MEDWIN PUBLISHERS
Committed to Create Value for Researchers

Open Access Journal of Gynecology
ISSN: 2474-9230

# Maternity Violence Must Whither for Safe Mother and Safe Child

**Chhabra S***

Emeritus Professor, Obstetrics Gynecology, Mahatma Gandhi Institute of Medical Science, India

***Corresponding author:** Shakuntala Chhabra, Emeritus Professor, Obstetrics Gynecology, Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha, Maharashtra, India, Tel: +91-9422141696; Email: chhabra_s@rediffmail.com

**Research Article**

**Volume 6 Issue 1**

**Received Date:** February 19, 2021

**Published Date:** March 16, 2021

DOI: 10.23880/oajg-16000211

## Abstract

**Introduction:** It is essential that all pregnant women get quality and dignified care. But it does not seem to be happening. Although there is no consensus on what constitutes respectful or disrespectful care, emerging respectful maternity care (RMC) movement has mission of trying women centered, evidence based, and quality maternity care.

**Objectives:** To collect information about burden of disrespectful care, interventions during pregnancy, birth, post birth which seem to violate woman's rights, and are likely to affect woman's life negatively, physically and mentally.

**Material and Methodology:** Various studies related to maternity care were looked into by using search engines like Google scholar, NCBI, Pub med, upto, date etc. There were no inclusion or exclusion criteria for studies, reviews. Whatever was available was looked into. Local, national and international opinions were also searched and added. Self-experiences too were added.

**Results:** Globally women's health rights advocates have reported that disrespect and abuse during reproductive health care, especially to marginalized women who have limited resources, is widespread. What constitutes disrespectful and abusive care is really not clear but lack of privacy, non-consensual care, verbal, physical abuse, neglect or abandonment, detainment for non-payment of fees and so on seem to be part of every-day care. So how much is the burden is also lacking. So globally researchers are working on finding extent of disrespectful, abusive (D and A) maternity care.

**Conclusion:** There is still no consensus on what constitutes, respectful or disrespectful, maternity care but whatever is believed to be disrespectful seems to be widespread global issue. It is essential that better designed studies are conducted. Studies need to incorporate cultural knowledge, responsiveness of health system, and health policies for delivery of quality maternal care with respect.

**Keywords:** Reproductive Health; Disrespectful; Abusive Care; Must Whither

## Introduction

It is essential that everyone including pregnant women get services which satisfy them and their families and are technically sound. As such it has been opined that if Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs) are to be achieved. It is essential that everyone including pregnant women get quality, dignified and equitable care [1]. On women's international day, April 2014, with launch by the Center for Health and Gender Equity (CHANGE) in conjunction with other Sexual and Reproductive Health Rights and Maternal Health and Rights (IDMHR) organizations, there has been growing consensus among global health leaders for advocacy of comprehensive, quality, respectful reproductive health care for all the women [2]. Because mistreatment during reproductive health care is a serious violation of human rights. However for providing quality care it is essential to understand what quality means to women and girls, because it means different things to different people, health providers as well as health seekers. Quality care seems to mean that whatever is done is evidence based appropriate and does not

do any harm to women, physical and mental and women, feel satisfied.

## Objective

To get information about burden of disrespectful, abusive care, interventions during reproductive health care, pregnancy, birth, post birth and beyond which violate women's rights, affect their physical and mental health negatively.

## Material and Methods

Review of published studies about maternity care was done by using various search engines like Google scholar, NCBI, PubMed, etc. There were no inclusion or exclusion criteria about inclusion of studies and reviews. Whatever could be accessed was looked into. Local, national and international opinions and self-experiences were also added.

## Results

Overall available information suggests that women across the world experience mistreatment during pregnancy, abortion, and childbirth services. They suffer from physical, verbal abuse, discrimination, non-consented interventions, in health facilities across the world. But the magnitude of the problem is really neither well understood, nor well documented. Attempts at definition have been made. Obstetric violence is a specific type of violation of women's rights, including the rights to equality, freedom from discrimination, lack of information, integrity, health, and reproductive autonomy called 'maternity violence [3]. Khosla [4] coined the term 'obstetric violence', which meant 'disrespectful and abusive'(D&A) care that women experienced at healthcare facilities during pregnancy, birth and in the postpartum period'. Bohren [5] and Bowser [6] suggested D&A care, as mistreatment in human care as "interactions or facility conditions during maternity care that are humiliating to women or look undignified [7]". Ogangah, et al. [8] reported that although recognized as an issue since the 1950s, it was not until 2007 that violations of care, D&A maternity services were recorded as part of violation of human rights. Diniz, et al. [9] reported that this aspect of health care began to be formally documented only in recent past. As the work on D&A is growing, defining and measuring this complex phenomenon is becoming a real challenge. Freedman, et al. [7] also opined that the definition and measurement of D&A were complicated because of the subjective nature of experience and the perception of normalization of some D&A practices. In many instances, women themselves did not perceive behaviors as D&A because their perception that was expected. Such practices are common in the health care context. Similarly, women sometimes perceived a behavior as an act of D&A that service providers did not, because it was engrained in their everyday practice. Gherardi [10] opined that D&A also included failure of adherence to evidence-based best practices. Freedman & Kruk [11] suggested that a complete definition of D&A must capture the complex relationship among expectations, normalizations and rights, while acknowledging the link between individual actions and the systemic conditions that sustained it. Bohren, et al. [5] reported that evidence suggested that women across the world experienced mistreatment during childbirth, which included physical, verbal abuse, discrimination non-consented procedures, and non-supportive care. Landscape analysis by Bowser and Hill [6] had brought the issue of D & A care to the attention of global community and review by Bohren, et al. [5] developed a typology of what constituted mistreatments. Still dilemma about what constitutes D, and A care continues.

### Frequency and Types

Rhiannon [12] reported that researchers have identified D &A maternity care widespread globally and they were working on finding out the real burden around the world. However it seems, as of now it is too complex to know the ground reality. Reasons are many. WHO [13] and Tuncalp [14] reported that over the years, a legal construct has emerged in Latin America that encompassed various elements of mistreatment of women during childbirth. Bohren, et al. [15] did a study in twelve health facilities, three per country in Ghana, Guinea, Myanmar, and Nigeria and found that more than a third of women reported experiencing mistreatment and were particularly vulnerable around the time of birth. Women who were younger and less educated were most at risk, suggesting inequalities in treatment. Understanding drivers and structural dimensions of mistreatment, like social inequalities, is also essential. In a study to explore the experiences of women giving birth in hospitals in different settings in Mozambique, prevalence of D & A maternity care was found to be 24% in the central hospitals and 80% in the district hospitals, included, lack of confidentiality, of privacy, being left alone, being shouted or scolded, and being given treatment without permission [16]. The differences in numbers might be due to human resources, infrastructure or behavioural issues too, which need to be understood if D and A care is to be eliminated. The findings of a recent study in Kenya revealed that 20% of women reported D&A care. They experienced feeling of getting humiliated during birth [1]. Exactly what made them feel humiliated was not clear. A 2015 systematic review of 65 qualitative, quantitative, and mixed-methods studies proposed a seven-category model for classifying instances of disrespect and physical, sexual, verbal abuse or stigma and discrimination, failure to meet



Copyright© Chhabra S.

professional standards of care like lack of informed consent and confidentiality, painful examinations and procedures or failure to provide pain relief, and neglect and abandonment, poor rapport between women and service providers; and health systems constraints [5]. In the study of 2016 women, in Ghana, Guinea, Myanmar, and Nigeria 838 (41.6%) reported physical, verbal, or stigma or discrimination, 282(14·0%) experienced physical abuse, most common being slapping, hitting, or punching with substantial variations. Across countries women who had caesarian births, as many as 13.4% had not consented. Those with vaginal birth with episiotomy were not asked consent and 33·8% of those asking for pain relief did not get anything for pain relief, 4·5% of who had VB did not have a provider present, with variations in countries. Most women, 93·8% did not have a birth companion present and quite a few were not allowed companion during labour birth (44·9%). Some of these issues like CS without consent have even legal implications. In Myanmar many women (38·8 %) who had VB did not have access even to oral fluids and many were not allowed food, clear violation of human rights. Most women in Nigeria and Ghana were not told that they could mobilize, during labour and they did not mobilise [15]. These are the reasons why it becomes complex as women do not even know of possibilities. Most women (94·4%) were not asked their preferred birth positions and many (88·5%) reported no preferred birth position too. Almost all women (99·1%) with non-instrumental VB used the dorsal, supine, or lithotomy positions without knowing /or thinking of any other possibilities. Women also reported that providers did not listen or respond to their concerns. According to qualitative research, midwives and doctors described women as "uncooperative" and justified using physical and verbal abuse as "punishment" for non-cooperation to ensure "good outcomes [5,17]". However this is not universal. Studies measured mistreatment using community-based surveys within a similar time period (2–12 weeks post-partum) in India, Brazil, and Tanzania which revealed lower frequencies of physical abuse and verbal abuse [18-21]. It may be women's perception too which makes the numbers low. Afulani, et al. [21] measured person-centred care in Ghana, India, and Kenya, and reported that two-thirds of women said providers did not explain the purpose of examinations or procedures. Woman's previous experiences with the health system and their perceptions of quality care at facilities were reported to influence care seeking for new-borns and children too. They demotivated mothers from utilizing public health facilities including long term services even for their children [22-25]. This aspect needs serious thinking for any health system to work to its optimum capacity. Schroll [26] reported that D&A could occur in low as well as high-income settings, in different forms depending on the context. Researchers reported that the health system constraints included lack of infrastructure to ensure privacy, supplies to ensure that standards of care were met; providers were not overly stressed to effectively attend to the needs of women and their babies. They also included lack of policies for appropriate behavior and facility cultures that promoted bribery and extortion; unclear fee structures or unreasonable requests to women by health workers [5]. Miller, et al. [27] reported that though sometimes effective, even lifesaving, when overused, some procedures, like enema, induction or augmentation of labour, continuous electronic fetal monitoring, episiotomy and CB lead to increase in sufferings of mothers and babies, including short term and long term sequlae but were used, without consultation and discussion with women. Research has shown wide variability in intrapartum practices across the hospitals, be it induction of labor, instrumental deliveries, medication during labor or CB or third stage management [28,29]. This could be due to various reasons including lack of knowledge, needed human resource, infrastructure or just the problem of right attitude. Sobby [30] reported that women undergoing CB in low and middle income countries faced around 100 times higher risk of death than women who had the procedure in the UK . In some regions around one third of CB babies did not survive. Also quarter of all maternal deaths in low and middle income countries were linked to CB (23.8%) and low quality care for those who reported late [30]. Health providers from low resource countries go by advocacy of rich countries without thinking of possibilities in low resource system where they live, do more harm than good, so it is essential that interventions are done to have the best in given circumstances unfortunately. Women hardly get an opportunity to decide about the management in countries where more complications are reported. A study in a Kenya also revealed that increase in facility births than infants born at home between 2009 and 2013 was not associated with a decline in perinatal mortality [31]. Mckenize [32] opined that for too long medical research focused on the quantity at the expense of the quality, more evident in the field of obstetrics. Kunkel, et al. [33] reported that Infants born in facilities had a 41% greater risk of perinatal mortality than infants born at home. Delays in referring and caring for complicated pregnancies, higher risk infants delivering at facilities, and poor quality of care in facilities were the major factors. Poor quality may include delays in reaching, inappropriate timely care due to lack of knowledge, skill or right attitude too.

In a study of public health facilities in Uttar Pradesh, India, it was revealed that women who reported mistreatment during childbirth experienced complications more often during delivery and in the postpartum period [33]. Poor physical outcomes were not the only health impact of D&A maternity care, it adversely affected mental health by creating fear of childbirth. It affected sexuality and even desire to have future pregnancy [26,34]. It generated life-long feelings of guilt and grief in some women [35]. Reed,


Copyright© Chhabra S.

et al. [36] reported that some women even shared that their experience with D&A care in childbirth actually triggered memories of sexual assault. Mothers were separated from their new-borns and detained in the hospitals until they paid for the delivery services [37]. In some health facilities helpers did not allow the mothers to breastfeed the baby unless they were given tips by the mother or family, more so if the baby was male and first child. As such with first child birth women have some difficulties in feeding the baby.

Research about group antenatal care initiative (Pregnancy Circles) in which women with similar duration of pregnancy were brought together for antenatal care which included information sharing and peer support, revealed dissatisfaction with current practices, complete lack of patient-provider communication, less involvement in decision making, and higher chances of perceived discrimination in healthcare [38]. A perceived lack of privacy in group setting, the ramifications of recording blood pressure and urine checks to women, and the involvement of partners in sessions were identified as sticking points.

Research is also lacking in pregnant women's health needs, be it nausea, vomiting of pregnancy and many other issues [38]. This seems to be due to taking all such things as part and parcel of pregnancy, which is bound to be there, revealing lack of concern for wellbeing of women during pregnancies. There has been a staggering lack of investment in drug development for obstetric conditions, a major public health concern, especially because pregnancy complications are the leading causes of mortality of mother, babies and in children under five also globally. Health during pregnancy is known to be a major determinant of women's long-term health and wellbeing [39]. There is mounting evidence of obesity, asthma and other disorders in babies of mothers who get antibiotics during pregnancy, labour. Yet antibiotics indicated / unindicted are being used during pregnancy, labour and postpartum without any discussion with the women [40].

A systematic mapping by Eleri, et al. [41] revealed that globally there was a critical need for better documentation of interventions. The Latin American Centre for Perinatology, Women and Reproductive Health have disseminated evidence-based practices during labour and delivery [8] and in the region, which increased health professionals' knowledge of the benefits of continuous support during labour and delivery, eventually led to the passage of laws in Argentina and Uruguay that provided women with the right to be accompanied by a birth companion of their choice [42]. The initial laws paved the way for a broader legal focus on the experiences of women during birth. Five countries Venezuela, Argentna, Panama, Mexico City. Williams [43] reported that Bolivia implemented legislation addressing maternity violence in slightly different way, but the similarities suggested a shared regional legislative approach that may provide useful lessons for other countries to combat mistreatment of women during childbirth [44,45]. While this is likely to sure change but to a extent as more broader response from health systems is needed. WHO [46] reported that while working with individuals, families and communities to improve maternal and neonatal health a large body of literature revealed that cultural factors affected women's use of services, Interventions around culture and maternal health services are heavily weighted in favour of evidence focusing on sub-populations in high-income countries. WHO [46] also reported that it was also essential to evaluate the ways in which cultural factors could be systematically mainstreamed into programs to improve maternity services? These indicators do not fully reflect or correlate well with quality, nor accounted for women's perceptions or experiences of care, particularly respect, communication, and emotional support [15,46].

## Discussion

D & A maternity care is not a new phenomenon. Women's health and rights advocates have long reported about poor treatment during reproductive and maternity services, especially to poor and marginalized women. However this has become visible in recent past. There are still many invisible, not so obvious aspects with which many women suffer. Understanding drivers and structural dimensions of mistreatment, including gender and social inequalities is essential to ensure adequate accountability for the broader context. In addition to being a health issue, D&A care has negative economic implications. Interventions cost money and time of health providers, and these costs can even be greater if overuse of interventions caused avoidable harm or set off a cascade of interventions. They have long term sequlae too, cascade effect on life cycle, Providers' neglect or abandonment, and can prevent timely or proper diagnosis and treatment of complications. By improving quality of care, facilities can minimize costs and increase efficiency also. There is a need to incorporate cultural knowledge and responsiveness to the development of health policies, and the delivery of culturally-competent maternal care with empathy. Any procedure to be done needed to be explained properly in a simple way which women understood. Women should be comfortable in asking questions, which sure needed to be answered. Pregnancy and birth are physiological processes. So all pregnant woman are not really sick persons and so not really patients. But some 10-15% does have complications which make them sick to be called patients. One must not do anything which makes pregnancy pathological. Health providers must always remember cascade effect, one ripple, leading to another. Women need support and assurance by someone they trust, who remains



Copyright© Chhabra S.

with them, physically allowing them to move according to their choices with reassurance. It is essential to provide them the right information and grant privacy, in terms of service delivery. Midwives who provided services needed to be adequately trained and retrained and supported. Hunter, et al. [47] reported that findings from midwives derived accomplishment and job satisfaction from group ANC revealed that it empowered women and enhanced their care.

The WHO Intrapartum care guidelines [48] recommended respectful maternity care that maintained "dignity, privacy, and confidentiality, ensured freedom from harm and mistreatment, and enabled informed choice and continuous support during labour and childbirth without stigma or discrimination. Human rights violation that undercut woman's autonomy, which erode satisfaction and trust in the health system, ultimately leading to adverse health outcomes need to be studied.

A technical consultation recommended that WHO initiate research to develop and validate tools to measure the mistreatment of women during childbirth [16]. Brizuela [49] opined that more research was needed to explore how women reported experiences of mistreatment during childbirth also further adaptation will be required to use these tools for facility-based assessment of women's experiences within widely used mechanisms. Long-term improvements will require collaborative, multi-sector efforts with healthcare institutions. New guidelines and accountability procedures are needed and advocacy groups too, which inform women of their legal and human rights in maternity settings. Public health researchers needed to document and monitor women's experiences of care. Some countries have made others are making laws about respectful care, empowering women and families to claim their rights to health care without discrimination. Also often when policies and programs meant for women and girls are made and designed, their voices are not heard. Women's and girls' opinions about their health and related issues must be valued so that they can best decide about their health. The legal concept of maternity violence can serve as a framework for combating systemic failures in implementation of quality maternity care by encouraging women to take their cases of rights violation to the courts, if the need be, clearly delineating responsibilities and obligations of healthcare providers.

While legislations may not solve all the problems of stopping mistreatment, but will sure provide foundations on which to build societies that protected women rights and advocated dignified, quality maternity care as right of every woman. May be Doula movement can make some change. According to DONA International, Doulas are non-clinical professionals who provided educational, emotional, and physical support to clients during pregnancy, labour, delivery, and postpartum [50]. Currently, there is no federal regulation of the Doula profession, and therefore, there are no universally-accepted competencies. Gebel, et al. [51] reported that in the United States, there were over 80 organizations and programs that trained or certified Doulas, and each had its own approach, scope of practice, and educational content. As Doula care is not currently a covered health service, the vast majority of Doulas make a living by serving clients who are able to pay out-of-pocket. Several states in America have introduced legislation related to Medicaid coverage. Doula services may have these effects by physical presence and moral support. Better communication also helps. A Cochrane review published in 2017 revealed continuous support during childbirth linked to benefits for birthing women, including higher patient satisfaction, increased like-hood of spontaneous VB, and shorter labors.

Some studies have also found that Doula care was associated with decreased risk of preterm birth and postpartum depression, better infant APGAR scores, and higher breastfeeding rated in some populations. Many of these outcomes need more rigorous research to better understand how Doula care impacted short- and long-term maternal and new-born health outcomes in different populations. Reductions in CB and preterm births in particular, can lead substantial cost savings for health care systems [52]. In addition to reducing costs, Doulas could offer a unique opportunity for health care systems to reduce workloads for nurses and frontline providers with many simultaneous responsibilities, retain patients for future pregnancies and other services, and attract new patients by providing a unique, valuable service with the shift towards value-based health care models. There is enough evidence to suggest that support during childbirth can decrease risk of cesarean and instrumental birth, as well as Intrapartum analgesia.

## Conclusion

Although there is still no consensus on what constitutes disrespectful, and respectful care, D&A maternity care is a widespread global issue. As the work on D&A is growing, defining and measuring this complex phenomenon are big challenges. Women's and girls' opinions about their health and related issues must be valued so that they can best decide about their health and help in complexity of understanding the complex problem and its burden. There is need to incorporate cultural knowledge, responsiveness into health system, development of health policies, for delivery of quality maternal care with respect, empathy and try have health providers with knowledge, skill, right attitude with infrastructure for them to serve pregnant women with respect.



Copyright© Chhabra S.

## References


1. Lin V, Leung G, Carter B (2019) Asia-Pacific countries moving toward universal health coverage. Health Systems & Reform 5(1): 1-6.

2. Harvard TH Chan (2018) Three of the B vitamins: folate, vitamin B. 6. School of Public Health.

3. Obstetric Violence. GIRE.

4. Khosla R, Zampas C, Vogel JP, Bohren MA, Roseman M, et al. (2016) International human rights and the mistreatment of women during childbirth. Health and human rights 18(2): 131-143.

5. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, et al. (2015) The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS medicine 12(6): e1001847.

6. Bowser D, Hill K (2010) Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis. USAID.

7. Freedman LP, Ramsey K, Abuya T, Bellows B, Ndwiga C, et al. (2014) Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. Bulletin of the World Health Organization 92: 915-917.

8. Ogangah C, Slattery E, Mehta A (2007) Failure to deliver: violations of Women's human rights in Kenyan health facilities. Center for Reproductive Rights.

9. Diniz SG, de Oliveira Salgado H, de Aguiar Andrezzo HF, de Carvalho PG, Carvalho PC, et al. (2015) Abuse and disrespect in childbirth care as a public health issue in Brazil: origins, definitions, impacts on maternal health, and proposals for its prevention. Journal of Human Growth and Development 25(3): 377-382.

10. Gherardi N (2016) Otras formas de violencia contra las mujeres que reconocer, nombrar y visibilizar. CEPAL.

11. Freedman LP, Kruk ME (2014) Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. The Lancet 384(9948): e42-e44.

12. Rhiannon C (2018) Landmark Ruling in Kenya: A Victory for Respectful Maternity Care. Maternal health Task Force.

13. WHO (2014) The prevention and elimination of disrespect and abuse during facility-based childbirth. World Health Organization.

14. Tunçalp Ö, Were WM, MacLennan C, Oladapo OT, Gülmezoglu AM, et al. (2015) Quality of care for pregnant women and newborns-the WHO vision. BJOG 122(8): 1045-1049.

15. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, et al. (2019) How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. The Lancet 394(10210): 1750-1763.

16. Galle A, Manaharlal H, Cumbane E, Picardo J, Griffin S, et al. (2019) Disrespect and abuse during facility-based childbirth in southern Mozambique: a cross-sectional study. BMC pregnancy and childbirth 19(1): 369.

17. Joseph G, Da Silva IC, Wehrmeister FC, Barros AJ, Victora CG (2016) Inequalities in the coverage of place of delivery and skilled birth attendance: analyses of cross-sectional surveys in 80 low and middle-income countries. Reproductive health 13(1): 1-3.

18. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, et al. (2018) Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. Health Policy and Planning 33(1): e26-e33.

19. Dey A, Shakya HB, Chandurkar D, Kumar S, Das AK, et al. (2017) Discordance in self-report and observation data on mistreatment of women by providers during childbirth in Uttar Pradesh, India. Reproductive health 14(1): 149.

20. Azhar Z, Oyebode O, Masud H (2018) Disrespect and abuse during childbirth in district Gujrat, Pakistan: a quest for respectful maternity care. PLoS One 13(7): e0200318.

21. Mesenburg MA, Victora CG, Serruya SJ, de León RP, Damaso AH, et al. (2018) Disrespect and abuse of women during the process of childbirth in the 2015 Pelotas birth cohort. Reproductive health 15(1): 54.

22. Afulani PA, Phillips B, Aborigo RA, Moyer CA (2019) Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India. The Lancet Global Health 7(1): e96-e109.

23. Syed U, Khadka N, Khan A, Wall S (2008) Care-seeking practices in South Asia: using formative research to design program interventions to save newborn lives. Journal of perinatology 28(2): S9-S13.

24. Atuyambe L, Mirembe F, Annika J, Kirumira EK, Faxelid E (2009) Seeking safety and empathy: adolescent health seeking behavior during pregnancy and early




Copyright© Chhabra S.

motherhood in central Uganda. Journal of adolescence 32(4): 781-796.

25. Colvin CJ, Smith HJ, Swartz A, Ahs JW, de Heer J, et al. (2013) Understanding careseeking for child illness in sub-Saharan Africa: a systematic review and conceptual framework based on qualitative research of household recognition and response to child diarrhoea, pneumonia and malaria. Soc Sci Med 86: 66-78.

26. Schroll AM, Kjærgaard H, Midtgaard J (2013) Encountering abuse in health care; lifetime experiences in postnatal women-a qualitative study. BMC pregnancy and childbirth 13(1): 74.

27. Miller S, Abalos E, Chamillard M, Ciapponi A, Colaci D, et al. (2016) Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. The Lancet 388(10056): 2176-2192.

28. Glantz JC (2003) Labor induction rate variation in upstate New York: what is the difference? Birth 30(3): 168-174.

29. Barger MK, Dunn JT, Bearman S, DeLain M, Gates E (2013) A survey of access to trial of labor in California hospitals in 2012. BMC Pregnancy and childbirth.

30. Torjesen I (2019) Caesarean section is highly risky for mothers and babies in low and middle income countries 364: l1499.

31. Kunkel M, Marete I, Cheng ER, Bucher S, Liechty E, et al. (2019) Place of delivery and perinatal mortality in Kenya. InSeminars in Perinatology 43(5): 252-259.

32. Lightly K, Weeks AD (2019) Induction of labour should be offered to all women at term. FOR: Induction of labour should be offered at term 126(13): 1598-1598.

33. Raj A, Dey A, Boyce S, Seth A, Bora S, et al. (2017) Associations between mistreatment by a provider during childbirth and maternal health complications in Uttar Pradesh, India. Maternal and Child Health Journal 21(9): 1821-1833.

34. Lukasse M, Schroll AM, Karro H, Schei B, Steingrimsdottir T, et al. (2015) Prevalence of experienced abuse in healthcare and associated obstetric characteristics in six European countries. Acta Obstet Gynecol Scand 94(5): 508-517.

35. Forssén AS (2012) Lifelong significance of disempowering experiences in prenatal and maternity care: interviews with elderly Swedish women. Qualitative Health Research 22(11): 1535-1546.

36. Reed R, Sharman R, Inglis C (2017) Women's descriptions of childbirth trauma relating to care provider actions and interactions. BMC pregnancy and childbirth 17(1): 21.

37. Saha S, Beach MC, Cooper LA (2008) Patient centeredness, cultural competence and healthcare quality. Journal of the National Medical Association 100(11): 1275-1285.

38. Jolivet RR, Uttekar BV, O'Connor M, Lakhwani K, Sharma J, et al. (2018) Exploring perceptions of group antenatal Care in Urban India: results of a feasibility study. Reproductive health 15(1): 1-1.

39. Sarah JE Stock, Jane E Norman (2019) Medicines in pregnancy. F1000Research.

40. Costelloe C, Metcalfe C, Lovering A, Mant D, Hay AD (2010) Effect of antibiotic prescribing in primary care on antimicrobial resistance in individual patients: systematic review and meta-analysis. The Bm 340: c2096.

41. Shahverdi H, Sohrabi M, Fatemi M, Jamiolahmady M (2011) Three-phase relative permeability and hysteresis effect during WAG process in mixed wet and low IFT systems. Journal of Petroleum Science and Engineering 78(3-4): 732-739.

42. Lavoie PM, Popescu CR, Molyneux EM, Wynn JL, Chiume M, et al. (2019) Rethinking management of neonates at risk of sepsis. The Lancet 394(10195): 279-281.

43. Williams CR, Jerez C, Klein K, Correa M, Belizan J, et al. (2018) Obstetric violence: a Latin American legal response to mistreatment during childbirth. BJOG 125(10): 1208-1211.

44. WHO (2003) Working with individuals, families and communities to improve maternal and newborn health. World Health Organization.

45. Barker G, Ricardo C, Nascimento M (2007) Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. World Health Organization.

46. WHO (2016) Standards for improving quality of maternal and newborn care in health facilities. World Health Organization.

47. Hunter L, Da Motta G, McCourt C, Wiseman O, Rayment J, et al. (2018) It makes sense and it works': Maternity care providers' perspectives on the feasibility of a group antenatal care model (Pregnancy Circles). Midwifery 66: 56-63.

48. Gabrysch S, Nesbitt RC, Schoeps A, Hurt L, Soremekun



Copyright© Chhabra S.

S, et al. (2019) Does facility birth reduce maternal and perinatal mortality in Brong Ahafo, Ghana? A secondary analysis using data on 119 244 pregnancies from two cluster-randomised controlled trials. The Lancet Global health 7(8): e1074-e1087.

49. Brizuela V, Leslie HH, Sharma J, Langer A, Tunçalp Ö (2019) Measuring quality of care for all women and newborns: how do we know if we are doing it right? A review of facility assessment tools. The Lancet Global Health 7(5): e624-e632.

50. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, et al. (2018) High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health 6(11): e1196-e1252.

51. Gebel C, Hodin S (2020) Expanding Access to Doula Care: State of the Union. Maternal Health Task Force.

52. Kozhimannil KB, Hardeman RR, Attanasio LB, Blauer Peterson C, O'brien M (2013) Doula care, birth outcomes, and costs among Medicaid beneficiaries. American journal of public health 103(4): e113-e121.

Copyright© Chhabra S.