Reviewer’s report

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

Version: 0 Date: 22 Oct 2017

Reviewer: Mrunal Shetye

Reviewer's report:

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.

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.

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 shoulderling 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.
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.

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.

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?

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.)?

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

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.

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.

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.
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.

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