CASE STUDY

Barriers to Respectful Maternity Care in a public teaching hospital

Over the last two decades governments across low- and middle-income countries have encouraged institutional childbirth to reduce maternal mortality.[1] However, accessing institutional intrapartum care alone does not ensure good quality care,[1] especially when the increased demand for childbirth in facilities is not matched by commensurate health system strengthening in terms of infrastructure, human resources and training.

In recent years, widespread reports of women, particularly disadvantaged women, experiencing disrespect and abuse during childbirth in facilities have captured global attention.[2] The World Health Organization has called for more research to understand the problem, and policy responses[3] to promote what is now termed 'Respectful Maternity Care', referred to as "care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth."[1]

In 2018, the Public Health Foundation of India's Ramalingaswami Centre on Equity and Social Determinants of Health conducted a qualitative study with obstetric care providers to understand the drivers of disrespect and abuse towards women during childbirth in different public institutional settings. The case study below draws on observations and in-depth interviews with obstetric care providers in a large teaching hospital. Some of the details presented here are for pedagogical purposes, and should not be interpreted as common practices in teaching hospitals.

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[1] Source: WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018.

[2] "In the context of obstetric care, we define disrespect as the violation of a woman's dignity as a person and as a human being on the basis of her economic status, gender, caste, race, ethnicity, marital status, disability, sexual orientation, or gender identity. Disrespect is often revealed in the biased normative judgements that health workers make about women and the resulting acts of omission or commission. Abuse refers to actions that increase the risk of harm to the woman and are not in the best interests of her health or well-being. Such actions may be learned and reproduced through the practices of institutional medicine. They may or may not be intended to cause harm and are often justified by resource constraints that can become a cover for prioritising the convenience of health providers over the well-being of the woman." Source: Sen G., Reddy B. & Iyer A. (2018). Beyond measurement: the drivers of disrespect and abuse in obstetric care. Sexual & Reproductive Health Matters, 26(53):6-18.

[3] Source: World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth. 2014.

As you pass through the gates and into the sprawling campus of the largest public teaching hospital[4] in a relatively developed Indian state, a combination of newly constructed and weathered colonial buildings tower over masses of people. A sea of patients and accompanying family members try to navigate a bureaucratic labyrinth of diagnostics, in-patient and out-patient care. As the final public referral facility, not only for the city but also for neighbouring districts, it serves more pregnant women than any other facility in the state, handling approximately 50 deliveries a day and around 15,000 per year.

Crowds swell as you approach the entrance to the Department of Obstetrics. Stern security personnel armed with batons demand documentation and grounds for entry; the majority of people are not permitted to enter. When a member of the hospital staff approaches, the crowd parts, allowing them to slip through. Periodically, when individuals who exude confidence, authority and privilege approach, the guards become less stringent and they enter with almost no questioning.

Inside the building and in the hallways, many pregnant women in early stages of labour are walking with the support of husbands and mothers. As you approach the labour wards, a large number of family members are crouched on the floor waiting for information while young children run around. Each day, a different unit head is in charge of each labour ward. They appear for rounds and are called in for serious complications. But it is a first-year postgraduate student (PG) who manages the ward round the clock, with the help of two interns, two nurses and cleaning staff. An additional second or final year PG is also usually posted to each ward, but these don't include long periods when they are preparing for and taking examinations.

The loudspeaker in one ward announces a name, and a slight woman, appearing no more than 16 or 17 years old, walks into the ward warily with her mother. An intern entering information in large registers directs her to lie down on the first labour table and asks her mother to wait outside; both instructions seem to frighten her. He tells the woman to lift up her skirt without explaining the procedure of a pelvic examination that he proceeds to perform. The young woman winces in pain during the examination, but the intern does not acknowledge it, instead continuing to engage in small talk with the nurse. As the PG in charge rushes by, he calls out, "only three centimetres, ma'am". Examination completed, the intern removes his gloves and walks away, but the woman remains there for several more minutes with

[4] Teaching hospitals are large multi-departmental hospitals administered by respective medical colleges, and serve the clinical learning needs of undergraduate and/or postgraduate medical students. The undergraduate students work as interns in these hospitals for a year, at the end of their course. They work for two months in the department of OBG, of which one month is in labour wards. The postgraduate students (PGs) are always at the hospital learning and managing front line medical responsibilities. PG training is for duration of 2-3 years depending on the type of course, and PGs work for 3 months/year in labour wards. Departments (like that of Obstetrics and Gynaecology) are typically divided into multiple units, each maintaining a strict hierarchy. Units are led by senior professors, comprise a few members of the teaching faculty, a few PGs and interns, and non-teaching staff (consultants, some resident doctors and nursing staff). Public teaching hospitals are funded by the central/state governments and provide a wide range of clinical services at nominal or no cost. They are also the preferred centres of learning for aspiring doctors since they are known for their affordable tuition, wide range of clinical cases, and a superior quality of students, who are admitted only after passing one of the most competitive entrance exams in the country.

her skirt and legs up, nervously waiting for further instructions. The nurse returns and admonishes her for exposing herself and tells her to pull her skirt down. “You’re not ready” the nurse then tersely says, directing her to continue walking the halls until she can be given a bed in the labour ward.

Back outside the ward, a strained conversation is unfolding between the PG and another woman’s family, intensifying because the family doesn’t speak the local language. The PG is trying to explain an unexpected medical complication and is telling the family to procure blood from the blood bank across campus, but they don’t understand and are asking for further explanation. PGs and interns describe communication about medical risks and complications to patients’ attenders in general as a very challenging aspect of their jobs: “They’re all uneducated people, so we have to explain to them thrice or four times before they actually do something which we have told them.” And many providers see migrant patients as an even greater source of frustration, not only for the communication challenges they pose, but to even manage clinically. “They are basically manual labourers and they are very difficult because they have no access to any other healthcare and they just land up without a single previous check-up or report”.

Inside another labour ward, the high-risk ward, there are almost 15 women at different points of active labour, ineffectively separated by undrawn curtains. Nurses are checking IV lines, interns are monitoring foetal heart rate, and the PG doesn’t have a moment to pause - the anxiety among providers is palpable. Patients are murmuring, moaning and shouting in pain for the nurse or doctor’s attention, but the staff seem to treat this as routine noise and rarely respond. There is an absence of reassuring looks or kind words - the women appear to labour alone around agitated and exhausted staff. When asked if labour companions would be helpful, a PG responds, “practically it is not possible for us to allow a labour companion. If it is possible, maybe it will do good for the patient’s psyche….[but] we do not have single delivery room suites. There are other patients. If I allow one attender with every patient, then what about sepsis?”

A woman begins to push and the baby’s head starts crowning. The PG in charge, who is completing paperwork, rushes over with a nurse. “Why didn’t you call us?” they bark. The woman tries to keep her legs closed. The frustrated PG, attempting to stay calm, says, “don’t close your legs, how can I deliver this baby?” When the woman repeatedly tries to close her legs, the increasingly agitated PG screams, “If you don’t open your legs and push harder, your baby will die!” Eventually the PG, two nurses and a cleaning staff member physically restrain the woman and force her legs apart. A baby girl is delivered amid the commotion.

Some professors see managing stress during postgraduate training as a learning curve, treating anger towards patients as collateral damage until they mature. Others explain that PGs are so focussed on performing and presenting clinical procedures accurately to supervisors that it eclipses any inclination to develop and display good interpersonal care. Others still point out a more fundamental gap in learning: “Soft skills are something we lack in medical education. In the curriculum we do not have

any subject such as counselling. No one teaches us. It is only what we see and learn from our seniors".

Within minutes another woman is about to deliver. A nervous intern, on her second day of posting in the labour room, stands before her calculating when to conduct an episiotomy.[5] She has seen the PG perform the procedure a few times and now it's her turn. Recalling her labour ward posting another intern reveals "…not all of our epi (episiotomy) scissors were sharp. Because some used to not cut at all. Some used to cut at only one particular angle." Despite being officially stocked with 20 pairs of scissors, the intern describes how it took until the end of her month-long internship for the ward to receive a new set. "But till then we had to use the same scissors…they used to just wash it in water, dip in [disinfectant], not even two seconds, 'yes use''...I felt very bad. We give antibiotic coverage yes, but still."

Teaching hospitals like this one are particularly overstretched in part because of a policy guideline on staffing which is driven by student load, not patient load. The policy considers the number of undergraduate and postgraduate students and specifies the minimum number of beds in a teaching hospital catering to those students. It designates teaching staff (who are senior obstetricians) based on the minimum number of beds, not taking into account the actual number of beds, let alone actual patient load. Other well-intentioned policies have inadvertently contributed to the stress on such tertiary teaching hospitals. "Once they started 108 (free ambulance service), the number of patients increased to limits and bounds, but the beds were not increased, the doctors' numbers were not increased. The nursing staff were not increased…what is the problem? They just want to stall the problem. And their administration is for two years…. After that somebody else will come," complains a unit head. The majority of referrals are also from secondary health facilities managed by the municipal health department. Providers frequently faulted these facilities for having too low a risk threshold and not taking the responsibility for managing smaller complications, engaging instead in irrational and unnecessary referrals.

The expectations of PGs, who are ultimately responsible for all normal births in the hospital, can seem unreasonable. They're unlikely to get a day off during a three-month long labour room posting, and they can be on call for up to 72 hours at a stretch. Some PGs describe being fearful even when they try to take a break to eat, because they're still on the line if a complication arises. In general, providers handling the bulk of cases want to do better, but cannot overcome these constraints. "I am less satisfied with the care I provide, because my patients are too many so I can't answer all of their questions. If I had one more [staff member] it would be good. I could tell them a little more calmly, more affectionately, I would like to as well. But it's not possible to do it in such a way. But to the extent possible, I do it, I try," reflects a PG.

[5] An episiotomy is an incision made between the vagina and rectum during childbirth to enlarge the opening for the baby to pass through, to aid a difficult delivery and/or to prevent perennial tears.

An ambitious, nation-wide government initiative is underway that focuses on quality improvement in labour rooms, setting guidelines for important aspects of infrastructure, human resources, drugs and equipment. While the initiative is still in its early stages and considerable barriers to implementation remain, it is an important first step in the country to ensuring respectful maternity care for all women.

Questions:

1. A widely used framework to understand health systems divides it into six building blocks with people at the centre.

   a) From reading the case study, which of these building blocks do you see operating?

   b) Of those that you identify, how is it working and what are any problems with it?

   c) Do constraints in one building blocks affect the other building blocks?

   d) How many such interdependencies can you identify?

2. A respectful maternity care framework lays emphasis on women's agency, including their right to information, consent and involvement in decision-making. Observe how each of these rights are working in the case study.

3. a) List the ways in which you see gender power at work in this case study.

b) What other dimensions of inequalities and power relationships do you observe in the case study?

4. In question 1 you identified how different elements of the health system are working in this case. In succeeding questions, you have also looked at gender and other inequalities. Can you think of ways in which changes can be made in the health system to make it more responsive to gender and other inequalities? What would those changes look like?