MORE UNKNOWNS THAN KNOWNS:
CHARTING A COURSE FROM OBSTETRIC MISTREATMENT TOWARDS ENSURING RESPECTFUL
MATERNITY CARE FOR ALL

by

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Abstract

In 2015, the World Health Organization issued a landmark systematic review on obstetric mistreatment – briefly defined as disrespectful, abusive and/or unprofessional treatment of women during childbirth by their health providers. However, definitions used in the literature are varied, and there is currently no gold standard measure for the phenomenon. This paper provides a commentary on the existing literature, and proposes two projects (a systematic literature review and an observational study) that respond to the critiques raised in the commentary. Taken together, these studies will help strengthen understanding of the prevalence of mistreatment during childbirth and its impact on health, and contribute to an emerging area in global maternal and child health.
Overview

Currently there is no scientific consensus for how “obstetric mistreatment”\(^1\) should be defined or measured, making an accurate estimation of prevalence difficult. However, an emerging body of literature suggests that obstetric mistreatment is pervasive, both in the public and private health sectors in many countries.

Members of the Department of Reproductive Health and Research at the World Health Organization (WHO) have developed an instrument for measuring the prevalence of obstetric mistreatment that is currently being pilot tested in Ghana, Guinea, Myanmar and Nigeria (1). However, there is strong evidence to suggest that disrespectful and abusive treatment also occurs in Latin America and the Caribbean, and that the form it takes may be different than in other regions, suggesting a need for the WHO’s instrument to also be validated in this context.

Moreover, little is known about the effect that obstetric mistreatment has on health outcomes. To-date the vast majority of the English-language research has focused on the effect of obstetric mistreatment on rates of facility delivery, positing that experiencing disrespectful or abusive care during childbirth could deter women from returning to health facilities during a subsequent pregnancy. Yet this assumption ignores the possible existence of another mechanism – namely that exposure to obstetric mistreatment might directly elevate the risk of adverse outcomes in the current pregnancy. Observational and anthropological studies conducted in settings with high rates of facility delivery, particularly Latin American and Caribbean countries, seem to

\(^1\) What the WHO refers to as “obstetric mistreatment” has also been referred to as “disrespect and abuse during childbirth”, “obstetric violence”, and “abuse in health care” by other researchers. Some authors and advocates have chosen to focus instead on its converse, called “respectful maternity care” or “humanized birth.” For the purposes of this paper, WHO’s definition and terminology will be used.
suggest the existence of such a direct causal pathway, yet conclusive evidence of this link is lacking.

More research is needed to determine whether and how the prevalence of obstetric mistreatment may vary in different regions of the world, and whether there is a direct association between obstetric mistreatment and adverse health outcomes. In this paper, I propose two studies: a prevalence study in Argentina using the WHO’s metric for disrespectful and abusive treatment during childbirth and a globally-oriented systematic review to help organize what is known with regards to the varied ways in which obstetric mistreatment impacts health outcomes. Together, these studies will help contribute to the development and evaluation of interventions to combat mistreatment during childbirth.

**Historical Context: Global**

Each year, approximately 303,000 women die from complications of pregnancy and childbirth (2). Though expert consensus is that maternal deaths may never be completely eliminated, the vast majority are believed to be preventable (3). Given their preventable nature, and the profound effect maternal deaths have on impacted families and communities, reducing maternal mortality has long been a primary concern of public health programs. Millennium Development Goal 5a (MDG5) challenged the global maternal health community to reduce the global maternal mortality ratio (MMR) by 75% from 1990 levels by the year 2015 (4). While many countries struggled to meet the ambitious target, nine countries achieved it (2). Globally, the number of maternal deaths was nearly halved, in spite of population growth (2). For the 2016-2030 period, Sustainable Development Goal 3.1 has set an even bolder goal: bring the global MMR down to no higher than 70 maternal deaths per 100,000 live births, from an estimated MMR of 216 maternal deaths per 100,000 live births in 2015 (5). In preparing to
launch into this new SDG era, a critical assessment of the lessons learned over the last few decades can help identify what has worked and where course-correction might be needed.

In an effort to reduce maternal mortality, global campaigns have primarily focused on ensuring women have access to timely, quality emergency obstetric care. Through the Safe Motherhood Initiative, launched in 1987, this often took the form of training traditional birth attendants (TBAs) to recognize signs and symptoms of complications and refer women with high-risk obstetric cases to health facilities. However, by the early 2000s, evidence had begun to accumulate that training of TBAs to assess obstetric risk and conduct referrals had limited effectiveness, in part because potentially life-threatening complications can arise suddenly and with little warning (6–9). Further, when such complications occur, they can be addressed successfully only with access to Emergency Obstetric Care (6,9). Consequently, in the MDG era, leading experts in the field called for public health campaigns to trained skilled birth attendants (SBAs) and to urge women to give birth in health facilities under the care of such attendants (8,9).

Through the first decade of the new millennium, this new strategy worked wonders, contributing to the largest decline in maternal mortality known to humankind. Yet as public health professionals around the world raced to meet the audacious target set by MDG5 in the final years of the global Goals, it became apparent that many programs had not laid the groundwork to ensure that health facilities were prepared to handle the influx of new patients. Facilities were understaffed and lacked key equipment and supplies. Those that had undertaken health worker training and capacitation were often staffed with newly minted health care providers who were ill-equipped to handle the pace of deliveries, or were only knowledgeable
enough to manage births with minor complications. Clinical quality of care was uneven and inconsistent (10–12).

Simultaneously, anecdotes began to surface about women refusing to give birth within a health facility due to poor treatment that they received from health providers, ranging from disrespectful interactions to allegations of abuse and corruption (13). In March 2010, the USAID Translating Research into Action (TRAAction) project convened a group of key government and NGO stakeholders to discuss the issue, eventually commissioning a landscaping report to better understand disrespectful and abusive treatment, as well as its converse, respectful maternity care (14). The global maternal health community began to develop a consensus that providing quality care also meant ensuring the human rights of childbearing women, and might require the involvement of a broader set of global health actors (15,16).

**Historical Context: Latin America and the Caribbean**

With the dawn of the new millennium, many Latin American countries began developing an awareness of what in that context was named “obstetric violence,” or mistreatment of women during childbirth. Definitions varied from context to context, but tended to include elements like unconsented care, denial of treatment, physical and verbal abuse, and use of non-medically indicated and/or outdated practices. What started as a series of small country-level activist networks blossomed into a region-wide movement on November 5, 2000 when feminist activists and concerned public health professionals converged in Fortaleza, Brazil for the first International Conference on the Humanization of Labor and Birth. Out of this meeting, the Latin American and Caribbean Network for the Humanization of Labor and Birth (dubbed RELACAHUPAN, for its name in Spanish) was formed (17).
After the Conference, participants returned to their home countries to pursue a political and public health agenda around humanizing birthing experiences for women across the region. Simultaneously, Latin American academics began studying obstetric mistreatment, working to better characterize its antecedents and the forms it took. In 2003, Chilean anthropologist Michelle Sadler published a scathing doctoral dissertation entitled “How They Birthed My Daughter” (“Así Me Nacieron a Mi Hija”), where she analyzed the ways in which poor quality clinical care and disrespectful and abusive treatment of women were intertwined and normalized within Chilean medical practice (18). This piece, and similar work across the region, began to inform RELACAHUAPAN’s emerging political demands.

In 2007, Venezuela became the first country in the world to adopt a law banning obstetric violence (19). Argentina and Mexico were the next to follow suit. In all three countries, the law posits obstetric mistreatment as a form of both clinical malpractice and gender-based violence, with critical feminist analysis underlying major pieces of the legislation (19,20). While these laws signaled major progress for public health and human rights, enforcement and accountability has been problematic since the beginning.

None of the three countries with a legal framework on obstetric violence has a national governmental body charged with surveillance of cases. Rather, civil society organizations have stepped in to fill this role (e.g., Mexico’s *Grupo de Información en Reproducción Elegida* (Information Group on Reproductive Choice) and *Argentina Cuenta la Violencia Machista* (Argentina Counts Sexist Violence)). These organizations record the number of cases reported to them, but do not have a consistent surveillance protocol in place (either active or passive) that would ensure that all cases are captured. To further complicate matters, in some jurisdictions there are multiple organizations that collect reports of obstetric mistreatment, and their roles
and responsibilities may not be clear. For example, a woman who experiences obstetric mistreatment in Buenos Aires, Argentina has the option to file a report with the hospital administration, the afore-mentioned Argentina Cuenta la Violencia Machista, an Obstetric Violence Observatory run by another feminist advocacy organization, and the Gender-Based Violence Observatory administered by the provincial government (21–24). The methodology for collecting information differs among organizations, resulting in widely variable estimates of prevalence. A survey conducted by Argentina Cuenta la Violencia Machista found that 71% of women surveyed in the city of Buenos Aires reported ever experiencing obstetric mistreatment (22). In contrast, over a two-year period covering 2014 and 2015, the Gender-Based Violence Observatory for the Province of Buenos Aires received information about 45 cases out of 579,906 live births (24,25). Such disparate figures suggest a need for standardized metrics and surveillance systems so that the prevalence of obstetric mistreatment can be well-documented.

Towards a single consensus metric

The Department of Reproductive Health and Research at WHO has taken the lead in recognizing the need for a consensus definition and a consistent prevalence metric that could be used to determine the extent of the problem. Bohren et al.’s 2015 article, “The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review” proposed a working definition (26) and that same year, Vogel et al. published a study protocol for developing a tool to measure the prevalence of this type of treatment in health facilities worldwide (1). The study protocol called for the tool to be piloted in Ghana, Guinea, Nigeria and Myanmar. Missing from this group of countries is a representative of Latin America and the Caribbean, despite 15 years of studies documenting the existence of obstetric mistreatment in the region, and considerable activism on the topic, as described above.
More importantly, the existing qualitative studies suggest that the way that disrespectful and abusive treatment presents in the Americas may be different than in other regions. Reports of physical abuse seem to be more frequent in the literature from sub-Saharan Africa, whereas studies from the Americas seem to report more verbal and psychological abuse, including what women perceive to be punitive use of unconsented surgical procedures such as cesarean section and episiotomy, and punitive withholding of evidence-based practices such as pain relief or a birth companion (18,21,27–30). However, without comparative studies using the same instrument across contexts, it is impossible to know whether this perceived difference truly exists.

In addition, some studies from sub-Saharan African countries have suggested that health system resource constraints may underpin some cases of obstetric mistreatment (31,32). Women in Guinea noted that some types of obstetric mistreatment (e.g., a provider slapping a patient) might arise because providers are under extreme duress given the workforce shortages, product and equipment stock-outs, and other resource constraints that define their work environment (31). The implicit observation here is that a higher-resourced health system might result in fewer instances of obstetric mistreatment. Yet without comparable data from more highly-resourced health systems, it is unclear how differential resource constraints (i.e., between a lower middle-income country and an upper middle-income country) might influence providers’ treatment of the women under their care. A prevalence study conducted in an upper-middle income country in Latin America might start to provide evidence to either support or reject this argument.
**Determining public health impact**

In 2010, Bowser and Hill published a proposed typology of the dimensions of obstetric mistreatment (14), which was later augmented by Bohren *et al.* in their 2015 systematic review (26). According to Bohren and colleagues, there are seven overarching dimensions of disrespectful and abusive treatment: physical abuse, verbal abuse, sexual abuse, stigma and discrimination, failure to adhere to professional standards, poor patient-provider communication, and health system limitations and constraints (see Appendix for additional detail) (26).

Currently, obstetric mistreatment is described in the English-language literature primarily as a factor that may deter women from seeking facility-based labor and delivery care, rather than a negative exposure that may directly contribute to adverse maternal, perinatal, or infant health outcomes. Yet authors like Mirjam Lukasse, Arachu Castro, and Rakime Elmir have demonstrated that this type of treatment also occurs in settings with high rates of facility delivery, including contexts as varied as Australia, Belgium, Brazil, Bolivia, Costa Rica, Cuba, Iceland, Mexico, Sweden, and the United States (30,33,34). In Latin America and the Caribbean, 97.2% of all births occur in a health facility and 96.0% are attended by a skilled birthing professional (35). Yet care is not necessarily more respectful than in other low- and middle-income countries outside of the region, nor is it necessarily of higher clinical quality. In Brazil, Nascimento Andrade *et al.* found that a startling 86.6% of women surveyed reported experiencing some form of obstetric mistreatment and/or outdated or harmful clinical practice during their last birth (36). Similarly, Karolinski *et al.* found limited use of evidence-based obstetric practices in public hospitals in Argentina (37), even as human rights organizations and feminist collectives reported cases of abusive care in several of those same hospitals (21). It is
unclear at this juncture the degree to which mistreatment and poor quality clinical care are linked, and what the resultant consequences might be for maternal and infant health outcomes.

Though definitive evidence does not yet exist linking disrespectful and abusive treatment directly to adverse health outcomes, some preliminary studies seem to suggest a causal pathway. In their 2015 review, Castro et al. found that in Latin America and the Caribbean, obstetric mistreatment sometimes took the form of intentional neglect of certain women during labor and delivery and even deliberate refusal of emergency obstetric care (30). These types of mistreatment have clear potential implications for these women’s health outcomes as well as the health outcomes of their infants. More recently, Raj et al. showed that pregnant women delivering in public hospitals in Uttar Pradesh, India who endured obstetric mistreatment had 1.32 times the odds of developing delivery complications (95% CI: 1.05-1.67) and 2.12 times the odds of developing postpartum complications (95% CI: 1.67-2.68) as women who did not experience such treatment (38). These disturbing findings suggest that more research is urgently needed to understand obstetric mistreatment in order to develop evidence-based interventions to protect the human rights of childbearing women and their infants, including potentially to help safeguard their health.

**Advancing the field: Proposals for moving forward**

As with any emerging topic in public health, the growing field of research around obstetric mistreatment still presents more unknowns than knowns. However, two key studies can help to build on existing knowledge and ensure that interventions to prevent disrespectful and abusive treatment are context-specific and culturally-appropriate. The first of these is a prevalence study in Latin America, to help elucidate how obstetric mistreatment presents in the region, and whether that differs from other parts of the world. The second is a systematic literature review
to organize what information is already known about how obstetric mistreatment may affect maternal and infant health outcomes, in order to inform future efforts to understand and prevent it. In this section, I present both proposed studies in additional detail, and discuss the context and new knowledge that they would provide to help advance the field.

Prevalence study in Argentina

As previously mentioned, Argentina is one of three countries in the world that has an existing legal framework regarding obstetric mistreatment. Argentine law locates obstetric mistreatment at the intersection of medical malpractice and gender-based violence, and particularly highlights the overmedicalization of childbirth (i.e., non-medically indicated cesarean sections, routine episiotomy in primigravidas) as a critical element. Against this backdrop, the Dr. Ramón Sardá Maternal-Infant Hospital in Buenos Aires developed clinical practice guidelines explicitly around providing respectful maternity care, and in 2008 they published an article describing their experiences and lessons learned with representatives from the Pan American Health Organization (39). In spite of this, there is currently no estimate of the prevalence of obstetric mistreatment in the country. While anecdotal reports of mistreatment surface periodically, it is unclear whether they represent extreme cases or the proverbial tip of the iceberg.

Given this clinical and legal context, the former may seem more likely. However, during a site visit to a maternity hospital in Tucumán, Argentina in July 2017 to conduct direct observations of provider-patient interactions during childbirth, I witnessed treatment that would meet the WHO’s definition of disrespectful and abusive care in all four births observed. That this occurred despite the presence of an outside observer (who was introduced as a doctoral student from the United States who focuses on quality of care) suggests that such treatment may be common, at least in this one hospital.
These preliminary observations, combined with grey literature publications from both feminist and provider organizations in Argentina, argue for a more systematic accounting of the prevalence of obstetric mistreatment in the country. Moreover, as an upper-middle income country where disrespectful and abusive treatment has received a fair amount of media coverage, Argentina would function as an interesting contrast to the four countries where the Department of Reproductive Health and Research at the WHO is currently conducting its prevalence studies. If the prevalence of obstetric mistreatment is found to be high in Argentina, additional studies would be warranted to understand why, and to explore what types of interventions might be used to reduce the prevalence. If, in contrast, the prevalence of obstetric mistreatment is found to be lower in Argentina than in other countries, future studies could be undertaken to better understand the Argentine experience, and use those learnings to inform interventions in other settings.

In addition, the few published studies with quantitative data on obstetric mistreatment suggest that it may be more commonly experienced by women with low socioeconomic status and/or high parity, women from marginalized or stigmatized populations, and adolescents (27,28,30,40). Despite its status as an upper-middle income country, Argentina has a poverty rate of 30.3% (41), and approximately 15% of all births in the country are to adolescent mothers (42). Thus, a prevalence study conducted in Argentina could be designed to target these groups and allow for subgroup analyses of prevalence in these two vulnerable populations.

An initial study might measure prevalence of obstetric mistreatment in several hospitals simultaneously, to explore whether there are differences in prevalence and types of
mistreatment in different regions of the country (e.g., in Buenos Aires and in more rural provinces) or between the public and private sectors².

The three objectives that such a study might seek to address are:

1. Measure the prevalence of obstetric mistreatment (both generally and across the seven dimensions identified by Bohren et al.) in Argentina.
2. Compare the overall prevalence of obstetric mistreatment between hospitals, as well as the prevalence of the seven dimensions of mistreatment, to determine whether they differ (after adjusting for patient demographics and hospital infrastructure/resources).
3. Explore providers’ perceptions around the causes or factors that may contribute to obstetric mistreatment, to help identify potential areas to target with future interventions.

A study that addresses these three objectives, particularly across multiple settings in Argentina, could provide key insights into the ways in which population- and institution-level factors may influence the prevalence of obstetric mistreatment, as well as the form in which it presents. Set within the broader context of prevalence studies coming out of sub-Saharan Africa and South/Southeast Asia, such information could prove critical for better understanding this complex issue. In addition, the final objective around exploring provider perceptions (which could be conducted through a mix of focus group discussions and in-depth interviews with key informants), would generate ideas for potential interventions, as well as offering important context for the complex milieu in which disrespectful and abusive treatment occurs.

² Interestingly, in the Province of Buenos Aires, 40% of the reports of obstetric mistreatment filed with the Gender-Based Violence Observatory have been from women who gave birth in private hospitals, indicating that this is not an issue that solely afflicts the public sector (24).
Systematic Review

Bohren et al.’s systematic review examined the various forms that obstetric mistreatment might take in order to provide a working definition to organize future work in the field (26). Castro et al.’s literature review focused on identifying potential upstream factors that influence the likelihood that a provider might direct disrespectful or abusive treatment at a pregnant woman (30). Yet there currently exists no comparable review exploring the existence of a causal mechanism that links obstetric mistreatment and poor health outcomes.

Thus, I propose a systematic review to begin addressing two important gaps in the literature: 1) determining whether obstetric mistreatment increases the risk of specific maternal, perinatal, and infant health outcomes related to the same pregnancy; and 2) identifying pathways through which this might occur, in order to guide further empirical research. Although obstetric mistreatment is a relatively new topic in public health, other disciplines including anthropology, sociology, and feminist critique have reported on it for decades, meaning that a review of all relevant literature could reap benefits for public health researchers looking to better understand the phenomenon. Similarly, human rights organizations including Amnesty International and the Center for Reproductive Rights have published case reports and even prosecuted legal cases around obstetric mistreatment, all of which could provide valuable insight towards developing targeted interventions. Thus, the proposed review would be designed to be interdisciplinary from the start, and to include not only peer-reviewed publications but also grey literature, in order to build synergistically off of this existing body of knowledge.

There are several dates that could provide reasonable starting points for this review, including the publication of the U.K.’s Peel Report in 1971, which advocated for all births in the U.K. to
occur within a health facility, influencing practice trends around the globe. However, the significant cultural and social shifts since the 1970s might make results difficult to compare meaningfully. Perhaps then a more useful start date for the review would be January 1, 2000, officially the start of the MDG era, since MDG 5 (Reduce maternal mortality by 75%) contributed to a dramatic increase in the focus placed on ensuring that women gave birth in health facilities with the aid of a skilled birth attendant. As this is an emerging area in the public health literature with studies being published with increasing frequency, the search would need to be conducted both at the start of the study and once the analysis was conducted and initial draft of the manuscript prepared, in order to ensure that newly published articles were included. The review could be divided into two components, to address each of the two objectives identified above.

In order to respond to the first gap (Is there a causal relationship between obstetric mistreatment and adverse health outcomes?), quantitative data like that collected by Raj et al. (38) could be used to calculate the odds of experiencing an adverse outcome between women who suffered mistreatment and those who did not (experience of mistreatment measured either by self-report or by direct observation). In order to address the second gap (How might obstetric mistreatment contribute to adverse outcomes?), qualitative data could be used to complement the quantitative data and identify potential pathways linking mistreatment to adverse maternal and infant health outcomes, such as those listed in Table 1 below:

<table>
<thead>
<tr>
<th>Table 1: Proposed outcomes</th>
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<tbody>
<tr>
<td>• Maternal mortality</td>
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<tr>
<td>• Maternal morbidity</td>
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<tr>
<td>• Stillbirth</td>
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<tr>
<td>• Infant mortality</td>
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<tr>
<td>• Infant morbidity</td>
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<td>---------------------------</td>
</tr>
<tr>
<td>• Initiation and exclusivity of breastfeeding</td>
</tr>
<tr>
<td>• Subsequent use of modern contraceptives</td>
</tr>
<tr>
<td>• Postpartum depression</td>
</tr>
<tr>
<td>• Posttraumatic stress disorder</td>
</tr>
<tr>
<td>• Mother-infant bonding</td>
</tr>
<tr>
<td>• Infant weight gain</td>
</tr>
<tr>
<td>• Timely immunization of the infant</td>
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</tbody>
</table>
The overall search strategy would consist of a comprehensive initial search of bibliographic databases, a review of the reference lists of the primary studies identified in the initial search, and then hand-searching of the archives of relevant government bodies and NGOs in order to identify relevant grey literature. In order to ensure that insights from the full range of disciplines working on obstetric mistreatment are taken into account, this review would intentionally search not only the key medical/public health databases (MEDLINE (using PubMed), CINAHL, Embase, and the Cochrane Library), but also databases they may be more commonly used by researchers working in Latin America and the Caribbean, such as LILACS, and those in pertinent disciplines beyond public health, such as PsycInfo and SocINDEX. The search would also be conducted in electronic repositories of grey literature such as the WHO Global Health Library, Popline, and Google Scholar.

The analysis of the literature reviewed would rely on the WHO definition of obstetric mistreatment. Given that this is a newer definition, not all published studies include all elements of the WHO definition in their definition of mistreatment as an exposure. For this reason, the review would include studies that analyze sub-sets of the WHO definition, while still considering them to be measuring the effect of obstetric mistreatment as an exposure. In this way, the association between obstetric mistreatment and health outcomes of interest could be conducted via a meta-analysis of crude and adjusted odds ratios with 95% confidence intervals. A sub-group analysis might then be conducted by each type of mistreatment to account for the above-mentioned variability in sub-sets of mistreatment in different studies, assuming adequate statistical power. That said, it is possible that sufficient quantitative data to warrant conducting a meta-analysis do not yet exist. In this case, a narrative description that summarizes findings to-date might still prove useful by organizing all known relationships in a single, coherent paper.
Meanwhile, qualitative data could also be explored to help define potential pathways linking disrespectful and abusive treatment to the aforementioned adverse health outcomes. Relevant content could be extracted from publications and then coded both according to the type of mistreatment described and the type of adverse health outcome to which it points. Then, the data could be mapped to show the potential pathways, which might then inform future research efforts to determine whether there is indeed a quantifiable association. Figure 3 below provides a conceptual map for this analytic process.

![Figure 3: Proposed deductive coding framework](image)

<table>
<thead>
<tr>
<th>Mistreatment</th>
<th>Second-order themes (Bohren et al., 2015)</th>
<th>Health outcomes</th>
<th>Third-order</th>
<th>Second-order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Use of force Physical restraint</td>
<td>Maternal health (physical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Sexual abuse</td>
<td>Maternal mortality/morbidity Use of family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>Harsh language Threats and blaming</td>
<td>Postpartum depression Postpartum PTSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma and discrimination</td>
<td>Discrimination based on sociodemographic conditions Discrimination based on medical conditions</td>
<td>Infant health Stillbirth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to meet professional standards of care</td>
<td>Lack of informed consent and confidentiality Physical examinations and procedures Neglect and abandonment</td>
<td>Infant mortality/morbidity Bonding Breastfeeding Infant weight gain Immunization First newborn visit</td>
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While this review might well raise more questions than it answers, it would be an important contribution to the literature by organizing existing knowledge and providing guidance for future research.

**Conclusion**

Despite increased attention to obstetric mistreatment in recent years, far more remains unknown than known about the phenomenon. The lack of a scientific consensus around how the phenomenon should be defined or measured has led to conflicting approaches and wide variance in estimations of prevalence. Even less is known about the severity of obstetric mistreatment across different settings, and the short- and long-term effects it might have on maternal and child health. The two proposed studies – a rigorous prevalence study in a middle-income country with high rates of facility delivery and a systematic review exploring evidence for how obstetric mistreatment may increase risk of adverse maternal and infant health outcomes – would contribute to the field. Ultimately, these two investigations would provide critical evidence needed to better understand obstetric mistreatment and design interventions to help prevent it.
References


20. Estados Unidos Mexicanos: Cámara de Diputados del H Congreso de la Unión. Ley general de acceso de las mujeres a una vida libre de violencia y de igualdad entre hombres y mujeres. 2011.


35. Belizán JM, Pingray V. Stillbirth rates in Latin America: An ecological study [unpublished data].


