Woman-centred Maternal Health Care

What does it mean and how can it be achieved – *A position paper based on women's voices*

Executive summary

For several decades, countries all over the world including India have made efforts to make safe maternal and child health services available. However, their focus has been on efficient technical/clinical interventions such as emergency obstetric care. Social determinants, and especially gender discrimination, even when acknowledged, are only tangentially addressed and rarely translated into interventions.

The feminist health movement has engaged for several years with issues such as the medicalisation of childbirth and professional control over the birthing process. Feminist critiques of the medicalisation of childbirth led to the emergence of the concept of 'woman-centred' maternal health care. Woman-centred care is also a cornerstone of good midwifery practice and in initiatives for 'Respectful Maternity Care'.

However, even after three decades since woman-centred maternal healthcare was acknowledged as a policy priority, the definitions of woman-centred maternal healthcare have often been informed by the perspectives of health professionals and experts and seldom by the perspectives of women, especially those from the most marginalised groups, who are most affected by policies and programs.

This paper draws from a study conducted by CommonHealth and its partners that set out to develop a discourse on woman-centred maternal health care and its different components by listening to and foregrounding the voices of women, especially those from disadvantaged and vulnerable communities. The specific research questions for the study were:

1. What is woman-centred maternal healthcare?
2. Do current maternal health policies and programmes provide for woman-centred care? Do they meet the maternal health needs of women?
3. What changes would be required to make maternal health policy and programmes woman-centred?

What does it mean to put women at the centre of maternal health care?

The principles of woman-centred maternal health care

Woman-Centred Maternal Health care is based on a set of principles. The principles draw from concepts related to *human rights*, *midwifery,* **and** *quality of care.* We believe that 'woman-centeredness' has to be applied *not only to women receivers of services but also providers of services.*

1) Human Rights Based Approach

A human rights-based approach (HRBA) to health requires mainstreaming fundamental human rights principles as well as standards based on the 'right to highest attainable standards of health' across health services and health system policies. We list below a set of key human rights principles adapted from various international frameworks that need to underlie maternal health care.

1. Right to non-discrimination and equality in maternal health information and services
2. Right to availability of maternal health information and services
3. Right to accessibility of maternal health information and services
4. Right to acceptability of maternal health information and services
5. Right to quality of maternal health information and services
6. Right to informed decision-making in maternal health information and services
7. Right to privacy and confidentiality of maternal health information and services
8. Right to participation in maternal health information and services
9. Right to accountability of maternal health information and services
10. Right to life and right to health
11. Right to freedom from harm and ill-treatment and right to respect and dignity
12. Right to the benefits of scientific progress
13. Right to the social determinants of health

2) Positive pregnancy experience

Women's expectations from maternal health care are centred around having a healthy pregnancy and a complication-free delivery within a safe and supportive environment, with positive outcome for the mother and the newborn.

3) Midwifery philosophy

The philosophy of Midwifery that aims to '*optimise the normal biological, psychological, social, and cultural processes of childbirth and the early life of the newborn, work in partnership with women, respecting the individual circumstances and views of each woman, promote women's personal capabilities to care for themselves and their families, and collaborate with midwives and other health professionals as necessary to provide holistic care that meets each woman's individual needs'* is key to the provision of woman-centred maternal health care.

4) Respect and Dignity of Women Healthcare Providers

Frontline health workers like ASHAs and ANMs, negotiate power dynamics as women within their own family realities and balance these within power-ridden professional spaces where they are at the bottom of the health system hierarchy. Woman-centredness has to include within its ambit these providers too.

5) Gender Power Relations and an Intersectional Analysis

There needs to be a recognition that all women are not 'one-class' There are diversities among women – there are women who are more vulnerable than others with multiple layers of marginalisations that have to be recognised and addressed.

The components of woman-centred maternal health care

We detail below the different components that need to be in place in order to operationalize the principles mentioned above.

1) *Technical quality of care*

Women across diverse settings in our study reported multiple experiences of receiving poor quality care or not receiving standard interventions that are recognised as part of good quality care. They also reported concerns about the overmedicalization of pregnancy care. Their reports revealed immense misinformation related to pregnancy and birthing.

By the 1970s, medicines and health technology had made sufficient progress to bring down the MMR to single digit levels in many countries. There is also good scientific evidence that several interventions that are considered woman-centred are now also known to result in good maternal and perinatal outcomes. Thus, it is important to ensure that women receive the best possible technical quality of care when they reach institutions for birth.

- Ensure that a full set of evidence-based interventions are available and provided with assurance of good quality. This should include care during pregnancy, birth and during the postpartum period.
- Interventions that do not have any evidence-base or are known to cause harm should be avoided. This includes the whole ambit of overmedicalized interventions during pregnancy and birth, for e.g. routine episiotomy, birthing in the supine position, multiple unindicated ultrasound examinations.
- Ensure functional referral systems that provide appropriate and timely referrals for women who need them while avoiding unnecessary referrals. Timely transport services in times of referral need to be ensured.

2) *Care with respect and dignity*

The experiences of the women interviewed as part of our study show that disrespectful care remains rampant and widespread and is compounded by the discriminatory behaviour of healthcare providers based on caste and poverty.

- Good technical quality of care alone is insufficient and needs to be accompanied simultaneously by a good experience of care, provided with respect and dignity.
- At the minimum, this means that physical violence, verbal abuse, shaming, communal and casteist slurs, and humiliation should stop in all health facilities, public or private.
- Women should be cared for with sensitivity and empathy during pregnancy and labour and not be neglected during labour.
- Informed consent for contraceptive procedures should be adhered to. Coercion and non-consensual insertion of PPIUCD should stop immediately.

3) *Continuum of care*

Currently, services only focus on the period of pregnancy and childbirth. There is a need for woman-centred care to focus beyond just maternal health on women's overall health through all stages of their lives.

- Healthcare conditions like anaemia, which is highly prevalent in pregnant women in the country, require interventions before and beyond the period of pregnancy and childbirth.
- Women also need gynaecological services for common conditions like menstrual disorders, uterine prolapse, reproductive tract infections and reproductive cancers.
- Absence of services when faced with such gynaecological morbidity pushes women into an exploitative private sector, leading to irrational procedures like unnecessary hysterectomy.

4) *Enabling environment at home and in the community*

The women who participated in this study saw their care during pregnancy as starting from their families and communities. They saw a nurturing, supportive, violence free environment at home as a key component of woman-centred maternal health care.

- Women wanted a nurturing and caring environment in the family with relief from their gender-defined roles of household chores and caregiving responsibilities.
- Women wanted the home environment to be free of violence.
- Women also expressed the desire to be able to make decisions about their own health and health care, including regarding their diets, work and rest, and medical care.
- They wanted their partners to take equal responsibility for contraception.
- They wanted both their families and communities to not pressurise them to have sons.

5) *Enabling health system environment*

Several of the frontline health workers we spoke to recounted challenges that they faced in providing care for women and their babies including lack of adequate human resources, lack of supplies of essential medicines and equipment, and poor governance, including in their postings, monitoring and surveillance, and division of work burden. Women across different settings complained about having to pay informal payments at multiple points throughout their care during pregnancy and childbirth.

- Health systems should be governed by robust mechanisms and a leadership that puts the focus on women and their needs.
- Services should be organized such that women receive good quality care close to home.
- Health facilities should have adequate human resources and infrastructure to avoid overcrowding and to cater to women's needs. They should have adequate supplies.
- Services should be close to women's homes, without them having to travel long distances for different services.

How do we move toward woman-centred maternal health care in the Indian setting?

The principles and components of woman-centred maternal health care described above and the policy recommendations detailed below emerge from the lived realities of women, especially those from marginalized communities. We focus here on some high level and overarching areas that need to be addressed in order to move towards woman-centred maternal health care.

1) *Reorienting the health system to a human rights-based focus*

There needs to be a reorientation of the system to a focus based on human rights. This would need changes in the design of the system to be able to address all of the human rights detailed in the earlier sections, training and sensitization of all care providers, programme managers and policy makers to ensure they are able to effectively play the role of duty bearers for provision of services, and efforts to ensure women and patients who seek services are aware of their entitlements and rights so as to be able to claim them.

2) *Higher allocation of public funds for health system strengthening*

Maternal health services cannot be improved in isolation and overall health system strengthening is essential. 'Silo'ed approaches that narrowly focus on one specific area such as maternal health will result in inefficient investment of resources and weakening of health systems. Maternal health services must be implemented within broader Universal Access to Health Care interventions and a comprehensive primary health care approach - only then will social determinants of maternal health be addressed. This needs increase budgetary allocation for health through tax-revenue based funding aimed at universal rather than targeted coverage.

3) *Participation and accountability for woman-centredness*

At the level of individual care, women's agency needs to be respected through robust informed consent processes and ensuring of explicit consent for various procedures. Over and above this, women's voices need to inform policies and programmes designed for them, and special efforts need to be made to ensure meaningful participation by women.

Health systems need to build mechanisms for accountability including regular audits of select indicators and processes like maternal deaths, referrals, caesarean sections. In addition to accountability within the health system, community accountability mechanisms must be established and strengthened. An effective Grievance Redressal System that includes both an immediate response system to provide immediate relief and a more medium-term review and systemic correction mechanism must be set up.

4) *Addressing gender as a determinant*

Health care providers must be trained and equipped with skills to address gender-based issues while providing care. Addressing gender in women's everyday lives in their homes and families would require more overarching programmes that include for example the education system and working with boys and young men. Gender will need to be addressed from a perspective of intersectionality.

5) *Addressing social determinants*

Health systems need structural reforms to be able to increase the system's sensitivity to social determinants in order for women and indeed all patients who seek care, especially those from marginalized communities, to be treated with empathy and compassion. Ways to do this include increasing the representation of those from marginalized communities in the health care workforce through affirmative action in pre service education and in recruitment, including specific curriculum on social determinants in medical and paramedical education, and having help desks staffed by community representatives in health facilities to provide support for those from marginalized communities seeking care.

6) *Addressing health care providers' needs*

Women FLWs, often from marginalized communities themselves, work under challenging circumstances and need the support of an enabling environment to provide services. They should also have decent working conditions including fair wages paid on time, safe spaces for rest during duties or when accompanying women to facilities, access to water and toilets. Respectful treatment of FLWs by their superiors within the health system is another key area that needs addressing.

What would be indicators to measure progress?

We list in the paper a few indicators, including at family and community level and at health system level, that can be used to measure progress and to check if maternal health care is woman-centred.

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