Disrespect & Abuse in Childbirth: Learning at the intersection of public health and human rights

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Assertion #1: Human rights dilemma

In economic and social rights concerning access to human services such as health care,

**Human rights dilemma:**

Human rts can expose-and-denounce, name-and-shame, BUT

It does not have the tools to fully design and implement evidence-based interventions to address violations
Assertion #2: Public health dilemma

In the areas of human services such as maternal health:

Public health dilemma:

“Persistent implementation failure”

PH view shaped by RCTs, “best practices” and logframes often misses social and political dynamics crucial to successful implementation
Pathway to address a problem

Identification
- Landscape analysis
- Human rights reports
- Anecdotal evidence

Measurement
- Definition
- Measurement methods

Intervention

Implementation
Building blocks of a definition of D&A

- A list of objective or observable actions/behaviors, some of which are context specific
- Actions that are experienced as disrespectful or abusive
- Intentional infliction of pain or emotional distress or humiliation, either by commission or omission
- Facility conditions and clinical treatment that do not meet accepted/consensus standards found in the human rights documents, national law, policies (AAAQ).
Defining disrespectful and abusive care

What women experience as D&A, but providers & the system consider normal and acceptable

What women experience as D&A, but providers are doing the best they can with what they have

National standards of good quality care

Human rights standards (available, accessible, acceptable, quality)
Defining disrespectful and abusive care

What all agree is D&A

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POLICY PURPOSES
Defining disrespectful and abusive care

What women experience as D&A, but providers & the system consider normal and acceptable

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National standards of good quality care

Human rights standards (available, accessible, acceptable, quality)

Prevalence

Measure

Measurement
Defining disrespectful and abusive care

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INTERVENTION PRIORITY

Measurement
## D&A categories and events

<table>
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<th>Category</th>
<th>Events</th>
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| **NON-DIGNIFIED CARE**                     | • Shouting at/scolding patient  
• Threaten to withhold treatment  
• Negative/discouraging comments to patient |
| **ABANDONMENT**                            | • Ignoring patients and requests for assistance  
• No attendant at delivery |
| **PHYSICAL ABUSE**                         | • Hitting/slapping/pushing/pinching, etc.  
• Rape |
| **NON-CONFIDENTIAL CARE**                  | • Discuss patient’s private health information in public  
• Share patient’s health information  
• Patient’s body seen by others |
| **NON-CONSENTED CARE**                     | • Tubal ligation, caesarean or hysterectomy without consent |
| **INAPPROPRIATE DEMANDS FOR PAYMENT**      | • Request bribes/informal payments  
• Mother or baby held at the facility due to failure to pay |
Measurement: 3 different prevalence measures in Tanga Region, Tanzania

- Any D&A: Facility Exit (n=1,761) - 19.5%, Community Follow-up (n=592) - 28.2%, Observation (n=310) - 71.3%
- Non-dignified: Facility Exit (n=1,761) - 12.9%, Community Follow-up (n=592) - 18.9%, Observation (n=310) - 63.6%
- Abandoned: Facility Exit (n=1,761) - 8.5%, Community Follow-up (n=592) - 15.5%, Observation (n=310) - 20.1%
- Non-confidential: Facility Exit (n=1,761) - 5.2%, Community Follow-up (n=592) - 6.2%, Observation (n=310) - 9.1%
- Physical abuse: Facility Exit (n=1,761) - 2.9%, Community Follow-up (n=592) - 5.1%, Observation (n=310) - 12.9%
- Demands for payment: Facility Exit (n=1,761) - 1.9%, Community Follow-up (n=592) - 3.4%, Observation (n=310) - 1.6%
- Non-consented: Facility Exit (n=1,761) - 0.2%, Community Follow-up (n=592) - 0.2%, Observation (n=310) - 0.3%
Pathway to address a problem

Identification → Measurement → Intervention → Implementation
“Common sense” interventions

- Patient charters: values/norms standardization
- Suggestion boxes: community voice
- Health facility governing committees: community participation
- Education/awareness: training and workshops

Often ignores: power dynamics, context, process, existing literature
Pathway to address a problem

Identification → Measurement → Intervention → Implementation

How do we support robust implementation?
Degrees of implementation

- **Paper implementation**: putting policies into place

- **Process implementation**: putting new operating procedures into place

- **Performance implementation**: putting procedures and processes into place in such a way that the identified functional components of change happen with intended health benefits for users

Fixsen et al, 2005
Staha Intervention Change Process

**Charter adaptation process**

1. District level patient-provider charter adaptation
2. Facility level patient-provider charter adaptation
3. Mutual respect norms and standards

**Facility-based process**

1. Maternity forum
2. Collaborative forum
3. Implement and monitor change

**Results**

- Build mutual respect
- Improve respectful care
- Reduced D&A during childbirth

**STAHA Change Process: 9 months**
References


