiradzulu district</td>
<td>14 women of reproductive age</td>
<td>In-depth interviews, Thematic analysis</td>
<td>Women reported unsatisfactory care during their delivery in a facility, which included poor provider attitudes, delays in providing care and neglect. Health providers sometimes shouted at and ridiculed women while they were in labor, and threatened them with poor health outcomes.</td>
</tr>
<tr>
<td>36</td>
<td>Silal SP, Penn-Kekana L, Harris B, Birch S, McIntyre D (2012)</td>
<td>South Africa</td>
<td>Qualitative: 16 women who recently delivered, Quantitative: 1200 women who recently delivered</td>
<td>Mixed-methods, only qualitative relevant to review. In-depth interviews, Thematic analysis</td>
<td>Women reported that negative interactions with providers inhibited their access to quality maternity care. Women may fear poor treatment by health workers and choose to deliver at home or have significant delays in reaching care. Women reported that health providers verbally abused them and did not communicate clinical processes or procedures with them. While women acknowledged that health workers are overworked and underpaid, they felt that these conditions should not impact the quality of care that they receive.</td>
</tr>
<tr>
<td>37</td>
<td>Forssen ASK (2012)</td>
<td>Sweden</td>
<td>20 elderly women who delivered between 1934 and 1966</td>
<td>In-depth interviews, Phenomenological analysis</td>
<td>Traumatic birth experiences where women faced abusive care and violations of their dignity impacted women throughout their life span. Women reported that health workers blamed women for poor health outcomes and neglected them during labor. Women felt that they suffered a loss of autonomy as they were not involved in the decision-making process, had non-consented procedures and were denied pain relief.</td>
</tr>
<tr>
<td>38</td>
<td>Garcia-Jorda D, Diaz-Bernal Z, Alamo MA (2012)</td>
<td>Havana, Cuba</td>
<td>36 women, 10 companions and 9 doctors</td>
<td>In-depth interviews and participant observation, Grounded theory</td>
<td>Women reported feeling a lack of supportive care during childbirth. Health providers used racial slurs when speaking to women. Women were not allowed to choose their own birth position and felt that their births were over-medicalized.</td>
</tr>
<tr>
<td>Study ID</td>
<td>Authors</td>
<td>Location</td>
<td>Sample Size</td>
<td>Methodology</td>
<td>Type of Analysis</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>----------</td>
<td>-------------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>39</td>
<td>McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RN, Winch PJ</td>
<td>Morogoro region, Tanzania</td>
<td>112 total participants: 49 women, 27 male partners, 20 CHWs, 5 community leaders, 11 religious leaders</td>
<td>In-depth interviews, Grounded theory, thematic analysis, comparison to existing frameworks</td>
<td>Women initially described their birth experiences in facilities in a positive light, but when probed more deeply, provided examples of mistreatment. The following themes related to disrespectful and abusive care were generated from the analysis: (1) feeling ignored or neglected; (2) monetary demands or discriminatory treatment; (3) verbal abuse; and (4) physical abuse. In response to this mistreatment, women tended to use acquiescence or non-confrontational strategies: resigning oneself to abuse, returning home, or bypassing certain facilities or providers. In contrast, male partners tended to use more assertive approaches: requesting better care, paying bribes, making complaints and assaulting a provider.</td>
</tr>
<tr>
<td>40</td>
<td>Faneite J, Feo A, Merlo JT</td>
<td>Venezuela</td>
<td>500 total participants: 158 obstetricians, 115 nurses, 113 obstetric residents, 48 general practitioners, 66 other</td>
<td>Quantitative survey</td>
<td>This study explored the level of knowledge of obstetric violence and legal implications among health providers working in Venezuela. Most providers (89.2%) were aware of the term obstetric violence. The majority of providers (63.6%) had witnessed obstetric violence perpetrated by doctors (42.8%) and nurses (42.5%). Providers were familiar with the term obstetric violence, but not necessarily of the laws governing it, specific acts of obstetric violence or reporting mechanisms.</td>
</tr>
<tr>
<td>41</td>
<td>Fonn S &amp; Philpott H</td>
<td>Johannesburg area, South Africa</td>
<td>146 women, unspecified number of doctors and nurses</td>
<td>Group discussions and interviews, Thematic and descriptive analysis</td>
<td>Women reported negative experiences with patient-provider interactions and the resources and structure available at the facilities. Health workers reportedly hit, shout and insult women during labor. Nurses were inattentive to women’s needs and women were left alone during labor. Facilities were dirty, lacked privacy and often ran out of supplies. Women were asked to clean the linens and floors after their own deliveries.</td>
</tr>
<tr>
<td>42</td>
<td>Davies MM &amp; Bath PA</td>
<td>Northern England</td>
<td>13 Somali women living in the United Kingdom</td>
<td>Semi-structured interviews and focus group discussions, Thematic analysis</td>
<td>Poor communication between health workers and non-English speaking Somali women was a significant barrier to seeking and understanding the childbirth process. Women consequently felt that they were denied information from their providers and believed that health workers were prejudiced against Somalis. Women disliked when their family members acted as interpreters due to privacy and confidentiality issues.</td>
</tr>
<tr>
<td>43</td>
<td>Kowalewski M, Jahn A &amp; Kimatta SS</td>
<td>Mtwara region, Tanzania</td>
<td>60 pregnant women, 26 health workers and 6 key informants</td>
<td>Semi-structured interviews, Content analysis</td>
<td>Women reported discrimination by health workers during maternity services. In particular, women from rural areas feared discrimination based on their socioeconomic status. Women felt neglected during their labor and felt that they lost autonomy over their childbirth experience.</td>
</tr>
<tr>
<td>44</td>
<td>Jewkes R, Abrahams N &amp; Mvo Z</td>
<td>Western Cape, South Africa</td>
<td>32 women, 9 midwives, 3 nurses, 1 family planning advisor, 4 group discussions</td>
<td>In-depth interviews and focus group discussions, Ethnographic analysis</td>
<td>Women reported verbal and physical abuse and neglect during childbirth in facilities. Women described nurses’ treatment of them as a few “rotten apples” but further analysis demonstrated that many other factors, including organizational, work place and power dynamics, contributed to the mistreatment of women. Nurses appeared to be struggling to create a social distance from their patients and mistreated women as a way to gain control.</td>
</tr>
<tr>
<td>Study ID</td>
<td>Authors</td>
<td>Location</td>
<td>Sample Size</td>
<td>Study Design</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>----------</td>
<td>-------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>45</td>
<td>Saizonou J, Godin I, Ouendo EM, Zerbo R, Dujardin B (2006)</td>
<td>Benin</td>
<td>Qualitative: 42 women who experienced near miss Quantitative: 557 women who experienced near miss</td>
<td>In-depth interview, quantitative interview (not relevant to review). Thematic analysis</td>
<td>In general, women reported feeling satisfied with their maternity services. However, women reported discrimination, lack of supportive care and long delays in receiving care. Facilities tended to be dirty and were unable to provide privacy to women during labor.</td>
</tr>
<tr>
<td>46</td>
<td>Atuyumbe L, Mirembe F, Johansson A, Kirumira EK, Faxelid E (2005)</td>
<td>Wakiso district, Uganda</td>
<td>44 adolescents who were pregnant or mothers, 6 key informants</td>
<td>Focus group discussions and in-depth interviews Thematic analysis</td>
<td>Adolescent women perceived facility-based health workers to be unfriendly, rude and have negative attitudes. Health workers made judgmental comments to adolescents regarding their sexual behavior. Adolescents perceive cesarean section as a punishment from the health worker for having a sexual relationship. Furthermore, confidentiality was not maintained during their care.</td>
</tr>
<tr>
<td>47</td>
<td>Hassan SJ, Sundby J, Hhusseini A, Bjertness E (2012)</td>
<td>Occupied Palestinian Territory</td>
<td>176 Palestinian women</td>
<td>Interviews with open ended questions Descriptive and content analysis</td>
<td>Women reported frequent and painful vaginal examinations during labor. While most women were informed that they would have a vaginal examination, few providers explained the examination and ways to cope with the exam. Women felt that the vaginal examinations were rushed, were not conducted privately and did not follow an appropriate informed consent process.</td>
</tr>
<tr>
<td>48</td>
<td>Igubara CO &amp; Ngilangwa DP (2010)</td>
<td>Slums of Nairobi, Kenya</td>
<td>10 groups of women, 2 groups of TBAs, 12 women with pregnancy complications</td>
<td>Focus group discussions and in-depth interviews Thematic analysis</td>
<td>Poor women residing in slums in Nairobi associated their poverty with poor quality of maternity care and discriminatory treatment by providers. Although many of these women used TBAs, those who delivered in a health facility expected poor treatment, including neglect and abandonment during labor. They felt that if they were unable to pay bribes, they would receive poor treatment.</td>
</tr>
<tr>
<td>49</td>
<td>Dietsch E, Shackleton P, Davies C, McLeod M, Alston M (2009)</td>
<td>Rural New South Wales, Australia</td>
<td>42 women who traveled at least 1 hour from a rural community to deliver</td>
<td>In-depth interviews Thematic analysis</td>
<td>Women felt that midwives were in a position of power and abused their authority over parturient women through threatening and aggressive behavior. Women felt alienated from their care providers as their concerns were dismissed by midwives and they were neglected while in labor. Aboriginal women felt that the midwives discriminated against them and treated them worse than other women on the ward.</td>
</tr>
<tr>
<td>50</td>
<td>Magoma M, Requejo J, Campbell OMR, Cousens S, Filippi V (2010)</td>
<td>Ngorongoro district, Tanzania</td>
<td>12 key informants, 3 groups of providers, 6 groups of women, 3 groups of TBAs, 3 groups of elder men</td>
<td>Focus group discussions and in-depth interviews Grounded theory</td>
<td>Communication between providers and women was insufficient to explain the importance of certain procedures, such as vaginal examinations, which women viewed as painful and dehumanizing. Providers reported that other colleagues verbally abuse women.</td>
</tr>
<tr>
<td>Study</td>
<td>Title</td>
<td>Location</td>
<td>Sample Size</td>
<td>Methodology</td>
<td>Data Collection</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
<td>----------</td>
<td>-------------</td>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>51</td>
<td>Human Rights Watch (2011)</td>
<td>Eastern Cape, South Africa</td>
<td>157 women, 30 nurses, 4 emergency medical services staff and unspecified number of key informants</td>
<td>In-depth interviews</td>
<td>Content analysis using human rights framework</td>
</tr>
<tr>
<td>52</td>
<td>Moyer CA, Adongo PB, Aborigo RA, Hodgson A, Engmann CM (2014)</td>
<td>Kassena-Nankana district, Ghana</td>
<td>7 focus groups and 43 interviews with 128 community members (women, TBAs, heads of household, leaders, grandmothers)</td>
<td>Focus group discussions, in-depth interviews</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>53</td>
<td>Oyerinde K, Harding Y, Amara P, Garbrah-Aidoo N, Kanu R, Oulare M, Shoo R, Daoh K (2013)</td>
<td>Sierra Leone</td>
<td>4 groups of young women, 4 groups of adult women, 4 groups of young men, 4 groups of adult men, 4 groups of TBAs</td>
<td>Focus group discussions</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>54</td>
<td>D’Ambruoso L, Abbey M, Hussein J (2005)</td>
<td>Suburbs of Accra, Ghana</td>
<td>21 women, 2 groups of women</td>
<td>In-depth interviews and focus group discussions</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>55</td>
<td>Grossman-Kendall F, Filippi V, De Koninck M, Kanhonou L (2001)</td>
<td>Cotonou &amp; Ouidah, Benin</td>
<td>19 women who delivered in a referral hospital</td>
<td>In-depth interviews</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>56</td>
<td>Aguiar JM, d’Oliveira AFP, Schraiber LB (2013)</td>
<td>Sao Paulo, Brazil</td>
<td>21 women, 10 obstetricians, 5 nurses, 3 nurse technicians</td>
<td>In-depth interviews</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>No.</td>
<td>Authors</td>
<td>Location</td>
<td>Participants</td>
<td>Methodology</td>
<td>Key Findings</td>
</tr>
<tr>
<td>-----</td>
<td>---------</td>
<td>-----------</td>
<td>--------------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>57</td>
<td>Chadwick RJ, Cooper D, Harries J (2014)</td>
<td>Cape Town, South Africa</td>
<td>33 low-income women of reproductive age who delivered in a public hospital</td>
<td>In-depth interviews, Thematic analysis</td>
<td>Women’s birth experiences in public hospitals in South Africa were riddled with “narratives of distress” in relation to the poor quality of intrapartum care. Four main themes emerged: (1) negative interpersonal relations with caregivers; (2) lack of information; (3) neglect and abandonment; and (4) the absence of a labor companion.</td>
</tr>
<tr>
<td>58</td>
<td>Crissman HP, Engmann CE, Adanu RM, Nimako D, Crespo K, Moyer CA (2013)</td>
<td>Akwatia, Ghana</td>
<td>85 pregnant women</td>
<td>In-depth interviews, Grounded theory</td>
<td>Ghanaian women attending antenatal care reported that harsh treatment by facility-based midwives was an important barrier to utilizing health facilities for childbirth. In particular, women reported hearing stories regarding verbal abuse from rude and impatient midwives. These women felt that they would do everything in their power to deliver in a facility, but viewed this mistreatment as a significant barrier to facility deliveries for women with home births.</td>
</tr>
<tr>
<td>59</td>
<td>Silan V, Kant S, Archana S, Misra P, Rizwan S (2014)</td>
<td>Dayalpur, Faridabad, Haryana, India</td>
<td>5 groups of female Accredited Social Health Activists (ASHAs)</td>
<td>Focus group discussions, Thematic analysis</td>
<td>In rural Haryana government health facilities, poor quality care and mistreatment by health workers constituted significant barriers to underutilization of services. Labor wards were dirty, lacked privacy and had substantial supply and staffing constraints. Women with poor experiences in these facilities during previous births were unlikely to use these services again in the future.</td>
</tr>
<tr>
<td>60</td>
<td>Sando D, Kendall T, Lyatuu G, Ratcliffe H, McDonald K, Mwanyika-Sando, M, Emil F, Chalamilla G and Langer A (2014)</td>
<td>Dar es Salaam, Tanzania</td>
<td>(1) 2000 post-partum women 3–6 hours after childbirth&lt;br&gt;(2) 208 women observed in labor&lt;br&gt;(3) 50 providers interviewed in study facility&lt;br&gt;(4) 18 providers interviewed in study facility</td>
<td>Mixed-methods design comprised of 4 main activities: (1) quantitative interviews with women; (2) direct observation of labor; (3) quantitative interviews with providers; and (4) IDIs with providers.</td>
<td>Overall, WLWH who received labor and delivery services at a large urban hospital in Tanzania were no more or less likely to report any type of disrespect and abuse during labor and delivery than HIV-negative women. However, many women, regardless of HIV-status, reported experiencing disrespect and abuse in the post-partum interviews. Direct observations of labor supported women’s experiences of disrespect and abuse during childbirth. Healthcare providers are aware that HIV-positive women may have more concerns about maintaining confidentiality during childbirth, but denied stigma and discrimination against them during intrapartum care.</td>
</tr>
<tr>
<td></td>
<td>Authors</td>
<td>Country/Location</td>
<td>Sample Description</td>
<td>Study Design</td>
<td>Findings</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>61</td>
<td>Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W &amp; Freedman LP (2014)</td>
<td>Rural, northeast Tanzania</td>
<td>Women who delivered in any of eight study facilities and were 15 years of age or older</td>
<td>Cross sectional design comprised of exit surveys of post-partum women, and follow-up survey with a subset of the same women 5 to 10 weeks postpartum</td>
<td>In the exit survey, 19% of women sampled reported experiencing at least one form of disrespectful or abusive treatment during childbirth. In the follow-up survey with a subset of the same women, 28% of women sampled reported experiencing at least one form of disrespectful or abusive treatment during childbirth. The most commonly reported experiences of mistreatment were being ignored when they needed help, shouting and scolding and negative comments. Between 3% and 5% of women reported being slapped or pinched and 4 to 5% of women reported delivering alone without a birth attendant.</td>
</tr>
<tr>
<td>62</td>
<td>Okafor II, Ugwu EO &amp; Obi SN (2014)</td>
<td>Enugu State, Nigeria</td>
<td>Women who delivered ≤ 6 weeks ago in Enugu State University Teaching Hospital Parklane, who accessed newborn services at the immunization clinic at the same hospital.</td>
<td>Cross sectional design comprised of interviews with post-partum women</td>
<td>Women in this sample commonly reported experiences of disrespectful and abusive care during childbirth in this facility. The most commonly reported experience was non-consented care (54.5%), including non-consent during episiotomy, augmentation of labor, sterilization, caesarean section, shaving of the pubic hair, and blood transfusion. Approximately 7.2% of women reported being beaten, slapped or pinched during labor and 17.3% of women reported being tied down or restrained during labor.</td>
</tr>
<tr>
<td>63</td>
<td>Ganle et al 2014</td>
<td>Ashanti and Northern regions, Ghana</td>
<td>185 pregnant and postpartum women and 20 healthcare providers</td>
<td>Focus group discussions, Key informant interviews</td>
<td>Ghana’s free maternal healthcare policy appears to have increased the rate of facility-based childbirth. However, the maternal healthcare delivery system in Ghana lack many attributes of a functional healthcare system, including limited and unequal distribution of maternity services, poor quality of care, distrust in the healthcare system, difficulties relating to arranging suitable transportation to facilitate efficient referrals, women’s experiences of intimidation in healthcare facilities, unfriendly healthcare providers, cultural insensitivity, long waiting time before care is received, limited birthing choices, and lack of privacy at healthcare facilities.</td>
</tr>
<tr>
<td>64</td>
<td>Mirkuzie et al 2014</td>
<td>Woreda 6 Gulele, Addis Ababa, Ethiopia</td>
<td>19 migrant women who gave birth within the past year</td>
<td>In-depth interviews</td>
<td>Migrant women constitute disadvantaged communities in Addis Ababa and have unequal access to skilled birth care. Physical access to the health facility, social influence, maternal education, risk perception, perceived quality of care and disrespect were reported to be responsible for the disparities to access and utilize skilled birth care. The perceived quality of care at the health facility was reported as the most important factor for accessing and utilizing skilled care at birth.</td>
</tr>
<tr>
<td>Study ID</td>
<td>Authors</td>
<td>Location</td>
<td>Sample Size and Characteristics</td>
<td>Data Collection Methods</td>
<td>Findings</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>65</td>
<td>Ng’Anjo-Phiri 2014</td>
<td>Kapiri Mposhi district, Zambia</td>
<td>25 stakeholders (5 women with previous home birth, 5 husbands, 5 community leaders, 5 TBAs, 5 health providers) Women attending ANC, women attending outpatient department</td>
<td>In-depth interviews with stakeholders Focus group discussions with women attending ANC and/or outpatient department</td>
<td>Perceived quality of care and trust of the health system were important and influenced care-seeking behaviors. Safety, privacy and confidentiality during childbirth encouraged women to seek care at the health facility. However, poor accessibility to health facilities with skilled birth attendants, poor responsiveness of healthcare providers, unexpected costs of supplies and cultural values surrounding endurance at childbirth discouraged care seeking at birth.</td>
</tr>
</tbody>
</table>
Appendix 2.10: Quantitative measures of mistreatment of women during childbirth in included studies

Appendix 2.10 is comprised of four tables (Table A, Table B, Table C, and Table D. Tables A, Table B and Table C present quantitative data extracted from three studies (Okafor et al 2014, Kruk et al 2014, and Sando et al 2014) that explored disrespectful and abusive care of women during childbirth as the primary outcome. Table D presents quantitative data extracted from 9 studies that indirectly explored or included an indicator that could be classified as an experience of disrespectful and abusive care of women during childbirth.

Table A. Quantitative measures of mistreatment extracted from Okafor et al (2014) study.

<table>
<thead>
<tr>
<th>Study characteristics</th>
<th>Outcome measure</th>
<th># of cases</th>
<th>Sample size (n)</th>
<th>Percent</th>
<th>Relationship to new domains of mistreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Okafor II, Ugwu EO &amp; Obi SN (2014)</td>
<td>Non-confidential care</td>
<td>116</td>
<td>446</td>
<td>26.00%</td>
<td>Lack of informed consent and confidentiality</td>
</tr>
<tr>
<td>Cross-sectional survey of postpartum women who accessed services for their newborns at the immunization clinic at a hospital in Nigeria</td>
<td>Age disclosure without consent</td>
<td>72</td>
<td>446</td>
<td>16.10%</td>
<td>Lack of informed consent and confidentiality</td>
</tr>
<tr>
<td></td>
<td>Provision of care without privacy</td>
<td>28</td>
<td>446</td>
<td>6.30%</td>
<td>Lack of privacy</td>
</tr>
<tr>
<td></td>
<td>Medical history disclosure without consent</td>
<td>8</td>
<td>446</td>
<td>1.80%</td>
<td>Lack of informed consent and confidentiality</td>
</tr>
<tr>
<td></td>
<td>Disclosure of HIV status without consent</td>
<td>8</td>
<td>446</td>
<td>1.80%</td>
<td>Lack of informed consent and confidentiality</td>
</tr>
<tr>
<td></td>
<td>Non-dignified care</td>
<td>132</td>
<td>446</td>
<td>29.60%</td>
<td>Poor rapport between women and providers</td>
</tr>
<tr>
<td></td>
<td>Blamed or intimidated during childbirth</td>
<td>55</td>
<td>446</td>
<td>12.30%</td>
<td>Verbal abuse</td>
</tr>
<tr>
<td></td>
<td>Threatened with caesarean delivery to discourage patient from shouting</td>
<td>34</td>
<td>446</td>
<td>7.60%</td>
<td>Verbal abuse</td>
</tr>
<tr>
<td></td>
<td>Received slanderous remarks (aspersions) from birth attendant</td>
<td>24</td>
<td>446</td>
<td>5.40%</td>
<td>Verbal abuse</td>
</tr>
<tr>
<td></td>
<td>Scolded, shouted at, or called stupid</td>
<td>19</td>
<td>446</td>
<td>4.50%</td>
<td>Verbal abuse</td>
</tr>
<tr>
<td></td>
<td>Non-consented care</td>
<td>243</td>
<td>446</td>
<td>54.50%</td>
<td>Lack of informed consent and confidentiality</td>
</tr>
<tr>
<td></td>
<td>Non-consent for c-section</td>
<td>20</td>
<td>446</td>
<td>4.50%</td>
<td>Lack of informed consent</td>
</tr>
<tr>
<td>Action</td>
<td>Incidence</td>
<td>Type</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------</td>
<td>-----------------------------</td>
<td>--------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-consent for episiotomy</td>
<td>114</td>
<td>Lack of informed consent</td>
<td>and confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-consent for augmentation of labor</td>
<td>42</td>
<td>Lack of informed consent</td>
<td>and confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-consent for shaving of pubic hair</td>
<td>34</td>
<td>Lack of informed consent</td>
<td>and confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-consent for sterilization</td>
<td>23</td>
<td>Lack of informed consent</td>
<td>and confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-consent for blood transfusion</td>
<td>10</td>
<td>Lack of informed consent</td>
<td>and confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>159</td>
<td>Physical abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restrained or tied down during labor</td>
<td>77</td>
<td>Physical abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episiotomy given or sutured without anesthesia</td>
<td>41</td>
<td>Physical abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beaten, slapped or pinched</td>
<td>32</td>
<td>Physical abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually abused by health worker</td>
<td>9</td>
<td>Physical abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detention in the health facility</td>
<td>98</td>
<td>Loss of autonomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge postponed until her hospital bills are paid</td>
<td>76</td>
<td>Loss of autonomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detained in the hospital until infant's bills are paid</td>
<td>22</td>
<td>Loss of autonomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abandonment/neglect of care</td>
<td>130</td>
<td>Neglect and abandonment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denied companionship by the husband or close relatives</td>
<td>63</td>
<td>Lack of supportive care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being left unattended in second stage of labor</td>
<td>41</td>
<td>Neglect and abandonment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth attendant failed to intervene in a life-threatening situation</td>
<td>22</td>
<td>Neglect and abandonment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination on the basis of specific patient attributes</td>
<td>89</td>
<td>Stigma and discrimination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denial of needed attention on the basis of ethnic origin</td>
<td>13</td>
<td>Stigma and discrimination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denial of needed attention because of low social class</td>
<td>61</td>
<td>446</td>
<td>13.70%</td>
<td>Stigma and discrimination</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----</td>
<td>-----</td>
<td>--------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>Denial of needed attention because of teenage (≤ 19 years)</td>
<td>9</td>
<td>446</td>
<td>2.00%</td>
<td>Stigma and discrimination</td>
<td></td>
</tr>
<tr>
<td>Denial of needed attention because of HIV-seropositive status</td>
<td>6</td>
<td>446</td>
<td>1.30%</td>
<td>Stigma and discrimination</td>
<td></td>
</tr>
</tbody>
</table>
Table B. Quantitative measures of mistreatment extracted from Kruk et al (2014) study.

<table>
<thead>
<tr>
<th>Study characteristics</th>
<th>Study characteristics</th>
<th>Outcome measure</th>
<th>Data collection method</th>
<th>Relationship to new domains of mistreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W &amp; Freedman LP (2014)</td>
<td>Cross sectional design comprised of exit interviews and follow-up surveys with the same women who delivered in any of eight health facilities in rural Tanzania.</td>
<td>Any experience of disrespect and abuse</td>
<td>Exit survey (n=1779)</td>
<td>Follow-up survey (n=593)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>343</td>
<td>19.48%</td>
<td>167</td>
</tr>
<tr>
<td></td>
<td>Specific experiences of disrespect and abuse</td>
<td>Non-confidential care</td>
<td>77</td>
<td>4.39%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of physical privacy</td>
<td>77</td>
<td>4.39%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-dignified care</td>
<td>227</td>
<td>12.89%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shouting/scolding</td>
<td>153</td>
<td>8.71%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Threat of withholding treatment</td>
<td>73</td>
<td>4.16%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Threatening or negative comments</td>
<td>93</td>
<td>5.28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neglect</td>
<td>150</td>
<td>8.53%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ignored when needed help</td>
<td>139</td>
<td>7.93%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delivery without attendant</td>
<td>68</td>
<td>3.91%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-consented care</td>
<td>1</td>
<td>0.06%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-consent for tubal ligation</td>
<td>1</td>
<td>0.06%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-consent for c-section</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-consent for hysterectomy</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical abuse</td>
<td>51</td>
<td>2.90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical abuse (slapping, pinching, etc)</td>
<td>47</td>
<td>2.68%</td>
</tr>
<tr>
<td>Incident Type</td>
<td>Count</td>
<td>Percentage</td>
<td>Category</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------</td>
<td>------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Sexual harassment</td>
<td>2</td>
<td>0.11%</td>
<td>Physical abuse</td>
<td></td>
</tr>
<tr>
<td>Rape</td>
<td>4</td>
<td>0.23%</td>
<td>Physical abuse</td>
<td></td>
</tr>
<tr>
<td>Beaten, slapped or pinched</td>
<td>34</td>
<td>1.94%</td>
<td>Physical abuse</td>
<td></td>
</tr>
<tr>
<td>Sexually abused by health worker</td>
<td>3</td>
<td>0.17%</td>
<td>Physical abuse</td>
<td></td>
</tr>
<tr>
<td><strong>Inappropriate demands for payment</strong></td>
<td>31</td>
<td>1.78%</td>
<td>Facility culture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>3.07%</td>
<td>Facility culture</td>
<td></td>
</tr>
</tbody>
</table>
Table C. Quantitative measures of mistreatment extracted from Sando et al (2014) study.

<table>
<thead>
<tr>
<th>Study</th>
<th>Study characteristics</th>
<th>Outcome measure</th>
<th>Data collection method</th>
<th>Relationship to new domains of mistreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sando D, Kendall T, Lyatuu G, Ratcliffe H, McDon ald K, Mwanyika-Sando, M, Emil F, Chalami ll G and Langer A (2014)</td>
<td>Mixed-methods design comprising 4 main activities: (1) quantitative interviews with postpartum women 3–6 hours after childbirth; (2) direct observation of labor; (3) quantitative interviews with providers; and (4) in-depth interviews with providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV positive (n=147)</td>
<td>HIV negative (n=1807)</td>
<td>HIV positive (n=18)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Any experience of disrespect and abuse</strong></td>
<td>18</td>
<td>12.20%</td>
<td>271</td>
<td>15.00%</td>
</tr>
<tr>
<td><strong>Specific experiences of disrespect and abuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-confidential care</td>
<td>1</td>
<td>0.70%</td>
<td>33</td>
<td>1.80%</td>
</tr>
<tr>
<td>Lack of physical privacy</td>
<td>1</td>
<td>0.70%</td>
<td>36</td>
<td>2.00%</td>
</tr>
<tr>
<td>Woman's medical history was discussed where others could hear</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Auditory privacy was not respected during postnatal examination</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-dignified care</td>
<td>7</td>
<td>4.80%</td>
<td>117</td>
<td>6.50%</td>
</tr>
<tr>
<td>Provider used non-dignified language during history taking</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provider used a harsh tone or shouted while taking the woman's medical history</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bed in postnatal ward was not clean</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-consented care</td>
<td>2</td>
<td>1.40%</td>
<td>3</td>
<td>0.20%</td>
</tr>
</tbody>
</table>

108
<table>
<thead>
<tr>
<th>Consent and confidentiality</th>
<th>Consent and confidentiality</th>
<th>Consent and confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Woman not asked for consent for first examination in antenatal ward</strong></td>
<td>16</td>
<td>156</td>
</tr>
<tr>
<td><strong>Woman not asked for consent for vaginal examination in antenatal ward</strong></td>
<td>18</td>
<td>146</td>
</tr>
<tr>
<td><strong>Physical abuse</strong></td>
<td>4</td>
<td>85</td>
</tr>
<tr>
<td>Episiotomy without anesthesia</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Woman's legs tied</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Woman's arms tied</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Detention in facility for failure to pay</td>
<td>10</td>
<td>143</td>
</tr>
<tr>
<td>Request for bribe</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Detention</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lack of privacy</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Partitions did not provide privacy</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Woman's naked body exposed/not well covered during labor and delivery</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Table D. Quantitative measures of the mistreatment of women during childbirth in other included studies that explored this concept indirectly (Note: none of the studies included in this table used the experience of the mistreatment of women during childbirth in facilities as a primary outcome. However, several studies reported on indicators that fall into the domains of mistreatment of women as defined by the qualitative evidence synthesis. Qualitative studies that reported descriptive statistics or used a quantitative analysis method are reported in the qualitative evidence synthesis and not in this table).

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Methodology</th>
<th>Event</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small R, Yelland J, Lumley J, Brown S, Liampoutong P (2002)</td>
<td>Cross-sectional population-based survey of immigrant women who delivered in Australia, structured interviews with some open ended questions</td>
<td>Several times decisions were taken without my wishes being taken into account</td>
<td>90</td>
<td>28.9%</td>
<td>Ineffective communication, loss of autonomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I felt my labor and/or the birth was taken over by strangers and/or machines</td>
<td>84</td>
<td>20.2%</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unwanted people were present at the birth</td>
<td>22</td>
<td>7.0%</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff lacking in concern, rude, cold, not gentle, uncaring, hostile</td>
<td>28</td>
<td>29.5%</td>
<td>Failure to meet professional standards, verbal abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff did not explain things, ignored requests</td>
<td>21</td>
<td>22.1%</td>
<td>Ineffective communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff did nothing to help with pain</td>
<td>6</td>
<td>6.3%</td>
<td>Refusal to provide pain relief</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Left alone too much in labor; felt neglected</td>
<td>14</td>
<td>14.7%</td>
<td>Lack of supportive care, neglect and abandonment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Problems communicating with staff (no interpreters, couldn’t express wishes)</td>
<td>12</td>
<td>12.6%</td>
<td>Ineffective communication</td>
</tr>
<tr>
<td>Chalmers B &amp; Hashi K (2000)</td>
<td>Cross-sectional survey of Somali women with female genital mutilation who delivered in Canada</td>
<td>Hurtful comments made by their caregivers regarding their circumcision (summary category)</td>
<td>-</td>
<td>-</td>
<td>Verbal abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Verbal expressions of surprise when the perineum was seen by their doctors</td>
<td>-</td>
<td>-</td>
<td>Lack of supportive care, stigma &amp; discrimination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-verbal expressions of surprise when the perineum was seen by their doctors</td>
<td>-</td>
<td>-</td>
<td>Lack of supportive care, stigma &amp; discrimination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regarded with disgust</td>
<td>-</td>
<td>-</td>
<td>Verbal abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No respect shown for their cultural practice</td>
<td>-</td>
<td>-</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Touched roughly during delivery</td>
<td>-</td>
<td>20.1%</td>
<td>Physical abuse, failure to meet professional standards</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Outcomes Reported</td>
<td>Percentages</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No discussion of possible procedures or options before delivery</td>
<td>79.9%</td>
<td>Loss of autonomy (passive participants), lack of informed consent process</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Felt that the nurses were generally highly insensitive to their postpartum pain</td>
<td>40.5%</td>
<td>Lack of supportive care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Felt that the nurses were unaware that women with circumcision experienced particularly severe postpartum pain</td>
<td>13.7%</td>
<td>Lack of supportive care</td>
<td></td>
</tr>
<tr>
<td>Silal S, Penn-Kekana L, Harris B, Birch S, McIntyre D (2012)</td>
<td>Mixed-methods with quantitative and in-depth interviews of women who delivered in South Africa</td>
<td>Not allowed companion</td>
<td>84.5%</td>
<td>Lack of supportive care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Left alone</td>
<td>16.2%</td>
<td>Neglect and abandonment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not allowed food</td>
<td>77.4%</td>
<td>Loss of autonomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not allowed fluids</td>
<td>83.6%</td>
<td>Loss of autonomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moving around not allowed during first stage of labor</td>
<td>46.6%</td>
<td>Loss of autonomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moving around not allowed during second stage of labor</td>
<td>97.1%</td>
<td>Loss of autonomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shouted at</td>
<td>17.7%</td>
<td>Verbal abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Slapped or struck</td>
<td>4.3%</td>
<td>Physical abuse</td>
<td></td>
</tr>
<tr>
<td>Busanello J, da Costa P, Mendoza-Sassi R</td>
<td>Cross-sectional survey of health workers in an obstetric center in Brazil on the</td>
<td>Disrespect to privacy and intimacy</td>
<td>30.4%</td>
<td>Lack of privacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bad or very bad relation with the parturient and family</td>
<td>17.4%</td>
<td>Ineffective communication, lack of supportive care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of information about delivery</td>
<td>8.7%</td>
<td>Ineffective communication, loss of autonomy</td>
<td></td>
</tr>
</tbody>
</table>
### Souza O, Gonsalves B (2011)

<table>
<thead>
<tr>
<th>Humanization of adolescent delivery services</th>
<th>Lithotomy as a routine position of delivery</th>
<th>22</th>
<th>23</th>
<th>95.6%</th>
<th>Loss of autonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not involved with the type of delivery</td>
<td>20</td>
<td>23</td>
<td>87.0%</td>
<td>Loss of autonomy</td>
<td></td>
</tr>
<tr>
<td>Routine trichotomy</td>
<td>16</td>
<td>23</td>
<td>69.6%</td>
<td>Loss of autonomy</td>
<td></td>
</tr>
<tr>
<td>Routine enema</td>
<td>1</td>
<td>23</td>
<td>4.3%</td>
<td>Loss of autonomy, failure to meet professional standards</td>
<td></td>
</tr>
<tr>
<td>Routine episiotomy</td>
<td>18</td>
<td>23</td>
<td>78.3%</td>
<td>Loss of autonomy, failure to meet professional standards</td>
<td></td>
</tr>
<tr>
<td>Fasting</td>
<td>5</td>
<td>23</td>
<td>21.7%</td>
<td>Loss of autonomy</td>
<td></td>
</tr>
</tbody>
</table>

### Nagahama E & Santiago S (2008)

<table>
<thead>
<tr>
<th>Cross-sectional survey of women in Parana, Brazil to identify facilitators and barriers to the implementing humanized care</th>
<th>Absence of companion in the labor ward</th>
<th>238</th>
<th>569</th>
<th>41.8%</th>
<th>Lack of supportive care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Absence of companion on the delivery ward</td>
<td>561</td>
<td>569</td>
<td>98.6%</td>
<td>Lack of supportive care</td>
</tr>
<tr>
<td></td>
<td>Lack of use of non-pharmacological pain killer methods</td>
<td>186</td>
<td>569</td>
<td>32.7%</td>
<td>Failure to meet professional standards</td>
</tr>
</tbody>
</table>

### Hulton L, Matthews Z & Stones R (2007)

<table>
<thead>
<tr>
<th>Mixed methods study employing qualitative observations, in-depth interviews and quantitative exit surveys and community surveys in urban India</th>
<th>No explanation from their principal attendant about what was happening to them during labor and childbirth</th>
<th>-</th>
<th>-</th>
<th>75.0%</th>
<th>Ineffective communication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Felt that care was hurried or neglectful</td>
<td>-</td>
<td>-</td>
<td>10.0%</td>
<td>Neglect and abandonment</td>
</tr>
<tr>
<td></td>
<td>Shouted at or slapped</td>
<td>-</td>
<td>-</td>
<td>9.0%</td>
<td>Verbal abuse, physical abuse</td>
</tr>
<tr>
<td>Study Authors</td>
<td>Study Design</td>
<td>Study Population</td>
<td>Key Findings</td>
<td>Frequency Distribution</td>
<td>Classification</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------</td>
<td>------------------</td>
<td>--------------</td>
<td>------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Hatamleh R, Shaban I &amp; Homer C (2013)</td>
<td>Mixed methods study using structured survey and semi-structured interviews to evaluate satisfaction with childbirth services in Jordan</td>
<td>Did not experience politeness, courtesy, or respect from care providers and did not have an opportunity to clarify advice or information</td>
<td>143 460 31.1%</td>
<td>Ineffective communication, lack of supportive care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treated as if they were a machine with no sense of individualized care and a lack of encouragement during labor and birth</td>
<td>101 460 22.0%</td>
<td>Loss of autonomy, lack of supportive care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of privacy or sensitivity</td>
<td>60 460 13.0%</td>
<td>Lack of privacy, lack of supportive care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health care provider had shouted at them, had neglected them, or had been unhelpful by failing to inform them about their progress in labor</td>
<td>166 460 36.1%</td>
<td>Verbal abuse, neglect and abandonment, ineffective communication</td>
<td></td>
</tr>
<tr>
<td>Faneite J, Feo A, Merlo JT (2012)</td>
<td>Descriptive cross-sectional study consisting of a survey of awareness of obstetric violence among obstetrics personnel in health centers across Venezuela</td>
<td>Awareness of Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia [Statute on the right of women to a life free from violence]</td>
<td>199 - 45.7%</td>
<td>Health systems policies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aware of the term “obstetric violence”</td>
<td>446 - 89.2%</td>
<td>Health system policies and culture</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Who perpetrates obstetric violence? [summary category]</td>
<td>- - -</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obstetric violence is exerted by any health provider</td>
<td>412 - 82.4%</td>
<td>Rapport between women and providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obstetric violence is exerted by only obstetricians</td>
<td>88 - 17.6%</td>
<td>Rapport between women and providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ever seen any mistreatment of a pregnant woman during their care (summary category)</td>
<td>318 - 63.6%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reported doctor as perpetrator</td>
<td>136 318 42.8%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reported nurse as perpetrator</td>
<td>135 318 42.5%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reported other health provider as perpetrator</td>
<td>47 318 14.8%</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facility does not have means to allow women to deliver vertically</td>
<td>473 500 94.6%</td>
<td>Lack of respect for birth position</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Frequency</td>
<td>Total</td>
<td>Percentage</td>
<td>Category</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------</td>
<td>------------</td>
<td>-----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>What are the complaint mechanisms for obstetric violence? (summary category)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Don’t know complaint mechanism</td>
<td>363</td>
<td>500</td>
<td>72.6%</td>
<td>Health system policies</td>
<td></td>
</tr>
<tr>
<td>Aware of complaint mechanism</td>
<td>137</td>
<td>500</td>
<td>27.4%</td>
<td>Health system policies</td>
<td></td>
</tr>
<tr>
<td>Correct identification of complaint mechanisms</td>
<td>82</td>
<td>137</td>
<td>59.9%</td>
<td>Health system policies</td>
<td></td>
</tr>
<tr>
<td>Aware of agencies responsible for providing support to women who experienced obstetric violence in Venezuela</td>
<td>359</td>
<td>500</td>
<td>71.8%</td>
<td>Health system resources, policies and culture</td>
<td></td>
</tr>
<tr>
<td>Correct identification of agencies responsible for providing support to women who experienced obstetric violence in Venezuela</td>
<td>103</td>
<td>141</td>
<td>73.0%</td>
<td>Health system resources, policies and culture</td>
<td></td>
</tr>
<tr>
<td>Ever sued for obstetric violence</td>
<td>2</td>
<td>500</td>
<td>0.4%</td>
<td>Health system resources, policies and culture</td>
<td></td>
</tr>
</tbody>
</table>
Chapter three:
Manuscript Two

Mistreatment of women during childbirth in Abuja, Nigeria: Perceptions and experiences of women and healthcare providers


Introduction

An estimated 303,000 maternal deaths occurred in 2015, with 66.3 percent of maternal deaths occurring in Sub-Saharan Africa [1]. While substantial progress has been made to reduce maternal mortality, one in 38 women residing in sub-Saharan Africa are still at risk of maternal death [2]. Maternal mortality refers to pregnancy-related mortality occurring during pregnancy or up to 42 days postpartum, and is primarily caused by post-partum hemorrhage, sepsis, obstructed labor, hypertensive disorders and abortion-related complications. The majority of maternal deaths are preventable and manageable with good quality reproductive health services and skilled birth attendance. However, only 68 percent of deliveries in developing countries were attended by skilled birth attendants in 2012 [3], and only 43% were in facilities [4].

While there are global efforts to increase facility-based childbirth, there are significant barriers in some settings, preventing women from attending facilities, including distance [5, 6], cost [7, 8], and perceived quality of care [7, 9, 10]. More recently, improving quality of care, including women’s experiences of care, has been highlighted as a key component of strategies to further reduce preventable maternal mortality and morbidity [11]. Efforts to improve quality of care must not only ensure access to timely, safe and effective care, but should also be delivered in a manner that protects and promotes women’s rights to dignified and respectful care [12]. However, recent evidence suggests that many women experience mistreatment during childbirth in health facilities across the world [13-22]. This mistreatment of women includes, but is not limited to, physical abuse (such as slapping or pinching), verbal abuse and discrimination by healthcare providers.
Background

*Mistreatment of women during childbirth*

The terminology used in different parts of the world to describe the poor treatment of women during childbirth is variable. For example, in Venezuela and Brazil, the term “obstetric violence” has been used in public health [23, 24] and law [25], whereas “disrespect and abuse” [26-31] and “dehumanized care” [32, 33] have been used elsewhere. In this study, we use the terminology “mistreatment of women during childbirth” as a more inclusive term than “disrespect and abuse” to “better capture the full range of experiences women and healthcare providers” have described, including intentional abuse, unintentional or passive abuse, and mistreatment resulting from both individual behaviors and health systems conditions [22].

In 2010, Bowser and Hill published a landscape analysis that explored the evidence for “disrespect and abuse” during facility-based childbirth, and proposed a model to categorize types of abuse [34]. Freedman and colleagues built on this work to propose criteria for determining when an interaction should be considered disrespectful or abusive, and the importance of considering local context in determining what is humiliating, disrespectful or abusive behavior [27, 28]. Using the categories proposed by Bowser and Hill, four recent studies in sub-Saharan Africa have developed operational definitions of disrespect and abuse to be measured through direct labor observations, facility exit interviews and community-based follow-up surveys [29-31, 35]. However, differential operational definitions, lack of consensus on what constitutes poor treatment and varying study designs have resulted in wide differences in prevalence, and it is unclear if differences in prevalence relate to differences in methodology or true variation [36]. These studies have highlighted that many women are mistreated during childbirth, but limitations exist to define and measure mistreatment during childbirth in a systematic and standardized way.
Study rationale

In this study, we sought to better understand women’s experiences during childbirth in facilities in Nigeria, by using qualitative methods to explore how women and healthcare providers in the Abuja metropolitan area perceive and experience mistreatment during childbirth. Detailed accounts of mistreatment from women are corroborated by both midwives and doctors in the same setting, and the typology of mistreatment resulting from the systematic review (paper one of this dissertation) [22] provided a framework in which to organize and present our findings. These findings were prioritized in order to provide contextually-specific evidence of mistreatment during childbirth in Nigeria.

Maternal health in Nigeria

The Nigerian health system is organized by the federal government, state government and local government areas (LGAs). The federal government is responsible for coordinating efforts between Federal Medical Centers (tertiary-level) and university teaching hospitals, while state governments are responsible for general hospitals (district-level) and LGAs are responsible for primary health care facilities. Most districts have government-run hospitals, which provide free or subsidized maternity care.

According to DHS estimates, the total fertility rate (TFR) in Nigeria in 2013 was 5.5, a slight drop from 6.4 in 1960 [37]. Nigeria accounts for 15% of the global burden of maternal mortality, with approximately 45,000 maternal deaths per year, and women in Nigeria have a 1 in 22 lifetime risk of maternal death [1]. Vast geographical health disparities exist, with poor health indicators in the northern region compared to the southern region, including an almost ten-fold difference in maternal mortality [37].
Poor use of maternal health services in Nigeria is a key factor contributing to high levels of maternal morbidity and mortality, as only 51.1 percent of women received four or more antenatal care visits and only 36 percent of births took place in a health facility in 2013 [37]. Poor perceived quality of care at facilities is a critical barrier [38-42], and poor health worker attitudes contribute to a woman’s choice of using a facility or traditional provider [40-42]. A study from northwestern Nigeria concluded that 23.7 percent of women who did not deliver in a health facility cited negative provider attitudes as the primary reason for not using delivery services, and 52.0 percent of women suggested that improvements in provider attitudes are necessary to increase demand for facility-based deliveries [38]. Another study in southern Nigeria showed that women viewed government facilities as providing poor quality maternity services and had poor availability of trained staff during childbirth [40].

Methods

Study Sites

This study was conducted in two districts of the North Central Zone (one peri-urban/rural and one urban), where approximately 45.7 percent of women delivered in a facility in 2013 [37]. In the North Central Zone, the median age at first marriage is 19.1 years (among women aged 20-49 years) and the total fertility rate is 5.3 [37]. Study facilities were chosen in collaboration with the local principal investigator using pre-specified inclusion criteria, including number of deliveries per month, number of staff currently employed, and an existing relationship between the research institution and the selected facilities. Characteristics of the study sites are shown in Table 3.1.
Study participants, recruitment and sampling

In order to understand women’s experiences during childbirth, three groups of participants were identified: (1) women; (2) healthcare providers; and (3) facility administrators. FGDs were conducted with women of reproductive age (15-49 years) who delivered in any facility in the past five years and resided in the selected facility catchment area, and IDIs were conducted with women of reproductive age (15-49 years) who delivered in a facility in the past twelve months and resided in the selected facility catchment area. IDIs were conducted with health care providers (nurses/midwives and doctors/specialists) and facility administrators (e.g.: medical director, head of obstetrics, matron-in-charge) in each study facility. Both IDIs and FGDs were conducted with women in order to gain a detailed understanding of experiences of mistreatment during childbirth (IDIs) and to better understand social norms related to mistreatment (FGDs). Only IDIs were conducted with providers and administrators, due to concerns that FGDs may breach the confidentiality of study participants through the disclosure of poor practices or “naming and blaming”.

An obstetrician and midwife from each selected facility who attended the study training workshop acted as an entry point to connect research assistants to healthcare providers. Community health workers helped to identify women who met the inclusion criteria, and research assistants initiated face-to-face contact with women health care providers meeting the inclusion criteria. Each eligible individual was invited to participate and provide consent.

Quota sampling was used to achieve a stratified purposive sample without random selection using specified parameters (setting, cadre, age, religion) to stratify the sample. Women were sampled from the urban and rural/peri-urban communities in the selected facility catchment area, and were recruited based on their age/parity in order to explore the experiences of both younger/primiparous and older/multiparous women. Although further stratification did not take
place across ethnicity or religion in the FGDs due to logistical difficulties of recruiting and hosting a FGD with multiple layers of stratification, interviewers sampled women across a mix of different ethnicities and religions. Healthcare providers were sampled from the study facilities based on their cadre, and across a mix of older/more experienced and younger/less experienced. Facility administrators were sampled from the study facilities. Three eligible participants declined to participate: one administrator refused to give an audio-recorded interview, one woman did not have sufficient time to be interviewed, and one woman needed her husband’s permission but he was unavailable.

**Study instruments**

All instruments were semi-structured discussion guides, fostering comparability across IDIs/FGDs and allowing participants to guide the discussion based on their experiences (Appendices 5.1-5.3). In the FGDs, women were not asked to disclose their individual experiences of mistreatment, but were asked to speak about “women like them” or an anonymous friend/family member who has experienced this treatment. Likewise, healthcare providers and administrators were not asked to disclose instances where they mistreated a woman; rather, they were asked to speak about mistreatment they witnessed. The following domains of interest were explored:

1. Expectations of care during childbirth at health facilities;
2. Experiences and perceptions of mistreatment during childbirth;
3. Decision-making processes to deliver at a facility;
4. Views of acceptability of mistreatment during childbirth;
5. Perceived factors influencing mistreatment of women during childbirth; and

6. Treatment of staff by colleagues and supervisors.

Data collection and management

Research assistants were female masters of public health graduates with training in qualitative research and maternal health. All research assistants were from Ibadan, Nigeria and underwent a two-day training and piloting workshop in Abuja prior to commencing data collection. Eligible individuals completed an oral or written consent form prior to participation. All FGDs and IDIs took place in a private setting with only participants present, were audio recorded, lasted 60 to 90 minutes and were conducted by research assistants. Participants received 2000 Naira (approximately $10 USD) and a refreshment to compensate their transportation cost. Data were collected from March to June 2015, until thematic saturation was reached. Transcription, translation and recording of field notes occurred in parallel, and transcripts were shared and reviewed on an on-going basis to ensure data quality. IDIs and FGDs conducted in English were transcribed in English. IDIs and FGDs conducted in a local language (Pidgin English, Hausa, Igbo or Yoruba) were translated and transcribed simultaneously by the research assistants. This method was most effective as the local languages are not commonly in written form, thus complicating transcription directly into the local language. De-identified transcripts were stored on a password protected computer.
Data analysis

This analysis employs a thematic analysis approach, as described by Braun & Clarke [43]. Thematic analysis is inherently a flexible method, and is useful for identifying key themes, richly describing large bodies of qualitative data and highlighting similarities and differences in experiences [43].

After transcription, line-by-line coding was performed on a subsample of transcripts by two independent researchers to develop an initial thematic framework. These codes emerged naturally from the data and were initially structured as “free codes” with no established link between them. Free codes were synthesized with questions from the discussion guide and systematic review findings [22] into a coding scheme transferable to other transcripts. The coding synthesis yielded a hierarchical codebook to explore higher-level concepts and themes and organize the codes into meaningful code families. Reliability testing of the codebook was conducted in two stages: (1) two researchers jointly coded three transcripts, one from each type of participant; and (2) two researchers independently coded two transcripts and discussed coding decisions until consensus. After reliability testing, the final codebook was developed (Appendix 5.4), which includes the structure of code families, code names, definitions, and an example of proper use. All transcripts were subsequently coded using Atlas.ti [44]. Memos were used to collate emerging thoughts, highlight areas of importance and develop ideas throughout the analysis process. A subset of the coded transcripts was reviewed by an independent researcher to check reliability of the coding.

Transcripts were organized according to meaningful “primary document families” in Atlas.ti [44], a method of organizing groups of transcripts based on common attributes, and used to restrict code-based searches or to filter coding outputs [45]. Primary document families consisted of: (1) type of participant; (2) facility/catchment area; and (3) religion. Output and reports were generated for specific codes using Atlas.ti [44] and filtered by primary document family where
appropriate. Data from these reports and output were further synthesized into meaningful sub-themes, narrative text and illustrative quotations to draw connections between recurrent patterns and themes. These themes were interpreted within the context of the study and the typology of mistreatment during childbirth developed from the systematic review (paper one of this dissertation) [22]. Throughout this iterative analysis process, the research team considered questions of reflexivity, including identifying and reflecting on assumptions and preconceptions regarding what constitutes mistreatment, exploring emergent findings, and considering the research relationship. This paper focuses on perceptions and experiences of physical and verbal abuse, discrimination and neglect, where data were richest.

Results

Eighty-five IDIs and 4 FGDs were conducted from March to June 2015. Table 3.2 reports sociodemographic characteristics of participants: women of reproductive age, and Table 3.3 reports sociodemographic characteristics of participants: healthcare providers and administrators. We present an overview of preferences for childbirth in Abuja, followed by an overview of the context of mistreatment in this setting, and specific experiences of physical abuse, verbal abuse, stigma and discrimination and neglect.

Preferences for childbirth in Abuja

Traditionally, women in the North Central region preferred home birth with an *iya agbébi* (traditional birth attendant) and family members present. This traditional model provided one-to-one care and support for the woman; however “anything can happen” if a woman delivers at home [Woman IDI, 25 years old, rural], and if complications arise during a home birth, traditional birth attendants may not know how to cope. As women become more educated and
“enlightened,” they tend to deliver at the hospital, but barriers to hospital attendance still exist, including financial cost, long distance and fear of mistreatment. Facility-based birth is now normative in urban and peri-urban areas, where women believe that health facilities provide safe and effective care by trained staff and ensure safe childbirth and proper management of the mother and baby. Although the government subsidizes care provided at public hospitals, women commonly believe that they will be insulted and poorly treated if they attend there. Therefore, women with the means to pay for services may prefer to deliver at private hospitals, where they perceive they will be treated with dignity and respect since they are paying customers.

Context of mistreatment in Abuja

While some participants described positive birth experiences where women were “well cared for” by the “helping hand” of the healthcare providers, both women and healthcare providers spontaneously brought up the topic of mistreatment, illustrating negative experiences that they had faced, witnessed or had heard about from others. Healthcare providers disclosed both scenarios where they felt that they had perpetrated mistreatment and where they witnessed a colleague mistreat a woman. Women and providers usually proffered explanations for why this situation occurred, and generally viewed them as by-products of an overstretched health system, rather than isolated events of intentional abuse. For example, a doctor from an urban facility explained that what women experience as neglect or abandonment by a healthcare provider may actually be a consequence of an understaffed facility:

R: ... let me give an example... if a midwife is already taking delivery of a baby is delivering a baby and another patient is calling for her attention you know she will not be able to attend at that particular time is that not so? No but to that patient she might feel that she has been treated wrongly isn't it? But we know that that is far from that [IDI male doctor, 42 years old, urban facility]
Healthcare providers described challenges faced on the labor ward, including “disobedient,” “uncooperative” and “unruly” women who made providing supportive care and “pampering” difficult. A doctor likened the labor ward to a war zone and explained that “in the warfront you don’t pamper; when you are at war, you are at war” [IDI male doctor, 40 years old, peri-urban facility]. Women sometimes lashed out at the healthcare providers, but explained that it was in retaliation for the poor treatment that they received:

*The labor started, they carried the woman go hospital, as they reached the hospital, they thing hooked the woman, so the woman was shouting and crying. That nurse, immediately, when she reach there, she gave the woman "baa!" (slap). Hey! Did woman was just looking at her like please you don't know what is wrong with me and you slapped me, okay thank you. As the woman deliver, she said, she did everything for her. As the woman wanted to go, wanted to leave the hospital, the woman called the nurse, "please I want to see you", she gave her (nurse) "fiam!" (slap). She said the thing you did to me, that is what I did back to you.* [FGD woman, 41 years old, urban]

Healthcare providers suggested that adolescents and primiparas may be more vulnerable to mistreatment, as healthcare providers may judge them for being pregnant too young, or they are unaware of what to expect during childbirth and appeared ill-prepared to engage with the health system. Furthermore, women who have not arranged to deliver in that facility (e.g.: unbooked for delivery) may be mistreated more often, as the lack of records contributes to a stressful environment for healthcare providers. These women were blamed for their lack of preparedness, even though providers were aware that they were more likely to be from disadvantaged backgrounds compared to women who had booked at that hospital for delivery.

A minority of healthcare providers, particularly doctors, believed that mistreatment does not occur in their setting. These doctors felt that women were dramatizing stories based on popular culture because they “watch all this film”, and were “exaggerating”, when in reality the healthcare providers “are professionals here, we don’t get angry, we only give professional advice.” These providers had the impression that because some women were unable to give detailed specifications of the mistreatment that they experienced, they were untruthful. However,
women in this setting do not have a forum for providing feedback on their experience or voicing experiences of mistreatment.

**Physical abuse**

Many healthcare providers and women detailed scenarios where women are slapped or beaten during childbirth, and commonly believed that slapping was used to ensure positive health outcomes for the woman and the baby. For example, if a woman closed her legs during delivery, health workers would slap the woman to “encourage” her or give her the “strength” to “open up and deliver well”.

> If the woman is not cooperating. Like, you have your legs apart, the baby's head is out, you understand, so and you are now trying to pull your legs back together. The, the nurse that could be taking delivery at that time could be so agitated. Thereby, just palm the woman on the this thing that "open up" so that she can actually delivery the baby. It is not really mistreatment. It is helping the woman indirectly. [IDI female doctor, 36 years old, urban facility]

Slapping is used to gain compliance and cooperation from a woman, and was often not considered to be mistreatment by women or healthcare providers provided that it was not done out of “malice”. Although women reported that it hurt, some women believe that healthcare providers would not act outside of the best interests of the woman, and would blame the other women for “trying to kill their babies”.

> I: Okay, how you feel when they slap you,

> R8: the slap, I felt bad but I, when I deliver the baby, I know that they help me, I didn't carry it in mind and go again, because if that baby die I lose, if I myself die, we all lose, so at least I prefer that slap than I miss the baby [FGD Woman, 35 years old, urban]

> But just what I'm telling you, it's just that if it is slapped during labor, it depends on what happened now. Just you know I've told you one instance, a woman is going, the head is out, she's closing her leg. If you were in my shoe, what would you do? Will you leave her to kill the baby? No answer me. Will you leave her to kill the baby? [IDI male doctor, 52 years old, peri-urban facility]
However, other women felt disempowered and experienced both physical and psychological pain that a healthcare provider would beat her: “let them stop that shouting that they do, even beat they shouldn't beat women, they should stop beating women for, during labor” [FGD Woman, 29 years old, peri-urban]. These experiences took a toll on the woman both emotionally and physically: “they slapped me, the five finger [mark] appear till when I reach home…I don’t even want to remember that past…she was supposed to pet me as far as it’s my first experience.”
Women felt that words of encouragement and a clear explanation of what the healthcare provider expected from the woman during delivery would mitigate the need to slap her.

P: Yes, I would, I pass through, through it also, they beat me enough...Yes, they beat me hard, so hard that at the end of the whole thing. With that I find out that if I don't push, I may end up dying or the baby may end up dying.

I: So how did you feel when they were beating you?

P: I was like telling them, "abeg now nurse now, take it easy, is not my fault, you see that is painful", that was just I, I was just pleading with them because I know them, they were also fed up with me. Do you understand me? I know they did their best. I know at that point in time, they were trying their best to save me. But because of I do not have strength, so I have to plead with them, not been cruel to them. [IDI Woman, 31 years old, urban]

Well, we are not supposed to, maybe a woman is pushing, and she is not cooperative, we, we're, we are not supposed to use our hand to say, to beat the woman. The way am taught, there is, there are better ways to communicate to her... But sometimes, you see midwives beating patients, 'you want to kill the baby!' Pow! Pow!! Pow!!! [IDI female nurse, 36 years old, urban facility]

Another method healthcare providers sometimes used to control a woman during childbirth was physically tying the woman to the delivery bed with ropes.

I was the only midwife on duty, that time we used to work alone, just one person on duty, on night duty with the attendant, this lady, this lady came in, it's her first time, she's a primi, she was fully dilated! But no way! She will rather get up and stand! When she starts having contractions she will climb up the couch and remain there, so eventually when we were able to bring her down, I had to call her relations, you understand? Her relations and I had to call her relations and then bring the bed and put still ropes to hold her legs [IDI female nurse, 39 years old, urban facility]
“Nurses will insult people like they’re not a human being”: Verbal abuse

Women described healthcare providers shouting, criticizing, insulting and speaking harshly during their delivery. Rudeness was pervasive, and women felt that healthcare providers “don’t care about human life”, “insult people like they’re not a human being” and “will maltreat you like a slave”. A woman who delivered in the peri-urban hospital explained that when she arrived for delivery, the midwife said “oye, go outside goat…Ehn see this goat, go outside, it’s not yet time, it not time, what are you doing here, you are disturbing me” [IDI Woman, 29 years old, peri-urban]. Women were yelled at for not bringing all of the supplies needed to conduct the delivery (e.g.: gauze, cotton, gloves, bed sheet) and for not complying with the healthcare providers’ demands.

P: You know is very, very common with general hospitals, some can be very, very rude. The way they talk to you sometimes as if they are not been sensitive to your situation. You understand? You go and you want to seek for help, the way they...sometimes you see mothers blinking their faces and they will be crying. You understand? You don't put their, themselves in your shoes. Talk to you anyhow, you know. Make you feel less important because you've come to general hospital…

I: Does it occur often or is something that is just rare?

P: Is something that is in their blood. Not rarely [IDI Woman, 31 years old, urban]

Healthcare providers also made judgmental comments about a woman’s sexual history, chastising them that they enjoyed having sex, but now the healthcare provider had to deal with the consequences of the pregnancy and birth.

Like when they insult you, "am I your husband? When your husband was doing it, it use to sweet you, but now you are disturbing us with your noise". When you hear that kind of insult, even when they come to attend to you, you’ll be feeling shy, anything you want to do sef, when they say "okay, spread your leg", you will be feeling shy to even spread your leg because they have already insult you that when your husband was doing it [FGD Woman, 25 years old, urban]
When they were verbally abused, women felt that they were more “vulnerable” and had reduced agency to communicate with the healthcare provider or to complain about poor services rendered. A woman who felt disrespected during her childbirth said “I don’t have anything to say, is only God that will help me in this condition now because I don’t have the power” [IDI Woman, 27 years old, rural]. Similarly, women’s cries of pain during labor were silenced by healthcare providers, who felt that women should be silent while they deliver:

R: but you know that I was in labor, everything was paining me, it’s not that... but when they say madam please shut up, let me hear word, meanwhile I am not myself, please shut up, shut up, that is why, it is not as if everything they did, but they did something that were paining me, paining me, you know I was in labor that’s why [IDI Woman, 27 years old, peri-urban]

Healthcare providers confirmed that verbal abuse is common, and explained that they felt “agitated,” “irritated” and “annoyed” when women did not “cooperate” with their demands, but that they were not intentionally trying to harm the woman. After an outburst, they would often feel badly about raising their voices, and apologize to the woman.

In general, let me say in the General Hospitals, that is big hospitals where you have so many women coming in and a few hands working, most times these women’s emotions are not taking into consideration, because you see... you’re doing this one, you have to run from one point to the other, you are doing so many things at the same time. So, most times you discover that people are shouting on this woman, madam do this! do this! You know but most times really it's not as if it’s something we want to do because at the end of it all you will discover that we will become friendly again and all that so I don’t think it's intentional that anybody will like to, we all know that that's not something to do but when you are confronted with a very difficult situation and you have to do so many things at the same time, it’s frustrating both for the health worker and for the patient. [IDI female nurse, 39 years old, urban facility]

**Stigma and discrimination**

Midwives and doctors explained that HIV-positive women may fear discrimination and hide their status from healthcare providers to prevent such discrimination from occurring. This may put
health workers and their babies at risk of contracting HIV if appropriate protection is not used.

Women also felt discriminated against when they were of different religions, ethnicities or from low socioeconomic status.

*The health workers try but they can do better... They’re not very nice, to women, okay especially if they look at the woman and they have some bias, yeah, they are like where is she from, you know that kind of thing, or she doesn’t look so clean, she looks dirty or something, most people don’t look at their patients with the human face, you look at people and you are already judging them, I think that if a woman comes, for example, she’s coming from a squalid background, she’s dirty, you can actually give her a bath and make her feel nice and then you bring her back in and continue what you're doing* [IDI female doctor, 36 years old, urban facility].

**Neglect and abandonment**

Women commonly felt neglected during labor and felt unable to summon healthcare providers when needed. They were seldom monitored during labor, and if complications arose, such as excessive bleeding, it was difficult to get the attention of a healthcare provider. Providers confirmed that in some cases, they felt overworked and did not take the appropriate time to address the needs of the woman:

*Like some patients they are not good, they just come from all these private hospitals and when they come like that, you have worked, worked and over worked yourself, they would just rush in and want you to leave what you are doing or... come and attend to them. You feel so irritated and you talk to them any how or you will even send them away that you are not going to attend to them... I have done it before too. Like 4 years ago we used to have more than 13 deliveries in a night and it will just be 2 nurses on duty, by the time you are handling over in the morning you will see that your legs are shaking, and they will now bring one unbooked patient for you to leave what you are doing to come and attend, your head will be banging and you won’t even know when you will tell them to go to hell anywhere they want to go let them go.* [IDI female nurse, 40 years old, peri-urban facility].

Furthermore, public facilities are often overcrowded, with not enough beds for women. As a result, women are sometimes forced to deliver on the floor, and without the support of a
healthcare provider. One woman described another woman delivering on the floor when she arrived at the hospital due to insufficient bed space:

\[ R8: \text{[the hospital has] four beds, but the population there people that want to deliver they are up to 8.... so as I was standing there, one Gbagyi woman they just hold the woman, the woman was even holding the baby, before they will check the woman, the woman just lie on the floor and deliver.} \] [FGD Woman, 31 years old, peri-urban].

Violations of privacy

The structure of the facility contributed to mistreatment, as women felt that their privacy was violated by the poor design of the labor wards, where women would be exposed to other patients, their families and providers. The delivery room contained several beds with no partitions between them, and if curtains were available, they were tattered or not closed properly. Windows were broken and lacked curtains to shield women from passersby.

\[ R: \text{honestly! Even when I was delivering many people are passing by, they were looking at me. It's supposed to be enclosed but they did not repair everything that they suppose, like window, everything have spoilt and they did not do it, they did not repair. So the people that were in outside they were looking at me, knowing my baby, everything! They were seeing it, and it's not supposed to be bad...I mean according to our religion is not allowed, everybody were seeing our naked. How the baby will come out, so...I was annoyed.} \] [IDI Woman, 31 years old, peri-urban].

Understaffing and overcrowding

Understaffing and overcrowding on the labor ward can create a stressful work environment. Providers may “snap” or can be “wicked” in part due to the stresses in the work environment. These conditions contribute to healthcare providers’ feelings of impulsivity, lower tolerance for
aberration, and exhaustion, and can contribute to a transference of aggression to the woman. Working in these conditions may cause healthcare providers to “not show the courtesy that is required of a health worker towards their client” [IDI female administrator, 55 years old, urban facility]. A woman acknowledged that overworked and stressed healthcare providers were “not computer, they are not engine, they get tired...it could lead to it [mistreatment] because when you are seeing the crowd alone...you are confused, you don’t even know where to start” [IDI Woman, 34 years old, peri-urban].

However, several nurses believe that they usually have enough staff on a shift to cope with the needs of the hospital, and there is no excuse for how women are treated. Even when the facility is not overcrowded, it is in some healthcare providers’ nature to be rude:

I tell you some of these times, nothing is happening, it's not overcrowding, it's not work...too much work, at times it happens! So many times it's because of the bulk of the work but at times these things just happen even when the place is really calm. [IDI female nurse, 39 years old, peri-urban facility].

**Impact of mistreatment on care-seeking**

Experiencing mistreatment could be “destabilizing” for women who are often vulnerable during childbirth:

The attitude of the health workers can influence on a woman either negatively or positively...if they teach you well, encourage you, it will give you that confidence, you understand, but if they are rude and harsh, it will destabilize you and add to your problem. [IDI Woman, 29 years old, urban]

Women feared mistreatment during facility-based childbirth to the extent that they sometimes avoided attending the facility altogether: “women they are dying at home because of they are fearing to go to hospital because of the way nurse and doctor they are treating them” [FGD
Woman, 30 years old, peri-urban]. These women believed that they would be better supported during a home birth, and that they will be mistreated if they attend the hospital.

Participants’ suggestions for improving the treatment of women during childbirth

At the end of the IDIs and FGDs, healthcare providers and women were asked what could be done so that women were treated better during labor and childbirth. Both groups noted that solutions to improve how women are treated during childbirth will need to be multifaceted and multidimensional across different levels of the health system, from provider sensitization and training through physical infrastructure strengthening. Training should be provided on how to give respectful and compassionate care, to reorient providers suffering from “compassion fatigue” and “put yourself in the woman’s shoe”. This training should be integrated with coping mechanisms for working in stressful environments, increase provider motivation and techniques for improving patience, tolerance and endurance. The physical structure of the facilities should be adapted to ensure that they are properly equipped to handle deliveries, such as providing adequate private space for women to deliver, designing the space that is compatible to labor companions, and providing clean toilet and washing facilities for women. Both women and healthcare providers suggested improving salaries of providers working in public facilities and increasing staffing to alleviate stress and pressure on the providers. There should also be facility-level redress mechanisms for women to express dissatisfaction or satisfaction with the services rendered. Creating a forum to promote engagement between healthcare providers and women to manage expectations could ultimately reduce provider stress as it would allow healthcare providers to better explain to women and their families what supplies to bring with them to the
hospital, and women to understand why such supplies are needed, and in what circumstances a woman may need to pay for services she receives.

**Discussion**

This study explored women and healthcare providers’ experiences and perceptions of mistreatment during childbirth in the North Central zone of Nigeria. The findings suggest that across urban and peri-urban/rural settings, age groups and religions, women experience and providers acknowledge mistreatment during childbirth. Women and providers reported experiencing or witnessing physical abuse such as slapping, being tied to a delivery bed, and detainment in the hospital and verbal abuse, such as shouting at, intimidating, and threatening women with physical abuse. In some cases, women overcame tremendous barriers to reach a hospital, only to deliver on the floor, unattended by a healthcare provider.

Participants in this study identified three main factors contributing to mistreatment: poor provider attitudes, women’s behavior, and health systems constraints. Women believed that healthcare providers were “rude”, “dismissive”, “wicked” and “hot tempered”, and that “it is in their nature” to treat women poorly. Furthermore, healthcare providers did not always view slapping as mistreatment; rather, slapping was a “subconscious” method to gain compliance and exert control over the woman. Women also believed their own actions were sometimes responsible for being mistreated by healthcare providers, such as being a difficult patient or not cooperating. Slapping a woman during childbirth was viewed as a means by which to ensure a positive outcome, and that women provoked healthcare providers when their disobedience endangered her baby.

Inadequate physical resources at the facilities further contributed to the poor treatment of women, such as poor labor room and facility design, broken windows, and a lack of privacy curtains. In
addition to feeling disempowered, neglected and in pain, when women experience or hear about mistreatment during childbirth in their communities, they may be less likely to deliver at a facility in the future. Systemic physical resource and staffing constraints contribute to a disabling work environment and propagate provider stress. When providers cannot cope with this stress, they may transfer their aggression onto the woman herself. Finally, although adequately stocked at the study facilities, facility policies dictate that women are not provided with pain relief throughout labor and delivery, and this sometimes extended to episiotomies provided without any analgesia.

In this study, both women and providers blamed mistreatment during childbirth on a disempowering health system where providers are overworked and facilities are understaffed and overcrowded. This explanation parallels other literature in the field [20, 21, 46]; however mistreatment cannot be blamed solely on the health system. In Nigeria, women and their families are unable to express their satisfaction or dissatisfaction with services rendered, thus hindering the ability to engage with users and improve the quality of care. When there are no ramifications for poor quality of care and women’s concerns are suppressed or ignored, there is little incentive to foster change. Similarly, Jewkes (1998) concluded that within the same system in South Africa, women of higher socioeconomic status were treated differently from women of lower socioeconomic status, suggesting that a disabling structural environment only told part of the story [17]. Jewkes hypothesizes that the construct of the “nursing identity” emphasizes moral superiority and control over the “inferior patient” and lacks a commitment to ethics that precludes mistreating a woman [17]. Understanding how and why exerting control over a woman in labor by slapping and shouting at her are acceptable actions requires deeper inquiry into normative attitudes and behaviors on the maternity ward.

This study was conducted in two facilities and facility-catchment areas in the Abuja metropolitan area, and may not reflect the experiences of women and healthcare providers across Nigeria. Interviews were conducted with women who had delivered any time during the previous year and
may therefore have recall bias. Similarly, mistreatment is a difficult topic to discuss with providers, and providers therefore may have underreported such experiences, particularly for interviews with providers conducted in health facilities (social desirability bias). Despite this, both women and providers in this study provided detailed accounts of mistreatment.

Moving forward, there are several critical next steps. First, findings from this study should be communicated to key stakeholders including providers and administrators at the study facilities. Such efforts should also demonstrate how physical resource and staffing constraints in the healthy system can have profound impacts on a woman’s birth experience. Similarly, Freedman and Kruk have highlighted the importance of building local consensus between healthcare providers, policymakers, women and other key players in determining actions deemed to be “humiliating or undignified” during childbirth (17). Women must be given a platform to voice their experiences of care, and tough discussions must be had with providers and policy-makers to unpack the uncomfortable topic of deliberate abuse versus unintentional neglect. Second, measurement tools to assess how often mistreatment occurs and in what manner must be developed for monitoring evaluation. Similar measurement efforts in the field of violence against women have been undertaken in the past decade, and have moved the field forward. Third, any intervention to prevent mistreatment will need to be multifaceted, and researchers should consider lessons learned from related interventions, such as increasing consistent and targeted feedback to promote provider compliance with a desired practice [47], encouraging women to provide feedback on quality of care received during childbirth [48], promoting the practice of and adapting facilities to accommodate labor companionship [49], and encouraging mindfulness and stress-coping training for providers [50]. Finally, global health leaders, researchers, advocacy groups and other key stakeholders must collaborate to develop a global definition of the mistreatment of women during childbirth. Such efforts are necessary to put mistreatment of women during childbirth on the global agenda.
Chapter Three References


38. Idris SH, Sambo Mn Fau - Ibrahim MS, Ibrahim MS. Barriers to utilisation of maternal health services in a semi-urban community in northern Nigeria: The clients' perspective. (0300-1652 (Print)).

39. Bawa SB, Umar Us Fau - Onadeko M, Onadeko M. Utilization of obstetric care services in a rural community in southwestern Nigeria. (0309-3913 (Print)).

40. Osubor KM, Fatusi Ao Fau - Chiwuzie JC, Chiwuzie JC. Maternal health-seeking behavior and associated factors in a rural Nigerian community. (1092-7875 (Print)).

41. Esimai OA, Ojo Os Fau - Fasubaa OB, Fasubaa OB. Utilization of approved health facilities for delivery in Ile-Ife, Osun State, Nigeria. (1115-2613 (Print)).

42. Uzochukwu BS, Onwujekwe Oe Fau - Akpala CO, Akpala CO. Community satisfaction with the quality of maternal and child health services in southeast Nigeria. (0012-835X (Print)).


## Table 3.1. Facility characteristics
(Note: facility characteristics as reported by the head of each facility in personal communication, August 2014.)

<table>
<thead>
<tr>
<th></th>
<th>Peri-urban facility</th>
<th>Urban facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrician/gynecologist</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Medical officer</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Midwife</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td><strong>Capacity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td># beds on delivery ward</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td><strong>Health outcomes (2013)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total births (n)</td>
<td>3231</td>
<td>2417</td>
</tr>
<tr>
<td>Live births (n)</td>
<td>2961</td>
<td>2182</td>
</tr>
<tr>
<td>Stillbirths (n)</td>
<td>270</td>
<td>235</td>
</tr>
<tr>
<td>Maternal deaths (n)</td>
<td>94</td>
<td>73</td>
</tr>
<tr>
<td><strong>Cost of childbirth services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal delivery</td>
<td>$0 USD</td>
<td>$0 USD</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>$215 USD</td>
<td>$215 USD</td>
</tr>
</tbody>
</table>
Table 3.2. Sociodemographic characteristics of participants: women of reproductive age

<table>
<thead>
<tr>
<th></th>
<th>IDIs (n=42)</th>
<th>FGDs (n=4 FGDs*)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>25-29</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>30-34</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>35-39</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>40+</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Married</td>
<td>41</td>
<td>34</td>
</tr>
<tr>
<td>Divorced/Widowed</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Peri-urban</td>
<td>21</td>
<td>34</td>
</tr>
<tr>
<td>Rural</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td>Muslim</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoruba</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Igbo</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Hausa</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Idoma</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Igala</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Tiv</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Other**/missing</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Secondary</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Tertiary</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Diploma</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business/private sector</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Civil servant</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Hair dresser</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Housewife</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Tailor</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Teacher</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Trader</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td><strong>Number of living children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>2-3</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>4-5</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>6+</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*Three FGDs conducted with 8 women, one FGD conducted with 10 women
** “Other” includes Akwa-ibom, Angas, Ebira, Igede, Katarf, Ogori, Zuru, Akoko Edo, Bekwarra, Edo, Isoko, Ogoja
Table 3.3. Sociodemographic characteristics of participants: healthcare providers and administrators

<table>
<thead>
<tr>
<th></th>
<th>Nurse/midwives n=17</th>
<th>Doctors n=17</th>
<th>Administrators n=9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>40-49</td>
<td>5</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>50+</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Married</td>
<td>15</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td><strong>Years of experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>5-9</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>10-15</td>
<td>4</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>15+</td>
<td>11</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban facility</td>
<td>8</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Peri-urban facility</td>
<td>9</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>
Chapter four:
Manuscript Three

“By slapping their laps, the patient will know that you truly care for her”: A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria
Introduction

A growing body of research suggests that many women experience mistreatment during childbirth in health facilities across the world [1], including physical abuse (such as pinching or slapping) [2-4], verbal abuse [5-7] and discrimination by healthcare providers [2, 8, 9]. Mistreatment during childbirth can amount to a human rights violation, as all women have the right to respectful and dignified sexual and reproductive healthcare, including during childbirth [10-16]. The importance of acknowledging and addressing this important area of women’s health has gained traction since the publication of Bowser and Hill’s 2010 report on disrespect and abuse during childbirth [17]. Most research has focused on descriptive qualitative analyses of experiences of mistreatment, with several small scale measurement studies [18-20]. Mistreatment during childbirth is a multi-dimensional issue, and prevention requires understanding the root causes that range from interpersonal behaviors to professional ethics and accountability to health systems constraints. To better understand how and why mistreatment during childbirth occurs, it is important to reflect on societal tolerance of violence and power dynamics. This paper explores the acceptability of four scenarios of mistreatment during childbirth, as presented to women, midwives and doctors in Nigeria: slapping, verbal abuse, neglect and physical restraint during labor.

Gender inequality, patient inferiority and violence against women

In 1998, Jewkes, Abrahams & Mvo published findings from a qualitative study on why nurses abuse patients on South African maternity wards [21]. The authors concluded that an “underpinning ideology of patient inferiority” was a primary driver of mistreatment, compounded by a complex relationship between “organizational issues, professional insecurities…[and the] perceived need to ‘control’” a woman’s behavior [21]. Jewkes and Penn-Kekana [22] draw a parallel between the typology of mistreatment during childbirth developed through a systematic
review conducted by Bohren and colleagues (paper one of this dissertation) [1] and violence against women more broadly. They argue that violence against women results from gender inequalities that place women in subordinate positions compared to men, thereby enabling the use of violence and promulgating disempowerment of women [22].

Similarly, research evidence on attitudes towards intimate partner violence (IPV) suggests that IPV is often considered normal in the context of marital relationships, and is justifiable in different scenarios, such as refusing to have sex, neglecting children, infidelity and burning the food [23-26]. Social norms around power dynamics and control influence both IPV and mistreatment during childbirth. As such, women in labor may be disempowered to speak out for their right to respectful care from healthcare providers, just as women are disempowered from standing up to abusive intimate partners. In low- and middle-income countries (LMICs), women often deliver at hospitals without birth companions who could advocate for their rights, bear witness to mistreatment and lack accountability and redress mechanisms to report mistreatment that does occur. In these settings, healthcare providers may use their position (sometimes unintentionally or unknowingly) to exert power over and gain compliance from women, and women may have little choice but to submit to their demands.

Social norms and attitudes towards mistreatment during childbirth

Attitudes towards IPV are well documented in the literature [23, 27-30], and a set of questions has been incorporated into the Demographic and Health Survey (DHS) (Attitudes toward wife-beating). This work has demonstrated that where societies accept and tolerate violence against women, eradication is complex, as those perpetrating abuse may not recognize their actions as abusive [31]. Similarly, Freedman and Kruk argue that during childbirth, “practices that to the outside advocate or trained observer seem unambiguously disrespectful or abusive are often normalized” [32]. Therefore, understanding how both women and providers perceive different
acts that could be classified as mistreatment by an independent observer, researcher or advocate is a crucial step to be able to measure accurately and develop preventive measures. However, limited research has been conducted globally on the influence of societal norms and attitudes towards the mistreatment of women during childbirth, and contextually-specific evidence is needed to understand how social and normative factors influence how women are treated during childbirth. This study aims to explore the acceptability of the mistreatment of women during childbirth in health facilities, among women and healthcare providers in the Abuja metropolitan area of Nigeria.

**Maternal health services in Nigeria**

The Nigerian health system is organized by the federal government, state government and local government areas (LGAs). The federal government is responsible for coordinating efforts between Federal Medical Centers (tertiary-level) and university teaching hospitals, while state governments are responsible for general hospitals (district-level) and LGAs are responsible for primary health care facilities. Most districts have government-run hospitals, which provide free or subsidized maternity care.

Human resources for health in Nigeria include doctors, nurses, midwives, public health nurses and community health workers (including community health officers, community health extension workers and health assistants). Healthcare providers working in public facilities are paid by the level of government responsible for their employment; for example, the state ministry of health is responsible for paying healthcare providers in district-level hospitals. Most doctors and nurses work in district- or tertiary-level facilities or in private practices, and few work in primary health facilities [33]. Better living and working conditions, including higher salaries, draw most providers to work in urban areas or private hospitals, and many healthcare providers have a secondary source of income as staff salaries are often irregularly paid [34]. For example, public-sector providers went on a nationwide strike from November 2014 to February 2015 due
in part to the government’s failure to honor collective bargaining agreements for improved wages and conditions of service, which left some healthcare providers without wages for over nine months [34]. These strikes paralyzed the health sector, leaving patients to seek care from private hospitals or through traditional medicine.

Poor use of maternal health services in Nigeria is a key factor contributing to high levels of maternal morbidity and mortality, as only 51.1 percent of women received four or more antenatal care visits and only 36 percent of deliveries took place in a health facility in 2013 [30]. In addition to problems related to availability and access, perceived poor quality of care at facilities is a critical barrier [35-39], and poor health worker attitudes contribute to a woman’s choice of using a facility or traditional provider [37-39]. A study from northwestern Nigeria concluded that 23.7 percent of women who did not deliver in a health facility cited negative provider attitudes as the primary reason for not using delivery services, and 52.0 percent of women suggested that improvements in provider attitudes are necessary to increase demand for facility-based deliveries [35]. Another study in southern Nigeria showed that women viewed government facilities as providing poor quality maternity services and had poor availability of trained staff during childbirth [38].

**Methods**

**Study Sites**

This study was conducted in two districts of the North Central Zone (one peri-urban/rural and one urban), where approximately 45.7 percent of women delivered in a facility in 2013 [30]. In this zone, the median age at first marriage is 19.1 years (among women aged 20-49 years) and the total fertility rate is 5.3 [30]. Study sites were chosen in collaboration with the local principal
investigator using pre-specified inclusion criteria, including number of deliveries per month, number of staff currently employed, and an existing relationship between the research institution and the selected facilities. Table 4.1 presents the characteristics of the study facilities.

**Study participants, recruitment and sampling**

In order to understand acceptability of mistreatment during childbirth, three groups of participants were identified: (1) women; (2) healthcare providers; and (3) facility administrators. FGDs were conducted with women of reproductive age (15-49 years) who delivered in any facility in the past five years and resided in the selected facility catchment area, and IDIs were conducted with women of reproductive age (15-49 years) who have delivered in a facility in the past twelve months and resided in the selected facility catchment area. Both IDIs and FGDs were conducted with women in order to gain a detailed understanding of experiences of mistreatment during childbirth (IDIs) and to better understand social norms related to mistreatment (FGDs). IDIs were conducted with health care providers (e.g.: nurses/midwives and doctors/specialists) and facility administrators (e.g.: medical director, head of obstetrics, matron-in-charge) in each study facility. Only IDIs were conducted with providers and administrators, due to concerns that FGDs may breach the confidentiality of study participants through the disclosure of poor practices or “naming and blaming”.

An obstetrician and midwife from each selected facility who attended the study training workshop acted as an entry point to connect research assistants to healthcare providers. Community health workers helped to identify women who met the inclusion criteria and research assistants initiated face-to-face contact with women and providers who met the inclusion criteria. Each individual was invited to participate and provide consent.
Quota sampling was used to achieve a stratified purposive sample without random selection using specified parameters (setting, cadre, age, religion) to stratify the sample. Women were sampled from the urban and rural/peri-urban communities in the selected facility catchment area, and were recruited based on their age/parity in order to explore the experiences of both younger/primiparous and older/multiparous women. Although further stratification did not take place across ethnicity or religion in the FGDs due to logistical difficulties of recruiting and hosting a FGD with multiple layers of stratification, interviewers sampled women across a mix of different ethnicities and religions. Healthcare providers were sampled from the study facilities based on their cadre, and across a mix of older/more experienced and younger/less experienced. Facility administrators were sampled from the study facilities. Three eligible participants declined to participate: one administrator refused to give an audio-recorded interview, one woman did not have sufficient time to be interviewed, and one woman needed her husband’s permission but he was unavailable.

**Study instruments**

All instruments were semi-structured discussion guides, fostering comparability across IDIs/FGDs and allowing participants to guide the discussion based on their experiences (Appendices 5.1-5.3). Instruments were pilot tested during a training workshop for research assistants. The following domains of interest were explored:

1. Expectations of care during childbirth at health facilities;
2. Experiences and perceptions of mistreatment during childbirth;
3. Decision-making processes to deliver at a facility;
4. Views of acceptability of mistreatment during childbirth; 

5. Perceived factors influencing mistreatment of women during childbirth; 

6. Treatment of staff by colleagues and supervisors. 

Women, midwives and doctors were presented with four scenarios that could be classified as mistreatment during childbirth (based on paper 1) [1] including slapping, verbal abuse, neglect and physical restraint during labor. 

**Data collection and management**

Research assistants were female masters of public health graduates with training in qualitative research and maternal health. All research assistants were from Ibadan, Nigeria and underwent a two-day training and piloting workshop in Abuja prior to commencing data collection. Eligible individuals completed an oral or written consent form prior to participation. All FGDs and IDIs took place in a private setting with no non-participants present (e.g.: home for women or private room in the facility for providers), were audio recorded, lasted 60 to 90 minutes and were conducted by research assistants. Participants received 2000 Naira (approximately $10 USD) and a refreshment to compensate their transportation cost. Data were collected from March to June 2015, until thematic saturation was reached. Transcription, translation and recording of field notes occurred in parallel, and transcripts were shared and reviewed on an on-going basis to ensure data quality. IDIs and FGDs conducted in English were transcribed in English. IDIs and FGDs conducted in a local language (Pidgin English, Hausa, Igbo or Yoruba) were translated and transcribed simultaneously by the research assistants. This method was most effective as the local languages are not commonly in written form, thus complicating transcription directly into the local language. De-identified transcripts were stored on a password-protected computer.
Data analysis

This analysis employs a thematic analysis approach, as described by Braun & Clarke [40]. Thematic analysis is inherently a flexible method and is useful for identifying key themes, richly describing large bodies of qualitative data and highlighting similarities and differences in experiences [40].

After transcription, line-by-line coding was performed on a subsample of transcripts by two independent researchers to develop an initial thematic framework. These codes emerged naturally from the data and were initially structured as “free codes” with no established link between them. Free codes were synthesized with questions from the discussion guide and systematic review findings [1] into a coding scheme transferable to other transcripts. The coding synthesis yielded a hierarchical codebook to explore higher-level concepts and themes and organize the codes into meaningful code families. Reliability testing of the codebook was conducted in two stages: (1) two researchers jointly coded three transcripts, one from each type of participant; and (2) two researchers independently coded two transcripts and discussed coding decisions until consensus. After reliability testing, the final codebook was developed (Appendix 5.4), which includes the structure of code families, code names, definitions, and an example of proper use. All transcripts were subsequently coded using Atlas.ti [41]. Memos were used to collate emerging thoughts, highlight areas of importance and develop ideas throughout the analysis process. A subset of the coded transcripts was reviewed by an independent researcher to check reliability of the coding.

Transcripts were organized according to meaningful “primary document families” in Atlas.ti [41], a method of organizing groups of transcripts based on common attributes, and used to restrict code-based searches or to filter coding outputs [42]. Primary document families consisted of: (1) type of participant; (2) facility/catchment area; and (3) religion. Output and reports were
generated for specific codes using Atlas.ti [41] and filtered by primary document family where appropriate. Data from these reports and output were further synthesized into meaningful sub-themes, narrative text and illustrative quotations to draw connections between recurrent patterns and themes. These themes were interpreted within the context of the study and the typology of mistreatment during childbirth developed from the systematic review [1]. Data on social norms and acceptability of the presented scenarios of mistreatment were rich and provide an important frame to understand how and why mistreatment during childbirth persists in this context. Throughout this iterative analysis process, the research team considered questions of reflexivity, including identifying and reflecting on assumptions and preconceptions regarding what constitutes mistreatment, exploring emergent findings, and considering the research relationship.

**Results**

**Overview**

Eighty-five IDIs and 4 FGDs were conducted from March to June 2015. Table 4.2 reports sociodemographic characteristics of participants: women of reproductive age, and Table 4.3 reports sociodemographic characteristics of participants: healthcare providers and administrators. This analysis focuses on women’s, midwives’ and doctors’ perceptions of the acceptability of mistreatment during childbirth. Participants were presented with four scenarios of mistreatment during childbirth: (1) pinching or slapping a woman; (2) shouting at a woman; (3) refusing to help a woman; and (4) physically restraining a woman, then were asked whether the scenario was acceptable, under what conditions (if any) the scenario would be acceptable, and how they would feel if it happened to them or their partners.
In this study, all seventeen midwives were female, and of seventeen doctors, five were female and twelve were male. In general, midwives found more of the presented scenarios of mistreatment to be acceptable practices, compared to the doctors. This was particularly true for the scenarios of slapping, pinching and shouting at a woman in labor, where several midwives viewed such behavior as a necessary practice to have a safe outcome for the baby. Both female and male doctors admitted that they had witnessed slapping, pinching and shouting at a woman on their wards, but that these tactics were unethical and primarily used by midwives.

**Acceptability of a provider pinching or slapping a woman**

Both women and healthcare providers agreed that if a woman was slapped “out of malice” or with ill intent, it would never be acceptable. However, opinions were more nuanced if a woman was slapped “to ensure a positive health outcome” for the baby or to help the woman to focus on pushing. Conditions where some felt that slapping could be acceptable included “when it was necessary” as a “punishment” for not cooperating, to ensure a good outcome for the baby or when all other means of supporting the woman were exhausted. Slaps were acceptable to signal the woman to become more alert and give her the strength to push.

*By slapping their laps, the patient will know that truly you care for her. After the delivery, you will tell the woman the reason that I did it for you, even some women will tell you, I'm sorry, thank you.* [IDI female nurse, 39 years old, peri-urban facility]

Furthermore, timing mattered: slapping a woman during the first stage of labor was considered poor practice, but slapping a woman during the second stage of labor, when she is about to deliver, was considered acceptable.

*R: It depends on the motive, because most, because most of the motive, I told you, okay, is just to encourage her, we are not being wicked, alright, at the end of it, we all smile, she’s happy and we’ll forget about it, although we would just discuss it jokingly, yes
understand. Arhhh, I slap you, if to say I no slap you, you for no born this pikin, [if I did not slap you, you would have not given birth to your baby]...you understand...we are not being wicked, we are just trying to, it’s out of passion, no, please we want this thing to be successful, why is this woman delaying, we are not just being, we are not being wicked, it’s not in our nature.

I: Okay, so bringing it to a more personal level, how would you feel if this happened to maybe your sister and she told you, or your wife?

R: ...I will like to ask at what stage [of labor], because if you do that in the first stage, it will be weird, but at the point of, at the second stage, about to deliver, yes, it’s acceptable, why? Just to encourage, you understand...it depends on at what point during labor, was this act committed, you understand [IDI male doctor, 44 years old, urban facility]

Those who felt that slapping was not acceptable under any conditions felt that women suffered enough from the pain of labor and slapping only contributed to that pain. Slapping was “unethical”, served no purpose, and women should be treated with respect since they are the customers.

I: Is there any situation where this would it be acceptable?

P: It is completely wrong for a woman to be pinched or slapped or harassed while in labor, because we all know labor is a painful thing [IDI male doctor, 42 years old, urban facility].

I won't accept it, why would you slap a woman in labor or pinched her, why? You know...it should go with reason, if you are slapping me you should tell me why you are slapping me, okay? I've never been slapped, neither have I been pinched, you don't need slap to do that or pinch me to do it, no. You need to encourage them, give them what will encourage them. Most times they will tell you they're tired but you have to because it is equally your own success that you are helping somebody to bring in a child into the world...at the end of the day you're happy...but if a child dies in your hand you always sad, you don't want it, or if anything goes wrong with the mother; you don't like it, you don't want such things to happen but it's equally the health workers success, so why would you slap a woman in labor or pinch her [IDI woman, 44 years old, peri-urban].
Generally, women felt that it was acceptable to slap other women who were uncooperative, but it was unacceptable if it happened to them personally. They believed that they would feel “pained” both physically and emotionally if it happened to them.

There is some woman, some women when they are pushing, when they are pushing the head of the baby will come and they will closing their leg so you have to slap her very well. When you slap her, she will open the leg the baby will come out. [IDI woman, 30 years old, peri-urban].

Acceptability of a provider shouting at a woman

Similar to slapping, many women and healthcare providers felt that shouting at a woman out of malice or anger was unacceptable. However, some women and healthcare providers agreed that shouting was acceptable if women were disobedient or arrived without a “mama kit” (safe delivery supplies including a plastic sheet, gauze, gloves, soap, razor blades, and cotton). They described that shouting can be helpful if it communicates the gravity of the situation and ensures a positive outcome. Using a raised voice to communicate the providers’ commands was acceptable, provided that the woman was not insulted through name-calling or criticism. Most providers felt that shouting was a “spontaneous” or “impulsive” reaction to working in a stressful environment, but also that shouting is “a normal thing” and a woman needs to “carry her cross”.

I: So, what of if a woman was yelled at or shouted at by a health worker during her childbirth? Will this be acceptable?

R: Well, it could be partially acceptable...When the woman is not cooperative. You are given instruction, she is not even listening, she is just shouting. She is just screaming, rolling in pain, you understand ahaa... Then, you can actually yell out instruction because if you talk in your normal voice, she will not hear. You will be drowned in the scream. You understand. So, you can yell. The yelling could be a good aspect actually [IDI female doctor, 36 years old, urban facility]
Some women felt that if they were shouted at, then the healthcare provider was doing their job and served as a reminder that the woman should also do her job and cooperate.

Women felt that shouting was more appropriate than slapping; however, shouting can scare, disempower and disrespect the woman. Healthcare providers felt that shouting was not part of their professional ethics or etiquette and they should take the time to communicate with women more clearly. They also felt that when healthcare providers shout, it is a “failure of the system” because they are transferring their stress from a challenging work environment to the woman.

R: Is not acceptable, because it will affect, it will hamper, you know it will discourage the woman, the woman might not be able to respond to the, you know, instruction given to her. She will not be happy.

I: Okay, okay. Is there any situation where it will be acceptable for a health worker to shout on a woman or to yell at her during delivery?

R: There should not be, there shouldn't be. The health workers are supposed to be like pastors, you know, you know they are supposed to be very courteous, they are suppose be calm, they are supposed to be receptive, and you know very nice to their patients. Because that goes a long way in making them achieve a good result in whatever they are doing [IDI woman, 34 years old, urban].

Like me I will tell the madam, I will call her name, when you call her name she will listen to you. Madam see we know this thing is painful but try to endure, that is the way I do it. If you shout, you're confusing her more...No you don't yell. What you do is, like now if I call your name, you no matter how what how painful, you will relax so that when I talk to you, you will hear. So what you do is don't yell, you call the person like I can call you now, the person will listen to you. By the time you, even if they shout by the time you call the person; even by the time you call two three times, the person would relax then you say; look madam this way now,...just tell the patient to relax they will listen to you, the whole thing will be over. [IDI male doctor, 52 years old, peri-urban facility].

Many women felt unhappy at the prospect of being shouted at and desired a feedback mechanism to share their dissatisfaction.
Is okay to shout, if you shout at a person the person will understand, at least the doctor will tell the person or nurse will tell the person to, concentrate so that your baby will come out, not to beat the person. To shout is better than to beat [FGD woman, 30 years old, peri-urban].

Acceptability of a provider refusing to help a woman

Women believed that a healthcare provider refusing to help was an egregious shortcoming, but argued that it does happen in both study facilities and is an explanation for why some women deliver alone in the facility, without a healthcare provider present. Women felt that if this happened to them, they would not attend that facility again and would seek redress from the provider.

It is not acceptable at all, at all. You can be sued for it. You are there as a health worker, you must, is not optional. Is a must, you must support the woman in all the ways, in all ramifications. Whatever the woman needs at that point, at that moment, you must do it. You must be there to support her. Leaving a woman that is in labor to even eat is a crime, you understand? No matter how hungry you are, you must not leave a woman that is in labor, you must be there for her, you must. So it is not acceptable at all that you didn't support a woman that is in labor [IDI woman, 36 years old, peri-urban].

Most healthcare providers from both study facilities did not feel that other providers ever refused to help a woman. They felt that if a provider refused to help, then they should not be called a health worker, as it is their occupation and responsibility to assist. Healthcare providers pondered if women might feel that they were refused help if they were referred to another facility during a period of overcrowding and suggested that improved communication could help to allay this perception.

There is no situation that should arise that a health worker would refuse. Because he knows this is human being, you are dealing with lives not paper. If it is a paper, you can neglect the paper for years it will be there, you'll meet it there, but a life is not like that because any little mistake can lead to another problem, so you don't neglect any patient, we know our count. Have told you experience of where a patient slap a nurse in the
process of assisting her during delivery yet we still carry on the delivery we didn't neglect the patient; on no account should we neglect a patient [IDI female nurse, 39 years old, peri-urban facility].

Acceptability of physically restraining a woman

Most healthcare providers believed that the only conditions under which it was appropriate to physically hold a woman down was if she was having an eclamptic seizure or if she was being uncooperative. In either situation, the onus is on the healthcare provider to clearly explain to the woman why they are holding her down.

*It depends on what the person want, what they are experiencing. There...are some women because of pain, they want to jump out of the couch, and some jump out and (laughs) start land on the floor. But if they can restraint, the restraining a patient is acceptable. What we call control restraint of the patient is acceptable. That is when somebody want to jump down. Women that during labour, they'll be struggling that they may even fall down from there and injure themselves hit the, the abdomen on the floor and you know what the danger that can portray, can even result in death of the baby and even rupture of the uterus and the like. So there is there is some restraints acceptable. And while they are been restrained, you can now call the attention of co-workers to find out if this woman can continue this labour or not, if she cannot continue, we have to book her for caesarian section straight. That's the practice here. We have to restrain, call the doctor to come and assess, that this person is not cooperating, is is jumping from bed to bed, is better to take her straight and get the baby out [IDI male doctor, 54 years old, urban facility].

Furthermore, both a doctor and a woman agreed that if physically restraining a woman yielded a positive birth outcome, then it was an acceptable practice.

*There's nothing wrong there, there's nothing wrong if she's held down and at the end we get the result, a good outcome [IDI male doctor, 52 years old, peri-urban facility].

*If there is a situation, if is to save your life and that of the baby, why not? [IDI woman, 31 years old, urban].
Several women did not understand this question, but those who did interpreted it to mean restraining a woman who was being disobedient. Most of these women believed that physical restraint was unnecessary under any conditions, as it restricted the woman’s movement and freedom and demonstrated a lack of empathy from the healthcare providers. Rather than restraining a woman, a provider should communicate, encourage and support a woman to bear down.

*Okay hold her down; hold her down to press her down. I don’t think it’s right, you can tell me to go down, you can talk to me really but not holding you down, pinning you down as if you must, you must do what I say per time, I don’t see it as right, but at least you can talk to the person and say you are not doing this right, do this right, do it this way you are not behaving well, it’s not right but when you are trying to hold down it’s as if you are forcefully telling the person and of course you know we are different set of individuals some might react negatively to it* [IDI woman, 28 years old, urban].

*The health, the person [healthcare provider] don’t suppose to hold me down when I'm in labor. You allow me to push by myself. I mean she will be controlling me. Then she's not supposed to hold me down* [IDI woman, 26 years old, rural].

A minority of women believed that a healthcare provider would not do anything harmful to a woman, so physical restraint must have a positive effect.

**Discussion**

This study explored the acceptability of mistreatment during childbirth, according to women, midwives and doctors in the North Central zone of Nigeria. In this area, women and providers reported witnessing and experiencing mistreatment during childbirth, including physical abuse such as slapping and being tied to a delivery bed, and verbal abuse, such as shouting at, intimidating, and threatening women with physical abuse or poor health outcomes. Women,
midwives and doctors were presented with four scenarios that could be classified as mistreatment during childbirth [1] including slapping, verbal abuse, neglect and physical restraint during labor. Each of these scenarios were considered appropriate measures to gain compliance and ensure a good outcome for the baby by about one-quarter to one-half of the providers and women. Midwives were comparably more accepting of these mistreatment scenarios compared to doctors, although this relationship is not statistically significant given the qualitative nature of this data. Both female and male doctors acknowledged that mistreatment occurs on their wards, but that these tactics were usually used by midwives to gain compliance. This analysis, therefore, suggests that female midwives may be primarily responsible for perpetrating this mistreatment against other women. However, it is possible that in order to be viewed more favorably by the interviewers, doctors responded to these scenarios in a manner that transferred blame to a lower and more disempowered cadre of providers (social desirability bias).

It is of great concern that both women and healthcare providers commonly blamed a woman’s “disobedience” and “uncooperativeness” during labor and delivery for her experience of mistreatment. When a woman is in labor, she should be supported to make empowered decisions over her body; she should not be abused by her healthcare providers. Such situations parallel the IPV literature, which has demonstrated how structural gender inequality “is perpetuated by traditional and customary practices that accord women lower status in the family, workplace, community and society, and it is exacerbated by social pressures” [43]. Such social pressures include the shame and difficulty in denouncing abusive acts towards women, a lack of means to address causes and consequences of violence and a scarcity of laws prohibiting violence [43, 44]. Responses to questions regarding acceptability of IPV under certain conditions parallel the acceptability questions asked in this study: women continue to accept physical violence and disempowerment [30, 43]. For example, the 2013 Nigerian DHS reports that in the North Central Zone of Nigeria, 39.0 percent of women justified wife-beating for at least one reason [30]. This
included for burning the food (20.0 percent), arguing with her husband (26.3 percent), going out without telling her husband (31.8 percent), neglecting the children (31.3 percent) or refusing sexual intercourse with her husband (21.5 percent) [30].

The systematic devaluation of women is further perpetuated through hegemonic power relations on the maternity ward, leading to the normalization and acceptance of healthcare providers using abusive tactics to gain control and punish disobedience [22]. Although midwives are the backbone of maternity services in LMICs, they often work in disempowering environments where their contributions may not be adequately recognized, and they may be disrespected and unsupported by their supervisors [45]. Midwives are predominantly women and frequently work in their own communities, facing the same challenges that other women face: low social status, disrespect and gender inequality. Furthermore the health system, particularly in public facilities, can be a disabling environment plagued by chronic low salaries, physical resource constraints, and understaffing. Working in such conditions is clearly disempowering for healthcare providers, and there are limited avenues to alleviate stress and foster motivation. However, such disabling work environments can provide only a partial explanation for mistreating a woman during childbirth, not a justification for such abuse. In Nigeria and other low-resource settings, no redress mechanisms exist to voice complaints over such treatment, and women are often not allowed a labor companion who could act as the woman’s advocate and provide her with emotional support.

Challenges with defining mistreatment during childbirth

The way in which mistreatment during childbirth is defined has a substantial impact on how it is measured and on resulting prevalence estimates. There are two main viewpoints to consider when developing definitions of a phenomenon of interest in the social sciences: emic and etic approaches [46, 47]. In the case of mistreatment during childbirth, an emic approach would rely exclusively on a woman’s and/or a provider’s own definition of mistreatment (e.g.: behaviors
determined to be mistreatment by local custom, meaning and belief), whereas an etic approach would rely on an externally derived definition of mistreatment (e.g.: generalizations about human behavior universally considered as true) [47]. An emic approach may be helpful if researchers want to understand contextually-specific perceptions of violence, but may be less useful when planning interventions or conducting cross-cultural comparisons. For example, asking a woman “have you ever been mistreated during childbirth” is likely to underestimate the true occurrence of mistreatment as women may experience poor treatment but not identify this behavior as such, or because poor treatment is normative in their setting. On the other hand, an etic approach may be helpful if researchers want to make cross-cultural comparisons, but may be less useful in understanding what meaning specific acts have on a woman. For example, asking women whether they have experienced a series of specific acts of mistreatment (punching with a closed fist, slapping with an open hand) would provide a response comparable across settings. However, an etic approach would not help a researcher to understand whether these acts have the same meaning to different women or in different cultures (e.g.: calling a laboring woman an “animal” may be more degrading than a slap on the thighs in some cultures).

In this study, we used a combined approach. During the IDIs and FGDs, the research team first asked women to broadly describe their previous birth experience, then if they had experienced anything that made them feel unhappy or uncomfortable during their previous childbirth, and if so, who perpetrated the event, how often it occurred, why they thought it happened and how this made them feel. Similarly, midwives and doctors were asked if they had ever heard of or seen women being poorly treated during childbirth. Participants were therefore able to answer freely and to describe any behaviors or experiences that they considered to be mistreatment. After these broad questions, participants were asked more focused open-ended questions about social norms and acceptability of specific behaviors that were classified as mistreatment in a systematic review (paper one of this dissertation) [1]. This combined approach allowed us to analyze and describe
evidence that can be compared to other settings, as well as to understand participants’ perceptions of mistreatment in their context.

Limitations and future research

This study was conducted in two facilities and facility-catchment areas in the Abuja metropolitan area, and may not reflect the experiences of women and healthcare providers across Nigeria. Mistreatment and provision of poor quality care are difficult topics to discuss with providers; consequently providers may have underreported the acceptability of such experiences (social desirability bias). This may be particularly true where doctors believed that most mistreatment occurred at the hands of midwives rather than doctors. However, both women and providers in this study were accepting of scenarios that can be classified as mistreatment [1]. This study explored acceptability and norms of mistreatment during childbirth using a qualitative approach. As a result, relationships between accepting mistreatment according to gender or cadre of healthcare provider should be viewed as hypothesis-generating.

Future research could explore the acceptability of mistreatment through a quantitative survey of both women and providers, similar to the DHS module focused on attitudes towards wife beating. Such research, particularly if conducted anonymously and without a human interviewer (e.g.: using audio computer assisted self-interview (ACASI)), could help further explore normative behaviors and prevalence of perpetration. Furthermore, future research on measuring mistreatment during childbirth should follow lessons learned from research on violence against women, including asking about specific behaviors of mistreatment [46]. Conducting a mixed-methods study with a qualitative component may be helpful to elucidate women’s and providers’ perceptions of mistreatment in a culturally appropriate manner.
Conclusions

It is critical to engage key stakeholders, including women, healthcare providers and policymakers, to challenge disruptive social norms and behaviors related to mistreatment during childbirth. Freedman and Kruk have highlighted the importance of building local consensus between healthcare providers, policymakers, women and other key players in determining actions deemed to be “humiliating or undignified” during childbirth (17). Findings from this qualitative study can be used to help facilitate this dialogue in Nigeria by engaging key stakeholders to discuss what can be done to challenge these norms and hold providers accountable for their actions. Jewkes hypothesizes that the construct of the “nursing identity” emphasizes moral superiority and control over the “inferior patient” and lacks a commitment to ethics that precludes mistreating a woman [21]. Until women and their families are able to freely condemn poor quality care in health facilities and healthcare providers are held accountable for their actions, there will be little incentive to foster change. Understanding how and why exerting control over a woman in labor by slapping and shouting at her are acceptable actions requires deeper inquiry into normative attitudes and behaviors on the maternity ward.
Chapter Four References


35. Idris S, Sambo M, Ibrahim M. Barriers to utilisation of maternal health services in a semi-urban community in northern Nigeria: The clients' perspective. (0300-1652 (Print)).


Table 4.1. Facility characteristics
(Note: facility characteristics as reported by the head of each facility in personal communication, August 2014.)

<table>
<thead>
<tr>
<th></th>
<th>Peri-urban facility</th>
<th>Urban facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrician/gynecologist</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Medical officer</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Midwife</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td><strong>Capacity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td># beds on delivery ward</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td><strong>Health outcomes (2013)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total births (n)</td>
<td>3231</td>
<td>2417</td>
</tr>
<tr>
<td>Live births (n)</td>
<td>2961</td>
<td>2182</td>
</tr>
<tr>
<td>Stillbirths (n)</td>
<td>270</td>
<td>235</td>
</tr>
<tr>
<td>Maternal deaths (n)</td>
<td>94</td>
<td>73</td>
</tr>
<tr>
<td><strong>Cost of childbirth services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal delivery</td>
<td>$0 USD</td>
<td>$0 USD</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>$215 USD</td>
<td>$215 USD</td>
</tr>
</tbody>
</table>
Table 4.2. Sociodemographic characteristics of participants: women of reproductive age

<table>
<thead>
<tr>
<th></th>
<th>IDIs (n=42)</th>
<th>FGDs (n=4 FGDs*)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>25-29</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>30-34</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>35-39</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>40+</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Married</td>
<td>41</td>
<td>34</td>
</tr>
<tr>
<td>Divorced/Widowed</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Peri-urban</td>
<td>21</td>
<td>34</td>
</tr>
<tr>
<td>Rural</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td>Muslim</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoruba</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Igbo</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Hausa</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Idoma</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Igala</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Tiv</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Other**/missing</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Secondary</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Tertiary</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Diploma</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business/private sector</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Civil servant</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Hairdresser</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Housewife</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Tailor</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Teacher</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Trader</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td><strong>Number of living children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>2-3</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>4-5</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>6+</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*Three FGDs conducted with 8 women, one FGD conducted with 10 women
**“Other” includes Akwa-ibom, Angas, Ebira, Igede, Katarf, Ogori, Zuru, Akoko Edo, Bekwarra, Edo, Isoko, Ogoja
Table 4.3. Sociodemographic characteristics of participants: healthcare providers and administrators

<table>
<thead>
<tr>
<th></th>
<th>Nurse/midwives n=17</th>
<th>Doctors n=17</th>
<th>Administrators n=9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>40-49</td>
<td>5</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>50+</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Married</td>
<td>15</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td><strong>Years of experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>5-9</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>10-15</td>
<td>4</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>15+</td>
<td>11</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban facility</td>
<td>8</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Peri-urban facility</td>
<td>9</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>
Chapter five:
Conclusions
Millennium Development Goal target 5A aimed to reduce the maternal mortality ratio (MMR) by three quarters between 1990 and 2015. While efforts to reduce maternal mortality in developing regions has led to a decrease from 370 to 239 maternal deaths per 100,000 live births, this falls far short of the MDG target [1]. Moving forward, Sustainable Development Goal (SDG) target 3.1 calls for a reduction of the global MMR to 70 maternal deaths per 100,000 live births by 2030 [2], down from 216 in 2015 [1]. A critical component to reduce maternal mortality is to ensure that women deliver with a skilled birth attendant, who has the necessary skills and supplies to administer life-saving treatment. Global improvements to increase women’s access to health facilities for childbirth have led to an increase in the proportion of deliveries attended by skilled birth attendants (SBA) in developing regions, from 57 percent in 2000 to 68 percent in 2012 [3]. Both supply and demand factors must be addressed in order to improve SBA outcomes: the number of facilities and providers should be adequate to attend to all women, but women must also seek these services, and often face substantial sociocultural, economic, geographical and infrastructural obstacles during their journeys. Once at a facility, women will consider the quality of care they receive and weigh this against the obstacles faced to receive care.

This dissertation focuses on women and providers describing a typology for measuring mistreatment of women during facility-based childbirth, as well as women’s and providers’ experiences with and attitudes towards mistreatment during facility-based childbirth in Abuja, Nigeria. This study adds to the literature through the proposed evidence-based typology of mistreatment, developed through the mixed-methods systematic review, which can be used in the development and application of measurement tools and interventions to reduce mistreatment. Furthermore, there is a scarcity of research conducted on the mistreatment of women during childbirth in Nigeria, which accounts for fifteen percent of the global burden of maternal deaths [3]. The qualitative study in this dissertation was conducted in Nigeria’s North Central Zone, where over 54 percent of women still deliver without skilled birth attendants [4]. The study aimed
to better understand women’s and healthcare providers’ experiences, perceptions and acceptability of the mistreatment of women during childbirth. Better understanding and documentation of how and why mistreatment occurs in is an important first step to prevent mistreatment from occurring.

This concluding chapter contains an overview of the three papers included in this dissertation, limitations and strengths of the study methods and data, public health implications and future areas of research, and overall conclusions of the study.

**Overview of Manuscript 1**

Previous studies have cursorily explored how women are mistreated during childbirth and attempted measurement of this phenomenon. The first manuscript is a mixed-methods systematic review synthesized data from 65 studies conducted across 34 countries: eleven countries in sub-Saharan Africa, five in Asia, two in Oceania, four in Europe, five in the Middle East and North Africa, two in North America, and five in Latin America. Synthesizing qualitative and quantitative evidence led to the development of a typology of the mistreatment of women during childbirth. Types of mistreatment were grouped into seven thematic categories: (1) physical abuse; (2) sexual abuse; (3) verbal abuse; (4) stigma and discrimination; (5) failure to meet professional standards of care; (6) poor rapport between women and providers; and (7) health systems conditions and constraints. The findings illustrate that women across all geographical regions and country-income levels are mistreated during childbirth, although the types of mistreatment they experience may vary.

The findings also illustrate that women can experience health system factors directly as mistreatment. For example, when women deliver on a crowded labor ward with no partitions
between beds, they may feel that their privacy was violated. Likewise, staffing constraints at both the facility- and country-level may mean that healthcare providers are unable to provide one-to-one care for women, which may be experienced directly by women as neglect or abandonment. Health system constraints also have indirect effects on the mistreatment of women, as staffing shortages and poor infrastructure can foster disabling work environments that may predispose healthcare providers to treating women poorly. However, health systems factors must be viewed as explanations for negative experiences, not as justification for mistreatment.

We were unable to differentiate between different levels of health facilities, as most primary studies did not specify the type of facility in the analysis. Different levels of health facilities have different environments that may facilitate or prevent the mistreatment of women during childbirth. Furthermore, we did not include studies that explored mistreatment during home birth experiences, as we viewed these as conceptually different from facility-based birth experiences. The scope of this review was to synthesize research evidence (both published and from gray literature). Given the interdisciplinary scope of this topic across medicine, public health, law, and human rights domains, it is possible that relevant human rights reports or legal documentation did not meet the inclusion criteria of this review. Moreover, given the large scope of this phenomenon, it is possible that we have missed some articles that may have been relevant. Although no language filters were used in the search, it is possible that the searches did not yield articles published in non-Latin alphabets, and four studies were excluded because they were not published in English, French, Spanish, or Portuguese. However, it is unlikely that the exclusion of these studies impacted the model generated by this review or limits its global applicability.

The typology depicts how mistreatment during childbirth relates to quality of care (Figure 1.2). When women are mistreated, it is often a result of poor experiences of care, particularly related to inadequate communication from providers, disrespect and a loss of dignity, and a lack of emotional support during labor. Such experiences are influenced by the structure of the health
system, such as disorganized service delivery, insufficient health workforce and a lack of leadership and governance. Moving forward, the typology of mistreatment during childbirth can be used to inform the development of measurement tools and interventions to prevent this mistreatment from occurring. The typology can also be used to inform the development of a definition of mistreatment during childbirth, as it is based on a synthesis of the perspectives and experiences of women and healthcare providers across 34 countries. Any definition will need to adequately consider the gender-roots of violence against women, include both physical and psychological harms, and reflect the need for cross-cultural applicability (particularly for developing operational definitions for research, monitoring and evaluation).

Overview of Manuscripts Two and Three

The first of the two qualitative analyses in this dissertation focuses on experiences and perceptions of mistreatment during childbirth by women, midwives, doctors and administrators in the North Central zone of Nigeria. Women and providers reported experiencing or witnessing physical abuse such as slapping, being tied to a delivery bed, and detention in the hospital and verbal abuse, such as shouting at, intimidating, and threatening women with physical abuse. When women were mistreated, they felt vulnerable and disempowered, and had reduced agency to communicate with the healthcare provider. Furthermore, experiences of mistreatment sometimes led women to avoid attending the facility that she delivered in for future deliveries.

Perceived factors contributing to mistreatment during childbirth, from the perspectives of women and providers, were categorized under three domains: (1) health system, facility and physical resource constraints; (2) health worker attitudes, behaviors and practices; and (3) women’s behavior and characteristics. Administrators, doctors and midwives described their physical workplace as a constrained environment that contributed to workplace stress and resulted in
aggression toward women. They emphasized that they and their colleagues were doing the “best they could” given the constraints, but were not provided with resources to cope with workplace stress. Women acknowledged constraints in the facility environment, but suggested such constraints were an explanation for stressful working conditions rather than a justification for mistreating a woman. In many cases, women felt that it was in the nature of the healthcare providers to treat women poorly, whereas providers felt that women were too quick to lash out when one thing went wrong. Women and providers agreed that a woman’s actions, such as not cooperating or arriving for delivery without a mama kit, contributed to mistreatment, and that mistreatment could be justifiable when a woman was disobedient. In this setting, lack of accountability for providers perpetrating this mistreatment or redress mechanisms for women to report their experiences allow these issues to continue without fear of repercussion.

The second of two qualitative analyses in this dissertation focuses on the acceptability of the mistreatment of women during childbirth in health facilities. In this study, participants were presented with four scenarios of mistreatment during childbirth: (1) pinching or slapping a woman; (2) shouting at a woman; (3) refusing to help a woman; and (4) physically restraining a woman, then were asked whether the scenario was acceptable, under what conditions (if any) the scenario would be acceptable, and how they would feel if it happened to them or their partners. These acceptability scenarios were drawn from the domains developed in the first paper of this dissertation.

Results show that both women and healthcare providers agreed that slapping a woman “out of malice” would never be acceptable. However, responses were more nuanced if a woman was slapped based on the perception that this behavior would “ensure a positive health outcome” for the baby or was used to gain compliance from an uncooperative woman. According to providers, shouting was similarly used to communicate anger and frustration to a disobedient woman, and often resulted from transference of stress from a challenging work environment. In contrast,
women felt that shouting made women feel disempowered, scared and disrespected. Both women and providers agreed that refusing to help a woman in labor was unacceptable, but hypothesized that a woman might feel this way if she was referred without proper communication or misunderstood the triage system. Most providers believed that physical restraint was only necessary if a woman had an eclamptic seizure, and that the provider should communicate to the woman why she is being restrained. Women felt that physical restraint was unacceptable, as it restricted a woman’s freedom and demonstrated lack of empathy from providers.

Midwives were comparably more accepting of these mistreatment scenarios compared to doctors. Both female and male doctors acknowledged that mistreatment occurs on their wards, but explained that these tactics were usually used by midwives, to gain compliance. Both women and healthcare providers commonly blamed a woman’s “disobedience” and “uncooperativeness” during labor for her experience of and justification for mistreatment. Such situations parallel the intimate partner violence (IPV) literature, which has demonstrated how structural gender inequality is perpetuated by the social norms that place women at a lower status in the family, workplace and community. Furthermore, patient-centered approaches to care are increasingly recognized as critical components to the provision of high quality of care, and include acknowledgement of the biopsychosocial perspective, patient-as-person, shared power and responsibility, a therapeutic alliance, and doctor-as-person [5]. The relationship between a patient and a provider should be considered the “keystone of care”, in which information is shared, plans are collaboratively developed, compliance is achieved and support is provided [6]. However, in LMICs, the patient-provider relationship often follows a unidirectional model, where the patient is a passive recipient of care. Hegemonic power relations on maternity wards have normalized the acceptance of providers using abusive tactics to gain control over women and punish disobedience. Women are disempowered as a result of poor patient-provider relationships, compounded by existing gender inequalities and low statuses in society. Moving forward, it is
critical to engage key stakeholders, including women, healthcare providers and policy-makers, to challenge these disruptive social norms and behaviors.

**Public health and research implications**

Findings from the qualitative study should be communicated to key stakeholders including providers and administrators at the study facilities. Such efforts should also demonstrate how physical resource and staffing constraints in the healthcare system can have profound impacts on a woman’s birth experience.

*The importance of measurement*

The field of violence against women has greatly benefitted from well-conducted research, which has been used to inform the development of preventative interventions and policy, as well as legal system reforms. An important finding from early studies on violence against women is that poorly constructed survey questions implemented by poorly trained research teams can lead to underestimations of the prevalence of violence [7, 8]. Researchers, healthcare providers, policy-makers, and donors working to prevent mistreatment during childbirth should consider the parallels between violence against women and mistreatment during childbirth, and learn from the important experiences of conducting research on violence. Likewise, advances made in measuring patient-centeredness [5] through clinical observation [9] and patient-self report [10, 11] will be useful resources.

The systematic review in this dissertation concluded that only three studies directly measured “disrespect and abuse” [12-14], but all three studies used different operational definitions of the Bowser and Hill framework [15] and different measurement methods. Measurement tools from these studies were reviewed and multiple issues with the construct of questions were identified,
including double-barreled questions and loaded terminology with unclear explanations of the outcome of interest.

A critical next step is the development of evidence-informed, validated measurement tools to quantify the burden of mistreatment during childbirth in a systematic way that is comparable across multiple contexts [16]. The systematic review and two qualitative papers on the mistreatment of women during childbirth are part of a larger, two-phased study to develop such measurement tools. The second phase is a tool development and validation phase, and will be informed by the findings from the formative phase. As such, the typology resulting from the systematic review will be used as the backbone to develop two measurement tools-- a labor observation tool and a follow-up survey tool. In accordance with best practices for research on violence against women [8], these tools are designed to avoid the use of “loaded” terminology (e.g.: rape, violence), and instead ask participants about whether or not they have experienced specific acts of mistreatment (e.g.: slapped with an open hand). These two tools will be applied, tested and refined in a development sample in Nigeria, then validated in Ghana, Guinea and Myanmar. By the conclusion of this study, two validated tools will be available for key stakeholders to apply in their settings in order to identify where, when and how mistreatment during childbirth occurs. Tools to measure mistreatment during childbirth provide the evidence base to measure progress towards several SDG targets, including target 5.1 to “end all forms of discrimination against all women and girls everywhere”, target 5.2 to “eliminate all forms of violence against all women and girls,” and target 5.3 to “eliminate all harmful practices” [2].

**Designing interventions to prevent mistreatment and promote respectful care**

In addition to measuring prevalence, validated measurement tools can also be used to measure the impact of an intervention on preventing mistreatment. Given the complex nature of the issue, a package of interventions that addresses root causes and systemic factors is likely needed and must consider interventions that function at both improving the structure and process of care. The
systematic review in this dissertation found limited data on interventions to reduce mistreatment; however, work done in similar areas may be a useful starting place. For example, a Cochrane review by Ivers and colleagues demonstrated that consistent and targeted audit and feedback have a statistically significant effect on improving healthcare providers’ compliance with a desired practice [17]. Similarly, providing an avenue to receive feedback from users on their birth experiences is likely an important component. As a proof of concept, Merck for Mothers has recently tested an interactive voice response (IVR) technology to receive feedback from women on their birth experiences in hospitals in Jharkand, India. The pilot study found that women across socioeconomic levels were eager to use such services and able to provide feedback on quality of care during childbirth [18]. Similarly, the Fundacja Rodzić po Ludzku (Childbirth with Dignity Foundation) of Poland created a national campaign for women to share their childbirth stories and provide feedback on the quality of care at specific hospitals, which resulted in changes to the health system including the allowance of labor companionship and reduced separation of the woman and her newborn [19]. In 2011, the Polish Ministry of Health issued the first national intrapartum and postpartum care guidelines that highlighted the Foundation’s work on promoting respectful care and reducing mistreatment during childbirth [19]. Such efforts to improve quality and accessibility of maternity care align with SDG target 3.7 to “ensure universal access to sexual and reproductive health care services” and SDG target 3.8 to achieve “access to quality essential healthcare services” [2].

In many low- and middle-income countries (LMICs), including the two facilities in the qualitative study of this dissertation, women are denied labor companionship. However, a review by Hodnett and colleagues concluded that women who received continuous one-to-one support (either by a skilled healthcare provider, doula/birth educator, member of the woman’s social network, or a stranger with no special training in labor support) were significantly less likely to have dissatisfaction and negatives views about the birth experience, intrapartum analgesia,
instrumental vaginal birth, regional analgesia or a baby with a low five-minute Apgar score, and more likely to have spontaneous vaginal birth [20]. It is possible that the benefits of labor companionship could also extend to reduce experiences of mistreatment. However, key knowledge gaps exist, particularly regarding how to implement labor companionship in LMICs. A qualitative evidence synthesis would be useful to identify barriers and facilitators to the successful implementation of labor companionship and to better understand how and why companionship leads to improved outcomes.

The systematic review and qualitative study in this dissertation found that overcrowded and understaffed maternity wards fostered a high-stress work environment. Promotion of interventions to promote mindfulness and other stress-coping mechanisms may be useful management tools [21]. Finally, Witter and colleagues conclude that “pay for performance” approaches may be useful to motivate healthcare providers to deliver higher quality services [22]. Interventions designed to improve the performance of healthcare providers align with the SDG target 3c, which calls for a substantial “increase in health financing and the recruitment, development, training and retention of the health workforce” in LMICs [2].

While these approaches may address critical health systems constraints that contribute to stressful and disabling work conditions, it is also important to develop accountability mechanisms to reprimand those who are guilty of intentional or deliberate abuse. Regardless of the components of the intervention, it is clear that any approach should be broad and incorporate the perspectives of women, healthcare providers and administrators of all cadres.
Conclusion

Mistreatment of women during childbirth occurs on many labor wards across the world, and has serious public health and human rights implications. The absence of an operational definition for what constitutes mistreatment, understanding of how and why such mistreatment occurs and validated measurement tools have been key barriers. This dissertation provides three contributions to this field. First, the mixed-methods systematic review provides evidence-informed typology of the mistreatment of women during childbirth, based on data from 65 studies conducted in 34 countries. Second, the qualitative study provides a contextual analysis of experiences and perceptions of mistreatment from the perspectives of women, midwives and doctors in Abuja, Nigeria. Third, the qualitative study unpacks the complex social norms and acceptability of mistreatment during childbirth in Nigeria and demonstrates the parallels between mistreatment and violence against women. These results can be used to develop and validate measurement tools to quantify the burden of mistreatment, and to inform future research and interventions to prevent mistreatment and promote respectful maternity care.
Chapter Five References


Appendices
Appendix 5.1: In–depth interview guide for women of reproductive age who delivered at a facility in the past 12 months

Step 1: Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain oral/written consent.

Step 2: Ask the participant to identify herself. Interviewer: fill out the information below prior to beginning the interview.

Step 3: Conduct the interview. Please remember to audio record the interview.

Participant information

Participant age (write in): ____________________________

Location (urban/rural): ________________________________

Religion (write in): _________________________________

Total number of living children (write in): __________________

Total number of deliveries (write in): __________________

Number of deliveries in a facility (write in): _____________

Number of deliveries outside the health facility (write in): _____________

Name of health facility delivered at (write in): __________________

Cadre and position (write in): _________________________

Marital status (Single, married/cohabitating, divorced, widowed): ____________

Interview date: ________________________________

Start time: ________________________________

End time: ________________________________

Interviewer: ________________________________
Interview discussion guide

A. Childbirth narrative

1. Please tell me about your most recent childbirth. I would like to know the most memorable parts – both good and bad. [Interviewer: allow the woman to describe the childbirth in her own words. Please probe using the prompts below]

   a. Who was involved in making this decision about where you would go to give birth?
      i. How were they involved?

   b. Were you planning to deliver in a health facility? Why or why not?
      i. What about the health facility where you delivered? Why did you go there? [Probe: were you referred to/from another health facility or elsewhere?]

   c. Did you deliver vaginally or by caesarean section?
      i. Did you want this mode of childbirth, or did you prefer something else? Why or why not?

   d. Was your baby healthy when it was born? Or were there complications? Please describe.

   e. Approximately how long were you in labor in the hospital before you delivered?

   f. Approximately how long did you stay in the hospital after you delivered?

   g. Did you feel like you had control over decisions around the childbirth? For example, the position that you delivered in? [Probe: lying on your back, kneeling, squatting or other?]
      i. Did the midwife offer for you to deliver in a different position? Please explain.
2. Now I would like to talk to you about the hospital that you delivered in. From the time you arrived until you had to start pushing, what do you remember about your surroundings? Who was there? (Interviewer: use the probes below).
   a. Where were you?
   b. What was the room like?
   c. What did you do while you were in this room (probe: move/walk around, take fluids)?
   d. Who else was there?
   e. While you were in labor [during contractions but before pushing], was someone with you besides a health worker? For example, a family member, friend or husband?
      i. Probe: what was this person’s role during this time?
   f. How did you feel while you were there?
   g. Would you deliver in the same hospital again? Why or why not?
   h. Would you recommend that a friend deliver in this hospital? Why or why not?
   i. Overall, how did you feel about your childbirth in that facility?

3. From the time that you started pushing until the baby came out, what do you remember about your surroundings? Who was there? (Interviewer: use the probes below).
   a. Where were you?
   b. What was the room like?
   c. What did you do while you were in this room (probe: move/walk around, take fluids)
   d. Who else was there?
   e. While you were delivering your baby [while you were pushing until when the baby came out], was someone with you besides a health worker? For example, a family member, friend or husband?
      i. Probe: what was this person’s role during this time?
   f. If there was not someone with you during labor or childbirth, would you have wanted someone to be there with you?
      i. Probe: what would this person’s role be?
   g. How did you feel while you were there?
B. Perceptions and experiences of care provided at the most recent facility-based childbirth, focusing on treatment by health workers and the facility environment.

4. Now I would like to talk to you about your perceptions and experiences of care during childbirth. In your opinion, how were you treated by the health workers during your most recent labor and childbirth? Please explain.
   a. How did this treatment that you have described make you feel?
   b. Did the type of care that you received meet your expectations? Please explain.
   c. Could you describe for me what supportive care during childbirth means to you?
   d. Did you feel supported by the staff during your childbirth? Please explain.
      i. If respondent says no, probe: what could be done to improve this in the future?
      ii. If respondent says yes, probe: what was the most memorable part of the way that you were cared for?
   e. In your opinion, what would you need from your MIDWIFE, NURSE OR DOCTOR in a health facility in order to feel supported during childbirth?

C. Elements and experiences of mistreatment of women during childbirth

5. Did you experience anything during your childbirth that made you feel unhappy or uncomfortable?
   a. Could you explain the situation?
   b. Who was involved in the situation?
   c. How were you [friend/family] mistreated?
   d. When did it happen? [Probe: time of day, during labor, during childbirth or postpartum].
   e. How often did it happen? [Probe: just once or more often].
   f. Why do you think this happened to you?
   g. How did this make you feel?
   h. In your opinion, how common is the situation that you described? [Probe: do situations like this happen often?]

Interviewer: After the woman explains the scenario, ask her if there were any other times or ways that she was mistreated. If she describes another scenario, follow-up with questions 5a-5g.
D. Perceived factors that influence how women are treated during childbirth

6. You mentioned these types of mistreatment: (Interviewer: restate what type of mistreatment the woman experienced. For example, you mentioned that you were hit or yelled at by the midwife). In your opinion, what factors influenced how you were mistreated? Please explain.
   a. Probe: Related to supplies (availability of medication, equipment)
   b. Probe: Related to health workers (number of staff, attitude towards patients)
   c. Probe: Related to patient load (number of patients, overcrowding)

7. In your opinion, what could be done so that women are treated better during labor and childbirth?

E. Acceptability of how women are treated during childbirth

8. Now I would like to ask your opinion on how you feel about the way that women are treated during childbirth. If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable?
   a. When would it be acceptable?
   b. How would you feel if this happened to you?

9. If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable?
   a. When would it be acceptable?
   b. How would you feel if this happened to you?

10. If a health worker was mean and refused to help a woman during her delivery, would this be acceptable?
    a. When would it be acceptable?
    b. How would you feel if this happened to you?

11. If a health worker physically held a woman down during her childbirth, would this be acceptable?
    a. When would it be acceptable?
    b. How would you feel if this happened to you?

F. Wrapping up

12. Is there anything else that you would like to tell me about your childbirth?

13. Thank the participant for their time. Remind them that the information they shared will be kept confidential.
Appendix 5.2: Focus group discussion guide for women of reproductive age who have delivered in a facility in the past 5

Step 1: Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain oral/written consent.
Step 2: Ask the participants to identify themselves. Interviewer: fill out the information below FOR EACH WOMAN prior to beginning the discussion.
Step 3: Conduct the discussion. Please remember to audio record the discussion.

Participant information

Participant age (write in): ________________________________

Location (urban/rural): ________________________________

Religion (write in): ________________________________

Total number of living children (write in): ________________________________

Total number of deliveries (write in): ________________________________

Number of deliveries in a facility (write in): ________________________________

Number of deliveries outside the health facility (write in): ________________________________

Name of health facility delivered at (write in): ________________________________

Cadre and position (write in): ________________________________

Marital status (Single, married/cohabitating, divorced, widowed): ________________________________

Discussion date: ________________________________

Start time: ________________________________

End time: ________________________________

Interviewer: ________________________________
Focus group discussion guide

A. Childbirth narrative
14. Please take a moment to think about how women give birth in your community. Could you tell me about how women give birth in your community?
a. Why do women give birth in health facilities?

b. Why do women give birth at home?

c. Who is involved in making this decision about where to give birth?
i. How are they involved?

d. Do you feel that women in your community have control over decisions that are made during their childbirth? Please explain. For example, the position that they deliver in? [Probe: lying on your back, kneeling, squatting or other?]
i. Do midwives offer for women to deliver in different positions? Please explain.

15. Now I would like to talk to you about the hospitals that you delivered in. From the time you arrived until you had to start pushing, what do you remember about your surroundings? Who was there? (Interviewer: use probes below):
a. Where were you?

b. What was the room like?

c. What did you do while you were in this room [probe: move/walk around, take fluids]?

d. Who else was there?

e. While you were in labor [during contractions but before pushing], was someone with you besides a health worker? For example, a family member, friend or husband?
   i. Probe: what was this person’s role during this time?

f. Would you recommend that a friend deliver in this hospital? Why or why not?

g. Is there anything that you would change about this place? Please explain.
16. From the time that you started pushing until the baby came out, what do you remember about your surroundings? Who was there? (Interviewer: use the probes below).
   a. Where were you?
   b. What was the room like?
   c. What did you do while you were in this room (probe: move/walk around, take fluids)
   d. Who else was there?
   e. While you were delivering your baby [while you were pushing until when the baby came out], was someone with you besides a health worker? For example, a family member, friend or husband?
      i. Probe: what was this person’s role during this time?
   f. If there was not someone with you during labor or childbirth, would you have wanted someone to be there with you?
      i. Probe: what would this person’s role be?
   g. How did you feel while you were there?

B. Perceptions and experiences of care provided at the most recent facility-based childbirth, focusing on treatment by health workers and the facility environment.

17. Now I would like to talk to you about your perceptions and experiences of care during childbirth. In your opinion, how are women in general treated by health workers in the hospital when they come for childbirth?
   a. How does this type of treatment that you have described make women feel?
   b. Could you describe for me what supportive care during childbirth means to you?
   c. In your opinion, what would you need from your MIDWIFE, NURSE or DOCTOR in a health facility in order to feel supported during childbirth?
C. Elements and experiences of mistreatment of women during childbirth

18. Do women in your community experience anything during childbirth in health facilities that makes them feel unhappy or upset?

   a. Could you explain the situation?
   b. Who is involved in the situation?
   c. How were the women mistreated?
   d. When did it happen? [Probe: time of day, during labor, during childbirth or postpartum].
   e. How often did it happen? [Probe: just once or more often].
   f. Why do you think this happened?
   g. In your opinion, how common is the situation that you described? [Probe: do situations like this happen often?]

Interviewer: After the woman explains the scenario, ask her if there were any other times or ways that she was mistreated. If she describes another scenario, follow-up with questions 5a-5g.

D. Perceived factors that influence how women are treated during childbirth

19. You mentioned these types of mistreatment: (Interviewer: restate what type of mistreatment the woman experienced. For example, you mentioned that you were hit or yelled at by the midwife). In your opinion, what factors influenced how you were mistreated? Please explain.
   a. Related to supplies (availability of medication, equipment)
   b. Related to health workers (number of staff, attitude towards patients)
   c. Related to patient load (number of patients, overcrowding)

20. In your opinion, what could be done to address these factors so that women are treated better during labor and childbirth?
E. Acceptability of how women are treated during childbirth

21. Now I would like to ask your opinion on how you feel about the way that women are treated during childbirth. If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable?
   a. When would it be acceptable?
   b. How would you feel if this happened to you?

22. If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable?
   a. When would it be acceptable?
   b. How would you feel if this happened to you?

23. If a health worker was mean and refused to help a woman during her delivery, would this be acceptable?
   a. When would it be acceptable?
   b. How would you feel if this happened to you?

24. If a health worker physically held a woman down during her childbirth, would this be acceptable?
   a. When would it be acceptable?
   b. How would you feel if this happened to you?

F. Wrapping up

25. Is there anything else that you would like to tell me about childbirth in your community?

26. Thank the participants for their time. Remind them that the information they shared will be kept confidential.
Appendix 5.3: In-depth interview guide for healthcare providers

**Step 1:** Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain oral/written consent.

**Step 2:** Ask the participant to identify herself. Interviewer: fill out the information below prior to beginning the interview.

**Step 3:** Conduct the interview. Please remember to audio record the interview.

**Participant information**

Participant age (write in): ____________________________

Location (urban/rural): ________________________________

Religion (write in): ________________________________

Total number of living children (write in): ________________

Total number of deliveries (write in): __________________

Number of deliveries in a facility (write in): ______________

Number of deliveries outside the health facility (write in): ___________

Name of health facility employed at (write in): ________________

Cadre and position (write in): ____________________________

Marital status (Single, married/cohabitating, divorced, widowed): ___________

Interview date: __________________

Start time: __________________

End time: __________________

Interviewer: __________________
Interview discussion guide

A. Introductions
1. Could you please introduce yourself and tell me a little bit about yourself, including about your current work position, how many years you have been in this position, and what your training was in?

2. In your opinion, why do women seek care at hospitals during childbirth?

3. In your opinion, how is the decision made for women to seek care at hospitals during childbirth? Who is involved in this decision-making?

B. Childbirth narrative
4. Now I would like for you to describe for me what it is like for a woman to deliver in your hospital, from when she first enters the hospital until she is discharged. Could you tell me about the place where women are when they are in the latent/first stage of labor?
   a. Where do they stay?
   b. What does this place look like?
   c. What do women do while they are in this room (probe: move/walk around, take fluids)?
   d. Who else is in this room?
   e. Do women have anyone there with them besides health workers? For example, family members, friends or a husband?
      i. What is this person’s role at this time?
      ii. If not, do you think that women want a non-medical person to be with them during this time?
   f. In your opinion, what is the most important thing to happen during this time?
   g. As a health worker, what is your role during this time?
   h. As a health worker, how do you feel during this time?
5. Could you tell me about the place where women are when they are in the active stage of labor?
   a. Where do they stay?
   b. What does this place look like?
   c. What do women do while they are in this room (probe: move/walk around, take fluids)?
   d. Who else is in this room?
   e. Do women have anyone there with them besides health workers? For example, family members, friends or a husband?
      i. What is this person’s role at this time?
      ii. If not, do you think that women want a non-medical person to be with them during this time?
   f. As a health worker, what is your role during this time?
   g. As a health worker, how do you feel during this time?
   h. In your hospital, what position do women deliver in? [Probe: lying on your back, kneeling, squatting or other?]
      i. Are women allowed to deliver in a different position? Please explain.
C. Perceptions and experiences of care provided at the most recent facility-based childbirth, focusing on treatment by health workers and the facility environment.

6. Now I would like to talk to you about your perceptions and experiences of care during childbirth. In your opinion, how are women treated by health workers in general during childbirth? Please explain.
   a. Does the type of care that you have described meet your expectations? Please explain.
   
   b. In your opinion, what is supportive care during childbirth? Please explain.
      ii. Do you think this kind of supportive care that you have described is provided to women during childbirth?
   
   c. In your opinion, what would you need from a WOMAN AND HER FAMILY in order to provide this type of supportive care?
   
   d. In your opinion, what would you need from your COLLEAGUES in order to provide this type of supportive care?
   
   e. In your opinion, what would you need from your SUPERVISOR in order to provide this type of supportive care?
   
   f. In your opinion, what would you need from your HOSPITAL in order to provide this type of supportive care?

D. Elements and experiences of mistreatment of women during childbirth

7. Sometimes women are mistreated or poorly treated during childbirth. Have you ever seen or heard of this type of mistreatment happening in your work?
   a. Could you explain the situation?
   
   b. Who was involved in the situation?
   
   c. How was the woman mistreated?
   
   d. When did it happen? [Probe: time of day, during labor, during childbirth or postpartum].
   
   e. How often did it happen? [Probe: just once or more often].
   
   f. Why do you think this happened?
   
   g. In your opinion, how common is the situation that you described? [Probe: do situations like this happen often?]

*Interviewer: after the health worker explains the scenario, ask if there were any other times or ways that mistreated happens. If they describe another scenario, follow-up with questions 10a-10g.*
E. Perceived factors that influence how women are treated during childbirth

8. You mentioned these types of mistreatment: (Interviewer: restate what type of mistreatment the woman experienced. For example, you mentioned that you were hit or yelled at by the midwife). In your opinion, what factors influenced how you were mistreated? Please explain.
   a. Related to supplies (availability of medication, equipment)
   b. Related to health workers (number of staff, attitude towards patients)
   c. Related to patient load (number of patients, overcrowding)
   d. Related to your health facility (policies, infrastructure, services)

9. In your opinion, what could be done to address these factors so that women are treated better during labor and childbirth?

F. Acceptability of how women are treated during childbirth

10. Now I would like to ask your opinion on how you feel about the way that women are treated during childbirth. If a woman was pinched or slapped by a health worker during her childbirth, would this be acceptable?
    a. When would it be acceptable?

11. If a woman was yelled or shouted at by a health worker during her childbirth, would this be acceptable?
    a. When would it be acceptable?

12. If a health worker was mean and refused to help a woman during her delivery, would this be acceptable?
    a. When would it be acceptable?

13. If a health worker physically held a woman down during her childbirth, would this be acceptable?
    a. When would it be acceptable?
G. How staff are treated
(Remind participant that all responses will be confidential and their responses will not impact their job in any way).

14. What is the most rewarding part of your work? Why?

15. What is the most challenging part of your work? Why?

16. Do you feel valued in your work? Why or why not?

17. Could you please describe for me what the relationship that you have with your colleagues (i.e.: other health workers of your cadre) is like?
   a. If you are struggling to meet the demands of your work, how can your peers help you?

   b. Do you feel supported by your colleagues? Why or why not?

18. Could you please describe for me what the relationship that you have with your supervisor is like?
   a. Could you tell me about a time when your supervisor supported you?

   b. Could you tell me about a time when your supervisor did not support you?

19. Overall, do you feel that your work environment is supportive? Please explain.

F. Wrapping up

20. Is there anything else that you would like to tell me about your work with women who are giving birth?

21. Thank the participant for their time. Remind them that the information they shared will be kept confidential.
Appendix 5.4: In-depth interview guide for hospital administrators

**Step 1:** Introduce yourself to the participant. Describe the purpose of the interview and how information will be used. Obtain oral/written consent.

**Step 2:** Ask the participant to identify herself. Interviewer: fill out the information below prior to beginning the interview.

**Step 3:** Conduct the interview. Please remember to audio record the interview.

**Participant information**

Participant age (write in): ________________________________

Location (urban/rural): ________________________________

Religion (write in): ________________________________

Total number of living children (write in): __________________

Total number of deliveries (write in): __________________

Number of deliveries in a facility (write in): __________________

Number of deliveries outside the health facility (write in): __________________

Name of health facility employed at (write in): __________________________

Cadre and position (write in): __________________________

Marital status (Single, married/cohabitating, divorced, widowed): ____________

Interview date: __________________________

Start time: __________________________

End time: __________________________

Interviewer: __________________________
Key informant interview guide

A. Introductions
   1. Could you please introduce yourself and tell me a little bit about yourself, including about your current work position, how many years you have been in this position, and what your training was in?

B. Perceptions and experiences of care during childbirth, focusing on treatment by health workers and the facility environment.
   2. In your opinion, how are women in general treated by health workers in the hospital when they come to deliver?

   3. Could you describe for me what supportive care during childbirth means to you?
      a. In your opinion, is this type of care provided to women during childbirth in your hospital? Please explain.

      b. In your opinion, what would health workers need from a WOMAN AND HER FAMILY in order to provide this type of supportive care?

      c. In your opinion, what would health workers need from their COLLEAGUES in order to provide this type of supportive care?

      d. In your opinion, what would health workers need from their SUPERVISORS in order to provide this type of supportive care?

      e. In your opinion, what would health workers need from their HOSPITAL in order to provide this type of supportive care?
4. Sometimes women are mistreated or poorly treated during childbirth. Have you ever seen or heard of this type of mistreatment happening in your work?
   a. Could you explain the situation?
   b. Who was involved in the situation?
   c. How were you [friend/family] mistreated?
   d. When did it happen? [Probe: time of day, during labor, during childbirth or postpartum].
   e. How often did it happen? [Probe: just once or more often].
   f. Why do you think this happened to you?
   g. In your opinion, how common is the situation that you described? [Probe: do situations like this happen often?]

   Interviewer: After the administrator explains the scenario, ask if there were any other times or ways that mistreated happens. If they describe another scenario, follow-up with questions 4a-4g.

C. Perceived factors that influence how women are treated during childbirth
5. You mentioned these types of mistreatment: (Interviewer: restate what type of mistreatment the woman experienced. For example, you mentioned that you were hit or yelled at by the midwife]. In your opinion, what factors influenced how you were mistreated? Please explain.
   a. Related to supplies (availability of medication, equipment)
   b. Related to health workers (number of staff, attitude towards patients)
   c. Related to patient load (number of patients, overcrowding)
   d. Related to your health facility (policies, infrastructure, services)
   e. Other factors at a health facility level
   f. Other factors at a health system level

6. In your opinion, what could be done to address these factors so that women are treated better during labor and childbirth from a FACILITY ADMINISTRATION perspective?

7. In your opinion, what could be done to address these factors so that women are treated better during labor and childbirth from a larger HEALTH SYSTEM perspective?
D. How staff are treated
(Remind participant that all responses will be confidential and their responses will not impact their job in any way).

8. What is the most rewarding part of your work? Why?

9. What is the most challenging part of your work? Why?

10. Do you feel valued in your work? Why or why not?

11. Could you please describe for me what the relationship that you have with your colleagues (i.e.: other administrators or managers) is like?
   a. If you are struggling to meet the demands of your work, how can your peers help you?

   b. Do you feel supported by your colleagues? Why or why not?

12. Could you please describe for me what the relationship that you have with your supervisor is like?
    a. Could you tell me about a time when your supervisor supported you?

    b. Could you tell me about a time when your supervisor did not support you?

13. Overall, do you feel that your work environment is supportive? Please explain.
    a. What do you think could be done to make your work environment more supportive?

E. Wrapping up

14. Is there anything else that you would like to tell me about your work with women who are giving birth?

15. Thank the participant for their time. Remind them that the information they shared will be kept confidential.
### Appendix 5.5: Qualitative codebook

<table>
<thead>
<tr>
<th>#</th>
<th>Code</th>
<th>Definition</th>
<th>Example of proper use</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.0</td>
<td>Childbirth narrative</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| A.01 | Childbirth narrative | Miscellaneous code regarding the childbirth experience that doesn't fit the codes below. |                                                                 | **R:** Please it was my auntie, my grandmother and my father.  
**I:** What did they do in this decision making process?  
**R:** Please my grandmother said that she has ever delivered in the house before and so she knows how both delivering at home and at the hospital are. When one delivers in the house it is possible that she would be affected by pains such that its effect would be experienced during another delivery of the woman. She said that she doesn’t like home delivery and so I should go to the hospital. |
| A.03 | Preference for delivery location | Any mention of preference for where delivery would occur (e.g.: home vs hospital, one facility vs another facility), or reasons why women deliver at health facilities | *I*: okay, thank you ma. So ma, in your opinion why do women seek care at the during child birth, in your own opinion why do you think women come to hospitals to seek for care during child birth?  
*R*: My own opinion why I feel they seek for care because they felt eh.. the hospital, those that are in the hospital are trained personnles that have knowledge of eh.. Pregnancy and how to manage it to a successful end. |
| A.04 | Mode of delivery | Any mention of the preference for mode of delivery, or reason given for why they had that mode of delivery. Includes reactions, feelings to the decision. | *I*: You have indicated that you were operated. Was this what you had wanted?  
*R*: No.  
*I*: What did you want?  
*R*: I wanted to deliver on my own.  
*I*: Why did you want to deliver by yourself?  
*R*: Please people say that operation is not good. It is a great worry to the woman that is operated because she will not be able to do the work that she wants. She will not be able to lift heavy objects and so on. |
| A.05 | Baby health status | If the baby cried or breathed when it was first born | *I*: so when you had the baby, was the baby crying immediately when you had your baby  
*R*: Yes immediately she came out, she cried |
<table>
<thead>
<tr>
<th>A.06</th>
<th>Labor length</th>
<th>Duration of labor, including how long she was in labor for at home and in the facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: How many hours were you in labour in the house before you went to the hospital?</td>
<td>R: Oh the labour started on Sunday evening but I didn’t know that it was labour and I didn’t tell my grandmother too. And so at dawn around 3 o’clock was when I felt the pain till...and so the woman that came and took care of me was saying oh you will deliver, you will deliver! And so it was around 6:30am before we were able to go to the government hospital. I: And so from morning till what time did you start feeling the pains?</td>
<td>R: In the morning around 4am. I: Up to 6:30 in the evening? R: Yes</td>
</tr>
<tr>
<td>I: How many hours were you in labour at the hospital before you were sent to the theatre for the operation?</td>
<td>R: I was operated around 1 o’clock. I: Was it 1 o’clock in the morning or in evening the following day? R: It was 1 o’clock in the afternoon. I: So how many hours will that be? If you were there at 6:30am and left for the operation at 1 o’clock then it implies that it was 19 hours?</td>
<td>R: Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A.07</th>
<th>Length of hospital stay</th>
<th>Duration of hospital stay during/after childbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: How long did you stay in the hospital after delivery?</td>
<td>R: Six days. I: Why did you stay that long? R: I was told after the operation that there was sore there so they were dressing it for me. And so it was when it was getting healed that we were given some of the medicine to go. And also they said that if care is not taken and I go home they would give me heavy meals and so they wanted me to wait for a while and be given lighter meals there so that I will not be affected when I go and eat heavy meals at home.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A.08</th>
<th>Birth position</th>
<th>Position of delivery, including preferred delivery position, actual delivery location, etc (e.g.: squatting, lying down)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: okay. But do women what to deliver in a different position when you tell them okay lie... R: well, some of them when they are in pain they will prefer to turn anyhow, but we keep encouraging them. Yes, because that position makes it better. I: so women are not allowed to deliver in a position of their choice? Or are they allowed to? R: sometimes they squat, that position too is good we allow them. I: okay, so you allow squatting (R: yes), if a woman says she prefers to squat? R: yes, we do. we do, we do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.01</td>
<td>Labor room</td>
<td>All encompassing code used as a double code when the labor room (e.g.: first stage room, or where a woman is before she starts to push) is being discussed/described. Should be used in conjunction with the B.04-B.10(*) below.</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>I:</td>
<td>thank you. Can you please give me a description of what this lying in ward looks like?</td>
<td>R: hmm...it's a ward that compose, we have two rooms there, and compose of three bed each and eh...the one by the passage is just because we are in short of space (I: okay) and em...three bed...two beds there, so comprise of eight beds all in all (I:okay) and three rooms,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I: okay, only beds that are there nothing else?</td>
</tr>
<tr>
<td>R:</td>
<td>we have...no, we have beds, tables, we have cupboards where they will put their neatly, (I: okay), yeah, we have ACs too incase the weather is too hot for them and they are not comfortable they can put it on, they have fan too (I: okay) yeah,</td>
<td></td>
</tr>
<tr>
<td>B.02</td>
<td>Delivery room</td>
<td>All encompassing code used as a double code when the delivery room (e.g.: second stage room, or where a woman is when she delivers) is being discussed/described. Should be used in conjunction with the B.04-B.10(*) below.</td>
</tr>
<tr>
<td>I:</td>
<td>when they're in the late first stage we take them to the labour room they stay there, in their second stage they're also in the labour room (I: okay), yes for delivery in the couch.</td>
<td></td>
</tr>
<tr>
<td>R:</td>
<td>ok ma, so you said they...you take them to the labour room (R: hmm labour room) okay..</td>
<td></td>
</tr>
<tr>
<td>R:</td>
<td>they'll be on the couch there (I: okay), yes, and they'll be lying in one position either the right or left depending on which one. (I: okay), yes to enable their baby breath well.</td>
<td></td>
</tr>
<tr>
<td>I:</td>
<td>thank you. Can you describe what this labour room looks like?</td>
<td></td>
</tr>
<tr>
<td>R:</td>
<td>well the labour room as a couch, that is adjustable, either lift it up or down, we have eh... cubicles or cupboards that is meant for them to keep their delivery items, we have eh... monitor, feotal monitor that mea...that monitors the babys' heart rate and we have thermometer, ehh.. BP aparatus, we have temperature eh! thermometer! then the Sphgs then the emm.. feotoscope cone in case the machine is not functioning well, we use the fetoscope to check.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>B.03</td>
<td>Unclear if labor or delivery room</td>
<td>All encompassing code used as a double code when it is unclear whether the labor/first stage or delivery/second stage room is being discussed/described. Should be used in conjunction with the B.04-B.10(*) below</td>
</tr>
</tbody>
</table>
| B.04 | *Layout/structure | Description of the physical layout, setting, infrastructure, etc of the labor or delivery room. | I: thank you. Can you please give me a description of what this lying in ward looks like?  
R: hmm...it's a ward that compose, we have two rooms there, and compose of three bed each and eh...the one by the passage is just because we are in short of space (I: okay) and em..three bed...two beds there, so comprise of eight beds all in all (I:okay) and three rooms,
I: okay, only beds that are there nothing else?
R: we have...no, we have beds, tables, we have cupboards where they will put their neatly, (I: okay), yeah, we have ACs too incase the weather is too hot for them and they are not comfortabl e they can put it on, they have fan too (I: okay) yeah, |
<p>| B.05 | *Mobility | Reference to a woman moving or walking during labor. Must be double coded with either B.01, B.02 or B.03 | R: well if she's in the first stage of labour she stays in the eh... lying in ward. She stays there, once in a while if she wants to stroll, if she's fit on her own she goes but we don't ask them, it depends on how they want to do it. |</p>
<table>
<thead>
<tr>
<th>B.06</th>
<th>*Fluids/food</th>
<th>Reference to a woman eating or drinking during labor. *Must be double coded with either B.01, B.02 or B.03</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><em>I</em>: okay, when women are in this lying in ward room do they things like eating, or taking fluid. You mentioned they take a stroll if they want to (R: if they want to), what other things do they do also aside from that?</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>R</em>: okay they eat, they drink since they're in the latent phase, they eat and drink.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>I</em>: okay</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>R</em>: food of their interest, there's no restriction concerning what to eat.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.07</th>
<th>*Presence of or preference for birth attendant/companion</th>
<th>Any mention of birth companion or birth attendant, or mention of being alone during labor/delivery. *Must be double coded with either B.01, B.02 or B.03</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><em>I</em>: so besides the health workers, you said something like if it's only one patient you allow the husbands to come in, that means that you don't allow non medical persons to come in during...(R: if other women) a woman's labour.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>R</em>: if other women are there, we are not going to allow because of privacy (I: okay), they need... others too need privacy (I: okay), yes, so if we allow relations to be there, the're different people. We have two patients and two different relations are there, they'll be seeing the other patient which is not good, they need privacy too.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.08</th>
<th>*Role of birth attendant/companion</th>
<th>Any mention of specific roles for a birth companion or birth attendant. *Must be double coded with either B.01, B.02 or B.03</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><em>R</em>: because err....accord...accord...based on what have told you earlier on, I told you that if the space is er... just a woman in the labour room her husband is allowed he supports, we too give our own necessary support, so that is what I feel that actually they’ve been supported, (I: okay), yeah.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.09</th>
<th>*Emotional state</th>
<th>Any mention of the emotional state of either a health worker or woman during labor. *Must be double coded with either B.01, B.02 or B.03</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><em>I</em>: okay. So how do you feel, that's your emotions during this first stage of labour? How do you feel?</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>R</em>: well during the first stage of labour, really I feel good and especially, though the problem is with the primemurch they tend to be more anxious and eh... you know their own takes a bit... a longer time but we counsel them and I feel happy because they adhere to our advise and they are relaxed.</td>
</tr>
<tr>
<td>B.10</td>
<td>*Role of health worker during labor/delivery</td>
<td>Any mention of specific roles for a health worker during labor/delivery. *Must be double coded with either B.01, B.02 or B.03</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>I: okay. So as a health care provider also what roles do you perform during this first stage of labour?</td>
<td>R: the first stage of labour, as I earlier told you, you need to counsel them to prepare their heart towards labour, because some of them may have the fear of labour, but if you counsel them and encourage them, that actually it might be painful, but the joy of it is that what is coming out of it, is your baby, you see your baby healthy so you need to be strong in heart you need to prepare yourself, it might be painful but not that that...you will also believe that others have pass through, you too will pass through it. You encourage them to do that.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.10</th>
<th>*Role of health worker during labor/delivery</th>
<th>Any mention of constraints of the hospital setting (e.g.: not enough space/beds, lack of equipment/drugs, not enough staff, overworked staff, etc).</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: so besides the health workers, you said something like if it's only one patient you allow the husbands to come in, that means that you don't allow non medical persons to come in during...(R: if other women) a woman's labour.</td>
<td>R: if other women are there, we are not going to allow because of privacy (I: okay), they need... others too need privacy (I: okay), yes, so if we allow relations to be there, the're different people. We have two patients and two different relations are there, they'll be seeing the other patient which is not good, they need privacy too.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C.00</th>
<th>Perceptions and experiences of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.01</td>
<td>Expectations during labor/delivery</td>
</tr>
<tr>
<td>I: so as a health care provider, what are you expectations during this first stage of labour that a woman comes in what are your own expectations?</td>
<td>R: okay, as a health care provider my expectations is that she will deliver safely if I examine her. Knowing quite well that all the parameters are adequate, I expect that sh...I'll manage her up to the stage of safe delivery, even manage postpartum, eh... third stage of labour actively. --- R: I was afraid when I entered the room because of the knives and other equipment that I saw there but it was because my grandmother had told me that if they realize that I am scared they would cut my private part carelessly and so I was also quiet and I was just looking at them as they were doing those things.</td>
</tr>
</tbody>
</table>
| C.02 | Defining support | How a respondent describes support during labor/delivery (e.g.: holding their hand, making tea, emotional support) | *I:* okay could you describe what it means to be supported during labour? What you believe the meaning of supported during labour means?
*R:* What I er.. understand by supported during labour because anybody that is with a patient could support him, morally, physically, because you will...the patient a time when they are in pain they would like you to rub their back. So if a supporter is there he assists in rubbing the back, if a supporter is there he assists in lifting the leg, sometimes they hardly lift their legs up, so when you help them they will also feel comfortable, they will feel secured, they have somebody with them that can help. |
| C.03 | What do women need from health workers | Explanation of what women need from health workers in order to experience supportive care during labor/delivery | *R:* What I will say is that the nurses should treat us like their children and they should desist from mistreating women at the facility. |
| C.04 | What is needed from woman/family | Explanation of what a health worker needs from a woman or her family in order to provide supportive care during labor/delivery (e.g.: to provide money and necessary equipment, to be obedient) | *I:* thank you ma, in your opinion what would you need from a woman and her family in order to provide this type of supportive care you have given, you know you explained that it involves physical, moral and other aspect, so in your own opinion what would you need from the woman and her family in order to provide this type of supportive care.
*R:* okay. in my own opinion what I would need from the woman, the family member is before the labour begins they need to prepare all the necessary things the hospital needs to assist the woman to safe delivery, because in some cases some of them will come even though with a supporter but the things needed are not there, the woman becomes the depressed, but in some you see the relations are there asking what do you need? What we have is it enough we want to get it before she goes into labour. You feel happy even you the health provider. so those things needed not only the hospital things, she might need some drinks too, so some relations actually are up and doing they'll provide all those things that she needs and it makes things easier for the patient and the nurse too nursing the patient. |
| C.05 | Support and relationship with colleagues | Explanation of what a health worker needs from their colleagues in order to provide supportive care during labor/delivery (e.g.: teamwork or good communication) | *I: okay, thank you ma. What of the things that you will need from your colleagues in order to make this kind of supportive care available (R: okay), now you've told us what the woman and her family can do, now we want to find out what of you colleagues, what can they do?*

*R: okay. actually in this issue of delivery it's not a one man business, if you have a supporter, a nurse with you she can assist in some areas because during the delivery she might be getting things ready for you, you too will be preparing with your gown, wearing your gloves ther...and if you’ve worn your gloves it's a sterile procedure you don't need to be touching some things, but if you colleague is there with you, there with you she would be helping you to give those things or open those things that you can pick in order not to contaminate the patient or the procedure. So actually its' good when you're conducting or when you're taking care of patient you have a professional colleague to assist, to support too.* |

| C.06 | Support and relationship with supervisors | Explanation of what a health worker needs from their supervisors in order to provide supportive care during labor/delivery (e.g.: motivation, second opinion, management of resources) | *I: okay. What of those things that you think you will need from your superi...em supervisor what you need from your supervisor this time? We've spoke about woman and family, we spoke about colleague now we are coming down to the supervisor, what are the things, in your opinion you would need from your supervisor in order to provide this type of supportive care.*

*R: okay. In order to provide supportive care, my supervisor I would need all the..the papers to document, I will need her to be around if she as the time so that she can supervise me while am taking care of the patient because there after which... in this unit that is what our supervisor does, our in charge. She is always there for us, she supervises, she gives advice, she makes correction where it's necessary (I: nmmm) and even thereafter, she gives us lectures. So this has been helping us very well.* |
| C.07 | Supportive work environment/needs from hospital | I: I will do that  
R: You will see that the work environment is so fantastic. As for the staff, they are cool to work with, the equipment, supplies, obviously it is a human institution once a while you will get shortage of certain things like supplies. In total the working environment is amazing. |
|---|---|---|
| C.08 | Overall perception of care received | I: In all what do you think about your labour in that hospital?  
R: As for me I was not happy about it. What made me a little happy was when the operation was over and they gave us the bill. Luckily for us the first nurse that I met….we didn’t know her but they asked us to pay GHS 240 but we ended up paying GHS 20. The nurse asked them not to collect the money from us. That was what made me a little happy and also they didn’t collect the soap and other items that I sent. They gave them back to me and then I came to the house with them. That was what made me happy but the delivery itself was not something that made me happy there.  
I: Why were you not happy?  
R: It was due to the way the nurses treated me that didn’t make me happy. The treatment that they gave me didn’t make me happy.  
I: And what else was the reason why you were not happy?  
R: When you go there and you are hungry they don’t allow you to buy food to eat. They said that the infusion was food but we would still be feeling hungry but they said that it was food but we were still hungry. |
| C.09 | Deliver in same hospital again | Whether a woman would prefer to deliver or intends to deliver in the same hospital as her previous birth and why. | I: Would you go there to deliver again?  
R: As for me I would prefer to give birth in the house.  
I: Why?  
R: Oh if I deliver in the house....I for instance.... my family members deliver pregnant women and so my family member will not beat me if she is assisting me to deliver. She will encourage me till I give birth. |
|-----|------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| C.10 | Recommend hospital to a friend | Whether a woman would recommend her friend/sister to deliver in the same hospital as her previous birth and why. | I: Would you advise your friend to deliver at the government hospital?  
R: As for me I won’t advise her to deliver at the government hospital but I will narrate my experience to her for her to decide what to do because even if I tell her she will be scared and so will want to deliver in the house.  
I: And so what you are saying is that you will never advise a friend to go there?  
R: Yes please.  
I: Why?  
R: Because of the way they beat me and kept saying ‘’push, push’’ and I was not able to deliver too. And so I will tell my friend the same thing that when she goes they would say ‘’push, push, push’’ but finally you will be operated. As for me that is what I will tell her. |
<table>
<thead>
<tr>
<th>D.00</th>
<th>Mistreatment experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.01</td>
<td>Unhappy/uncomfortable experience</td>
</tr>
</tbody>
</table>

R: ...And so when she came she said ‘‘that long time that you were brought you haven’t delivered yet’’? And then I said Maame nurse please one nurse came and attended to me and said that I will be operated. And then she said no I should not agree to any operation and that I should try and deliver by my self and then I said okay. And so I was there when she brought something and inserted it into my buttocks and then she examined it and said push. Then I said ‘‘Maame nurse I can’t push’’. Then she slapped my thigh and said ‘‘I say push’’. Then she said ‘‘I say push’’. So anytime she would say push she would slap my thighs. It was there that the other nurse came and said ahh why are you worrying the girl like that? Look at her tomy. Can’t you see that the baby has not descended? And they said that my baby was coming out with his buttocks. And so she insulted the other nurse and they carried me to the theatre for the operation.
| D.02 | **How common is this experience** | Any general mention of frequency of occurrence of mistreatment. If not clearly mentioned in the text unit, memo what the experience is that they are referring to. | *I: okay, thank you ma. Yeah so as we were talking earlier on you know you talked about emm.. care generally given to women and you said its' meeting your expectation but there're some exceptional few. So sometimes women are mistreated or poorly treated or managed during child birth. Have you ever seen or heard of this type of mis...mismanagement or mistreatment. Like those few people you explained maybe the woman stepped on the uniform and you know the nurse can now get a little bit temperamental.*<br>**R: have once seen it but its' not in this hospital....**<br>**I: But in your working experience so far you've never heard of anything like that?**<br>**R: Have not, (I: here?) to be honest here* |
| D.03 | **Factors influencing mistreatment** | Any factors/drivers/reason for mistreatment occurring that is NOT covered by D.04.1-D.04.4 (e.g.: miscellaneous factors for mistreatment) |  |
| D.04 | ***Essential physical resources** | When a lack of essential physical resources contributes to the occurrence of mistreatment (e.g.: not enough beds so women deliver on the floor) | *I: okay you don't think maybe because they don't have enough equipments or maybe like the chair is not enough, or maybe drugs could be a reason why they are acting like that*<br>**R: well I don't, I can’t really say it because anything we need to use we are the one buying it, because I don’t really think they are using government equipment, because anything they want to use for you, they will ask you to go and buy it* |
| D.05 | **Facility/health system** | When facility or health systems policies or practices contribute to the occurrence of mistreatment. Also includes staffing issues, such as provider/patient ratios and workload. | *I: Do you think that the reason why you were beaten was due to the fact that women that had come to deliver were many... [Respondent interjected]*.  
*R: No it was not because of the work load.* |
| D.06 | **Health workers attitudes/practices** | When poor health worker attitudes or practices contribute to the occurrence of mistreatment (e.g.: "bad apple" or rude health workers, overtired health workers etc) | *R: No it was not because of the work load. That is how they are. It was just because I couldn’t push. If you couldn’t push then they will be beating you. It is not because the clients were many that is why we were beating me.*  
*I: Can it also be because they didn’t have enough supplies of medicines and equipment with which they would use to assist you to deliver?*  
*R: Oh even if the nurses have medicine they will be expecting you to give them money before they can help you. That is what they always do.*  
*I: And so it is not because they lack the supplies of medicine?*  
*R: No.*  
*I: Or maybe the nurses are not many and so.....*  
*R: Oh there are some grown up nurses that are mean.* |
| D.07 | **Patient behavior or characteristics** | When patient behavior or characteristics is provided as a reason for mistreatment (e.g.: adolescents, disobedient or aggressive patients) | *I: Now I want to know what you think about the way women are taken care of when they go to deliver. You told me of how you were beaten to push. What do you think was the cause of this mistreatment?*  
*R: It was because I wasn’t able to push.* |
I: Is there anything else that you would like to tell me about your work with women who are giving birth?

R: I think we are not doing a very good job by educating the population and our competitors that is what I prefer to call them the herbal practitioners are actually drawing us back. They don’t seem to have excuse the language ethics guiding their practice. Because they seems to be abusing the illiterate nature of our women. I think we could do with more education, and better training for our midwives and our district facilities should not try to do too much, not try to bit more than they can chew. We are not tired to work in this hospital if it means referring everybody so be it. They should refer any case that they cannot handle, they should do well to refer but not to do too much. We know the patient may refuse to come or insist to stay but you need to communicate it well to the patient and it will be sorted out. In all case we should be able to have a midwife who will be able to sell a deep freezer to an Eskimo ... laughing ... that is how convincing our midwives are supposed to be, so that we don’t have women dying on them there.

---

### Positive birth experience

**E.01**

Positive birth experience Example of positive or supportive care during labor/delivery

R: When I went she said “oh Maame you have come to deliver”? And then I said yes. She asked me about my husband and then I said that I didn’t have one and then she asked why and then she said that I shouldn’t worry because God will do it and so I should follow her. And then I followed her and then she went and laid my bed for me to lie down. And so when I laid down one male nurse came and then called her. They said that she is the senior nurse at the government hospital. She was called to take care of the people at the eye clinic and so it was the one that came later that beat me.
<table>
<thead>
<tr>
<th>F.00</th>
<th>Acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td>F.01</td>
<td>Acceptable to pinch or slap during labor?</td>
</tr>
</tbody>
</table>

I: thank you ma, so now I would like to ask your opinion on how you feel about the way women are treated during child birth, I'll just give you some statement and you tell me your own opinion (R: okay) and when you think it will be acceptable to do such. Okay. So if a woman was pinched or slapped by a health worker during child birth would this be acceptable?  
R: it's not acceptable  
I: why? why do you say that?  
R: Actually it's not acceptable because slapping her can make her angry, it can make her to...to have a problem but if you calm her down no matter how distressful she is; she's also a human being she will relax. But slapping her could make her misbehave and it could bother...further cause a lot of problem to her, to her own health.  
I: nmm.  
R: yes  
I: So bringing it to a more personal level how would you feel if this happened to you?  
R: Actually I would feel very bad! Very very bad because we are all human beings, no matter how you, you the care provider know that that woman is in distress is in pain, it's not a comfortable thing. The next thing you're supposed to do is to try and at least encourage her to make her feel strong but if you're slapping her or pinching her certainly it won't be good. So certainly if anything is done to me too I won't be happy, I will feel bad.
### F.02 Acceptable to yell or shout during labor?

<table>
<thead>
<tr>
<th>Q: if a woman was yelled or shouted at by a health worker during child birth would this be acceptable and if it is when is it acceptable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>R: it's not acceptable at any point</td>
</tr>
<tr>
<td>I: nmmm?</td>
</tr>
<tr>
<td>R: there's no point in time that a woman should be shouted at.</td>
</tr>
<tr>
<td>I: okay. How would you feel if this happened to you, if the nurse shouted at you? But I just want to ask again what if the nurse actually did the shouting for a particular reason? or its' not just...</td>
</tr>
<tr>
<td>R: no matter the reason</td>
</tr>
<tr>
<td>I: nmmm</td>
</tr>
<tr>
<td>R: if you politely explain things to your patient (I: nmmm) it , makes it better, she feels relaxed too. So no matter the condition you have to try as much as you can to explain things in a low tune to a patient than shouting.</td>
</tr>
<tr>
<td>I: nmmm. so when I was saying before I now brought in the other question, how would you feel if this happened to you?</td>
</tr>
<tr>
<td>R: Actually i will feel bad, am also a human being, when am a patient too I will feel bad!</td>
</tr>
</tbody>
</table>

### F.03 Acceptable to refuse to help during labor?

<table>
<thead>
<tr>
<th>Q: what of if a health worker refused to help a woman during her delivery would this be acceptable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>R: then why is she there! She is employed to render services so why should she refuse? I don't think there's any reason for her to refuse because the position of her patient can even er be life threatening to her patient so if you have the loves of your patient you won't refuse. You will run to render the necessary assistance needed to save the life of the woman. You know quite well she can tear and bleed to death. But if you're there for her, guiding the perinum well she will deliver safely and have her baby, no problem she can go home. And its' also cost implicative on the patient because if she delivers on her own and bleeds if she did not die, she might need blood to be transfused (back ground noise calling Sandra). So its' saver if she delivers normally without any complications and go home.</td>
</tr>
<tr>
<td>I: thank you, how would you feel if this happened to you?</td>
</tr>
<tr>
<td>R: actually based on these explanation am giving you I will feel bad too.</td>
</tr>
</tbody>
</table>
Any quotations of the respondent's reactions to this specific question of if it is acceptable to physically restrain a woman during labor, including any subsequent/related probes.

I: okay. What of if a health worker physically held a woman down during her child birth will this be acceptable?
R: It's not acceptable, it's not acceptable
I: in any instance
R: in any instances its' not acceptable.
I: can you explain why you feel its' not acceptable?
R: to hold her down?
I: nmm
R: to press her down?
I: well physically hold her down
R: ha han! when she's in labour?
I: yeah, during her child birth, yeah giving birth.
R: mnh. This question is not ..... 
I: okay if a health worker physically held a woman down during her child birth...
R: is it angrily or just normally...
I: No! just physically held there is nothing explaining wether it is angrily or lovingly it's just that the woman was held down
R: well do you feel...yo have held her freedom, ideally yo explain to her she will cooperate with you, even if its' I know it's’ painful just go down do it this way, she will do. And if she's not cooperating there are ways you can encourage your patient jokingly: ha ha my dear you've been cooperating and I know definitely this is the time we need more of your cooperation, do it... it depends on approach, once you approach her very well she will relax. (I: nmm) she will there's no need to do it yourself. Okay.
<table>
<thead>
<tr>
<th>G.00</th>
<th>Staffing</th>
</tr>
</thead>
</table>
| G.01 | Motivation for being a health worker | *I: Okay, any other additional thing you want us to know about you?  
R: well, what I would want you to know about me, I joined the nursing profession because of the love I have for patients, to help the needy and that is what thrills me; because, first of all went to teachers' college, but emm... because I love taking care of the sick, that is what made me to join the profession.* |
| G.02 | Rewarding part of work | *I: okay, so the next set of questions i want to ask, again I just want to reassure you, and remind you your responses are confidential, whatever you tell is solely for the purpose of the study. So the next set of questions will be in relations to how your work environment is, and how staff are treated and stuffs like that. So i would want to ask what is the most rewarding part of your work and why is it the most rewarding part?  
R: well the most rewarding part of our work is the sacrifice we give to our patients, sometimes even when we close from our work we don't leave home to see the success of our patient delivering so I know it's' rewarding God will reward that effort because we are going extra miles, not only me, all of us that are in this unit. In one way or the other we've been straining ourselves going beyond our time to see to our patients' success, that is what I feel is the most rewarding.* |
| G.03 | Challenging part of work | *I: Okay, what is the most challenging part of your work and why?  
R: the most challenging, sometimes women come with eclamps...eclamptic fits and em.. you don't have the necessary things like the magnesium sulphate like the...things you need to attend to them promptly (I: mmm) that is the most challenging. It might be in the hospital store but the money is not there to purchase it but I think this time around that as been taken care of by another researchers, they provided those things we needed and its' to be given to the patients free. So those patients that are in need for now I don't think that problem is there, (I: okay), another one is the blood the women need, some may not have the money to run the test so its' another part that's challenging problem here. Because they actually need blood especially those that have exceeded their months of delivery they need it for induction, some they need it for CS and the money is not there. That one keeps us off...it makes us ...feel bad because we want to see that this patients are being taken care at the appropriate time, so that the baby and the mother comes out in good health, but if those things are not there; its' delaying to the...woman...it's also detrimental to her, the baby too could be having breath...difficulty because of delay and that may even lead to admission or losing the baby so it's' very painful.* |
<table>
<thead>
<tr>
<th>Code</th>
<th>Category</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
</table>
| G.04 | Valued in work| Description of if they feel valued in their work as a health worker.       | *I: Do you feel valued in your work?  
R: Actually I feel highly valued because it's a work that you feel happy, it's a work that you know you are helping, it's a work that when the outcome is good you are happy. So I actually feel valued.* |
| H.00 | Miscellaneous | Anything not captured by the codes above                                   | *n/a*                          |
Appendix 5.6 – Technical and ethical approvals

This study received a waiver from the Institutional Review Board of the Johns Hopkins Bloomberg School of Public Health. Scientific and technical approval was obtained from the World Health Organization Human Reproduction Programme (HRP) Review Panel on Research Projects (RP2), and ethical approval was obtained from the World Health Organization Ethical Review Committee (protocol ID, A65880) and the Federal Capital Territory Health Research Ethics Committee in Nigeria (protocol ID, FHREC/2014/01/72/28-11-14).
WHO ERC
Review Summary

Protocol ID: A65880
Country: ---
Protocol Title: How women are treated during facility-based childbirth: development and validation of measurement tools in three countries.
Version: 1.2 Dated: 10/07/2014
WHO Responsible Staff Member: Vogel, JP
Responsible Unit: RHR/MPA
Meeting Date: NIL

Dear Dr. Vogel, JP,

Please find the review summary of the Protocol “How women are treated during facility-based childbirth: development and validation of measurement tools in three countries”, which was submitted to the Secretariat on 15/09/2014. This proposal underwent Committee Review.

The outcome of the review is provided below. When responding, please submit the following:
1. A cover memorandum that addresses your responses, POINT BY POINT, to each of the queries in sections A and B.
   Section C covers Suggestions to improve the protocol but there is no obligation to follow them.
2. An Amended protocol including the responses in bold, highlighted or in track changes. The protocol should include all relevant documentation (ICF, study instruments, peer review, etc.) even if already submitted.

Please note that comments in the introductory paragraph are meant for the WHO Responsible Staff Member, though you may decide to share them with the PI.

PLEASE RESPOND TO THIS REVIEW SUMMARY WITHIN A THREE-MONTH PERIOD, OR PROVIDE THE ERC SECRETARIAT A VALID JUSTIFICATION FOR THE DELAY.

The ERC reviewed this interesting protocol. Phase 1 of the study, the formative phase will use qualitative research methods. The findings from this phase will be used to develop the study tools for Phase 2. The ERC will re-review the protocol at the time that the observation tool and the community survey tool are ready. Hence, please note that this conditional approval relates only to Phase 1 of the study. However, comments on the phase 2 are included to help the study team think in advance on the potential ethical concerns that may arise in relation to this phase.

A. Amendments (Response and change required)
   This section includes queries and comments on your protocol, study instruments or the informed consent form for which the ERC requires your responses and where relevant, appropriate amendments to the protocol, study instruments or the informed consent.

1. Protocol
   1.1. Please provide an amended proposal specifying the version number and/or date on each page.
   1.2. Please label the appendices clearly (appendix number, title, and phase of the study that relates to).
   1.3. Please specify how the institutions where the study will be carried out will be selected.
   1.4. Please clearly specify that institutional permission is being obtained to observe health care workers and that individual consent will not be required.
   1.5. Please discuss how the study will benefit the community and the health facilities in relation to the subject of the study (e.g. development/provision of education materials, sensitization sessions offered to health personnel at the end of the study, etc.).
   1.6. Please provide a clear and comprehensive description of the different sites and health facilities where the study will be carried out (Nigeria, Mozambique, and the third country to be determined).
In relation to Phase 1 of the study:

1.7. The protocol does not take into consideration some factors that may influence how women are treated during labour (e.g., health system factors such as mentorship, how staff themselves are treated by their peers, policies in place, etc.). Given that they are related to objective 3, please address.

1.8. Please specify how the three groups of participants (women, healthcare providers and facility administrators) will be identified and selected.

1.9. Focus Group Discussions (FGDs) will be carried out. Participants will be women who have delivered in the facility during the past five years. In view of possible recall bias—please elaborate on the rationale for this selection criteria.

1.10. FGDs and in-depth interviews (IDIs) will be tape-recorded. Please specify where the tapes will be safely stored, who will have access to them, and when they will be destroyed.

1.11. Section 3.5.1 states that an information sheet will be provided to all healthcare providers. They will describe the study in a generic manner in order to minimize bias or change in behaviour. Please explain how and when the document will be distributed.

1.12. In relation to the previous point, the fact that the information provided and the presence of observers may affect health providers' behaviour should be acknowledged and stated as a study limitation.

1.13. The budget specifies an amount of USD5,300 for 'Participant transport and compensation in Phase 1 (totaling $5,300)'. The protocol only refers to a 'gift' for those that participate in the community survey in phase 2 (mentioned as well in the consent document). Please address and ensure consistency.

In relation to Phase 2 of the study:

1.14. Please specify whether healthcare providers and/or ancillary staff will be observed.

1.15. The protocol states that in specified cases observers call the Medical Officer in-charge. Observers will be advised not to intervene but to call this person for assistance:

1.15.1. Please provide a step-wise guidance on how observers will manage the situations that fulfill the criteria (e.g., what will be done should the medical officer in-charge not answer).

1.15.2. Please address the implications for women of having an observer witness them being abused and not intervening.

1.15.3. Please discuss the potential implications for the participant should the medical officer be called up.

1.15.4. Please specify whether all observers will have a telephone.

1.16. Debriefing sessions will be held within the research team. Please specify whether they will be facilitated by someone with counselling experience in this area of work.

1.17. Please provide the rationale for discontinuing women—if not delivered after 24 hours, since they may be at greater risk of being the recipients of disrespectful behavior.

1.18. Please clarify if data collectors who will observe the women at delivery will be female.

1.19. Section 3.5.3 specifies that data collectors will complete the observation period and return to the admission location and approach the next women who presents to the facility that meets the inclusion criteria. Please specify what will be done in case more than one woman is present. Please note that women should have equal opportunity of being selected for the study.

1.20. Women will be approached as they come in for admission. This may not be the best time as they are primarily there for medical assistance. It is suggested to, as much as possible, inform women of the study when they come for antenatal care visits and request their consent to take part in the study at the time of admission. Researchers could approach women once admitted and settled comfortably after receiving an initial medical assessment to determine which stage of labour they are in and whether they meet inclusion criteria.

1.21. A facility assessment survey will be carried out. Please specify whether this is an existing tool or whether it will be developed in the context of the study.
2. Study Instruments

2.1. Health care providers in-depth interview guide: Please note that health workers are not asked about their own experiences of childbirth, their training, and mentorship experiences. Health care providers may "learn" disrespectful behaviour from their prior experience and may feel such experience is norm and acceptable. It seems relevant to explore policies and mentorship programs that are in place.

2.2. Participant Screening Form: It is suggested to remove the references made to "she" and use a more respectful way of referring to the participant.

2.3. Interview Discussion Guide:

2.3.1. It includes some leading questions. For example, in the questions for women, they are asked 'In your opinion, how were you treated by health workers during your most recent labour? If a woman answers that she was treated well, the interviewer is instructed to ask whether she has any friends or family members who are treated poorly. This is a leading question and is hearsay and suggests that the researchers are seeking data that increases the probability of the desired outcome (i.e. demonstrating high prevalence of bad treatment in maternity facilities). A more neutral question would be 'Do you think that your friends and family had a similar experience?' For Q.8 the participant is recounting someone else's story and therefore will not be able to answer probes 'a-c' accurately.

2.3.2. Please avoid asking interviewees questions that cannot be accurately answered i.e. 'how often does it happen? Prevalence can only be determined by the research study. Rather, interviewees can only give an opinion based on their experience.

2.3.3. Please review each IDI questionnaire to see if it is appropriate for each group of respondents. For example, in asking Q.15 to women, 'What are the factors that influence the mistreatment of women during labour and delivery?' the probes for the interviewer are a) related to supplies b) related to health provider staffing c) related to patient overcrowding. These factors are more likely to be relevant to health staff and administrators rather than women patients. Probing for these without women raising them first may introduce artificial categories into the narrative and subsequent analysis as they may not otherwise be drawn upon by women in their accounts. An inductive approach seems more appropriate for this study than a deductive approach, especially as it is now research on an under investigated area.

3. Informed Consent Forms

Please review the consent documents to ensure that the correct information is being provided to the different group of participants (e.g., effect on employment or future care at the facility).

3.3. The Informed Consent Form for women who have delivered in the last 12 months specifies that the knowledge obtained from the study will be shared with participants and the community. However, section 6.1 specifies that a community-based awareness campaign will not be used given the sensitivity of the project. Please correct as appropriate and make the protocol and consent document consistent.

3.3. Please ensure that the Certificate of Consent specifies the research activity that the participant is consenting to (i.e. FGD, IDIs, etc.)

3.4. Consent forms for health care providers and facility administrators: please ensure that all sections are relevant (e.g. attention drawn from people in the community, sharing of results, in case interviews will be conducted at workplace, why is re-inbursement being paid?

3.5. The protocol states that the facility research officer will randomly and without warning observe each data collector and community interviewer twice. The consent document should specify that for quality assurance purposes, in some occasions, there will be two researchers present.

3.6. Please submit a copy of the Information Sheet for health care workers that will provide information on the study.

3.7. Informed consent form for eligible women to take part in phase 2 of the study:

3.7.1. Please reword the phrase "...women say they were treated poorly by people looking after them". The phrase may generate anxiety and fears among potential participants.
Protocol ID: A65880 / Meeting Date: NIL

Review Summary (contd)

3.7.2. Under “Voluntary participation” instead of the phrase “You may change your mind later...”, participants could be told that the can ask for the researcher to leave the room at any time.

3.7.3. Point 1 of section 4.2 specifies “A diversionary questionnaire will be built into the tool to also mitigate against risk of interruption”. Please include this information in the consent document in simple language.

3.7.4. The information sheet mentions that participants will have the opportunity to review their answers. How will this be undertaken if the interview is taped? This may also take a long time to do and could be very confusing to the participant as it may sound like some kind of test or exam. Please explain rationale for this. Rather, interviewers might ask respondents if they would like to add anything or clarify anything at the end of the interview.

B. Clarifications (Response required but change may not be required)

NIL

C. Suggestions

This section consists of suggestions for alternative scientific or technical approaches or methods for conducting the research but which do not raise critical, ethical issues. These are meant to be helpful to investigators and are presented as suggestions for you to consider incorporating into a revised protocol. No response from you is required for any comment in this section. If, however, you do make changes to the protocol as a result of these suggestions, please submit the revised protocol to the ERC.

1. In order to provide more neutrality to the title of the study, please consider using the terms “being cared for” - that seems a gentler and less threatening term, instead of “treated”.

2. While maintaining a sense of nonintrusiveness, it is suggested that data collectors introduce themselves to the birthing mother and for the departing researcher to say goodbye at the time of changing shifts.

3. It is suggested to take into consideration how the potential tension between companions and health providers influences the stress of women and, potentially, the treatment they receive.

4. At the time of data analysis, it is suggested to stratify by provider's gender in order to develop a gender-sensitive intervention.
Protocol ID: A65880 / Meeting Date: N/A. Review Summary (contd)

Based on the above comments, the Committee has the following recommendation(s) for this proposal:

[X] The proposal is Approved as submitted. No modifications are required.

[ ] Phase 1 of the proposal is Conditionally Approved; requires amendments and/or clarifications. Final approval is contingent upon an adequate response by the Principal Investigator, to the satisfaction of the reviewers or the Chair on behalf of the ERC.

[ ] The proposal is Not approved; requires additional information and/or rewriting. A revised version of the proposal should be resubmitted by the WHO responsible staff member as a new submission to the ERC for re-review by Committee.

[ ] The proposal is Rejected. The proposal is ethically unacceptable, for the reasons stated above. The Principal Investigator may submit a new proposal that takes into consideration the ethical issues raised by the Committee. If you do not agree with the Committee’s assessment, please feel free to submit an appeal to the Chair of the ERC, through the Secretariat.

NOTE: Final Approval of the Proposal is contingent upon submission of the following:

[ ] Local ethics approval(s) [ ] Other relevant documents

The ERC would like to receive a copy of the recommendations of the local ethics committee when available.

IMPORTANT
1. Any changes to the proposal or to the attachments (informed consent/study instruments etc.) should be approved by ERC before being implemented.
2. The approval for this proposal is valid for a period of one year only.
3. Please resubmit this proposal for a Continuing Review at least 2 months before the next re-approval period.

Chairperson: [Signature] Date: 25.9.2014

Name: Melba Gomes

---

FINAL APPROVAL

Amendments and Clarifications to the proposal have been reviewed.
The protocol (Version: 1.5 Date: 25/09/2014) and informed consent
Forms (Dated: — ) submitted on 25/09/2014 are approved by the ERC

Chairperson: [Signature] Name: MG/AC/EA
Date: 25/09/2014

FOR THE SECRETARIAT

Amendments and Clarifications to be reviewed:
[ ] Electronically by ERC
[X] By Primary reviewers
[X] By Secretariat

Amendments approved /
Clariations accepted on
Local ERC approval(s) obtained on

Relevant Documents submitted on
Comments:

Signature Date: 25/09/2014
FEDERAL CAPITAL TERRITORY
HEALTH RESEARCH ETHICS COMMITTEE
Research Unit, Room 10, Block A Annex, HHSS
FCT Secretariat, No. 1 Kapital Street, Area 11, Garki, Abuja - Nigeria

Name of Principal Investigator: Dr. Francis E. Alu
Address of Principal Investigator: C/o Maitama District Hospital, Maitama - Abuja, Nigeria.
Date of receipt of valid application: 24/10/2014

NOTICE OF RESEARCH APPROVAL
Protocol Approval Number: FHREC/2014/01/72/28-11-14

Study Title: How Women are Treated During Facility Based Childbirth: Development and Validation of Measurement Tools in Three Countries

This is to certify that the FCT Health Research Ethics Committee (FCT HREC) has fully approved the research described in the above stated protocol.

Approval Date: 28/11/2014
Expiration Date: 27/11/2015

Note that no activity related to this research may be conducted outside of these dates. Only the FCT HREC approved informed consent forms may be used when written informed consent is required. They must carry FCT HREC assigned protocol approval number and duration of approval of the study.

The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the code. The FCT HREC reserves the right to conduct compliance visit to your research site without previous notification.

Modifications: Subsequent changes are not permitted in this research without prior approval by the FCT HREC.

Problems: All adverse events or unexpected side effects arising from this project must be reported promptly to FCT HREC.

Renewal: This approval is valid until the expiration date. If you are continuing your project beyond the expiration date, endeavor to submit your annual report to FCT HREC early, and request for renewal of your approval to avoid disruption of your project.

Closure of Study: At the end of the project, a copy of the final report of the research should be forwarded to FCT HREC for record purposes, and to enable us close the project.

Desmond Emerenonyeokwe
For: Secretary FCT HREC
November 28, 2014
Appendix 5.7: Communications materials

The systematic review included in this dissertation was published in PLOS Medicine on 30 June 2015. PLOS Medicine published a press release 24 hours prior to publication, which generated media coverage of the article across the radio, newspapers, magazines and blog postings, including coverage from the BBC World Service, New York Times and Reuters. In total, I have identified 4 radio shows and 34 newspaper, magazine and blog postings on the article:

- Across nine countries: United States, United Kingdom, Australia, India, Malaysia, Indonesia, South Africa, Poland, Brazil
- Published in six languages: English, French, Spanish, Portuguese, Polish, and Indonesian

The article also received coverage on several different Twitter platforms, including USAID, Cochrane Collaboration, Johns Hopkins University, Reddit, Michel Sidebe (Executive Director – UNAIDS), Planned Parenthood, Cosmopolitan magazine, FHI 360, UNFPA, UN Women and Royal College of Obstetricians and Gynaecologists. Below are examples of the media and Twitter coverage.

Radio interviews

1. BBC World Service Health Check: “Women being Pinched and Slapped during Childbirth”
   July 8, 2015
   Accessible from: [http://www.bbc.co.uk/programmes/p02w11fy](http://www.bbc.co.uk/programmes/p02w11fy)

2. 94.1 KPFA Women’s Magazine, out of Berkeley, California
   July 20, 2015
   Accessible from the archives: [https://kpfa.org/program/womens-magazine/](https://kpfa.org/program/womens-magazine/)

3. 2SER Think: Health, out of Sydney, Australia
   August 2, 2015

4. Rádio Estadão “Mapeamento de violência no parto quer prevenir ocorrências nos serviços de saúde”
Newspaper, magazine and blog articles

1. **PUBLIC RELEASE: 30-JUN-2015**

   Targeting mistreatment of women during childbirth

   **PLOS**


   In a new systematic review appearing this week in PLOS Medicine, Meghan Bøhren and colleagues of the WHO Department of Reproductive Health and Research, including HRP, and Johns Hopkins Bloomberg School of Public Health synthesize qualitative and quantitative evidence to form a clearer picture of the extent and types of mistreatment that occur during childbirth in health facilities. Such initiatives are key to developing policies to reduce and ultimately eliminate this inhumane and degrading phenomenon.

   One of the United Nations Millennium Development Goals is to bring about a 75% reduction in the maternal mortality ratio. In 2010, some 289,000 maternal deaths occurred worldwide, many in low and middle income countries. While these numbers explain why attention is focused on a reduction in maternal deaths, attention is also needed to defining and measuring the extent of problems around childbirth, such as mistreatment, to better inform constructive changes in policies and practices.

   The authors assess 65 published studies undertaken in 34 countries and they identify 7 areas of mistreatment and abuse: physical (such as slapping), sexual, verbal, stigma and discrimination; a failure to meet professional standards of care; poor rapport between women and providers and health system constraints (such as a lack of resources to provide women with privacy). This study is the first to provide a comprehensive and evidence-based typology of the mistreatment of women during childbirth. It can be used to develop tools, policies and programs to prevent the mistreatment of women at an obviously vulnerable time. The authors also call for the adoption of the evidence based typology as a means of documenting and measuring mistreatment. Promoting positive birth experiences for women and their families, and providing clinics with adequate resources and trained staff are essential factors to improve the quality of care for mothers and newborns and is critical to further reduce the burden of mortality and morbidity and to reach the United Nations Millennium Development Goals.

---

**Research Article**

Funding: The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript. Funding for this project was received from The United States Agency for International Development (USAID)/USAID Amendment #20, WHO Consolidated Grant GHA-G-00-09-0033) and the UNDP/UNICEF/UNFPA/WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction (HRP), Department of Reproductive Health and Research, World Health Organization. This article represents the views of the named authors only.

Competing Interests: The authors have declared that no competing interests exist.


**Author Affiliations:**

- Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States of America
- Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States of America
- Department of Epidemiology, Biostatistics and Occupational Health, McGill University, Montreal, Quebec, Canada
- Population Services International, Washington, D.C., United States of America
- Department of Social Medicine, Ribeirão Preto Medical School, University of São Paulo, Ribeirão Preto, São Paulo, Brazil

IN YOUR COVERAGE PLEASE USE THIS URL TO PROVIDE ACCESS TO THE FREELY AVAILABLE PAPER:

[http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001847](http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001847)

**Contact:**

Dr Meghan A. Bøhren
mbahren@jhu.edu

---

2. **Report Shows Widespread Mistreatment by Health Workers During Childbirth**

   **By DENISE GRADY**

   **JUNE 30, 2015**

Report Shows Widespread Mistreatment by Health Workers During Childbirth

By DENISE GRADY  JUNE 30, 2015

They are slapped and pinched during labor, yelled at, denied pain medicine, neglected and forced to share beds with other women who just gave birth. And that is just a partial list of the abuses and humiliations inflicted on women around the world as their babies are born.

A new report based on information from 34 countries, published in the journal PLOS Medicine, finds that "many women globally experience poor treatment during childbirth, including abusive, neglectful or disrespectful care."

This kind of mistreatment can drive women away from hospitals and undermine international goals of reducing deaths during childbirth — now about 300,000 a year. Most maternal deaths are preventable. They are caused by problems that can be treated, like bleeding, infection and high blood pressure. Often, to save the woman’s life, the care must be quick and expert.

Health officials say the key to reducing maternal mortality is to increase the proportion of women who give birth in hospitals rather than at home. But women will avoid hospitals if they fear being abused when they are most vulnerable.

"To imagine that women are mistreated during this very special time is truly devastating," said Meghan A. Bohren, a research consultant at the World Health Organization and the first author of the new report.

The W.H.O. had already expressed concern about the issue in a 2014 statement that mentioned many forms of abuse, such as women’s being forced into medical procedures, including sterilization, and mothers’ and infants’ being held in detention in medical facilities for inability to pay.

A commentary in The Lancet in 2014 by researchers from Columbia University said the problem of abusive treatment "runs wide and deep within the maternity services of many countries."

Ms. Bohren said she had worked on women’s health issues in Ghana, Sudan, Uganda, Guinea and Nigeria, and had heard shocking accounts of mistreatment from women, as well as encountering such reports in studies by other researchers.

She said that although many of the abuses occurred on a personal, one-to-one level between health workers and patients, some of the fault also lay with hospitals and health systems. Insufficient staffing, poor training and lack of supervision can all contribute, as can the lack of supplies, water and electricity. A more fundamental problem is the low status of and lack of respect for women in many cultures.

The PLOS article compiles information from 65 studies but does not provide new data or give global measurements of how commonly abuses occur. It cites several studies that do provide estimates based on groups of several hundred to nearly 2,000 women. For instance, a study in Nigeria found that 48 percent of 446 women reported some form of mistreatment. In another study, based on 593 women in Tanzania, the figure was 28 percent.

One goal of the article, Ms. Bohren said, was to categorize the types of problems that women encounter, to aid further studies and to develop ways to
There were seven categories of abuse: physical, sexual, verbal, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and problems with health systems.

The research was paid for by the United States Agency for International Development.

Ms. Bohren said researchers wanted to know, “What do people mean when they say they’re mistreated by health workers?”

Nearly all of the 300,000 women a year who die from complications of pregnancy or birth live in low- and middle-income countries. In poorer countries, about a third of women give birth without what experts call a skilled birth attendant, meaning someone with medical training like a professional midwife, doctor or nurse.

The maternal death rate has dropped in recent years, but not as much as the United Nations hoped in 2000 when it set a millennium development goal of a 75 percent reduction from the 1990 rate by 2015. In 1990, there were 380 maternal deaths per 100,000 births, so a 75 percent reduction would have lowered it to 95 per 100,000. But in 2013, the figure was still 290 per 100,000.

A version of this article appears in print on July 1, 2015, on page A12 of the New York edition with the headline: Abusive Treatment in Childbirth Is Detailed.
8. Report: Women Slapped, Abused During Childbirth WIDESPREAD ABUSES AT THE HANDS OF HEALTH CARE WORKERS
By Brownie Marie, Newser Staff Posted Jul 1, 2015 12:35 PM CDT

9. Startling Number of Women Report Being Abused While Giving Birth
Megan Zander Wednesday at 2:45 PM

10. WHO confirms women face sexual abuse even during childbirth!
Agencies Jul 02, 2015 at 04:09 pm

11. Women face sexual abuse even during childbirth – THE TIMES OF INDIA
IANS | Jul 3, 2015, 01.57PM IST

12. Report Finds Widespread Global Mistreatment of Women during Childbirth
July 2nd, 2015 by Sharon Muza

13. The abuse women suffer from during childbirth that no one’s talking about
http://national.deseretnews.com/article/5058/The-abuse-women-suffer-from-during-childbirth-that-no-one7s-talking-about.html#RyIsUpu2IW2G6ZLd.99

14. Report: Mistreatment of women during childbirth is widespread
July 03, 01:00 PM By Margret Aldrich

15. Targeting indignity of women during childbirth
Wednesday, July 1st, 2015
http://az-neweer.com/targeting-mistreatment-of-women-during-childbirth/

16. Women Around the World Mistreated by Hospital Workers During Childbirth, Says New Study
Maura Hohman
17. Women face sexual abuse even during childbirth, says WHO
   By FPJ Bureau | Jul 03, 2015 12:07 am
   http://www.freepressjournal.in/women-face-sexual-abuse-even-during-childbirth-says-who/

18. Mistreatment Marring Childbirth
   Global Health - NOW
   Jul 01, 2015 9:24:00 AM EDT
   http://www.globalhealthnow.org/news/keyword/maternal%20health

19. Report shows global mistreatment of women during childbirth
   Women in the World

20. Women face sexual abuse even during childbirth: WHO

21. Women face sexual abuse even during childbirth: WHO
    BBC Hindi
    http://bbchindi.net/world-health-organization-women-face-sexual-abuse-even-during-childbirth/

22. Mistreatment during childbirth – Medical Brief
    http://www.medicalbrief.co.za/archives/mistreatment-during-childbirth/

23. Women worldwide are subjected to abuse in labour, study finds
    BMJ
    http://www.bmj.com/content/bmj/351/bmj.h3656.full.pdf

24. PSI email list – MoW article (see pdf)

25. Worldwide, women often face abuse during childbirth
    July 12, 2015
    http://www.freemalaysiatoday.com/category/leisure/2015/07/12/worldwide-women-often-face-abuse-during-childbirth/

26. Women across the globe often face abuse during childbirth
    Source: Fri, 10 Jul 2015 17:45 GMT
    Author: Reuters Health
    http://www.trust.org/item/20150713185102-32b4k/?source=search

27. Mistreatment of women during childbirth in health facilities: in the literature and in the news
    Thursday, July 9, 2015
    by: Emily Peca, Technical Advisor, TRAction Project
28. Mistreatment of women on reddit
   https://www.reddit.com/r/science/comments/3d0eev/the_mistreatment_of_women_during_childbirth_in/

29. Global Mistreatment of Women During Childbirth
   By Gabriella Dentamaro , July 13, 2015

30. WHO pokazuje, że złe traktowanie kobiet przez personel medyczny w trakcie porodu jest powszechne w skali całego świata. Najnowsza publikacja dot. klasyfikacji przemocy w porodzie. / 30.06.2015
   [Polish]

31. Insultées, giflées, pincées : l'incroyable boom des femmes maltraitées durant leur accouchement
   Terrafemina – 17 July

32. WHO: Wanita Sering Mendapat Perlakuan Buruk Petugas Medis Saat Melahirkan
   detikHealth – Nina Sari, 3 July 2015

33. Sederet Daftar Penyiksaan Dialami Ibu Kala Persalinan
   Liputan 6 - Benedikta Desideria

34. Persalinan: Menargetkan Aspek Perlakuan Buruk Pada Wanita
   Bhataramedia 5 July, 2015
   http://www.bhataramedia.com/5739/persalinan-menargetkan-aspek-perlakuan-buruk-pada-wanita/2015/07/05/

35. Folha de São Paulo: Por prevenção, OMS mapeia 7 tipos de violência no parto em serviço de saúde
   12 August 2015

Selected Twitter coverage

**PLOS Medicine** @PLOSMedicine • Jun 30
The Mistreatment of Women During Childbirth in Health Facilities Globally journals.plos.org/plosmedicine/a...

**New York Times World** @nytimesworld • Jun 30
Report shows widespread mistreatment by health workers during childbirth nyt.ms/1KMWYa

**Kay Johnson** @kg813 • Jun 30
Systematic review @JohnsHopkins: Targeting mistreatment of women during childbirth globally ow.ly/30MajL cc @JohnsHopkinsSPH

**Sharon K. D'Agostino** @SharonDAgostino • Jun 30
"Many women globally experience poor treatment during childbirth including abusive,neglectful or disrespectful care" nyt.ms/1T23A8

**Johns Hopkins** @JohnsHopkins • Jun 30
Targeting mistreatment of women during childbirth ow.ly/30MajL cc: @JohnsHopkinsSPH
Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. journa...

@josh_vogel

The mistreatment a shocking number of women face during childbirth is absolutely horrifying. cosm.agi6019B8Z0x

28% of women in Tanzania reported mistreatment during childbirth, says @USAID study. nyti.ms/lRkt3F via @nytimes @PLOSMedicine

Women in health facilities worldwide can be subjected to various types of mistreatment & abuse during birth. bit.ly/1U9929Y @WHO

Report by @PLOSMedicine shows mistreatment of women during childbirth globally. ow.ly/P3hO @nytimes

@USAID-funded study categorizes types of problems women encounter, aids further studies, & develops ways to stop abuse. ow.ly/P3Ay

Abusive treatment "runs wide & deep within maternity services of many countries." Read more: ow.ly/P3AI2 @PLOSMedicine

Proportion of women giving birth in hospitals key to maternal mortality, but they'll avoid them if fear abuse: ow.ly/P3Aq
GirlsGlobe @GirlsGlobe · Jul 2
Report reveals horrific mistreatment of women by health workers during childbirth - including verbal & physical abuse ow.ly/P471Y

USAID Global Health @USAIDGH · Jul 2
Report: mistrust of women drives them away from hospitals & undermines int goals of reducing deaths during childbirth ow.ly/P3AmZ

USAID Global Health @USAIDGH · Jul 2
@USAID-funded study seeks to understand "what do people mean when they say they're mistreated by #HealthWorkers?" ow.ly/P3F9H

USAID Global Health @USAIDGH · Jul 2
New report based on info from 34 countries finds "many women globally experience poor treatment during childbirth..." ow.ly/P3AgS

Women&ForeignPolicy @CFR_WFP · Jul 2
@PLOSMedicine report finds many women globally victim of abusive, neglectful or disrespectful care during childbirth nyt.ms/15G6ILR

USAID Global Health @USAIDGH · Jul 2
@USAID supported study in Tanzania found 28% women reported mistreatment by #HealthWorkers ow.ly/P3Aed @PLOSMedicine

Health SystemsGlobal @H_S_Global · Jul 2
New report: mistreatment by health workers during childbirth - fault lies on #healthsystems? ow.ly/P3Avy

USAID Global Health @USAIDGH
"Though many abuses were 1-on-1 btw #HealthWorkers & patients, some fault also lies w/ hospitals & #HealthSystems." ow.ly/P3Avy

Trent get a warrant @twentysnow · Jul 1
Mistreatment of Women during childbirth - a new dimension of violence against women - @PLOSMedicine journals.plos.org/plosmedicine/a...

Half the Sky Mvmt @Half · Jul 1
Many women experience poor treatment, abuse and humiliation during childbirth, per new @PLOSMedicine report. nyt.ms/1USuqga
USAID Global Health @USAIDGH - Jul 1
Report Shows Widespread Mistreatment by #HealthWorkers During Childbirth ow.ly/P39H via @NYtimes

INAjoch @INAjoch - Jul 1
@RCOObGyn @WHO @PLOSMedicine - a key factor is poor health literacy - so women accept poor care #EndDisrespect

To #EndDisrespect
Mothers Must Know What To EXPECT

RoyalCollegeObGyn @RCOObGyn - Jul 1
Mistreatment and abuse of the women during childbirth ow.ly/P26LF @who @PLOSMedicine - see the science: ow.ly/P27Qa
MEGHAN BOHREN
Boulevard des Philosophes 12  ▪  1205 Geneva, Switzerland  ▪  mbohren1@jhu.edu  ▪  +41 78 68 38 214

EDUCATION

Doctor of Philosophy (PhD) 08/2013 – 02/2016
Department of Population, Family, and Reproductive Health
JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, Baltimore, MD, USA

- **Concentration:** women’s and reproductive health
- **Advisor:** Michelle Hindin
- **Dissertation:** “If I did not slap you, you would not have given birth to your baby”: The mistreatment of women during childbirth
- **Honors:** departmental scholarship, Caroline Cochran Scholarship in Population and Reproductive Health, Bernard and Jane Guyer Scholarship in Maternal and Child Health

Masters of Science in Public Health (MSPH) 08/2010 – 05/2012
Department of Population, Family, and Reproductive Health
JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH, Baltimore, MD, USA

- **Concentration:** women’s and reproductive health; Certificate in Population and Health
- **Advisor:** Amy Tsui
- **Thesis:** Mama REC: Mama is a Researcher, Evaluator, and Change Agent, a PEER Study in Makali, Sudan
- **Honors:** Robertson Endowment, Gates Institute scholarship.

Bachelor of Arts (BA), African Studies
Bachelor of Arts (BA), Psychology 08/2004 – 05/2008
THE COLLEGE OF WILLIAM & MARY, Williamsburg, VA, USA

- **Concentration:** behavioral psychology, sub-Saharan African politics and development
- **Independent study:** The Legacy of the “Dop” System: Impact of Wine Rations on South African Wine Farmers
- **Honors:** Pi Gamma Mu International Honor Society for the Social Sciences, American Institute for Foreign Study International Scholarship.

Certification in Community Development 01/2007 – 12/2007
STELLENBOSCH UNIVERSITY, Stellenbosch, South Africa

- **Concentration:** community development, transitional justice, Xhosa language

PROFESSIONAL EXPERIENCE

World Health Organization, Geneva, Switzerland
**Consultant Research Officer** 06/2014 – present
Maternal and Perinatal Health and Preventing Unsafe Abortion

- Design and manage the formative research component of the Better Outcomes in Labour Difficulty (BOLD) study (Nigeria and Uganda), including protocol and tool development, training of data collectors and data analysis.
- Design and manage the formative research component of the “How women are treated during childbirth: development and validation of measurement tools in four countries” (Ghana, Guinea, Nigeria and Myanmar), including protocol and tool development, training of data collectors and data analysis.
World Health Organization, Geneva, Switzerland  
Consultant 06/2012 – 03/2014
Maternal and Perinatal Health and Preventing Unsafe Abortion
- Conducted a mixed-methods systematic review on the mistreatment of women during childbirth in facilities.
- Conducted a qualitative evidence synthesis on facilitators and barriers to facility-based childbirth in low- and middle-income countries.

Department of International Health, Johns Hopkins Bloomberg School of Public Health
Research Assistant 05/2012 – 05/2014
- Conducted qualitative analysis of longitudinal case studies on the transition of Avahan, a large-scale HIV prevention intervention, from the Gates Foundation to the Indian Government.
- Conducted a bibliometric and funding analysis for research on male circumcision and PMTCT of HIV in Kenya, as part of an evaluation of the Fogarty International Center.

Reproductive and Child Health Research Unit, Khartoum and Kassala, Sudan
Program Manager & Research Fellow 09/2011 – 05/2012
- Designed and implemented a community-based participatory research project in Makali village to investigate maternal and child health priorities.
- Designed and implemented a baseline demographic and health survey, including questionnaire design, data analysis, and GIS measurement.

World Health Organization, Geneva, Switzerland
Intern 06/2011 – 09/2011
- Collaborated to write a policy brief on including sexual and reproductive health in disaster risk reduction plans.

Center for Refugee and Disaster Response, Johns Hopkins Bloomberg School of Public Health
Research Assistant 08/2010 – 06/2011
- Collaborated to conduct a study on mortality in Iraq. Developed and maintained a database in EpiData.

Population Services International, Washington, DC
Research Ethics Board (REB) Coordinator 09/2008 – 08/2010
- Designed toolkits on the REB submission process and trained in-country researchers on ethical treatment of research participants and the REB process. Trained 10 board members.
- Evaluated research conducted by PSI in 66 countries according to ethical standards, and convened monthly REB meetings to review and approve 72 studies in 18 months.
- Honors: Received the Q1 2009 “High Flyer Award” for role in establishing the first REB.

Stellenbosch University HIV Programme, Stellenbosch, South Africa
Peer Educator and Community Outreach Coordinator 01/2007 – 12/2007
- Provided voluntary HIV counseling and testing in townships in the Western Cape
- Organized campus-wide HIV awareness, education, and testing campaign to reduce HIV stigma.

ACADEMIC EXPERIENCE

Cochrane Effective Practice and Organisation of Care (EPOC) Group
Associate editor 05/2015 – present
- Provide peer review of protocols, reviews and review updates for EPOC reviews.
CERQual (Confidence in Evidence from Reviews of Qualitative Research)

Steering group member 11/2014 – present
- Develop the CERQual approach through writing a methodological journal series, user testing and technical support.
- Conduct training workshops for qualitative evidence syntheses and using the CERQual approach.

Johns Hopkins Bloomberg School of Public Health

Teaching assistant 08/2010 – 05/2014
- Life Course Perspectives on Health: 2013
- eHealth and mHealth: Using Technology to Improve Health in LMIC: 2012
- Armed Conflict and Health: 2011, 2012

SELECTED PUBLICATIONS


**COMPETENCIES**

Atlas.ti, Stata, EpiInfo, EpiData, REDCap, Microsoft Access.

**PERSONAL**

Citizenship: United States of America, Bermuda