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Respectful Maternity Care and the Media: A Guide for NGOs and Advocates was copyedited by John Engels and designed by Gwendolyn Stinger.
When media coverage of maternity care is sensitive and accurate, women, their newborns, and care providers stand to benefit greatly. Journalists can be key players in spreading the message that every woman has a right to quality, respectful and dignified care. They can be helpful in highlighting cases of disrespectful maternity care and in reminding their audience – from parents and their communities to maternal healthcare providers and governments – that simply enabling women to access high-quality, respectful maternity care can drastically reduce maternal and newborn deaths.1

When media coverage of maternity care is insensitive and inaccurate however, enormous damage can be done to the wellbeing and survival chances of women and their newborns, and to the reputation of health facilities and health workers. Lurid stories of abuse and disrespect, with headlines blaming wicked midwives or nurses, can deter women from seeking the care that could save their lives and make it harder to recruit health workers and support them with the resources they need. Journalists, therefore, can do a great deal of damage by sensationalizing provider actions rather than illustrating how a comprehensive health systems approach can benefit both providers and the communities they serve.

The stakes are high. Respectful maternity care (RMC) is central to the health, wellbeing, and survival of millions of women and newborns. There is now a growing global consensus that assuring safe, high-quality maternal and newborn care must include standards to protect the human rights and emotional security of women.2 Ensuring accessible and women-centered environments free of mistreatment and abuse is essential for encouraging mothers to seek skilled medical care and ensuring high-quality, skilled care during pregnancy and labor.

How, then, do we work with the media to enable a better understanding of how closely RMC relates to maternal and newborn health, so that they will in turn provide coverage that helps rather than hinders global efforts to save the lives of pregnant women and mothers?

1 (World Health Organization 2017)
2 (World Health Organization 2016)
Know your media

The media work differently in different places. For example, in some countries, “objectivity” is paramount and journalists are not supposed to accept cash or other rewards for their work. In others, journalists cannot survive without some form of outside remuneration for their work, whether that takes the form of travel expenses or per diems at workshops. Understanding the climate and protocols for the journalists you are targeting is vital to knowing how to approach and work with them effectively.

However hard journalists may try to provide fair coverage of RMC, decisions about what is published are rarely in their hands. It tends to be senior journalists/editors rather than reporters who select the stories that will be published. They will usually decide based on their judgment about what is newsworthy, interesting, and engaging – and/or what will please their manager. Editors are often under pressure to make sure that their stories also generate income by encouraging the public to tune in to their channel or buy their publications with exaggerated headlines.

Partnering with experienced media contacts and consultants during training offers valuable insight on this local media landscape. Overall, one must be sure to approach this target audience well versed in their interests and restrictions. Media partnerships can also provide important information on the media consumption habits, language barriers, and dominant forms of communication in a region. All this local knowledge is readily available if one establishes respectful and mutually beneficial partnerships with local media contacts. Through such professional partnerships, training exercises, and ongoing collaboration, maternal and child health advocates can benefit greatly from thoughtful and informed media coverage.
This guide is intended for those who want to work with the media on stories about maternal and reproductive health.* It summarizes the latest evidence on global maternal health and RMC, providing quotes and examples of stories from women around the world. It goes on to provide practical exercises, materials, and resources designed to be used in workshops or training sessions with journalists, specifically on issues of respectful maternity care.

The guide also encourages sensitive reporting skills, with suggestions for how to interview women about their own maternal healthcare and birth experiences, and how best to report on complex maternal health issues. The language we use about birth, women, and their healthcare is also a measure of a journalist’s skills, and so this guide includes advice on how to avoid gender bias and a glossary of terminology related to reproductive health.

This guide also contains several brief factsheets and exercises that may be useful to journalists. Given the unique circumstances of the communications infrastructure within different settings, the exercises and worksheets should be adapted to suit local contexts. The facilitators’ guidance notes on page 34, should be used as the basis for adaptation and dissemination of the information and exercises.
Maternal and newborn deaths are overwhelmingly preventable with access to quality healthcare. However, mistreatment during pregnancy and childbirth increases the likelihood of maternal and infant mortality by discouraging women from using facility-based care. Additionally, mistreatment in pregnancy and childbirth constitutes a significant lapse in overall quality of care, often resulting in grave health outcomes. Notable quality lapses such as abandonment of care, illegal detainment, and failure to address patient complaints are just a few examples of scenarios that may quickly lead to a fatality.

As mistreatment during pregnancy and childbirth can greatly discourage women from seeking care at health facilities, there is a growing international movement to reduce maternal and newborn deaths by ensuring equity, dignity, and respect in facility-based care. This includes services for antenatal care, family planning, skilled delivery attendance, emergency obstetric care, and postnatal care. As of 2012, about 70% of births worldwide occurred with the presence of a skilled birth attendant, but only 46% of births were overseen by a skilled birth attendant in least-developed countries.

- An estimated 303,000 women die annually due to childbirth related illnesses.
- Between 1990 and 2015, the annual number of maternal deaths dropped by 43%.
- Despite significant reductions in the global rate of maternal mortality, these improvements have been uneven between and within countries. Higher rates of maternal deaths are often concentrated within more vulnerable, marginalized communities.
Both formal research and anecdotal evidence indicate that mistreatment within maternal healthcare significantly decreases a woman’s likelihood of utilizing professional healthcare services. In facility-based care, health risks posed by physical abuse and neglect, excessive medical interventions, and dehumanizing treatment such as unnecessary or painful vaginal examinations can inflict overwhelming emotional damage, turning the process of birth into a form of torture. It is not uncommon for women to compare the violation and vulnerability they have experienced to sexual assault, as both experiences involve deeply intimate and violent violations of one’s body and personal security.

The need for systematic elimination of mistreatment during pregnancy and childbirth is recognized by the World Health Organization (WHO) as critical in global health. WHO’s 2016 Standards for Improving Quality Maternal and Newborn Care in Health Facilities emphasizes the significance of women’s and newborns’ experience of care, which should provide emotional support, dignity, and personal choice (such as birth companions) for mothers.

In health systems experiencing high rates of abusive care in facilities, some women choose to prioritize emotional security and dignity over medical intervention; they regard facility-based care as a last resort, choosing instead to receive care from traditional birth attendants.

The choice to avoid skilled care significantly increases the likelihood of maternal and newborn deaths. To guarantee care in accordance with human rights and global health standards, governments must safeguard the rights of women in childbirth. This means establishing health systems equipped with the training, resources, and professional environment to provide both the emotional support and quality health services to which all women and their newborns are entitled. Given that maternal abuse and neglect are intimately linked to issues of gender discrimination, ensuring RMC within a health system also requires systemic changes at the cultural and institutional level, to create an environment in which women’s and newborns’ rights and needs are adequately defended.

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Here is what is scary about childbirth…

being treated for nine months like the most glorious representation of womanhood, complimented, treated with care and respect only to be treated on the day that should be the crowning day…of pregnancy as less than an animal, with little to no respect or dignity, no real information, emotional blackmail over giving up your rights, misleading information, and isolation.

–Mother from Glasgow, Scotland

They sent a woman to the washroom outside. She delivered over there. Thousands of men were seeing her. A few men and women took her inside in a very bad manner. I was having my ninth month of pregnancy. Having seen this I returned home and decided not to go to hospital for delivery and get my babies delivered at home.

–Mother from Pakistan
The right to respectful maternity care

The violent and preventable trauma so often experienced in childbirth can be the most brutal and terrifying experience a woman will ever face. Not only is this a source of great personal suffering, but discrimination and abuse in childbirth are a violation of the rights of every citizen. The Charter for Respectful Maternity Care (see page 15) succinctly summarizes these rights and spells out how they can be violated.

The Charter draws on long-established human rights instruments, including the United Nations Universal Declaration of Human Rights, which recognizes 30 basic human rights that are reinforced through international and domestic law. These rights include, but are not limited to, the rights to freedom from discrimination and to equal treatment under the law. Women’s recent testimonies reveal that these rights are being violated.

The United Nations Universal Declaration of Human Rights also includes the right to health, the right to privacy, and rights related to bodily integrity and personal safety. Collectively, these protections preserve

During labor I was shouting because of the pain when the midwife yelled at me ‘If you shout once more I will push the pillow into your face’…. The doctor also walked in and said, ‘If you had shouted once more I would have called the psychiatrist, who would have taken your child away and then you wouldn’t receive the child benefit, because anyway, you gypsies give birth only for the money!’

—Romany mother from Budapest, Hungary

For C section [they] only take signatures from [the] husband, saying that [the] operation will be done and do not tell details. The pregnant woman is not told anything.

—Mother from Abbotabad, Pakistan

I started crying out and screaming, ‘I can’t breathe!’… Then I [passed out]. [I] was discharged after three days, but no one ever explained what had happened. [I did not receive any follow-up care or get any of the recommended medications. I had no way to pay, so I never got any.’

—Mother from Memphis, United States

I did not know what my entitlements were, so I could not question anything that was told to me. I want information displayed at health facilities in clear and simple words, so that I can demand better services.

—Mother from India

23 (European Roma Rights Centre 2017)
24 (Amnesty International 2010)
25 (White Ribbon Alliance India 2017)
I would be told from time to time to ‘calm down’ because it was not real labor and I was going to know pain then…. I was forced and held down on a mattress because fetal monitoring had to happen. I was lied to that it was mandatory and couldn’t be refused.

—Mother from Glasgow, Scotland

I remember telling them for at least two of my deliveries to get their hands out of my vagina. They don’t listen. They figure it’s the pain talking and if you were in your right mind, of course, you would agree to it. It’s easier to refuse in the beginning, when you’re clear-headed, but once the pain takes you, they will force your legs open and stick their hand in – whether you’re screaming at them or not.

—Mother from Ontario, Canada

Before the first vaginal examination, I informed [the staff] that I have an allergy to latex and usually I complain of [a] scary irritation and burning sensation if latex gloves are used for vaginal examination. I asked for the staff to change the gloves, and they answered that it is not possible. I had severe pain, burning, and [swelling] because of the vaginal examination with the latex gloves.

—Mother from Ramallah, Palestine

The safety, dignity, and equity of women and infants in all contexts. The range of documented abuses that occur in pregnancy and childbirth, including verbal abuse, physical violence, forced procedures, and outright abandonment of care, represent gross violations of these core human rights.

Subsequent human rights treaties, which impose binding legal obligations on states that ratify them, also protect these rights. Although there are gaps between these international instruments and their implementation, all states are equally bound to protect the universal rights of people within their jurisdiction in all scenarios, including healthcare settings.

Thus, the issue of maternal mortality is not just a matter of development and health, but of discrimination and social inequality, both of which threaten the lives and welfare of women around the world. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) is a UN document that guarantees women equal rights and protection under the law. By signing and ratifying it, a nation commits itself to the elimination of all forms of discrimination against women and girls in all institutions within the state, whether public or private. This includes ensuring that women are able to enjoy the highest attainable levels of physical and mental health and freedom from abusive treatment.

CEDAW Article 12 states that the period of pregnancy, childbirth, and the postnatal period should be afforded special consideration and protection.32

The rights of women in childbirth are also protected under the International Covenant on Civil and Political Rights (ICCPR) Articles 2, 3, 7, 9, 17, 18, 19, and 26; the International Covenant on Economic, Social and Cultural Rights (ICESCR) Articles 1, 2, 3, 10, and 12; the Universal Declaration of Bioethics and Human Rights Articles 4, 6, 8, 9, 10, 11, and 14; and the Universal Declaration of Human Rights Articles 1, 2, 5, 7, 12, and 25.35

Furthermore, the Sustainable Development Goals (SDGs),36 as agreed to by all governments with specific tracking and indicator frameworks, include Goal 3, which refers specifically to the reduction of maternal and newborn mortality. Furthermore, as the SDGs have been designed as interrelated and interdependent, the achievement of Goal 3 relies on many other goals, including Goal 5 on gender equity, Goal 6 on clean water and sanitation, Goal 8 on decent work, and Goal 10 on reducing inequality within and among countries. When implemented, these goals would enable women to experience childbirth with the full and compassionate support of skilled healthcare providers, an experience that many already benefit from and value greatly.

When I visit [my doctor] I feel relaxed, I feel less pain, because I like her. She asks me about my problems; I tell her and she answers all my questions. She talks about everything and she explains everything.

– Mother from Lebanon33

When I used strength [the midwife] would say that you were wonderful…. When I said that I needed a rest, she say, ’You’d better take a rest.’ The midwife made me feel that I could make my own decision. She allowed me to be my own self. She highly respected my feelings and she gave me much freedom about my own body.

– Mother from Taiwan34

I will recommend that facility because the providers were caring…. The nurse asked me to pray and the doctor said what he would do was going to be painful; but he reassured me. They injected me again [when I said it was painful] to make sure it was bearable.

– Mother from Ghana37

During the delivery, the support of the doctor was very important to me. He was very kind and humane. I will never forget his encouragement.

– Mother from Lebanon38

33 (Mannava, et al. 2015)
34 (Kuo, Wu and Mu 2010)
36 (United Nations 2017)
37 (D’Ambruoso, Abbey and Hussein 2005)
38 (Mannava, et al. 2015)
Mistreatment in childbirth occurs in all nations, no matter their economic status. Regardless of level of wealth, governments should guard against inferior care practices by providing the resources and training providers need to deliver quality care. They should also develop a health-system culture that acknowledges and champions the rights of women in childbirth. Unfortunately, many health systems are plagued by infrastructural weaknesses that limit women’s access to high-quality, respectful maternity care. The WHO recommends a minimum of 23 doctors, nurses, and midwives for a population of 10,000 to provide adequate maternal and child health services.\(^{39}\) However, as of 2010 Pakistan averaged about 12 healthcare workers per 10,000, while Malawi averaged 3 and India 24.5.\(^{40}\) The reasons behind workforce and resource shortages vary depending on the setting. Regardless of the cause, overworked healthcare staff are often under enormous pressure. Nurses and midwives are often poorly and inconsistently paid while also working long hours in isolated rural locations.\(^{41}\) Under these conditions, workers can become stressed and burned out, or their work performance simply declines due to exhaustion.\(^{42}\) 

Unsupportive environments and irregular training can also lead to poor practices and inconsistent care, increasing the likelihood of neglect and abuse.\(^{43}\) While not direct mistreatment, shortages of surgical equipment, medicine, and emergency transport also contribute to delays in care and negative provider interactions.

Some of the recognized factors that contribute to mistreatment include individual provider prejudices and actions, lack of citizen accountability mechanisms within hospitals, lack of legal regulations protecting patients’ rights, lack of enforcement or commitment to human rights legislation, and community attitudes that tolerate or support negative care interactions.\(^{44}\)

Although disrespect and abuse occur between people, these actions are most often driven and reinforced by cultural norms and national laws.

Effective coverage of maternal healthcare in the media can shed light on these interlinked barriers, informing and aiding lawmakers and communities in planning how to improve care systems.
The realities of midwives’ lives

Mothers, newborns, and their families throughout the world need the help of competent, caring, and respectful caregivers to survive childbirth, thrive in the months and years after it, and realize their full potential to transform our world. The Lancet Series on Midwifery shows that midwives can provide up to 87% of pregnancy-required services. If midwifery were universally scaled up, it could reduce up to 82% of maternal and neonatal deaths and stillbirths. The evidence further supports a shift from fragmented maternal and newborn care provision that is focused on identification and treatment of pathology to a whole-system approach that provides skilled, person-centered care for all.

Evidence, however, also shows that midwives are too often disrespected. They are highly committed to providing the best care to women, newborns, and their families but are constrained by multiple barriers, including lack of an enabled environment, lack of a fully functional team, lack of integration into and support from the health system, lack of referral mechanisms, inadequate pay, unsafe environment at work and at home, lack of proper resources and supplies and, importantly, a lack of voice. In order to reap the benefits that midwifery care can provide, there is a need to change complex hierarchies of power and transform the gender dynamics that play a critical role in the provision of maternity services.

I find it nearly impossible to give safe, high-quality care to women and their babies when I have so many others to care for. I cannot always be compassionate and kind when I am hungry and tired from not being relieved by another member of staff. This is personally devastating, as it is caring for women, giving safe and high-quality care and being compassionate that first inspired me to be a midwife.

–Midwife from the UK

Seeing those who came for services again and hearing them say thank you goes straight to the heart. I remember a woman thanking me for helping her deliver. This woman had very little but she gave me some eggs. It was really motivating to be appreciated so warmly.”

–Midwife from Burkina Faso

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45 (World Health Organization 2017)
46 (Homer, et al. 2014).
47 (The Lancet 2014)
48 (World Health Organization 2016)
49 (Anonymous NHS midwife 2014)
50 (Prytherch, et al. 2013)
Those who work in reproductive health often face poor working conditions that prevent them from providing the highest quality of care. Midwives often face particularly harsh conditions, due in part to the hierarchy within medical systems as well as gender discrimination. These poor conditions combined with a lack of professional support can diminish morale and performance.

Within developing countries, providers are often tasked with caring for a rapidly growing numbers of patients without the resources or infrastructure to adequately meet the demand. In 2016 WHO, White Ribbon Alliance, and the International Confederation of Midwives published *Midwives Voices, Midwives Realities*, which documented the voices and experiences of 2,470 midwives in 93 countries. The report identified a variety of constraints that prevented midwives from providing the highest possible standard of care. Many midwives testified to enduring poor working conditions, including a lack of resources, supervision support, and professional respect. The report attributed much of this to gender discrimination and identified it as a barrier preventing midwives from contributing to health policy decisions at a leadership level.

If the colleague is struggling to meet some costs and his work is heavy and the roof of his house is leaking, then all of this will play on his work. Someone who is angry all the time about things that are out of reach...this person can pour his anger on the patients!

– Nurse from Burkina Faso
Furthermore, 70–80% of African midwives surveyed felt that midwives were treated badly and experienced poor work conditions due to insufficient numbers of staff and poor pay. These ongoing constraints are particularly common in sub-Saharan Africa, where poor resources and low/irregular pay for providers causes many to leave midwifery, decreasing the overall experience level of staff and increasing the burden on the remaining providers.

In addition to preventing midwives from providing the desired level of care, poor pay, overwork, and a lack of institutional support can result in a vicious circle in which women receive substandard care for which they blame midwives; midwives in turn become further demoralized – and so it goes on.

Many midwives, the women they care for, and their governments wish to fix these problems and are working toward achieving the highest possible quality of care. It is often midwives who have championed the Charter for Respectful Maternity Care, passionately committed to ensuring that all their colleagues comply with the highest standards in order to safeguard the rights of women and do justice to their profession.
Disrespect and abuse during maternity care are a violation of women’s basic human rights.

In seeking and receiving maternity care before, during and after childbirth:

1. **Article I**
   - **EVERY WOMAN HAS THE RIGHT TO**
   - **BE FREE FROM HARM AND ILL TREATMENT**
   - **NO ONE CAN PHYSICALLY ABUSE YOU**

2. **Article II**
   - **EVERY WOMAN HAS THE RIGHT TO**
   - **INFORMATION, INFORMED CONSENT AND REFUSAL, AND RESPECT FOR HER CHOICES AND PREFERENCES, INCLUDING COMPANIONSHIP DURING MATERNITY CARE**
   - **NO ONE CAN FORCE YOU OR DO THINGS TO YOU WITHOUT YOUR KNOWLEDGE AND CONSENT**

3. **Article III**
   - **EVERY WOMAN HAS THE RIGHT TO**
   - **PRIVACY AND CONFIDENTIALITY**
   - **NO ONE CAN EXPOSE YOU OR YOUR PERSONAL INFORMATION**

4. **Article IV**
   - **EVERY WOMAN HAS THE RIGHT TO**
   - **BE TREATED WITH DIGNITY AND RESPECT**
   - **NO ONE CAN HUMILIATE OR VERBALLY ABUSE YOU**

5. **Article V**
   - **EVERY WOMAN HAS THE RIGHT TO**
   - **EQUALITY, FREEDOM FROM DISCRIMINATION, AND EQUITABLE CARE**
   - **NO ONE CAN DISCRIMINATE BECAUSE OF SOMETHING THEY DO NOT LIKE ABOUT YOU**

6. **Article VI**
   - **EVERY WOMAN HAS THE RIGHT TO**
   - **HEALTHCARE AND TO THE HIGHEST ATTAINABLE LEVEL OF HEALTH**
   - **NO ONE CAN PREVENT YOU FROM GETTING THE MATERNITY CARE YOU NEED**

7. **Article VII**
   - **EVERY WOMAN HAS THE RIGHT TO**
   - **LIBERTY, AUTONOMY, SELF-DETERMINATION, AND FREEDOM FROM COERCION**
   - **NO ONE CAN DETAIN YOU OR YOUR BABY WITHOUT LEGAL AUTHORITY**

Safe Motherhood is more than the prevention of death and disability...It is respect for every woman’s humanity, feelings, choices, and preferences.

All rights are grounded in established international human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women.

For more information visit: [www.whiteribbonalliance.org/respectfulcare](http://www.whiteribbonalliance.org/respectfulcare)
The Charter for Respectful Maternity Care is based on universally recognized international instruments to which most countries are signatories, such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of all Forms of Discrimination against Women. This document provides the most widely accepted standard of RMC, developed through multi-stakeholder partnership and endorsed by numerous governmental, nongovernmental, and international institutions.
Breaking the silence: A positive role for the media

As we have seen, mistreatment during pregnancy and childbirth continues to push women away from life-saving medical interventions and interferes with the provision of high-quality care. Sensitive, accurate, and well-informed media coverage can make a huge difference.

Mistreatment in maternal healthcare often stems from attitudes to women and childbirth, while gender bias further silences women's voices. The media can play an enormous role in breaking this silence by informing women of their rights, drawing attention to lapses in care, and inspiring action for change amongst communities, providers, and policymakers.

In many countries, childbirth is a private matter not publicly discussed. Yet women who have suffered abuse, disrespect, or the loss of a child have a right to speak out about what happened to them. Furthermore, they possess vital insights that can improve quality of care and prevent providers from repeating mistakes.

Sensitive reporting by the media can help women tell their stories to national audiences, which in turn enables lawmakers, providers, and other women to understand the systematic improvements needed within their healthcare system. It can also inform men about the traditionally hidden issues and risks that women face in childbirth, helping them to support their family members in seeking dignified care. For women, it can be therapeutic to know that they are not alone, that others recognize what happened was wrong, and that they are now part of a movement for change.

Investing in media relations

Interactions with media can take many forms. Investing in personal relationships with journalists is time-consuming but can be very fruitful. Journalists and editors are often in a hurry. If you become a trusted source of accurate and compelling information, they are far more likely to call you – or answer your call – when they want a new story or expert comment. And if you have a good relationship, they are more likely to listen if you want facts corrected or a more balanced story told in the future.

Investing in journalist workshops and press trips can also reap rewards, providing the foundation for trust and mutually beneficial relationships. Furthermore, workshops that bring “citizen journalists” together with professional journalists can build sustainable, long-term relationships between citizens and mainstream media, while providing a powerful springboard for new and compelling stories.

Below are some exercises and materials for facilitators of workshops and trainings for journalists.
Partner with respected members of the media

Media partners can be valuable in delivering and designing training. Veteran reporters can anticipate the questions and needs of their peers and adjust training programs to accommodate these concerns. Partnering with a local media member or institution gives credibility to the overall training program and reduces the likelihood that the facilitators will be viewed as outsiders.

Know the media landscape

If the intended outcome of this training is to inform the public more efficiently, one must determine how information is disseminated and consumed throughout the region before designing training. Are most people receiving their news through the radio? Are there language barriers in certain communities? Establishing a basic understanding of how information travels within a community is essential, as it can ensure that the media representatives contacted will know how to reach your intended audience.

BEST PRACTICES: HOW TO PLAN YOUR MEDIA TRAINING

Just as RMC helps providers partner with mothers to deliver high-quality care, partnering with journalists should be undertaken as a joint effort to overcome personal and structural obstacles impeding high-quality RMC coverage. Given the diversity of media institutions and infrastructure in various contexts, there is no universal path towards this goal. Rather, one must examine the field from the perspective of local reporters and adjust the method of information delivery to fit the target audience. Below are some broad guidelines facilitators can use to structure training regimens and media partnerships.

Identify barriers and provide solutions

In some areas, reporters cannot obtain quotes from hospitals or health workers due to health system bureaucracy. In other contexts, reporters may lack the travel funds or communication resources to obtain quotes from otherwise willing sources. Longevity of impact is also an issue within the industry, as poorly paid reporters will often leave the field for more enticing employment opportunities abroad. Training should offer reporters solutions to these issues whenever possible. For example, in Malawi, WRA has trained 30 midwives as citizen journalists, opening a new line of communication between health workers and the media. Offering proven solutions and examples of past success shows reporters that the changes you are suggesting are possible and encourages them to take action.
Adapt your goals and “asks” to local circumstances

Some standard practices for reporters in Western contexts are not feasible in other settings. Placing unrealistic demands on reporters in low-resource settings can create tension and limit the message impact. In such circumstances, it is important to prioritize attainable goals, or the most notable problems that need addressing.

Provide resources for action

Reporters are often on short deadlines with limited time to fact-check or learn new material. It is important to provide them with tools to access the most current information and sources in the field quickly and efficiently. This includes local NGOs that can link them to experts, health officials, and hospitals to contact for comment on an issue, as well as recent information and fact sheets produced by global institutions like the WHO. Providing such information can increase both the quantity and quality of maternal health reporting.

Draw relevant examples from the news

Using current articles from the news brings abstract concepts into concrete reality. It is important to see things from the perspective of a reporter and translate policy language into tangible results. One can use positive and negative examples from the news to stimulate group discussion on how the selected works succeeded or failed to incorporate RMC values.
There are many difficulties in persuading the media to cover maternal health stories, let alone from an RMC angle. Some obstacles may require collaboration with media partners at various levels of the media hierarchy. Below are some of the barriers, with suggested solutions.

**Barrier:** Women dying in childbirth is not news

Unfortunately, it happens all the time. (Journalists have a saying: “Dog bites man” is not news; “man bites dog” is.)

**Solution:** Take the angle that while deaths in childbirth may not be news, RMC is.

This relatively new focus on rights is at the cutting edge of change, and leading, innovative journalists will want to cover it. We have known anecdotally for a long time that women will avoid health facilities where they are not well treated, but now we have the evidence that when countries provide respectful care, many maternal and newborn deaths can be averted.

**Barrier:** This is a story mostly about women, and nurses and midwives are usually women. Despite there being many women journalists, the media is a male-dominated industry; only a small percentage of media owners and decision-makers are women. Women are not seen as powerful while male decision-makers are often just not interested in “women’s stories.”

**Solution:** Find a champion or spokesperson for RMC who is of interest to the media.

This can be a man or a woman who is well known and respected and who may be motivated by personal experience of pain and loss during pregnancy and childbirth. Also, utilize human stories of birth and triumph over adversity to tell the story, as they have great appeal, especially when accompanied by compelling photographs. Or show midwives and other health workers as heroes.

**Barrier:** At its core, RMC is an issue of reproductive health and rights. Improving these often poses a challenge to established hierarchies and power structures. The media, whether intentionally or not, often contributes to perpetuating these power structures.

**Solution:** Social media and citizen journalism provide wide-reaching alternatives to mainstream and traditional media.

Often, when an issue gains traction in social media, editors will notice the appeal to audiences and will show new interest. Remember to approach media as experts and partners, even when trying to get them to see things differently.

**Barrier:** Senior journalists tend to be men, and girls and women may feel embarrassment, shame, or fear in speaking about intimate issues with men. Health providers may also face retribution from employers after speaking to the media about the shortcomings of their health facility or health system.

**Solution:** Foster relationships with women journalists and with sympathetic male journalists.

Enable anonymity for those sharing stories that may carry risks, while also ensuring consent. Provide safeguards for whistleblowers by introducing them to journalists as the source of tips; but only do so if you trust the journalist to protect his or her source.
Key messages for journalists

1. Every woman and baby has a right to respectful care

There is a growing global consensus that ensuring safe, high-quality maternal care must include standards to protect the human rights and emotional security of women. Accessible and user-friendly environments, free of mistreatment and abuse, are essential in encouraging mothers to seek skilled medical care during pregnancy and birth. Highlighting disrespectful maternal care and how it closely relates to maternal and newborn mortality is essential to accurate media coverage of health issues.

2. Disrespect and abuse are widespread

Every expectant mother has a right to a relationship with her care provider that is respectful, empathetic, based on mutual trust, and supportive and empowering. Unfortunately, the reality of birth in many health facilities around the world leaves mothers traumatized and fosters a dread of facility-based care. Indeed, some pregnant women shun health facilities altogether in a bid to protect their self-esteem from being robbed or their moment of joy ruined during their time of greatest need.

3. Fear of disrespect and abuse costs lives

Avoiding health facilities for fear of disrespect and abuse leaves women vulnerable to the life-threatening complications that can occur during pregnancy and childbirth, and without the professional care that can save their lives and those of their newborns. The World Health Organization (WHO) estimates that 303,000 women die annually around the world due to pregnancy-related complications, 2.7 million newborns die each year, and 2.6 million babies are stillborn. Most these deaths can be prevented with access to skilled care before, during, and after pregnancy.

4. Disrespect and abuse are about health systems, not individuals

Gender discrimination limits the sexual and reproductive rights of women around the world. Discrimination on grounds of marital status, race, income, and other factors are at the root of much disrespect and abuse of women in pregnancy and birth. Health systems have historically prioritized medical intervention alone, versus the entire human experience while receiving medical care particularly with regard to women in childbirth. Many providers are therefore trained to believe that coercing or bullying a woman into “seeing things their way” is in the best interest of her health and that of her baby.

In poorly resourced healthcare systems, some providers are severely overworked and underpaid, with insufficient funds to provide the best possible care. Preventing mistreatment requires more than individual accountability. Providers must be given the necessary information, training, and support to include respectful care as an essential part of the care they provide women and their families.

At the health facility, a nurse came over and asked me whether I had changed the pad of my daughter who was in labor. I could not understand what she was saying because we use cloth for this and did not know about pads. I confused pad with par [foot] and said that her foot was fine. The nurse then slapped my daughter forcefully and said to me, ‘If you could not understand why didn’t your daughter reply?’ It was my daughter’s first baby and she was in too much pain to respond. I had to restrain myself from hitting that nurse myself.

– Mother from Pakistan

References:

58 (World Health Organization 2016) (World Health Organization 2016)
59 (White Ribbon Alliance 2015)
60 (World Health Organization 2015)
61 (Scientific & Technical Advisory Group & Gender Rights Advisory Panel 2017)
63 (World Health Organization 2016)
The following pages contain several handouts that can be distributed as training and guidance materials for journalists. Facilitators should take care to add materials as needed to suit the specific context.

1. **Key facts for journalists about respectful maternity care**
   
   This represents a condensed version of the background material provided above. It can be paired with training to contextualize the scale of maternal abuse and its effect on women’s health. This material establishes a baseline of knowledge so that reporters can join a global conversation about disrespect and abuse using proper terminology and up-to-date information. This fact sheet should be paired with local resources for points of contact within health systems and government institutions to accelerate the fact-checking process.

2. **Four scenarios of maternal abuse**
   
   This is an opportunity for reporters to engage in active thinking and discuss the nature of various abuses described in the RMC charter. Maternal health, and particularly RMC, requires a working knowledge of basic reproductive health and the childbirth process as well as the ability to identify abusive behavior. This exercise is an opportunity for reporters to voice skepticism, ask questions, and discuss areas of confusion that might limit their ability to report on this subject effectively. This handout provides a facilitator copy with detailed instructions, and a handout version that can be distributed for the exercise.

3. **Framing the narrative: Best practices and useful exercises for journalists**
   
   The most effective reporting on maternal healthcare and RMC will offer insight on the larger contextual issues that drive provider actions and encourage patients, providers, and policymakers to seek reform. However, RMC is a new topic for many members of the media. Optimal reporting can be limited by lack of knowledge or context on current maternal health issues, sensationalizing provider actions, or ingrained biases and gender stereotypes. This handout provides several guiding principles to aid in proper reporting on issues related to female reproductive care.

4. **Guidelines for conducting respectful interviews**
   
   Some community feedback has shown that women are reluctant to speak to reporters if they do not trust that they will be treated well or that their identities will be appropriately protected. In addition to restricting the number of available sources, poor interview practices can overpower the voice and message of a woman’s story, distort the truth, and perpetuate the marginalization of women. Therefore, it is important to teach and practice respectful interview conduct and demonstrate to reporters how significantly their conduct can positively or negatively impact a subject and story.

5. **The Charter for Respectful Maternity Care**
   
   The Charter for Respectful Maternity Care was developed collaboratively by a multi-stakeholder group, with expertise in the fields of clinical care, research, advocacy, and human rights. The Charter draws upon long-established human rights instruments reinforced through international and domestic law to situate the legitimate place of maternal health rights within a human rights context. This charter is a widely-accepted tool in the identification and classification of abusive care, and is among the most effective and concise instruments available for teaching the identification of disrespect and abuse.
**Most deaths of mothers and newborns can be prevented.** However, mistreatment at health facilities can stop women from seeking the care that could save their lives. There is a growing international movement for RMC to reduce maternal and newborn deaths by ensuring dignity and respect in facility-based care.

- 303,000 women die each year in pregnancy and childbirth.
- 99% of maternal deaths occur in developing nations, mostly in marginalized communities.
- Some 2.7 million newborns die each year, and 2.6 million babies are stillborn.
- Maternal mortality is the second leading cause of death worldwide for girls aged 15–19.
- The number of deaths has dropped by 43% in the past two decades.

**The right to RMC**

The trauma so often experienced in childbirth is not only a source of great personal suffering, but discrimination and abuse in childbirth are a violation of the rights of every person, everywhere. The Charter for Respectful Maternity Care /link/ draws on the United Nations Universal Declaration of Human Rights and other international instruments to spell out seven rights of childbearing women:

1. Freedom from harm and ill treatment
2. Information, informed consent, and refusal
3. Confidentiality, privacy
4. Dignity, respect
5. Equality, freedom from discrimination, equitable care
6. Timely healthcare and highest attainable level of health
7. Liberty, autonomy, self-determination, and freedom from coercion

**Factors that contribute to mistreatment in childbirth**

- Shortages of midwives, nurses, and other health workers who work long hours for low pay in challenging environments.
- Shortages of resources, equipment, supplies, and emergency transport contribute to delays in care and a stressed workforce.
- Lack of citizen accountability mechanisms and legal regulations to protect human rights.
- Individual and/or community attitudes that tolerate or support mistreatment.
Key messages for change

1. **Every woman has a right to respectful maternity care:** There is a growing global consensus that ensuring safe, high-quality maternal care must include standards to protect the human rights and emotional security of women.

2. **Disrespect and abuse are widespread:** Birth experiences in many health facilities around the world leave mothers traumatized.

3. **Fear of disrespect and abuse costs lives:** Avoiding health facilities for fear of disrespect and abuse leaves women vulnerable to life-threatening complications.

4. **Disrespect and abuse are about health systems, not individuals:** Health workers need information, training, and support to provide quality, respectful care.

5. **Discrimination limits the rights of women around the world:** Gender, race, marital status, age, and income are at the root of much disrespect and abuse of women in pregnancy and birth.

Facilitators:

Use this section to provide information, resources, and contacts for reporters. Adapt the information to suit your subject and location.
Can you identify disrespect and abuse in these four scenarios?

Separate into small groups of three to five people. Each group should read through the scenarios and discuss the following questions.

- Briefly describe what happened in each scenario from the perspective of each of the characters involved.
- Were the characters happy with the outcome? What might they have wanted to change?
- **WHY** did the characters in each scenario act the way they did?
  - Make a list of possible reasons and causes.
- Based upon the reasons identified in the previous question, how might these problems have come about? This could involve factors outside the interaction, including hospital policies, supplies, pay scale, hospital oversight, and laws.
- **SOLUTIONS:** for the problems discussed, what are the possible solutions?
- Discuss the RMC charter and which rights are being violated by each interaction.

### Scenario 1

*A healthcare worker tells a mother in labor that her baby is in distress and must be born quickly.*

The mother does not know about her right to informed consent. She is not aware of any benefits or entitlements that might exist to pay for her care. She is told she needs a painful and expensive procedure or her baby will die. When she asks what the other options are, the healthcare worker yells at her and says she is wasting time and needs to deliver immediately. The woman agrees to the procedure.

**Breach of respectful maternity care rights:**
Scenario 2

A doctor approaches a woman in labor and tells her to lie down. With no warning, he performs a vaginal examination, involving inserting his hand into the woman’s cervix to evaluate her progress in labor. The examination is very painful and the woman begs the doctor to stop. He replies that the exam is almost over and completes the procedure despite her protests.

Breach of respectful maternity care rights:

Scenario 3

A mother lives very far from the nearest health center and was unable to receive antenatal care. She is unaware of any complications with her pregnancy that might require her to deliver at a hospital. She went to her local health center for delivery, which has only one midwife and no resources for emergency intervention. Her labor progressed very slowly and after several hours of pushing she is exhausted. The midwife has no equipment to accelerate the labor or offer pain relief and the nearest hospital is several hours away. There is no emergency transport available. She screams at the mother that if she stops pushing she will lose her baby.

Breach of respectful maternity care rights

Scenario 4

An HIV-positive woman arrives at the local public hospital. She is in labor and her baby is coming very soon. Because of her HIV status, she knows there are increased health risks for her and her baby, and she is anxious about the delivery. The health workers realize that she is HIV positive and are reluctant to care for her. They do not have the equipment to take care of her properly. They take care of several other patients first, telling her to wait. She delivers her baby without assistance while waiting for care.

Breach of respectful maternity care rights
Separate into small groups of three to five people. Read through the scenarios and discuss the questions below. The facilitator prompts accompanying each scenario can be used to guide discussion.

- Briefly describe what happened in each scenario from the perspective of each of the characters involved.
- Were the characters happy with the outcome? What might they have wanted to change?
- **WHY** did the characters in each scenario act the way they did?
  - Make a list of possible reasons and causes.
- Based upon the reasons identified in the previous question, how might these problems have come about? This could involve factors outside the interaction, including hospital policies, supplies, pay scale, hospital oversight, and laws.
- **SOLUTIONS:** for the problems discussed, what are the possible solutions?
- Discuss the RMC charter and which rights are being violated by each interaction.

**Scenario 1**

*A healthcare worker tells a mother in labor that her baby is in distress and must be born quickly.*

The mother does not know about her right to informed consent. She is not aware of any benefits or entitlements that might exist to pay for her care. She is told she needs a painful and expensive procedure or her baby will die. When she asks what the other options are, the healthcare worker yells at her and says she is wasting time and needs to deliver immediately. The woman agrees to the procedure.

**Appropriate responses:**

The responses below represent good examples of the desired responses. Additional thoughts should be encouraged. At all times the problems identified should avoid personal blame and focus on structural changes that promote person-centered, evidence-based care.
**WHAT**

**Mother**
She is unaware of any benefits or entitlements that might make this procedure affordable. She was also unprepared for the possibility of complications and an expensive procedure. She is scared by the healthcare worker's attitude and is not given time or counseling to consider the matter. She is frightened by the cost of the procedure and how it will affect her family.

**Healthcare worker**
She sees an urgent problem that she cannot correct without an invasive procedure. The mother does not understand what she is telling her, because she has not had procedures like episiotomies or C-sections explained to her before. The healthcare worker feels very strongly that she is right and tells the mother the baby might die without this procedure. She has many patients and does not feel she has time to explain the risks and benefits of the procedure.

**WHY**

**Mother**
She was not properly informed in advance of childbirth about the birth process and the complications that might arise. She does not have a relationship with the healthcare worker and does not know if she should trust this advice. She may also lack the money to pay for a procedure and is reluctant to agree unless it is truly necessary.

Hospital or government inefficiency often prevents women from being fully informed of the benefits they are entitled to. Further complications with registration, informal payments, and bureaucratic inefficiency make it harder for women to receive entitlements.

**Healthcare worker**
Instead of helping the mother understand her circumstances, she became angry. There are many possible causes. She may not have been properly trained to provide informed consent. She may be tired with too many patients to provide the desired level of care. There are not enough health workers to provide continuity of care or become well acquainted with the women they are serving.

**SOLUTIONS**
- Increased antenatal counseling and healthcare education
- Continuity of care – women become acquainted with health provider during antenatal visits
- Hospital policies that reinforce the right to informed consent
- More staff to counsel mothers
- Increased provider training to help them stay calm and counsel patients
- Improved government accountability to ensure benefits are received
- What else?

**Breach of respectful maternity care rights**
- Coerced consent/lack of informed consent, disrespectful and undignified treatment, failure to provide the highest attainable level of healthcare
Scenario 2

A doctor approaches a woman in labor and tells her to lie down. With no warning, he performs a vaginal examination, involving inserting his hand into the woman’s cervix to evaluate her progress in labor. The examination is very painful and the woman begs the doctor to stop. He replies that the exam is almost over and completes the procedure despite her protests.

**WHAT**

**Mother**
The woman experienced pain from a procedure and asked that it be stopped. The doctor ignored her request and continued the procedure.

**Provider**
The provider sees this procedure as necessary to track the status of delivery. Many women experience similar discomfort during procedures and do not complain, so the provider feels he is doing nothing wrong.

**WHY**
The provider may not have been trained to perform this procedure in a way that is pain free. Perhaps he was in a rush and not able to perform it properly. The mother is vulnerable due to labor pain and unable to leave or more actively refuse this procedure.

**SOLUTIONS:**
- Increased training on informed consent and patient rights
- Training in performing pain-free procedures
- Increased focus on person-centered care
- Oversight to ensure procedures are performed respectfully
- What else?

**Breach of respectful maternity care rights**
- Non-consented care, physical abuse, failure to provide the highest attainable level of healthcare
Scenario 3

A mother lives very far from the nearest health center and was unable to receive antenatal care. She is unaware of any complications with her pregnancy that might require her to deliver at a hospital. She went to her local health center for delivery, which has only one midwife and no resources for emergency intervention. Her labor progressed very slowly and after several hours of pushing she is exhausted. The midwife has no equipment to accelerate the labor or offer pain relief and the nearest hospital is several hours away. There is no emergency transport available. She screams at the mother that if she stops pushing she will lose her baby.

**WHAT**

**Mother**
Mother’s labor is slow due to complications and she is becoming exhausted. These complications have not been explained to her and she does not understand the risks and context of her current situation. She is trapped in a state of prolonged pain and frightened because she does not know why this is happening or when or whether it will end.

**Provider**
The provider is worried that the labor is progressing slowly and understands the complications delaying the delivery and the risks to mother and child. She does not explain these complications to the mother. If she had the resources perhaps she would refer the patient for a C-section or other medical intervention. She does not have the resources or skills to intervene medically and panics. She shouts at the mother to frighten her, as it is the only method she knows to accelerate the labor.

**WHY**
The mother did not have adequate access to a health center and antenatal care. Because the health center was hard to reach, she was unable to build a relationship with the provider that might improve their communication. Adequate antenatal care can lower the likelihood of delivery complications and educate women about the health of their pregnancy so they can make the safest choice for where they want to deliver. Inadequate birth planning and education make women less prepared to deal with frightening or discouraging complications. Lack of education and empowerment can limit women's ability to demand explanations and information during labor. Inadequate numbers of health centers make it less likely for women to access care. Poor provider training can limit their ability to provide comfort, educate women, and provide emergency interventions.

**SOLUTIONS**
- Increase number of government health workers to provide accessible care
- Increase number of health centers to increase access to comprehensive care
- Equitably distribute health workers and health centers
- Improve reproductive health education
- Provide comprehensive antenatal care, including birth planning and preparation
- Provide continuity of care – women become acquainted with health provider during antenatal visits
• Ensure proper resources and training are available for emergency interventions
• Ensure provider training and supervision to prevent abusive care
• Provide emergency transport to transfer patients when a health center is unequipped to treat them
• What else?

**Breach of respectful maternity care rights**
• Undignified treatment, failure to provide the highest attainable level of healthcare

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### Scenario 4

**An HIV-positive woman arrives at the local public hospital.** She is in labor and her baby is coming very soon. Because of her HIV status, she knows there are increased health risks for her and her baby, and she is anxious about the delivery. The health workers realize that she is HIV positive and are reluctant to care for her. They do not have the equipment to take care of her properly. They take care of several other patients first, telling her to wait. She delivers her baby without assistance while waiting for care.

**WHAT**

**Mother**
The mother is concerned because she knows there is special care required for her delivery. She may also be afraid of discrimination and poor treatment from providers and other members of her community. She has seen patients who complain or make strong demands turned away or deliberately neglected. She therefore waits patiently for doctors to care for her but they never do.

**Provider**
The provider knows how to take care of this woman and deliver her baby with a low risk of HIV transmission to her baby. However, there is not enough staff or equipment to provide this care. Additionally, in a crowded hospital with many patients, there might not be adequate resources to properly sanitize an area and prevent transmission to other patients. They ignore the woman and allow her to deliver alone to minimize the amount of contact with her.

**SOLUTIONS INCLUDE:**
• Increase staff, beds, and equipment to ensure that all women can receive personal care in a timely manner
• Provide sufficient supervision and oversight to prevent patients from being ignored
• Provide emergency transport to transfer patients when a health center is unequipped to accommodate them
• Identify ways for a woman to assert her rights without alienating the health worker.
• What else?

**Breach of respectful maternity care rights**
Undignified treatment, discrimination, abandonment, failure to provide the highest attainable level of healthcare
FRAMING THE NARRATIVE:
BEST PRACTICES AND USEFUL EXERCISES FOR JOURNALISTS

1. Just imagine…
Women can experience childbirth as exciting, terrifying, exhilarating, painful, exhausting, uplifting…the list goes on. However, birth is especially a time when women need safety and support. Imagine how it would feel to be shouted at, or slapped, or bullied during a moment of intense vulnerability. Imagine how it would feel to give birth in a place of danger, or to be abused because you are young, unmarried, or of a specific ethnic group or religion.
Ask questions to encourage girls and women to share experiences like these.

“Break the Silence” video

2. Become familiar with reproductive health language
Effective maternal and reproductive health reporting requires knowledge of certain terminology, procedures, and complications. This knowledge helps reporters distinguish between appropriate and inappropriate healthcare, ask the right questions, and develop stories that effectively inform the public.

It is not uncommon for women to experience procedures or complications during birth without themselves knowing the right words to describe what happened and, in some cases, without being given an explanation by healthcare staff. While women are experts about their own experience, health professionals can help make sure journalists don’t miss any critical information.

3. Stay up to date
The field of health is changing – a procedure or practice that was unsafe several years ago, may in fact be saving lives today, and the opposite might also be true. When citing facts on reproductive health, check that the data is both recent and endorsed by experts. Actions taken by policymakers or patients based on out-of-date information could have grave health consequences for women and newborns.

4. Define abuse and disrespect
White Ribbon Alliance provides a succinct overview of what constitutes disrespect and abuse within the Respectful Maternity Care Charter. Journalists can provide an enormous service to the community by informing women about the standard of care they should expect. Despite its focus upon childbearing women, the standards described in this document apply to everyone in a healthcare setting.

Sometimes women are not aware that their rights have been disregarded, but the Charter can clarify and give a name and validity to their subjective experience. Above all, women are the experts as to whether their dignity has been respected.

5. Portray women respectfully
Every woman is a person in her own right, worthy of respect and being heard. She is more than how she looks, how many children she has, or whom she marries. Ask yourself, “Would I include this information if the subject were a man?” These broad classifications are rooted in gender stereotypes, and so help perpetuate rather than challenge imbalances of power.
7. Use accurate, nonjudgmental language

Violence and trauma are never the victim’s fault, either directly or indirectly. Abusive maternal care is a violation of human rights and cannot be justified in any circumstances.

As in any story, there may be conflicting narratives – such as different versions of what happened per women and their healthcare providers. Journalists are expected to present both sides of the story as well as the context in which an incident takes place. Think about how this can be done without blaming the victim.

8. Locate the human story within the bigger picture

Maternal abuse and disrespect is not limited to one woman, one provider, or one hospital. It persists because of larger issues such as lack of accountability and low care standards, lack of resources and poor working conditions for providers, discrimination specific to one’s gender, race or class, and lack of government action to address these issues. A well-written story will extend beyond the emotional drama of one woman’s experience and contextualize her story within national healthcare trends. Statistics, expert testimony, and recent government initiatives all help illustrate the current state of maternal and reproductive healthcare and what must change to improve the overall quality of care.

9. Listen to the minority voices

Many nations have significantly reduced the rate of maternal and newborn mortality in the past two decades. However, these reductions are most often concentrated within populations with higher income levels and easier access to health facilities. For some minority communities, maternal and newborn mortality has remained the same or even increased. People who are HIV positive, disabled, working in the sex industry, from a religious or ethnic minority, are part of migrant communities, or are rural or urban poor, to name a few, face unique barriers to obtaining satisfactory healthcare.

Often these barriers take the form of blatant discrimination or an inability or unwillingness on the part of the healthcare system to accommodate the needs or cultural preferences of a minority group. Although some of these practices may seem harmless, failing to address the needs of minorities discourages them from seeking medical attention and contributes to the ongoing negative trends in maternal mortality. Institutional discrimination such as providing poor care to minorities goes beyond just one hospital or an individual person or group. Allowing discrimination to continue in hospitals leaves all people vulnerable to persecution.

10. How can you help?

Many communities are unaware of their rights and of the actions they can take to demand higher standards of care. Journalists can provide information and contacts to organizations that can support people to learn about their rights and demand accountability. Journalists can also share examples of community actions that have created change and helped to ensure that human rights in childbirth are being upheld.

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64 (World Health Organization 2016)
65 (White Ribbon Alliance India 2017)
66 (World Health Organization 2016)
Given the intimate nature of pregnancy and childbirth, many women are reluctant to share their experiences, particularly after experiencing trauma or abuse. When a reporter takes the time to treat women with dignity and respect, this forms a bond of trust that encourages the interviewee to share her story more freely and present a more complete and engaging narrative. Accessing more intimate narratives attracts greater public attention and provides a more complete picture of the structural issues within the healthcare system. Furthermore, many patients and providers fail to contact the media due to fear of repercussions if their identity is revealed or their story misused. Establishing oneself as a respectful and trustworthy member of the media encourages community members, both providers and patients, to act as sources.

1. **Build a partnership on informed consent**

Systematic maternal disrespect often arises when the emotional needs of patients are not accounted for within healthcare systems. Reporters should consider themselves to be partners collaborating with a woman to amplify her voice and add context to her narrative. To initiate this relationship, a reporter should always obtain fully informed consent to use a woman's story. Informed consent includes informing the woman to what extent her story might be altered and explaining all formats that the story might appear in the future. These terms should be discussed and agreed upon before the interview takes place.

2. **Respectfully discuss the parameters of the interview**

Reproductive care is a sensitive and private matter that many women are reluctant to talk about. Be sure to conduct the interview in such a way that the subject feels respected, valued, and safe. Before the subject agrees to an interview, she should be told how her story will be distributed, whether in print, radio, etc. If the reporter intends to film or record the interview, this should also be addressed beforehand. It is important to explain the social value of the story and how it will help other families in similar situations. Be sure to ask if the subject prefers a male or female interviewer, as the wrong pairing can affect comfort level and, subsequently, the generosity of a subject's testimony.

3. **Be mindful of the emotional trauma the man or woman might have suffered**

In some cases, the interviewee may have recently lost a family member or child due to substandard care. Be cautious and respectful when approaching grieving family members for comment. Do not conduct interviews with subjects while they are visibly distressed. If they become distressed, pause and allow them to collect themselves. Sometimes it might be necessary to reschedule or halt the interview altogether. Always begin with open-ended questions to allow him or her to guide the conversation to where he or she feels safe. For example, “Tell me about what happened at the hospital,” is preferable to, “Tell me how you lost your wife.”
4. Ensure the privacy of the interviewee

Given the intimate nature of reproductive healthcare, many women will desire some degree of anonymity. There are often too few providers in communities, and women may be forced to receive care from abusive providers repeatedly during their lives. For this and many other reasons, it is important to offer anonymity and show discretion.

Ask the woman of there is any information she would like to conceal. Photographs should be taken only with the subject’s permission and approval to ensure they do not compromise anonymity. If they wish to remain anonymous, be aware of specific details that might reveal their identity in a report. In small communities, it may be quite easy to identify someone, even if you’ve used a pseudonym and changed other details of your subject’s identity. It is also important to explain exactly what “on the record” and “off the record” mean so that an interviewee can make informed decisions about what information she would like disseminated.

5. Follow-up with interviewee

Follow-up to inform a woman of how and where her story was used; this helps her feel valued and respected and shows her that her story was treated with care. This positive experience will encourage others to describe their stories and generally provide more material for journalists in the future.

6. Use citizen journalists when appropriate

White Ribbon Alliance has provided training for community members and healthcare professionals to act as citizen journalists reporting on RMC issues. In Malawi, many citizen journalists are midwives and are therefore an excellent source of tips and expertise for professional journalists. In areas with high maternal mortality, there are often concerned citizen groups, social media activists, and other local resources who can provide local knowledge and useful contacts within health systems or government institutions.
Moving forward

Discrimination and abuse within maternity care are often quietly accepted as an unfortunate reality of health systems. This fatalism reflects systematic structural inefficiencies that limit the quality of care accessible to women. Bringing attention to the reality of women’s suffering and the systemic causes of abusive care cannot be accomplished without engaging journalists and the media. At the very least, media engagement can help combat institutional discrimination and the spread of misinformation about women’s rights and reproductive health within the media industry. Under the right circumstances, partnerships with journalists who are passionate about the subject can prove to be transformative within a community. There is no substitute for local knowledge and commitment, and consequently the most productive training helps build a community of partners in the media. To achieve this, it is important to include local media leaders within the training process and offer solutions and information to keep reporters engaged. The combination of a committed health advocate, clear messaging, and accessible resources offers an enormous opportunity for improved coverage and awareness of maternal health issues in a town, city, region, or country.

As the media landscape evolves, our approach to the media must also evolve. We hope this guide is a valuable source of insights and guidance you can use to begin a rewarding journey of working with reporters to tell truthful, informative, and compelling stories that have the power to improve the health of women and their newborns.
Glossary

Antenatal care
Also known as prenatal care, this refers to the necessary monitoring, counseling, and medical care that mothers receive while pregnant. A minimum of eight antenatal visits is defined by the WHO as an acceptable standard of care.67

Citizen Journalist
Refers to an individual who is not a professional journalist by trade, but has been trained by White Ribbon Alliance to document their own and others’ stories with words, photos and/or video and use that information to advocate for improvements in reproductive, maternal and newborn health.

Emergency obstetric care
Refers to a series of life-saving interventions needed to treat complications during pregnancy and childbirth. These interventions include caesarian section, assisted labor, resuscitation, blood transfusion, and others. These services should be available 24 hours a day, 7 days a week.68

Family planning
Family planning and contraceptive care allow women to avoid unwanted pregnancies or pregnancies that may endanger their wellbeing. This lowers her lifetime risk of maternal mortality.69

Labor
Childbirth involves three stages. First stage: Begins from the onset of true labor and lasts until the cervix is completely dilated to 10 cm. Second stage: Continues after the cervix is dilated to 10 cm until the delivery of the baby. Third stage: Delivery of the placenta (this is the shortest stage).

Maternal health
Refers to the health of women during pregnancy, childbirth, and the postpartum period.70

Maternal morbidity
The definition of morbidity varies greatly, and this guide shall refer to the definition developed by a WHO-led working group on maternal morbidity. They define morbidity as, “any health condition attributed to or complicating pregnancy, childbirth, or following pregnancy that has a negative impact on the women's wellbeing or functioning.”71

Maternal mortality rate
Maternal mortality rate refers to the number of maternal deaths per 100,000 live births. According to the WHO, a maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Neonatal
Neonatal refers to a baby during the first 28 days of life, also known as the “neonatal period.”72

Neonatal mortality rate
According to the WHO, the neonatal mortality rate is the number of deaths during the first 28 completed days of life per 1,000 live births.73

67 (World Health Organization 2016)
68 (World Health Organization, UNFPA, UNICEF, AMDD 2009)
69 (World Health Organization 2015)
70 (World Health Organization 2017)
71 (World Health Organization 2015)
72 (World Health Organization 2017)
73 (World Health Organization 2017)
Postnatal care

The postnatal period is the first six weeks after childbirth. Most maternal and infant deaths occur during this period. The WHO recommends that after normal births, women should receive facility care for the first 24 hours or within 24 hours if birth was at home. This should be followed by at least three additional care visits. Postnatal care also includes counseling on danger signs to mother and newborn, infant care and breastfeeding, family planning, and other vital services.74

Reproductive health

The WHO defines health as a state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity. Reproductive health addresses the reproductive processes, functions, and systems at all stages of life. Reproductive health, therefore, implies that people can have a responsible, satisfying and safe sex life, the ability to reproduce, and the freedom to decide if, when, and how often to do so.75

By this definition, men and women have the right to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy baby.

Skilled birth attendant

This term refers exclusively to people with midwifery skills (for example midwives, nurses, and doctors) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage,* or refer obstetric complications.76

Skilled delivery

There are a variety of skilled birth attendants including midwives, neonatal and obstetric nurses, and doctors with specialized training. A trained birth attendant is essential to maternal and newborn health to avoid life threatening complications. Traditional birth attendants, though they may have an important role to play, however, lack the medical knowledge and equipment to provide an acceptable level of safety and care.77

73 (World Health Organization 2006)
74 (World Health Organization 2013)
75 (UNFPA 2017)
76 (World Health Organization 2002)
77 (World Health Organization 2002)
Bibliography


