Author’s response to reviews

Title: An investigation into mistreatment of women during labour and childbirth in maternity care facilities in Uttar Pradesh, India: a mixed methods study

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Author’s response to reviews:

Reviewer reports:

Reviewer #1: I commend the authors for their diligent research on this important subject. 275 observations over 26 facilities are a significant sample. That it encompasses both the Pvt. & the Public sector is laudable.

An overarching comment is that we need to agree on which lens or context are we going to evaluate the observations on? Will these be the accepted global standards of care, or will they evaluated in the context of UP, a resource constrained setting? If global standards are to be applied (e.g. Browsers scale for mistreatment or its truncated modification used by the authors), then the availability of resources for provision of care too must be evaluated accordingly....number of labour tables, staff, drugs, etc. their availability in proportion to the "delivery load", and conclusions drawn accordingly. The challenge with this approach will be that there will be poor scores all across and much of the focus is likely to shift on the failure of the health system (procurement, supplies, HR, etc.) which needs to fixed (a correct interpretation) in order to strive for appropriate care. However, I suspect that the authors would rather want to focus on the mistreatment that a women has to endure during the course of her intra partum period, its gravity and potential ways to minimize it.

Thank you for this comment. We agree with the reviewer; however, we would like to clarify that our study focussed on assessing “processes of care”. We did not measure other elements of quality such as structure (availability of resources, staff, and drugs) and outcomes (mortality or morbidity rates) in this study. Specifically, for assessment of processes of care, we defined quality as application of evidence-based guidelines for normal vaginal deliveries and application
of respectful maternity care practices. Our previous paper published in the B-WHO1 specifically focussed on application of evidence-based guidelines whereas this paper specifically focuses on mistreatment during labour and childbirth.

Another comment is around the classification or "gravity" of mistreatments. Is not offering a "position of choice" during birthing as grave a mistreatment as physical abuse? If the intent of the paper is (and I fervently hope so!) to guide policy makers and implementers in UP towards providing better quality of care and respectful care, then in my opinion it would be better to make a clearer distinction between the types of mistreatment and highlight the serious departures from accepted care, rather than provide a line list of all infractions. While mistreatment of any sort is not acceptable, it would be useful to focus on a few, bring it out further through deeper descriptions and analysis and provide concrete recommendations for its corrections.

We agree with the sentiments of the reviewer and have had discussions on this issue. However, there is no scientific basis for applying intervention-specific weights to different indicators of mistreatment. In this paper, our aim is to provide a descriptive account of what, how and why mistreatment of women during labour and childbirth occurs. In order to be transparent, we felt that it would be best to give the same rating to all indicators of mistreatment. While there are methods to assign intervention specific weights to different elements of quality of care such as Delphi techniques, consensus panels and nominal group processes – all of these methods have their own limitations and were beyond the scope of the present study.

The issue of unqualified providers is an important one. It deserves more description and narration and should not be lost in the general narrative. It is important as "training programs" around quality and respectful care are usually not focused on these providers, who seem to be shouldering the bulk of the workload. If not discussed in detail, the recommendations may fail to address this gap either ways i.e. to ensure that qualified providers are available to conduct the deliveries or that the unqualified providers need to be included in trainings/orientations.

Thank you for this comment. We have added the following paragraph from line 588 onwards.

The Indian government recommends provision of maternity services by appropriately trained and qualified skilled birth attendants at health facilities. However, given the various context specific challenges in Uttar Pradesh, the prospect of all deliveries being cared for by qualified personnel at health facilities remains an important challenge. Therefore, it is important for policymakers to issue clear and comprehensive guidance on the role of unqualified providers at maternity facilities. Women that go to institutions for maternity care have a right to expect care from
qualified personnel irrespective of whether it is the public or private sector. It is the duty of the government to protect those rights and design robust monitoring mechanisms to ensure that that unqualified personnel are not involved in provision of services.

With regards to the section on overtreatment, episiotomies, enema, etc. were all the standard of care in the past. It would be good to link these practices to the training or re-training that they have or have not received and draw conclusions. Currently it reads as if all of the qualified staff have been trained but despite this training they have not changed their practices. Is this an individuals failure to change or was this a system failure that failed to retrain its cadre on new guidelines...from the policy makers vantage point, the solutions would differ.

Thank you for the comment. We would like to clarify that we only assessed processes of care. We did not collect data on trainings received by health workers and did not look at the content of their training curricula. Further, we would expect the training curricula of health workers to vary depending on the year they were trained, and the curricula adopted at their university. We agree that episiotomies and enemas were recommended in the past but are not considered evidence-based practice now. We think the use of harmful practices is a multi-faceted issue as we have elaborated in the discussion section (lines 643-646).

In summary, the literature suggests that mistreatment during labour and childbirth may be the result of many factors such as unfavourable institutional policies, resource and infrastructural constraints, socio-cultural factors, power differences between health workers and clients, limited knowledge and skills of health workers.2-5

We have added the following sentence as a limitation line 684-687.

Unfortunately, we do not have detailed information on pre or in-service trainings received by health workers at maternity facilities so we cannot draw firm conclusions on whether mistreatment arises due to individuals’ failure to change or due to inappropriate training opportunities.

In the discussion section, there are a few "pairs" of observations that need further explanation: Mistreatment was more in women aged 35 or more but also in primis, it was more in the lower castes but also in the richest.

Thank you for this suggestion. We have added the following line to the discussion section (lines 573-580).
Mistreatment was found to be higher amongst women > 35 years perhaps because they had higher rates of physical abuse (p=0.04) compared to women in other age groups. Primiparas also received higher mistreatment scores because they had higher rates of episiotomies (p<0.001) and pubic shaving (p=0.003) compared to women with higher parity. Women in the fifth wealth quintile (highest) also received higher mistreatment scores compared to other women because they had higher rates of episiotomies (p=0.001), pubic shaving (p=0.001) and were not allowed birth companions (p=0.01), probably a reflection of where they went for labour.

Women referred in from other facilities also reported higher mistreatment. Could this be explored against the level of facility? Medical College vs District Hosp vs CHCs? Do we have a sense of why that is happening?

Thank you for this suggestion. The objective of the paper was to describe the differences amongst the types of mistreatment in public and private sectors rather than discuss different types of facilities, hence we did not add these data in table 2 which is already very complicated. However, in response to the reviewer’s comments, we have also added the following text to the results section (lines 324-328).

Our data shows that the highest mistreatment scores were amongst women that came to district hospitals (6.1) where they experienced higher rates of no privacy (p = <0.001), not being informed prior to vaginal examination (0.001), using unsterile gloves to conduct vaginal examinations (p=0.031), application of fundal pressure (<0.001) and episiotomies (p = <0.001).

Additionally, in the discussion section we have added the following (lines 521-522).

We found that total mistreatment scores were higher amongst women attending district hospitals (6.14), women above than 35 years of age (5.1), primiparous (5.2), those that were referred from another facility (5.0), amongst women belonging to the “scheduled caste and tribe” (5.0), those in the fifth (richest) wealth quintile (5.1), and amongst cases admitted during work-hours (5.0) on weekdays (5.0) in the public sector (4.9).

Do we have a sense of the workload in the labour room and if they are appropriately staffed for it? Is there a relationship between the availability of human resources and beds/labour tables and the mistreatment levels? Were unqualified providers pitching in as the qualified staff were overwhelmed by the workload or was it a case where they pitched in as the qualified staff were not available (absent, on a long break, etc)?
We did not collect any information on structural elements of quality (for example: number of beds/ labour tables or number of staff) since our study was primarily an observational study that tried to capture elements of care provision as they occurred. Previous literature from Uttar Pradesh suggests that human resources is an important challenge in this setting. We have added a few sentences in the discussion section to reflect this (lines 621-624).

Previous research has uncovered that there is a serious shortage of health workers in Uttar Pradesh. In fact, data from the National Sample survey (2011-2012) estimated that the density of doctors, nurses and midwives in Uttar Pradesh of 7.8 per 10,000 population was significantly below the WHO benchmark of 22.8 workers per 10,000 population. 6

Was there a relationship between the "wealth quintile" of a women and the informal payments she had to pay?

Unfortunately, as we highlight in the paper our observational checklist only captured elements of care provided during labour and childbirth. We did not collect quantitative data on informal payments. We found out that informal payments were a pervasive issue in this setting after analysis of the field notes which identified that informal payments were the most common theme identified from observers’ comments.

In the discussion (see lines 634-635) we have highlighted that, “upon reflection our QoC tool should have specifically captured detailed information on informal payments”.

A few additional thoughts that came to me while reading through the paper.

Is there a correlation between the stage of labour in which the women was admitted, the duration she stayed postpartum and the mistreatment (especially the grave infarctions) she suffered? Hypothesis: Since women come in very late, there is very little time to have a conversation with them and inform them of their choices.

Thank you for this interesting comment. 51% the women recruited in our study were in the latent phase of labour (some degree of cervical effacement and upto 5 cm cervical dilation). We feel that conducting a separate analysis is beyond the scope of the current paper, however, we think this is an interesting research question for further analysis.
Is there a correlation between the time of admission and the change in the duty hour of the labour room staff? Hypothesis: Labour room staff want the deliveries to be conducted during their duty hours so that they can collect any informal payments. Thus they augment the process of labour as the time for a shift change comes closer.

Unfortunately, as mentioned previously, we did not collect detailed quantitative data on informal payments or when they are given. We are unable to say anything definite about the relationship between time of admission and change of staff (or possible augmentation).

Is there a sense of who are the ones who are mistreating more often? Qualified providers or unqualified providers? Is there a pattern there? Hypothesis: None: Just want to understand if the qualified providers are providing less mistreatment than the non-qualified.

Thank you for this comment. Table 2 shows the prevalence of mistreatment by types of providers.

We have also edited the existing paragraph (lines 581-586, Page 20) in the discussion section to ensure that the differences between qualified and unqualified providers is more explicit.

“Overall mistreatment scores were marginally higher for qualified attendants (4.9) compared to unqualified attendants (4.8). However, the prevalence of mistreatment is different depending on the on the type of provider. Unqualified attendants had higher rates of not informing women prior to a vaginal exam (p=0.01) whereas qualified attendants were more likely to work in settings that did not allow birth companions (p=0.01), and routinely performed enemas (0.001) and episiotomies (p=0.001).”

Based on the above inputs, the conclusion section could be more specific and focused.

I have no comments on the methodology or analysis as this is a very respected group of investigators with great experience in these areas. I trust that they have done the needful.

A thought: Would it be useful to mention that the 3 districts chosen are not part of the HIGH PRIORITY DISTRICTS (HPD's) identified by the Govt. of India. The HPD's are significantly worse off in terms of indicators. Thus these findings (of poor care) would highlight the poor overall state of affairs in UP....if this is the condition in the not so bad districts, one can only imagine the plight in the HPD's.
Thank you for this suggestion. We have now added the following sentences in the discussion section as follows (lines 639-641).

The three districts where this study was conducted are not a part of the high priority districts of the Government of India. Therefore, it would be useful to conduct a similar study in high priority districts in Uttar Pradesh.

Reviewer #2: General comments

This paper makes an important and timely contribution to the discussion of mistreatment of women during institutional births in India. At a time when institutional births have been expanding at an unprecedented rate in India, it is critical to examine women's experiences of birth in facilities. The use of both quantitative and qualitative methods to describe the nature of mistreatment is also a welcome contribution and one that is absent in several current studies. Although mistreatment, obstetric violence, and dehumanising birthing practices have been documented extensively and for over thirty years, in many other parts of the world, there is relatively little scholarship on this issue in India.

The part on out of pocket expenses or informal payments in the paper is particularly well articulated and it is good to see that the author include this as a form of mistreatment.

Major comments

The overall framing of the paper needs to be made more explicit- intentionality is an important aspect of this discussion and it is good to see that the authors have introduced this issue. However, I am unsure if the distinction between mistreatment and poor quality of care captures this aspect of intentionality as argued by the author in lines 586-593 of the paper. Generally, intentionality has been discussed in the literature using the framing of obstetric violence and several Latin American scholars have suggested that this framing was essential to introduce laws that would criminalise these types of actions. While it is true that fundal pressure or routine episiotomies may be part of health workers' medical training, clubbing these practices, as poor quality of care is contradictory according to the authors' own arguments stated earlier in the paper. The health workers have learnt this is good and appropriate care and therefore they use it. The framing of these arguments needs to be revisited to avoid contradictory arguments. While the literature review is adequate, it is not underpinned by an analytical framework that would help the reader situate mistreatment in the Indian context - for example, the authors find in the quantitative data that women who are SC/ST experience greater mistreatment. This has also been reinforced quantitatively in the work by Diamond-Smith et al. and qualitatively in the work on
Chattopadhyay et al (2017). Given that in the Indian context, both gender and caste (and class) intersect to create health inequities as well as vulnerability to mistreatment, this needs to be foregrounded in the paper.

Thank you for your comment. We would like to clarify further what we mean by the term intentionality. Intentionality is deliberate actions by health workers that constitute mistreatment. For example: a deliberate act of physical violence or shouting and using degrading language towards the pregnant woman seeking care. Other examples could include deliberate withholding of care if the patient is poor or detention in health facility if the family cannot afford to pay hospital fees. The figure below clarifies our conceptual framework. We are arguing that mistreatment falls on a spectrum which ranges from under-treatment, intentional disrespect & abuse to overtreatment.

Our argument builds on Freedman et al.’s. work who have highlighted that the challenges to establishing a definition of mistreatment need to consider not only women's and provider's experiences, but also intentionality, the role of local societal norms about what constitutes disrespectful or abusive behaviour in different cultures, and how underlying deficiencies in health systems contribute to disrespectful and abusive care.

In lines 625-632, we are discussing intentionality in terms of measurement of mistreatment. The health worker may have been taught (once upon a time) that an episiotomy is for the women’s benefit and may genuinely think that they are providing good quality service. However, episiotomies are no longer considered good practice, and some have even compared it to genital mutilation, if done without proper indications. Nevertheless, there are questions as to whether we should categorise/ measure episiotomy as mistreatment in this situation. We are calling for more studies and further research to clarify the conceptual boundaries because this is a grey area.

We have discussed the role of socio-economic status, gender and caste in the discussion section (lines 528-529) and as suggested have also added in the references by Diamond-Smith and Chattopadhyay (2017).9

Lines 604-632: Related to 1, the summary of the global literature also suggests that mistreatment is due to the difference in power between health providers and beneficiaries, a point that is not made explicit in the paper. The work of Jewkes et al. in the context of South Africa, as well as the work of Sriram et al. (2018) on the analysis of power in health systems, may be helpful here.

Thank you. We have now referred to the work of Jewkes et al.4 and Sriram et al.’s5 and highlighted that power differences between health workers and beneficiaries is an important factor to consider.
In the conclusion of the abstract the authors state the following: "The paper contributes to the literature by articulating new constructs of overtreatment and undertreatment that results in mistreatment of women in maternity facilities". This line is awkwardly written and needs to be rephrased.

We have now rephrased this as:

This paper contributes to the literature on mistreatment of women during labour and childbirth at maternity facilities in India by articulating new constructs of overtreatment and undertreatment.

The abstract further states "There are five key implications of this study. First, a systematic and context-specific effort to measure mistreatment in public and private sector facilities in high burden states in India is required. Second, a training initiative to orient all maternity care personnel to the principles of respectful maternity care would be useful. Third, innovative mechanisms to improve accountability towards respectful maternity care are required. Fourth, participatory community and health system interventions to support respectful maternity care would be useful. Lastly, we note that there needs to be a long-term, sustained investment in health systems so that supportive and enabling work-environments are available to frontline health workers". Of these recommendations, I find that the authors have good reason to suggest #1. However, it is not clear whether a single training initiative would succeed in orienting care personnel to respectful maternity care. It has been well-established that not all women are equally or similarly mistreated during birth. Gender along with other aspects of social stratification such as caste/tribe/ethnicity, class, education etc. have a large role to play. In the context of health systems in India - for further discussion see Iyer, Sen and Ostlin (2008). Though the authors in several places use the term "socio-cultural context" there needs to be a deeper discussion of what constitutes the socio-cultural context within health systems that allow for such actions on the part of health workers against pregnant women in India? The third and fourth part of the implications find connections in the rest of the paper, though the question of accountability has not been discussed in the findings of the paper. The fifth is really crucial especially for front-line workers in the developing world, most of whom tend to be largely female and also generally not very privileged women. Also, many scholars have categorised mistreatment during childbirth as a specific kind of violence against women. The paper raises these issues at multiple points, but it presents a more benign explanation of mistreatment than current scholarship suggests.

Previous literature from India and our own experiences during field work indicate that what health workers consider mistreatment is different from client’s perceptions of mistreatment.
Therefore, we believe that orienting and training health workers on mistreatment is likely to be of some value as part of a broader package of interventions.

Unfortunately, as we have mentioned in the limitation section, our study is a quantitative study employing clinical practice observations with a qualitative component limited to field notes. We did not undertake extensive anthropological or qualitative work and therefore are not in a position to discuss socio-cultural context within the health system or discuss violence against women.

In the methodology section there are three main concerns:

The ways in which mistreatment has been enumerated appears to be based on typologies of mistreatment - for example shaving the perineal area, applying fundal pressure, denying birth companions, routine episiotomies or episiotomies with anaesthesia etc. However, it is not clear to the reader how repeated instances of mistreatment have been incorporated. If the median is based on typologies alone (as seems to be the case), then repeated instances against the same birthing mother which may cause greater harm also need to be incorporated into this indicators. The authors should think about how best to incorporate this information, if it was collected. If it was not collected, then the authors need to explain what is the rationale behind enumerating singular typologies of mistreatment, when repeated instances may indeed cause more harm.

Thank you for this suggestion. The objective of this paper is to investigate and describe patterns of mistreatment encountered by women with different characteristics during labour and childbirth at 26 public and private sector facilities. In the interest of transparency, we gave equal rating to all indicators of mistreatment and enumerated all instances where mistreatment had occurred.

We have now added a sentence in the results section (line 316) highlighting that “most women had repeat instances of mistreatment (mean=4.8 and SD=1.7).

Related to the above is the lack of weighting of types of mistreatment. Since the goal of the paper is to provide insight into the nature and context of mistreatment, the reader may expect that different types of mistreatment should be weighted differently. For example, episiotomies without analgesia where women are screaming in pain (as the comments indicate) can lead to both short-term and long-term harm including PTSD. Perhaps this needs to be given a greater weight than shaving the perineal area given that the harm though present is of the letter is of a lesser degree. The authors can choose either a medical rationale for assigning weights based on the degree of harm done or some other rationale. Since the authors have collected both quantitative and qualitative data, this type of analysis would be possible and be a major
contribution to enumerating mistreatment in a sophisticated manner. This kind of hierarchy would also help prioritise resources to best address health systems interventions in low-resource settings like public health facilities in India.

We have discussed this comment earlier while discussing the first reviewers’ comment. In this paper, our aim is to provide a descriptive account of what, how and why mistreatment of women during labour and childbirth occurs. In order to be transparent, we felt that it would be best to give the same rating to all indicators of mistreatment. While there are methods to assign intervention specific weights to different elements of quality of care such as Delphi techniques, consensus panels and nominal group processes, all of these methods have their own limitations including selection bias, poor validity and reliability.

However, we do recognise that some infarctions are more severe than others and have added the following sentences (lines 687-692) in the limitation section to reflect this.

Although, we recognise that some indicators of mistreatment are of a much more serious than others, there were limitations in terms of assigning weights to these different indicators. While there are methods to assign intervention specific weights to different elements of quality of care such as Delphi techniques, consensus panels and nominal group processes, all of these methods have their own limitations including selection bias, poor validity and reliability.

The role of the observers is an important one- the authors have mentioned that these are health workers. They have also mentioned that younger observers tended to take more detailed notes than older observers. It would be helpful to know how these observers were chosen and what kind of prior qualifications did they possess. Were these former government workers like Anganwadi or ANM or ASHAs? Or were they fresh social science graduates? Given the large numbers of sites where this study was conducted it would be important methodologically to spell out whether this was likely to have impacted the collection of the data.

Thank you for this comment. Under the data collection section (lines 233-234), we have now clarified that clinical observers were all auxiliary nurse midwives and had history of working in maternal and child health.

5. Table 3 - in the list of themes and elucidation of actions, the framing of over-treatment, under treatment and disrespect and abuse needs some rethinking. For example, doing routine episiotomies may be overtreatment but should doing so without analgesia be classified as over-treatment? Bohren et al.’s work already catalogues different types of mistreatment. Would it not be helpful if the authors used that classification? And if there is a reason why they are not using
these earlier developed classifications, it would be helpful to explain to the reader why this is the case.

To clarify, we use the same categories of mistreatment as used by Bohren et al. Routine episiotomies falls under the category of overtreatment as shown in the table. While analysing the theme of routine episiotomy we found that they are often conducted without anaesthesia. Hence they have been discussed under composition of that particular theme in Table 3. We feel that the table is fine as it is.

Minor comments

It would be helpful to know why these specific 4 districts were chosen out of 75 districts in U.P. This study was conducted in three districts and not four districts. We have now clarified this further in lines 181-182. The study was conducted in the districts of Kannauj, Kanpur Nagar and Kanpur Dehat of Uttar Pradesh in the context of a large evaluation of the Matrika social franchise programme by the LSHTM. 10.

Lines 89-90 - JSY has undergone some recent changes - the article should incorporate these in the edited version.

We have added the following sentence in lines 92-95.

Since 2013, JSY guidelines have been revised and conditionalities associated with parity and minimum age of the mother for institutional deliveries in high and low performing states and union territories have been removed.

Lines 109-123- This paragraph should be made more concise. If the reader needs more information about the work they can read the paper.

We have shortened the paragraph in the revised version as follows (lines 114-121):

Given these challenges, a recent WHO systematic review tried to establish the evidence-base for mistreatment globally.2 They found that most studies use different operational definitions and measurement approaches. 2 Amongst the quantitative studies, only three studies reported a prevalence of mistreatment at maternity facilities, which varied from 15 to 98%.2 This review
also proposed a typology of items considered mistreatment and identified the following: physical, verbal or sexual abuse, stigma and discrimination, lack of informed consent, breaches of confidentiality, neglect and abandonment, refusal to provide pain relief, lack of supportive care, detainment in facilities, bribery and extortion.2

Line 153- Please specify on what basis U.P. is being classified as being most deprived? Is it the number of people who have BPL cards or some other indicator of deprivation?

We use the term deprived since Uttar Pradesh has the greatest number of poor people in India. In fact, the world bank estimates (2016) that out of 200 million inhabitants, 60 million people in Uttar Pradesh are poor. 11 The pace of poverty reduction in the state has been slower than the rest of the country.11

The paragraph on fundal pressure would benefit from reviewing Iyengar et al.'s work (2008) in Rajasthan, also in North India. For example, Iyengar found that often relatives and others including male hospital attendants are invited to bear down upon the woman because nurses get tired from applying so much pressure. Was this the case also in this study?

Our findings are similar to Iyengar et al.’s findings in Rajasthan. The results section discusses our findings that help is often sought from others present in the room including family members while health workers are applying fundal pressure. This has also been highlighted in Table 3. Since there were no statistically significant differences in the prevalence of fundal pressure between public and private sectors and between qualified and unqualified personnel, we have chosen not to elaborate on this result.

The following sentence "Caste was only associated with episiotomy and women in the so-called "general caste" were found to have greater proportions of routine episiotomies (p=0.04) perhaps because they used public sector facilities more often" is a bit confusing. Wouldn't the general caste category women who tend to be less socioeconomically disadvantaged than the SC/ST group use private facilities more often than public facilities? If this wasn't the case, it needs to be made more explicit in the paper and the reason stated.

Our results indicate that higher proportions of pregnant women in the private sector belonged to the caste category known as ‘other backward’ (P = 0.002) and – although not statistically significant – to the wealthiest quintile (P = 0.07). Further details on sample characteristics are available in the previously published work in the Bulletin of WHO1.
Qualified versus unqualified providers- The authors have categorised care by unqualified providers as a form of under-treatment using a rights-based argument that suggests that all women have a right to be treated by qualified personnel. However, this framing contradicts some of their own findings. For example, the authors write (lines 57-573) "Interestingly, we found that total mistreatment scores (mean) were higher for deliveries conducted by qualified attendants (4.9) as compared to unqualified attendants (4.8) which supports the notion of over-treatment by qualified personnel". If this is the case, then isn’t it the case that harm that could come to women from mistreatment is not really substantially higher from unqualified versus qualified providers? The authors should rethink how to frame this interesting finding, reading against the grain.

We are reporting exactly what we found. We believe that it is every woman’s right to receive care from an appropriately qualified health worker when they seek care at a health facility. However, this does not mean that qualified health workers may not provide worse care. Our results are consistent with other studies that have found that provider effort is a key determinant for quality of care12. In our study 60% of deliveries in the private sector were done by qualified personnel. There is a tendency amongst these personnel to conduct more interventions as a way of demonstrating that they are providing better value for money or better quality of services. For example: unnecessary procedures like opening an IV line, pubic hair shaving or episiotomies are frequently done without any indication and hence constitute overtreatment.

Table 1 suggests that the only two statistically significant relationships are between mistreatment and time of admission and between mistreatment and, the type of facility. The latter has been explained more fully but the former has not been adequately elaborated. Could the authors explain why women who are admitted out of working hours, suffer less mistreatment? Is this related to fewer qualified personnel being present out of hours (a point that the authors have made earlier reporting that the score for mistreatment was lower with unqualified personnel)? Or is there some other reason?

This could be due to many factors. First, most women came to the hospital for deliveries during day time work hours and therefore most observations (92%) were done during daytime work hours (between 9:00 – 17:00). Second, busy day shifts translated to higher workloads for health workers and busier labour rooms and wards as a result of which most infarctions were observed during this time. Although we see higher rates of mistreatment amongst cases cared for by qualified personnel, we cannot make firm conclusions since our study is an observational study.
References:


