health care and services to women, newborn infants, and children, are often not included in the policy dialogue on health plans and health-system strengthening.

To make progress and optimise use of skills of all who are contributing to reproductive, maternal, newborn and child health, we need to work in a coherent way recognising the strengths and limitations of every cadre of provider. Systems need to be in place for integration of care across facility and community settings. Respectful women-centred care needs to follow women from the community to acute settings if required and back to the community again. Care delivery needs to be flexible, particularly in rural and remote settings. Midwifery care providers need to be well equipped to detect early warning signs of problems or complications, particularly in those settings in which access to other providers and services might not be easy. They need to have mechanisms, processes, and transport in place to appropriately refer patients, be prepared to provide emergency care as needed, be appropriately resourced and equipped with the right skill set, and authorised with the right scope of practice.

Multidisciplinary collaboration and effective teamwork among the various contributors to maternal child health are needed at the local, country, regional, and international level. We need to move beyond turf wars and always keep the health and wellbeing of the mother and baby central in any decision making and practice.

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# Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas

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The framework for Quality Maternal and Newborn Care on which the *Lancet* Midwifery Series is based,[1] signals a welcome shift in the perspective that should guide planning, implementation, and assessment of maternal newborn health services: the analysis starts with what women need and want during pregnancy and childbirth. From this perspective, quality is not the last step in a chronological sequence of actions to expand coverage of clinical interventions to reduce mortality and morbidity; rather, quality must be a priority from the start.[2] Yet, as Wim van Lerberghe and colleagues[3] have put it, managing quality will entail addressing the "blind-spot" of respectful, women-centred care.

Blind-spot is indeed an appropriate metaphor for the way that disrespectful and abusive treatment (D&A) of women during childbirth in facilities has evaded the attention of the global health community and of national and local health authorities, including those governing midwifery and other health professions, in countries worldwide, both rich and poor. But it has not evaded the attention of women themselves: women choose where to deliver based in large part on their perceptions of the way they will be treated in the facilities available to them.[4,5] Nor has it evaded the attention of human rights organisations that have issued searing reports of abuse,[6] or of advocates and plaintiffs who have challenged egregious cases through litigation in national courts.[7]

Research on the prevalence and nature of D&A reveals that this is not the phenomenon of a few bad apples. Rather, it runs wide and deep within the maternity services of many countries. And the spectrum of D&A is broad too: from shouting and scolding, to slapping and pinching, to abandonment of patients, discrimination, and non-consented interventions.[8] D&A is inflicted not only by individual providers, but also by health systems as a whole when the conditions in facilities deviate greatly from accepted standards of care and of infrastructure, staff, equipment, and supplies needed to deliver that care.

To define D&A, which is essential both for measurement and for accountability, is a complex challenge. The "legitimate right to and expectations for equitable, high-quality, safe, and respectful care" that the *Lancet* Midwifery Series endorses,[2] although straightforward as a statement of aspiration for the health system, is harder to discern and use as a principle for research and intervention on the ground. Practices that to the outside advocate or trained observer seem unambiguously disrespectful or

abusive are often normalised by patients or providers, or both. The expectations, meanings, intentions, and rationalisations that surround a sharp slap and angry word while a woman struggles to push in the final stages of labour remind us that health systems often reflect the deeper dynamics of power and inequity that shape the broader societies in which they are embedded.

Working on this challenge, our multidisciplinary team including researchers from Columbia University (NY, USA) and Ifakara Health Institute (Dar es Salaam, Tanzania), advocates, and health managers from Tanga region in Tanzania, together with a multidisciplinary, multiorganisational team led by the Population Council in Kenya, developed a definition of D&A that is expressed through the bullseye diagram shown in the figure. The bullseye captures the complex relationship among expectations, normalisation, and rights, while acknowledging the link between individual action and the systemic conditions that sustain it.

Defined and understood in this way, D&A is a signal of a health system in crisis—a crisis of quality and accountability. At the most fundamental level, a health system that tolerates D&A devalues women, which itself is an underlying cause of slow progress on reduction of maternal mortality. Moreover, D&A represents a breakdown in accountability of the health system not only to its users but also to the women and men it employs as service providers. Themselves subject to degrading and disrespectful working conditions, providers' professional ideals often succumb to the pressure of emotional and physical survival strategies—a midwife providing compassionate care at one moment might be overwhelmed by the stress of unmeetable demands in the next and lash out at the women she attends.[9]

Yet, action at the global level to address both quality and accountability reflects little recognition of these dynamics. Dominated by a top-down approach focused on promoting effective coverage of evidence-based clinical interventions, the push has been to find the right metrics against which countries must then report their progress in achieving set targets. This technocratic approach puts its faith in the power of measurement and transparent information to drive action. Yet global advocacy for standards of respectful maternity care that can be measured and monitored is far from sufficient.

We do not dismiss the use of normative standards and traditional accountability techniques in a broader effort to address D&A. But if we are serious in saying that quality starts with what women need and want, then quality of care efforts must start where women live and labour. These efforts need to confront the often harsh realities at the front line of resource-constrained health systems by supporting and reinforcing the agency of women and communities to demand better care and empowering health workers and managers to make necessary changes.

We certainly need a vision of respectful maternity care that is meaningful for all women and health providers everywhere. But when D&A is called out for what it is—the symptom of fractured health systems and locally expressed power dynamics that conspire against both patients and providers—then the real work of improving quality and creating accountability can begin.

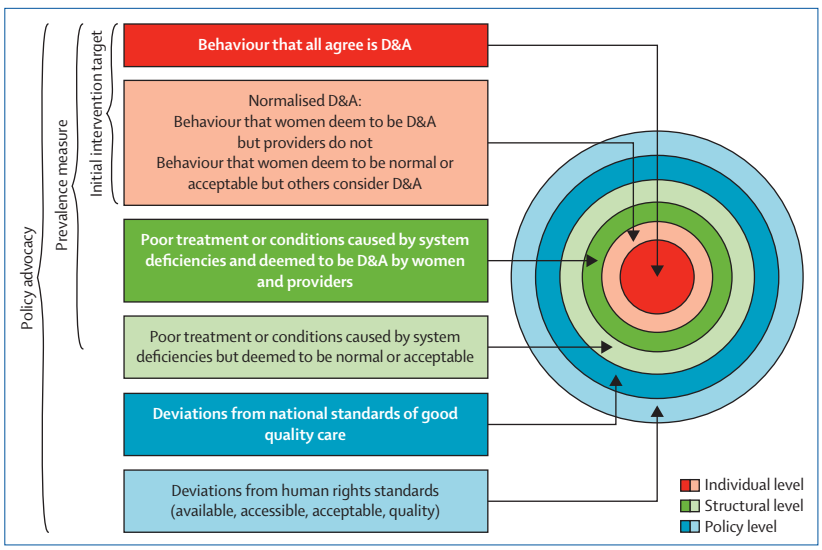


*Figure:* **Definition of disrespectful and abusive treatment (D&A) of women in childbirth**

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