Focusing on what works for person-centred maternity care

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The benefits of the move to institutions for birth have been undermined by poor quality care, including disrespectful and abusive behaviours.[1,2] In a study of person-centred maternity care (PCMC) in *The Lancet Global Health*, Patience Afulani and colleagues[3] note that the plethora of recent, mostly qualitative, studies has produced different taxonomies of disrespectful and abusive care, and that estimates of prevalence vary widely as a result of different methodological approaches. There is far less information about what works to improve respectful care. There is also debate about the components of respect, and which ones matter the most in improving women's (and, indeed, staff and birth companion) experience, and consequent willingness to seek access. Recent qualitative reviews of what matters to women in pregnancy and birth suggest that both safety and a positive birth experience matter, and this finding is now incorporated into WHO guidelines.[4]

Afulani and colleagues' study aims to address an important gap, by establishing where maternity care might actually be doing well in relation to personalised care. The analysis centred on the use of the PCMC scale—a validated scale that includes elements of three domains: dignity and respect, communication and autonomy, and supportive care—to examine factors associated with PCMC in Kenya, Ghana, and India. Data came from four cross-sectional surveys of 3625 women aged 15–49 years who had recently given birth in facilities. The mean raw scores for the full PCMC in the three countries ranged from 46·5 out of 90 (SD 6·9) in rural Ghana to 60·2 (SD 12·3) in urban Kenya.

In line with other studies on this topic, the predictors for low scores on the PCMC tool were (in general) lower maternal literacy and socioeconomic status, use of public hospitals rather than clinics or private hospitals, and the length of time between the birth and the interview. These three issues need to be addressed to optimise the effectiveness of practical interventions such as staff training or additional resources.

Women who are more literate and who have higher socioeconomic status are more likely to have higher expectations, more likely to be able to demand better treatment in line with these expectations, and more likely to be able to pay for personal attention.[5] Conversely, those who are less literate and less wealthy are more likely to be marginalised by health-care providers, especially if they are from groups or castes that are already marginalised. Women from these latter groups are less likely to expect good care, are more likely to accept a degree of mistreatment as the norm, and not to be able to challenge it. Changing this inequity depends not only on undertaking fundamental cultural competence training with staff, but also on changing cultural norms and mindsets in local communities. Interventions that have included this latter element seem to have had some success.[6]

The study has some shortcomings. First, although less physical abuse was reported than in some other studies (only 108 women [3%] reported physical abuse), it is difficult to know whether this is an artefact of the inclusion criteria or a robust rebuttal of the higher rates found previously. However, the use of one tool in all four included studies, and the inclusion of both African and Indian settings and of cohorts that span multiple facility settings, is a strength. Second, Afulani and colleagues focus their interpretation on failings, rather than successes. More data on where services are not providing good quality care is useful, but the potential for understanding where person-centred care is working well is important and often missed. Third, Afulani and colleagues rightly note in their discussion that their analysis of data from women who gave birth in facilities may not be fully generalisable and probably underestimates the true burden of poor PCMC. Finally, timing is critical for administration of questionnaires and interviews relating to maternity care experiences. Women tend to be more positive immediately after birth than later in the postnatal period.[8] For some, negative experiences of their birth only surface when they are planning another pregnancy. The psychological factors that underpin this finding, and the impact on longer-term wellbeing, have not yet been fully explored. Future prospectively designed studies of childbirth experiences should ensure that assessments are conducted at least once after the participants have left the health-care facility.

Reports of lower levels of person-centred care in large, centralised, specialised institutions are endemic, and not restricted to low-income countries or maternity care. The issues include bureaucratic or technocratic philosophies of health-care provision that result in protocols and rules (and not guidelines and individualised flexible care) from which staff dare not deviate for fear of punishment or even litigation.[8] Sometimes this philosophy is a consequence of investment in machinery, monitors, technology, software,

testing, treatment, drugs, and equipment in preference to investment in people, relationships, skills, and attitudes. Until funders and service providers are willing to invest in skilled, competent, and respectful staff, who have time to care safely and positively, and to form good-quality relationships with each other to reduce burnout and consequent cynicism, this finding will continue.

This study adds to the growing evidence around the need to improve human relationships to optimise the quality of maternity care. No childbearing woman (or, indeed, birth companion) should experience care that is not person-centred, or that is disrespectful or abusive. Solving this problem requires more research on the drivers of care in facilities where women report positive experiences, in the context of good overall outcomes for them and for their babies, as a basis of wider roll-out of what works.

Soo Downe
School of Community Health and Midwifery, University of Central Lancashire, Preston PR1 2HE, UK
sdowne@uclan.ac.uk

I declare no competing interests.

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