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The relationship between women's experiences of mistreatment at facilities during childbirth, types of support received and person providing the support in Lucknow, India

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ABSTRACT

Background: a growing body of literature has highlighted the prevalence of mistreatment that women experience around the globe during childbirth, including verbal and physical abuse, neglect, lack of support, and disrespect. Much of this has been qualitative. Research around the world suggests that support during childbirth can improve health outcomes and behaviours, and improve experiences. Support can be instrumental, informational, or emotional, and can be provided by a variety of people including family (husbands, mothers) or health providers of various professional levels. This study explores women's reported experiences of mistreatment during childbirth quantitatively, and how these varied by specific types of support available and provided by specific individuals.

Methods: participants were women age 16–30 who had delivered infants in a health facility in the previous five years and were living in slums of Lucknow India. Data were collected on their experiences of mistreatment, the types of support they received, and who provided that support.

Results: women who reported lack of support were more likely to report mistreatment. Lack of support in regards to discussions with providers and provider information were most strongly associated with a higher mistreatment score. Women who received any type of support from their husband or a health worker were significantly more likely to report lower mistreatment scores. Receiving informational support from a mother/mother-in-law or emotional support from a health worker was also associated with lower mistreatment scores. However, receiving emotional support from a friend/neighbour/other family member was associated with a higher mistreatment score.

Conclusions: women rely on different people to provide different types of support during childbirth in this setting. Some of these individuals provide specific types of support that ultimately improve a woman's overall experience of her childbirth. Interventions aiming to reduce mistreatment to women during childbirth should consider the important role of increasing support for women, and who might be the most appropriate person to provide the most essential types of support through this process.

Introduction

There is a growing body of evidence on the mistreatment that some women experience during childbirth, including a recent systematic review on the topic (Bohren et al., 2015). Mistreatment can encompass a number of factors, including verbal and physical abuse, disrespect, and neglect of various forms (Vogel et al., 2015). Most of the current research on mistreatment is qualitative, and there are few quantitative studies, especially in low and middle-income countries. One mixed-methods study in India that included observations, interviews, surveys, mystery clients (simulated clients), and medical record reviews found evidence of many forms of mistreatment, including disrespect, abuse, and poor emotional support during childbirth (Hulton et al., 2007).

There is increasing awareness of the importance of companionship and support for women during childbirth. For example, a systematic review of interventions that provided continuous

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support by health workers or lay people to women during childbirth found that women who had support were more likely to have a spontaneous vaginal birth, and less likely to use anesthetics, have a infant with a low APGAR score, and report negative feelings about childbirth (Hodnett et al., 2012). They also had shorter labours than women who did not have one- on- one continuous support. One study in the US found that women who had a doula (a type of support in pregnancy) were 4 times less likely to have a low-birth weight infant and more likely to initiate breast feeding post partum (Gruber et al., 2013). Women who had doulas reported that they experienced less anxiety and had increased rates of breast feeding initiation than women who did not have doulas (Berghella et al., 2008; Hodnett et al., 2012). In addition to the more clinical outcomes described above, past research has also looked at women's experiences during childbirth. Continuous support from partners and providers were found to be important factors in improving psychosocial outcomes and coping with labour (Gibbins and Thomson, 2001). Social and emotional support can also be provided by family or friends. For example, a study in India found that women preferred the emotional support of a family member (generally a female relative, especially mothers-in-law or mothers) while delivering in facilities (Bhattacharyya et al., 2013).

While most of the past research on the impact of support for women has been in the developed world, including all of the studies in the systematic review mentioned above, there is increasing awareness in the developing world, including India, on the importance of support during childbirth. For example, the government of the state of Tamil Nadu issued an order entitling women in government hospitals the right to have one companion in the delivery room. Qualitative interviews with women and support companions in Tamil Nadu, found that they felt that this would help protect them and their loved ones from abuse in health facilities; however, people were not aware of the government order allowing family members to be present (Sri, 2009). One intervention, called Yashoda, aimed at increasing support for women in India, placed a support worker or birth companion in facilities with high delivery volumes. The Yashoda intervention has been shown to improve exclusive breast feeding, family planning uptake, nutrition, immunisation, identification of danger signs and various aspects of postnatal care such as blood pressure and temperature checks of the infants (Varghese et al., 2014). Further research is needed to identify how support during childbirth is associated with mistreatment in order to improve women's experiences.

Although the growing body of literature has noted high prevalence of mistreatment during childbirth in facilities, there has been no known quantitative research that measures the association between support (who was with a woman at the time of childbirth), what type of support that person provided, and the level of mistreatment a woman experienced. Few studies have attempted to disentangle what components of support are most helpful to women, and who specifically can provide these types of support most effectively. Qualitative interviews from women who experienced an infant death in New Delhi found that women felt that prohibiting partners from being allowed in the room for antenatal care or childbirth led to difficulty understanding what the doctor was telling them about their care and to problems convincing their partners to allow them to take the actions that the doctor instructed (Saikia et al., 2015). Another qualitative study from this study setting (Lucknow) included women who recently delivered, and described how husbands and mothers-in-law were yelled at and not allowed in the room with the woman during childbirth (Sudhinaraset et al., 2015). In the Indian context, female family members, usually mothers or mothers-in-law, accompany women to health facility during antenatal care and childbirth, but are not allowed in the delivery room for reasons such as to avoid crowding. Increasingly, husbands are accompanying women to the facility for childbirth as they are expected to do tasks such as arranging transport, or getting blood and medicines. Their consent is also needed to undertake caesarean if the situation arises. For the last five years, a community level health worker (Accredited Social Health Activists or ASHAs), appointed by government, is expected to accompany rural women to health facilities for childbirth, for which she gets paid.

Studies have not quantitatively assessed the type of support that different family members and close ties provide, and how it influences experiences of mistreatment. Social support is typically divided into three types of support: (1) emotional support, typically provided by a close intimate tie; (2) instrumental support, referring to aid or assistance of needs such as cooking, cleaning, paying bills; and (3) informational support (Berkman et al., 2000). Qualitative findings suggest that husbands and mother/mothers-in-law may play different roles during the childbirth process. For example, husbands may be more likely to provide instrumental support, such as paying for bills and buying women needed medication, whereas mother/mothers-in-law provide emotional support during and after childbirth (Sudhinaraset et al., 2015). It appears that family members could potentially be important sources for women to get information and be able to act on that information, but there are other types of support, including emotional or instrumental (bringing the woman water, supplies) that might also be important.

It is important to understand what types of support women are lacking and who currently provides specific type of support to women, given that women might be supported by their husbands, mothers or mothers-in-law, other family members, local health workers, or providers in the facility in this setting. Family members and health professionals can provide support before, during, and after childbirth, including both post partum in the facility and at home. Especially in India, where women are incentivized to stay in facilities for 48 hours after childbirth, their family members could provide important care and also help identify adverse outcomes if they arise in the postpartum period. Furthermore, it is important to understand if specific supporters are more protective of women experiencing mistreatment, not only adverse clinical outcomes.

Data and methods

Data collection

Data was collected from a cross-sectional sample in Lucknow, Uttar Pradesh, India in May, 2015 from a total of 759 young women living in economically disadvantaged (slum) areas. Eligibility criteria included having given birth in the previous five years and being aged 16–30 years at the time of the survey. This age range was chosen as we were particularly interested in whether younger women are more at risk of experiencing mistreatment and these are the prime childbearing years. An initial sampling frame of households in the slum areas was constructed, and from that, households were approached to determine if an eligible woman lived in that household. This analysis is limited to the 392 women from that sample who had delivered in a health facility (not at home). Household surveys were administered by four trained research assistants and covered a broad scope of topics including demographic characteristics, migration experiences, fertility, pregnancy, and childbirth experiences. Respondents were interviewed in their home or in another private setting selected by the respondent.

Verbal informed consent was obtained from all study