brief

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Respectful Maternity Care in Pakistan

White Ribbon Alliance Pakistan (WRAP)

White Ribbon Alliance aims to make the seven aspects of the Universal Rights of Childbearing Women Charter the basis of maternity care systems around the world, including Pakistan. The Health Policy Project supported WRA Pakistan to undertake the study for developing insights about the state of disrespect and abuse around facility based births in public sector health facilities in Pakistan.

Objectives

The overall purpose of the research was to contextualize RMC with respect to Pakistan, the specific objectives are:

- To identify practices of disrespect and abuse that women face while seeking maternity care services at public sector facilities
- To gauge users' perceptions about the state of RMC in services delivery at public sector health facilities
- To determine key supply and supply-side barriers to the delivery of RMC by the public sector

Methodology

Formative in nature, the study was driven by Borwser and Hill (2010) framework and employed Focus Group Discussions (FGDs) with users and In-depth Interviews (IDIs) with maternal health experts to collect the data. The FGDs were conducted in 5 districts (2 in Sindh province, 2 in KP and 1 in Punjab). IDIs were conducted with experts (academicians, practitioners, managers, advisors) in all 3 provinces.

What is RMC?

Respectful Maternity Care (RMC) refers to several important aspects of maternity care services. It describes the interpersonal interaction, embraces the fundamental rights of mothers, newborns and their families, and recognizes that all childbearing women need and deserve respectful care and protection of the women's rights to choice and preferences. It is an approach that centers on the individual, builds upon principles of ethics and respect for human rights, and upholds practices that recognize women's preferences and women's and newborns' needs. In 2010, Browser and Hill explored the evidence of disrespect and abuse in facility based childbirths in their Landscape Analysis and identified seven categories of disrespect and abuse: physical abuse, non–consented care, non–confidential care, non–dignified care (including verbal abuse), discrimination based on specific attributes, abandonment or denial of care and detention in facilities. The analysis further found that disrespect and abuse might sometimes act as more powerful deterrents to skilled birth care utilization than other more commonly recognized deterrents such as geographic and financial obstacles.

PRACTICES

1. Physical Abuse

- Episiotomy without anesthesia
- Slapping, tying the legs to the stretcher
- During the night, speeding up the drip for quick delivery, doing more operations rather than giving time

2. Non-Consented Care

- Not seeking permission before check up
- Not permitting the woman to move around, scolding if she does so
- Misinforming
- Refusing permission for attendant
- Doctors talk harshly, abuses, talk disrespectfully, sarcastically referring to the marital relationship, scolds, yells, talks ambiguously, snubs on questioning, scolds if attendant tells re patient
- Ultrasound performed by male
- Staff do not listen, do not value what patient is saying, and just write prescription/ investigations
- Women not permitted to express themselves
- Procedures not explained
- A maternity care seeker does not know where to go when comes to hospital
- No choice of doctor
- No counseling provided
- Does not inform the woman about an operation, just gets consent from attendants who are outside
- Attendant not informed about what is happening inside.

3. Non-Confidential Care

- Taking pains in the waiting area outside the labour room
- No privacy, other women present, ward boy moving around, other male doctors present, all women lying uncovered in front of each other and others
- Multiple women sharing a bed
- Women lying uncovered
- Deliveries happening on tables outside labor rooms, on the ground, at the door of the Rural Health Centre (RHC), staff do not receive patients despite of emergencies, if the duty time is over the staff asks the women to come next day irrespective of her condition

4. Non-Dignified Care (Incl. Verbal Abuse)

- No seating areas, pregnant ladies standing, no shade in waiting areas
- Junior staff treat women badly, in non-dignified manner
- No one cares, treat women very disrespectfully especially when one screams, and scolds
- Staff outside the labour room treat women with disrespect
- Women sent out of the room, insulted and sent out of room
- Junior staff (midwives) see bleeding with suspicion
- Junior staff (midwives) scold patients
- Doctors talk harshly, abuse, talk disrespectfully, sarcastically referring to the marital relationship, scold, yell, talk ambiguously, snub on questioning, scold if attendant tells them about the patient
- Women scolded when screaming with pain

5. Discrimination based on specific attributes

- Poor rural women made to sit at a distance
- RHC does not take primigravida cases
- Misbehave towards the poor, staff scold that those who have no money should not come here, no respect for the poor

6. Abandonment or Denial of Care

- Long Queues, pushing, overcrowding, long waiting times
- Admission not granted without prior registration
- Gives medicine during the first visit only and not in the follow up visits
- Senior doctors do not check patients, only tell the juniors to check
- Doctor/Staff come in their own time but not when asked/requested
- Steal and sell medicines from public facilities
- Referral without properly examining
- No seating areas, pregnant women standing, no shade for standing
- Do not conduct physical examination, sent away without checking, sometimes check only at last moments of delivery, not at all in OPD, only writes ultrasound

- First shift doctor will not check women if second shift staff is late in arriving
- Doctors send to nurse saying she will describe the prescription
- Does not attend a woman in labour without registration card of that hospital despite there being an emergency
- Examinations performed very quickly
- Women insulted and sent out of room
- RHC does not take primigravida cases
- No doctors /staff around , only come when head appears, do not come despite calling, midwife goes away for taking gifts from attendants, leave alone in labour room, give drip and go away and only come at the time of delivery,.
- 3-4 children lying in one incubator
- Those who makes more noise are attended less
- Multiple women on each bed
- Deliveries happening on tables outside labor rooms, woman sent to outside wash room and delivered there, on ground, at the door of RHC, staff do not receive patients despite of emergencies, in case the duty time is over the staff will ask the woman to come next day irrespective of her condition

REASONS

Demand Side

- Lack of awareness of the care seeker about their right to respectful care that is free from abuse
- Maternity care seekers accept the doctors' poor behavior as normal practice.
- Poverty, illiteracy, lack of education, lack of information about health issues, lack of information about grievance redress mechanisms, fear of deprivation
- Lack of community participation resulting in a lack of community ownership of the health services

Supply Side

- Gaps in theory and practical trainings of health facilitator/provider
- Lack of focus on public/community health in the curriculum
- Absence of role models to follow by students.
- Heavy client load
- Lack of human resource and lack of infrastructure
- Seniors over-involvement in managerial tasks
- Poor supervision and lack of accountability
- Lack of grievance redress mechanisms in the system
- Political interference, VVIP culture and bribery
- The personality issues of doctors such as lack of sensitivity and attitudinal problems
- Misuse of social power and authority vested in doctors by society

Relevant Policies and Instruments Presence

- Only key element mentioned in this regard was the Medical Ethics that is included in the Oath of doctors
- The attitudinal and behavioral aspects of the client-provider interaction not included in any service delivery standards

RECOMMENDATIONS

The recent Pakistan Demographic and Health Survey (PDHS 2012-13) has documented an increase in the facility-based births that has long been pursued as a strategy to decrease maternal mortality. Decades of efforts on demand generation for skilled birth attendance have brought this window of opportunity. RMC is a key to capitalize on this. **Government should focus on this aspect of maternity care for optimum utilization of the resources and translating demand into positive health outcomes.**

The **RMC related indicators should be included in the monitoring framework of maternity health services monitoring mechanisms.** The monitoring mechanism such as District Health Information System, Roadmap Stock takes by Independent Monitoring Units (IMUs) and the provincial and national surveys include RMC indicators and regularly capture data on this. Citizen feedback models can also be valuable entry points in this regard.

The governments should include special provisions for pregnant women grievance redress. The standards of waiting time be reduced in line with the pregnant women needs. The governments should **develop strategies to manage the workload** that has been reported as one of the key determinants of misconduct of health care providers. Resources need to be increased in proportion to the client load to have more facilities, improve the waiting areas, increasing the labor rooms, making referral system functional. The **primary health care utilization** needs to strengthen in order to reduce burden on tertiary care. An **effective referral system** needs to be put in place at secondary health care facilities that can enable these facilities to accept primigravida and other high risk cases which can be referred in case of emergency.

The issue of RMC does sit well within **Quality of Care (QoC)** approach and can be dealt under that accordingly. However, it is important to not to lose the rights perspective that can be an unwanted outcome of dealing with it solely within the QoC paradigm.

The curriculum of the medical staff including both doctors and non-doctors should be improved to include RMC in the teaching. The Medical Colleges, Pakistan Medical and Dental Council (PMDC), Federal Ministry of Health Services Regulation and public health teaching institutes such as Health Services Academy (HSA), Institute of Public Health (Lahore), Provincial Health Services Academies need to include **RMC into the teaching curriculum under medical ethics and community medicine courses.**

The practices of services delivery are usually internalized by doctors through their observations of their seniors' in House Job component of the medical training. **Senior doctors should promote RMC at the practices level by being role models.** The professional associations that set standards of practices such as Society of Obstetricians and Gynecologists Pakistan (SOGP) and Pakistan Medical Association of Pakistan should come forward in promoting RMC standards.

Public demand can be a fundamental driver of change in this regard. Public awareness of the rights of childbearing women must be increased to form the corner stone of the drive for change. A **mass media campaign on the rights and entitlements of childbearing women, championed by society's well-known figures,** would be very effective in this regard.

Given the overall policy deficit, coupled with the demand side issues, it is recommended that a multipronged **advocacy strategy** is adopted by civil society especially the organizations working on RMNCH, human rights and accountability that targets all key policy stakeholders including decision makers, policy influencers and the beneficiaries. **The media, civil society, NGOs, CBOs and others should join together to promote RMC.** Along with a promotional campaign, targeted advocacy to include RMC into Health Care Charters, Right to Services offer, and Right to Information services can be a strategic entry points to introduce **RMC into the health governance.**

Whereas the study does not provides estimates of prevalence of these practices, it does however highlight the existence of such practices which have been described by the users of health facilities as well as experts such as managers, practitioners, academicians etc. as barriers to access of public sector maternity services especially by poor and marginalized. It opens the avenues of further research in this area. Important in this regard would be **finding estimates of existence of such practices, more in-depth comparisons with private sector, study of different accountability mechanisms** for their potential to contribute towards ensuring respectful care for women.

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White Ribbon Alliance formed over a decade ago to give a voice to the women at risk of dying in childbirth. Our mission is to inspire and convene advocates who campaign to uphold the right of all women to be safe and healthy before, during and after childbirth. We help citizens recognize their rights and hold their governments to account for commitments made to maternal and newborn health.