Preventing and addressing obstetric violence in humanitarian contexts

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1. Introduction

During pregnancy, childbirth and the postnatal period, women may experience a range of harmful practices, abuse, neglect and other forms of mistreatment by health-care providers and other personnel within the health system. These include physical, sexual, verbal, emotional and psychological abuse; disrespect and neglect; procedures performed without informed consent, including forced sterilization, abortion or the administration of postpartum contraception; breaches of privacy and confidentiality; denial of a companion during childbirth; and practices that are not supported by evidence, such as routine episiotomy and restricting women's choice of physiological birth positions[1].

Different terms have been used to describe these experiences. The World Health Organization primarily uses the term mistreatment, disrespect and abuse during childbirth, while obstetric violence has been adopted in human rights mechanisms, national legal frameworks and parts of the academic literature. In 2019, the United Nations Special Rapporteur on Violence against Women, its Causes and Consequences, described obstetric violence as violence experienced by women during facility-based childbirth.[2] Although terminology continues to evolve and is not used consistently across normative frameworks, there is broad recognition that these practices are unacceptable and require prevention and response. Regardless of the terminology used, the shared objective is to ensure that every woman receives safe, respectful, rights-based and evidence-informed maternity care.[3]

Consistent with UNFPA's work on reproductive violence[4,5] , this guidance uses the term obstetric violence. In this guidance, the term refers to violence, abuse, coercion, neglect and other harmful practices experienced during pregnancy, childbirth and the postnatal period. Within UNFPA's conceptual framework, obstetric violence is understood as a manifestation of reproductive violence and a form of gender-based violence rooted in gender inequality, discrimination and unequal power relations. The use of this terminology aligns with UNFPA's evolving normative framework while recognizing that other organizations and professional bodies may use different terminology.

This guidance focuses on humanitarian settings, where heightened vulnerabilities, disruptions to health systems, limited provider choice and barriers to accountability may increase women's exposure to harmful practices during maternity care. Preventing and addressing obstetric violence is therefore essential to improving the quality of maternity care[6], strengthening trust in health systems, advancing maternal and newborn health and sexual and reproductive health and rights, and upholding the humanitarian commitment to "do no harm".

1 International Confederation of Midwives. Obstetric violence, mistreatment, and violence against women in reproductive health services. Human rights, respectful maternity care, 22 November 2024. Available at https://internationalmidwives.org/resources/obstetric-violence-and-mistreatment-and-violence-against-women-in-reproductive-health-services.

2 United Nations Special Rapporteur on Violence Against Women (2019). *Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*. United Nations General Assembly seventy-fourth session. A/74/137 (11 July 2019). Available at https://documents.un.org/doc/undoc/gen/n19/213/27/pdf/n1921327.pdf.

3 World Health Organization. 2015. *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth.* Geneva, WHO, 2015. Available at https://documents.un.org/doc/undoc/gen/n19/213/27/pdf/n1921327.pdf.

4 UNFPA personnel: see the document from Nora Piay-Fernández and others, *Shining a Light on Reproductive Violence: A Contribution to Understanding All Forms of Gender-Based Violence Against Women and Girls.* New York, United Nations Population Fund, 2026. Available at https://www.unfpa.org/sites/default/files/pub-pdf/Web_Shining%20a%20Light%20on%20Reproductive%20Violence%20UNFPA.pdf.pdf

5 Reproductive violence is a form of GBV against women and girls that compromises reproductive autonomy, agency and self-determination; that is, individuals' ability to decide whether, when, how and under what conditions to become pregnant, give birth and raise children, as defined at the International Conference on Population and Development. This includes, but is not limited to, physical, sexual, emotional, psychosocial, economic, normative and symbolic abuse, force, coercion or exploitation within relationships, communities, institutions and societies.

6 World Health Organization. *Intrapartum Care for a Positive Childbirth Experience*. Geneva, WHO, 2018. Available at https://www.who.int/publications/i/item/9789241550215.

Global context and statistics

Measuring the incidence of obstetric violence is challenging, due to the lack of consensus on the terminology (as described above), the lack of recognition among healthcare providers that it is an issue, and lack of standard, widely-agreed mechanisms to report and follow up on incidents. As noted by the United Nations Special Rapporteur on Violence against Women "violence against women in childbirth is so normalized that it is not (yet) considered violence against women."[7]

> ***"Before this interview, I had never encountered the term "obstetric violence" in my day-to-day work, despite frequently witnessing related incidents."*** GBV specialist, north-west Syrian Arab Republic

Over one third of women experience some form of mistreatment during facility-based delivery.[8] Examples from development contexts highlight how common obstetric violence is in non-crisis settings. A systematic review and meta-analysis of 33 studies conducted in sub-Saharan Africa demonstrated a 44 per cent prevalence of disrespect and abuse towards women during facility-based delivery.[9] Similarly, a systematic review and meta-analysis of 18 studies in Latin America and the Caribbean found a 43 per cent prevalence.[10] A literature review of 12 studies conducted in the United Republic of Tanzania found that up to 73 per cent of women reported at least one form of disrespect and abuse during labour, with common violations involving non-dignified care, non-confidential care and physical abuse. One study involving 439 nurses, midwives and nursing assistants, reflects that a large majority (96.1%) recognizes having engaged in at least one form of disrespect or abuse.[11]

In general, unmarried, young or uneducated women are at higher risk of obstetric violence,[12] as well as women with disabilities, people with HIV/AIDS, women in rural areas, and migrant and refugee women.[13] In humanitarian settings, these risks may be exacerbated by shortages of essential medicines and equipment, overwork, insecurity, stress or burnout among healthcare providers, stigma or bias against crisis-affected groups, and language and cultural differences between healthcare providers and patients.

Purpose of the guidance note

This guidance note aims to raise awareness about obstetric violence among front-line humanitarian SRH and GBV service providers, programme managers and implementing agencies, and propose ways to prevent and address the problem. The guidance is informed by a literature review and key informant interviews with SRH and GBV professionals working in humanitarian settings at headquarters, regional and country levels, as well as review by inter-agency experts in SRH in SRH and GBV working in both development and humanitarian contexts.

7 United Nations Special Rapporteur on Violence Against Women (2019). *Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*. United Nations General Assembly seventy-fourth session. A/74/137 (11 July 2019). Available at https://documents.un.org/doc/undoc/gen/n19/213/27/pdf/n1921327.pdf.

8 Meghan A. Bohren and others. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLOS Medicine*, vol. 12, No. 6 (June 2015). Available at https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001847.

9 Zemenu Yohannes Kassa, Berhan Tsegaye and Abebaw Abeje. Disrespect and abuse of women during the process of childbirth at health facilities in sub-Saharan Africa: A systematic review and meta-analysis. *BMC International Health and Human Rights*, vol. 20 (September 2020). Available at https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/s12914-020-00242-y.

10 Constanza Tobasía-Hege and others. Irrespeto y maltrato durante el parto y el aborto en América Latina: revisión sistemática y metaanálisis. *Revista Panamericana de Salud Pública* – Pan American Journal of Public Health, vol. 43 (May 2019). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC6474288.

11 Gopika Das and others. Patient and provider perspectives of disrespect and abuse during childbirth in Tanzania: A literature review. *Open Journal of Obstetrics and Gynecology*, vol. 11, No. 9 (September 2021). https://www.scirp.org/journal/paperinformation?paperid=112245.

12 Meghan A. Bohren and others. How women are treated during facility-based childbirth in four countries: A cross-sectional study with labour observations and community-based surveys. *The Lancet*, vol. 394, No. 10210 (November 2019). Available at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31992-0/fulltext.

13 Human Rights Watch. Addressing 'obstetric violence' in Africa: Abuse in health care system amounts to violence against women, 13 November 2024. Available at https://www.hrw.org/news/2024/11/13/addressing-obstetric-violence-africa.

2. Obstetric violence in humanitarian settings

Underlying factors

Obstetric violence arises from a complex interplay of systemic, institutional, community and individual factors, which are often exacerbated during emergencies.[14]

Structural issues within the healthcare system

Insufficient staffing, lack of training and outdated practices such as routine episiotomy; stock outs of essential medicines and supplies; inadequate infrastructure; funding shortfalls; and gaps in supervision are common weaknesses in healthcare systems that can intensify during times of crisis. Healthcare workers in humanitarian settings face significant challenges, including high stress levels, increased workloads, fear and burnout, which can contribute to disrespectful, abusive or neglectful treatment of their patients.

> ***Doctors frequently say, "I know best. How dare you question me?"***
> SRH specialist, Global

> ***Some staff engage in obstetric violence without knowing it is abuse.***
> GBV specialist, Arab States Region

Lack of accountability mechanisms

Healthcare systems often lack clear protocols to hold providers accountable for mistreatment of patients.[15] Even when policies or protocols are in place, there can be a disconnect between them and how they are implemented in practice. Obstetric violence may be so commonplace that it is normalized among women and girls delivering in healthcare facilities. Complaints mechanisms may be unknown to patients, not user-friendly or not confidential (or perceived as not confidential), thus inhibiting women from reporting.

Social and gender norms and stereotypes

Existing social and gender norms and stereotypes related to the position of women in society, adolescent or unmarried mothers, people of different ethnic groups, and people of diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) all contribute to OV and may be amplified during times of crisis. This is further influenced by unequal power relations between health-care providers and women, gender stereotypes, institutional norms and practices, and health systems that do not consistently uphold women's autonomy, dignity and informed decision-making.

14 Sylvester R. Okeke and others. Collateral damage: The overlooked reproductive health crisis in conflict zones. *Reproductive Health*, vol. 21 (December 2024). Available at https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-024-01941-8.

15 Prudence Jarrett and others. Healthcare governance during humanitarian responses: A survey of current practice among international humanitarian actors. *Conflict and Health*, vol. 15, No. 25 (April 2021). Available at https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-021-00355-8.

Language and cultural barriers

Forced migration of displaced or marginalized populations to areas where they do not speak the language, are unfamiliar with the culture or cultural norms, or where they are unwelcome or marginalized, can contribute to communication barriers, difficulties providing informed consent, and feelings of intimidation or disempowerment. Healthcare providers may also be deployed from other regions and be unfamiliar with the local language, customs or context. Healthcare workers who are not aware of, or sensitive to, the cultural norms and values of their patients, may treat them in a manner that is (or is perceived to be) disrespectful or abusive. Existing biases towards certain populations may be heightened in times of crisis, and this can be exacerbated when healthcare workers are overstretched or rushed during emergencies.

> ***In Cox's Bazar, most healthcare workers speak Bengali, a language not commonly spoken or understood by the Rohingya refugee population. This language barrier has led to misunderstandings, and significantly hinders effective communication between healthcare providers and refugees.***
> Midwife mentor, Cox's Bazar, Bangladesh

Types of obstetric violence

Obstetric violence can fall under several categories: 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.[16]

Physical abuse

Physical mistreatment in maternity care may be rooted in a combination of factors including negative attitudes, prejudice, cultural biases, overwork and stress among healthcare providers, which can result in abusive practices. Bohren and others compiled reports of both general and specific forms of physical violence against women in labour, including hitting with hands or instruments, pinching (particularly on the thighs), kicking, and using physical restraints to tie women to beds or gag them during labour.[17] Key informants who contributed to this guidance described maternity workers slapping or shouting at women, forcing them into painful birthing positions and using dangerous techniques, such as applying wooden paddles to push on a woman's abdomen during labour.

Sexual abuse

Sexual abuse during labour and delivery may include negative comments made by healthcare workers about the patient's sexual activity or sexuality, inappropriate touching, and unnecessary vaginal examinations. Sexual assault, or penetration of the obstetric patient with a penis or other object, can also occur.

16 Meghan A. Bohren and others. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLOS Medicine*, vol. 12, No. 6 (June 2015). Available at https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001847.

17 Ibid.

Verbal abuse

This includes shouting, ridicule, threats, or belittling and discriminatory comments that humiliate women during childbirth. Verbal abuse reinforces the dehumanization of women in labour. One key informant from the Syrian Arab Republic recalled midwives shouting at women in labour and dismissing their pain with remarks such as "Stop crying, you are not a child."

The 2019 Report of the Special Rapporteur on Violence Against Women[18] further documents widespread accounts of women being mocked, scolded and subjected to deeply sexist and degrading language by healthcare providers. In Honduras, for instance, adolescent girls in labour were shamed with remarks like, "You didn't scream during sex, so why are you screaming now?" or "Open your legs or your baby will die, and it will be your fault." These forms of verbal abuse can cause significant emotional distress and are recognized as a form of psychological violence.

Lack of privacy and confidentiality

With spatial constraints due to overcrowding, and the use of informal structures such as tents and mobile units in humanitarian settings, maintaining confidentiality as well as auditory and visual privacy can be particularly challenging. Women have reported violations of privacy and confidentiality during labour and childbirth, including vaginal examinations conducted in the presence of others, in rooms without privacy screens or with open doors, unauthorized observation by medical students, and the disclosure of sensitive health information such as HIV status to third parties.[19]

Non-consensual medical interventions

Procedures conducted without the direct, informed consent of the patient, or under conditions of force or coercion, deny a woman's right to bodily autonomy and are considered obstetric violence. Examples of this may include conducting caesarean sections without informing women of the associated risks and benefits, forced or non-consensual sterilization, or the administration of post-partum contraception after delivery without the patient's consent. In Kenya, women have expressed fear or avoidance of delivering in health facilities due to concerns about HIV testing being conducted without their permission,[20] and the International Community of Women Living with HIV has documented forced or coerced sterilization of women living with HIV in many countries across Africa, Asia, Europe and Latin America.[21]

Denial or delay of care

Women may be refused admission to maternity care facilities, or ignored or inadequately monitored during labour and the post-partum period, contributing to delayed recognition and treatment of complications. In a study conducted in the Gaza Strip and the West Bank, respondents reported that limited resources and delays at military checkpoints caused restricted transportation of labouring women and blocked their access to hospitals, leading to an increase in home births, deliveries at military checkpoints and maternal deaths.[22] A study published in 2024 by the Women's

18 United Nations Special Rapporteur on Violence Against Women (2019). *Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*. United Nations General Assembly seventy-fourth session. A/74/137 (11 July 2019). Available at https://documents.un.org/doc/undoc/gen/n19/213/27/pdf/n1921327.pdf.

19 Ibid.

20 Janet M. Turan and others. HIV/AIDS and maternity care in Kenya: how fears of stigma and discrimination affect uptake and provision of labor and delivery services. *AIDS Care*, vol. 20, No. 8 (September 2008). Available at https://pubmed.ncbi.nlm.nih.gov/18777222.

21 Kudzai Bakare and Shelene Gentz. Experiences of forced sterilisation and coercion to sterilise among women living with HIV (WLHIV) in Namibia: an analysis of the psychological and socio-cultural effects. *Sexual and Reproductive Health Matters*, vol. 28, No. 1 (May 2020). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7887903.

22 Marleen Bosmans and others. Palestinian women's sexual and reproductive health rights in a longstanding humanitarian crisis. *Reproductive Health Matters*, vol. 16, No. 31 (May 2008). Available at https://www.tandfonline.com/doi/10.1016/S0968-8080(08)31343-3.

Affairs Center – Gaza, highlights the destruction of healthcare facilities that provide maternity care, which has resulted in reduced accessibility of places for women to safely give birth. The same study cites Palestinian women who have gone through labour and delivery with inadequate pain management, or who have been discharged with their newborns immediately after delivery, without receiving adequate health information about newborn care or lactation, or psychological support.[23]

Neglect and abandonment

In crisis settings, discrimination, high patient loads, and limited personnel and supplies can exacerbate the risks of a woman being left unattended during labour, refused accompaniment by a family member or caregiver, or denied basic care such as labour monitoring and pain management. In a qualitative study in two refugee camps in Chad, women reported being left unattended at health centres, often for extended periods. Some who arrived in labour were not attended to promptly due to overcrowding, leaving them feeling neglected and forgotten. Women also reported being left alone in the hospital for extended periods during labour, without any support, including from their families.[24]

23 Women's Affairs Center – Gaza. *Research Paper on: Reality of Pregnant and Postpartum Women During the War on Gaza (2023–2024): "Difficulties, Challenges, and Development Needs"*. Gaza, Women's Affairs Center – Gaza, 2024. Available at https://new.wac.ps/public/file_pdf/1733824698.pdf.

24 Alexis Ngarmbatedjimal and others. Refugee women's and providers' perceptions of person-centered maternity care: A qualitative study in two refugee camps in Chad. *BMC Pregnancy and Childbirth*, vol. 24 (April 2024). Available at https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-024-06424-z.

3. Respectful maternity care

Respectful maternity care (RMC) offers a solution to prevent and address obstetric violence in the healthcare setting. RMC is defined as care that ensures the dignity, privacy and confidentiality of women, free from harm and mistreatment, while allowing informed choices and continuous support during childbirth.[25] RMC is rooted in the principles of human rights and promotes dignified, equitable and patient-centred care throughout pregnancy, childbirth and the post-partum period. By addressing both systemic and behavioural contributors to OV, RMC provides a framework for eliminating mistreatment and ensuring healthcare environments are safe, inclusive and respectful.

Key pillars of RMC include **informed consent, non-discrimination and confidentiality**, which are strengthened by shared decision-making and effective communication. Incorporating RMC into humanitarian programming can increase accessibility, quality and uptake of obstetric services, improves accountability to affected populations, promotes mainstreaming of protection, and aligns with women-centred empowerment approaches.[26]

The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) brief on *Approaching Implementation of Respectful Maternity Care in Humanitarian Settings* outlines interventions for RMC and has been adapted for implementation in humanitarian contexts. These are separated into interventions directed towards **women and communities, healthcare providers and health systems**. These interventions are outlined below and detailed in the table in Annex 1:[27]

- ***Women and communities:*** Raising awareness on the right to RMC, supporting local advocacy, and developing contextualized and culturally appropriate messaging.
- ***Healthcare providers:*** Building cultural competency to address diverse issues, including their rights to informed consent, confidentiality and dignified care among women and girls from affected populations, host communities and marginalized groups. This includes sensitizing and building capacities of healthcare providers to provide RMC.
- ***Health systems:*** Adapt structures to support privacy and confidentiality; support increased engagement/deployment of midwives to provide RMC; ensure adequate water, sanitation and hygiene facilities in healthcare facilities; introduce and enforce protocols to ensure informed consent and other measures of quality service delivery (including pain management, regular monitoring); adapt policies to allow women to be accompanied by family members or caregivers during labour and the immediate post-partum period; and strengthen feedback mechanisms at service delivery points to allow women and girls to share their experiences and concerns about the service received.

Further information on RMC can be found in the *Compendium on Respectful Maternal and Newborn Care*.[28]

25 World Health Organization. *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth*. Geneva, WHO, 2015. Available at https://documents.un.org/doc/undoc/gen/n19/213/27/pdf/n1921327.pdf.
World Health Organization. *Intrapartum Care for a Positive Childbirth Experience*. Geneva, WHO, 2018. Available at https://www.who.int/publications/i/item/9789241550215.

26 Inter-Agency Working Group for Reproductive Health in Crises, Maternal and Newborn Health Sub-working Group. *Approaching Implementation of Respectful Maternity Care in Humanitarian Settings*. New York, Inter-Agency Working Group for Reproductive Health in Crises, 2022.
Available at https://cdn.iawg.rygn.io/documents/COMPRESSED_Approaching-Implementation-of-Respectful-Maternity-Care-in-Humanitarian-Settings-Brief.pdf.

27 Ibid.

28 World Health Organization. *Intrapartum Care for a Positive Childbirth Experience*. Geneva, WHO, 2018. Available at https://www.who.int/publications/i/item/9789241550215.

4. Recommendations for preventing and addressing obstetric violence

Identify and address obstetric violence through humanitarian coordination mechanisms

Strengthen coordination between health, SRH, GBV and MHPSS actors to prevent and respond appropriately to mistreatment, abuse, and violations of informed consent or confidentiality in maternity care, ensuring that referral pathways are determined by the nature of the incident and the survivor's needs and preferences.

Include obstetric violence awareness, prevention and response in integrated SRH and GBV initiatives

Recognize obstetric violence as a form of GBV and ensure that relevant reporting and support mechanisms are identified and functional and include GBV referral pathways and GBV case management.

Conduct joint SRH-GBV health facility assessments to assess for issues related to privacy, confidentiality and consent in maternity care services.

Address contributing factors within health systems and prioritize quality healthcare services by supporting implementing partners, health facility management and healthcare providers to address the conditions (staffing, crowding, supplies, etc.) that may contribute to OV and to prioritize the provision of quality maternal and newborn health services.

Support healthcare providers/facilities and GBV actors to develop **discreet, confidential mechanisms for reporting** OV and **link survivors to referral pathways**.

Ensure that mechanisms are in place to investigate reports of obstetric violence and **ensure accountability for healthcare workers** who mistreat their patients.

Advocate for **integration of RMC into national midwifery curricula** (both pre-service and in-service).

Incorporate OV and RMC into predeployment capacity strengthening and briefings for SRH and GBV service providers and programme managers.

Conduct **structured reflection and training on respectful care, informed consent, non-discrimination and provider bias** with SRH and GBV service providers, ancillary healthcare workers and programme managers to help them recognize and address their own biases and resulting behaviour.

Strengthen MHPSS skills such as basic psychosocial skills, active listening, empathy and respect among front-line SRH and GBV providers to improve quality of care and support the mental health and psychosocial needs of survivors of obstetric violence.

Raise awareness among pregnant women, communities and healthcare workers about OV through integrated SRH and GBV campaigns. Support health facilities to adapt and display the "**Respectful Maternity Care Charter**"[29] in local languages, and pictorially in low-literacy contexts.

29 Inter-Agency Working Group for Reproductive Health in Crises, Maternal and Newborn Health Sub-working Group. *Approaching Implementation of Respectful Maternity Care in Humanitarian Settings*. New York, Inter-Agency Working Group for Reproductive Health in Crises, 2022. Available at https://cdn.iawg.rygn.io/documents/COMPRESSED_Approaching-Implementation-of-Respectful-Maternity-Care-in-Humanitarian-Settings-Brief.pdf.

Box 1: Respectful Maternity Care Charter:
The Universal Rights of Women and Newborns

1. Everyone has the right to freedom from harm and ill-treatment.
2. Everyone has the right to information, informed consent, and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.
3. Everyone has the right to privacy and confidentiality.
4. Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.
5. Everyone has the right to equality, freedom from discrimination, and equitable care.
6. Everyone has the right to healthcare and to the highest attainable level of health.
7. Everyone has the right to liberty, autonomy, self-determination, and freedom from arbitrary detention.
8. Every child has the right to be with their parents or guardians.
9. Every child has the right to an identity and nationality from birth.
10. Everyone has the right to adequate nutrition and clean water.

Conclusion

Every woman has the right to safe, respectful and dignified maternity care, including in humanitarian settings. Humanitarian crises do not diminish these rights; rather, they reinforce the responsibility of humanitarian actors to ensure that the care they support protects women's dignity, bodily autonomy and safety.

This guidance has highlighted that harmful practices experienced during pregnancy, childbirth and the postnatal period—referred to in this guidance as obstetric violence, while recognizing that other terminology is also used—may arise from individual acts, institutional practices and broader systemic failures. Humanitarian settings can heighten these risks through overstretched health systems, workforce shortages, provider stress and burnout, inadequate infrastructure, insecurity, discrimination and limited accountability.

Preventing and addressing these practices requires coordinated action across the humanitarian health and GBV response. SRH and GBV actors should work together to strengthen respectful maternity care, integrate prevention and response measures into programmes, support health-care workers through training, supervision and staff well-being, establish safe referral pathways, and ensure accessible, confidential reporting and accountability mechanisms for women and girls.

Humanitarian assistance must never enable, tolerate or inadvertently reinforce harmful practices. Programmes should be deliberately designed and monitored to identify and mitigate risks of obstetric violence, strengthen accountability to affected women and girls, and uphold the humanitarian principle of do no harm. This includes ensuring that humanitarian action contributes to health systems that promote respectful, rights-based maternity care rather than perpetuating practices that compromise women's rights, dignity or quality of care.

Ultimately, preventing obstetric violence is not only essential to improving maternal and newborn health outcomes but also to advancing gender equality, strengthening trust in health services and ensuring that humanitarian responses uphold the rights, dignity and autonomy of every woman and girl.

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Annex 1

Table extracted from Approaching Implementation of Respectful Maternity Care in Humanitarian Settings IAWG Maternal and Newborn Health Sub-working Group | March 2022, available at https://cdn.iawg.rygn.io/documents/COMPRESSED_Approaching-Implementation-of-Respectful-Maternity-Care-in-Humanitarian-Settings-Brief.pdf?v=1646663634

RMC Interventions implemented in settings not affected by humanitarian crises	Considerations for implementation in humanitarian settings	Examples and resource links
Communities and Women		
Provide **Birth companions** or **obstetric care navigators** to support women throughout their pregnancy and childbirth so their choices are respected, and needs met.	This has varied levels of possibility because of restrictive facility permissions around birth companions (male or female) allowed into a delivery room.	• Birth companionship at government hospitals in Tanzania • Obstetric care navigators for Indigenous women in Guatemala
Hold "**Open Days**" to familiarize women with health facility settings in which they aim to give birth.	In settings with unpredictable access to facilities, consider a less formal mechanism for women to come to their birthing facility and discuss issues with the staff. This could be linked to ANC visits.	• "Open Birth Days" in Tanzania • "Maternity Open Days" in Kenya: Bringing communities together to promote maternal health • GOAL with Irish Aid working to Reduce Teenage Pregnancy in Sierra Leone
Maternity waiting homes in order to provide places to stay before and immediately after women give birth. **Note:** Maternity waiting homes are typically seen as an intervention used to promote facility delivery (not as an RMC intervention).	Maternity waiting homes for women and companions to stay at prior to and immediately following birth are helpful in insecure contexts.	• In Mexico, these are established alongside health facilities for both expectant mothers, family members and/or birth companions.
Raising awareness of RMC rights among communities through socialization of the RMC Charter, community dialogue, or pregnancy groups. **Note:** Awareness-raising strategies are closely related to the accountability enhancing approaches under health systems interventions.	Local-language or pictorial representation of the RMC charter can be helpful when working with non-literate women. Try to engage youth in designing awareness raising strategies, especially those that target young women and girls, particularly in settings with high rates of early marriage and adolescent pregnancy.	• What's Behind Disrespectful Maternity Care Video (Yemen, Syria) • Pictorial RMC Charter (Afghanistan) • Hosting 'mothers nights': invite mothers and pregnant women to an event hosted by policymakers, politicians, or other government officials to tell their personal stories with the goal of advocating for RMC (Afghanistan)
Healthcare Providers		
Integration of RMC in pre-service (undergraduate, graduate, postgraduate) **and in-service training** for healthcare providers. RMC training for healthcare providers, health administrators, and supervisors. Key topics to cover include understanding patient rights and how to uphold them in a particular context, values clarification and attitude transformation (VCAT) exercises.	RMC training must incorporate cultural competency given diversity of women and girls seeking services – including host communities, refugees, internally displaced persons, young mothers, ethnic groups, socioeconomic status, and other vulnerable groups. Each group may have varied understandings of respectful communication and behaviour. It is recommended to use print and audiovisual presentations as a part of training provision.	• Lessons learned through RMC training and implementation in Ethiopia • Respectful Maternity Care Resource Package • IAWG S-CORT trainings which include RMC guidance and content • Afghan Midwives Association recorded videos for each right in the RMC Charter and published the videos on their Facebook page for member viewership • Include RMC as a topic in graduate public health curricula and postgraduate diploma as a way of normalizing its importance (e.g. Yemen) • Utilize the power of social media in promoting RMC by choosing one day a year as a dedicated day for RMC dialogue, conversation and training on social media

On-going support for providers: Caring for the Carers, supportive supervision strategies, and modelling kind/ compassionate care.	This was successful with colleagues in Afghanistan who rewarded champions' kind and compassionate care. Psychosocial support is a priority need for providers working in contexts of various shocks and stresses, including insecurity and violence.	• Promoting RMC Resource Package: Debriefing sessions – caring for the carers • Caring for the carers: ensuring the provision of quality maternity care during a global pandemic • WHO Psychological First Aid Guide for Field Workers • mhGAP Intervention Guide for Humanitarian Settings
Health Systems		
Facility improvements to infrastructure or process changes that promote RMC.	Infrastructure and process can pose constraints in humanitarian settings, though the most challenging gap raised was supply chain interruptions that affect facility capacity. Work to improve waiting rooms and facility architecture, introduce screens or privacy curtains, get informed consent for medical procedures, enhance WASH, and better manage equipment, drugs and supplies. Use more windows so that mothers can watch their babies when not together. Put incentive mechanisms in place to support deployment of midwives to remote and rural areas that promote autonomous, evidence-based, and midwife-led RMC.	In Cox's Bazar, RTI International utilizes Women Centers to address women's general and maternal health, gender-based violence (GBV) prevention, and MHPSS in an integrated way. This is an example of a process change that promotes RMC and maternal mental health. In Ethiopia, evidence proved that improving facility infrastructure, and providing supplies led to enhanced respectful maternal care. Establishing policies and governance to ensure that training, staffing, supervision and monitoring, supplies, equipment, and infrastructure are addressed in facilities to support the provision of RMC.
Advocacy for integration of RMC in national health policies and facility-level policies and procedures as well as standardized indicators for RMC across all levels.	Multi-level advocacy and application of RMC charter is needed. One suggestion is to post local-language or pictorial RMC charter representations in facilities. When advocating, emphasize RMC in Interagency Field Manual (IAFM), disseminate charter as part of Minimum Initial Service Package (MISP) training, integrate RMC in humanitarian MNH trainings.	White Ribbon Alliance has print-ready versions of the RMC Charter in various languages. There is currently no globally recognized core outcome set related to respectful care or mistreatment but there are some successful qualitative and quantitative mechanisms to measure RMC.

*Considerations were identified by 20 maternal and newborn health care providers and programme managers that participated in an IAWG technical consultation held in November 2021. The 20 participants either currently work or have worked in a range of fragile and conflict-affected settings in Afghanistan, Bangladesh, Colombia, Mexico, Myanmar, Niger, Nigeria, Uganda, South Sudan, Yemen and Syria. In a few cases, considerations were supplemented by a technical consultation held in 2018 among research, programmatic and advocacy actors across humanitarian and development agencies.

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