ORIGINAL RESEARCH

Maternal care during pregnancy, childbirth, and the postpartum period in primary care units, Oaxaca, Mexico

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Abstract

Introduction: The care provided to Mexican women during pregnancy, childbirth, and the postpartum period is imbued with deep inequalities and inequities. These problems are seen in both the access to and the quality of maternal health services. They stem from the poverty, marginalization, and discrimination experienced by Mexico's indigenous peoples.

Research Question: This study was conducted to identify situations that might compromise the quality of healthcare provided to women during pregnancy, childbirth, and the postpartum period.

Methods: This was a descriptive study examining the obstetric and post-partum care provided in two public clinics located in rural areas within the municipality of Oaxaca de Juarez, the capital of Oaxaca state. Standardized surveys and direct observation were used to collect data. Data was inputted into an Excel spreadsheet in order to obtain descriptive statistics (frequencies and percentages).

Results: Specific human and reproductive rights are denied to women receiving care at the two health centers. These violations include the right to equal treatment, non-discrimination, access to information, respect for their physical integrity, health, and reproductive autonomy.

Discussion: The human rights violations documented in this paper emphasize the importance of studying obstetric care across the continuum and not simply limiting health system evaluation to compliance (or non-compliance) with regulations or established standards. These violations are the product of a complex framework within which institutional violence and gender violence interact.

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Introduction

Maternity care in Mexico is characterized by deep inequalities and inequities. This is particularly evident in the care of women who are poor and/or marginalized. Not only do such women have limited access to health care services, but the services they do receive are of poor quality. Both problems are related to the marginalization, discrimination, and inequities experienced by Mexico's indigenous peoples. These problems are particularly acute in areas not covered by the Mexican social security system and in rural areas. Many women die needlessly of poverty.

There is abundant evidence documenting that social, demographic, economic, political, and cultural factors have led to the systematic denial of the human rights of indigenous women; these rights are specified in Article 4 of the Mexican Constitution.[1] This has been documented by the National Women's Institute[2], by Freyermuth and Sesia[3], and Sachse and colleagues.[4] Simply stated, marginalized women are denied both their human and sexual rights. This study was undertaken to identify conditions that compromise the provision of

quality healthcare to women during pregnancy, childbirth, and the postpartum period.

Methods

This is a descriptive study carried out in two public clinics (called health units) providing maternity and post-partum care. Rural Unit 1 provides care to three primary care clinics. It has five examination rooms, all in functioning order. Rural Unit 2 serves two primary care clinics. Both units are located on the outskirts of Oaxaca de Juarez, the capital of Oaxaca State (see Figure).

Figure: Map of Mexico showing Oaxaca State

Source: http://practicaoaxaca20083010.blogspot.mx/2008_11_-01_archive.html

Administrative survey: We used a survey entitled "Evaluating Maternal Health in Primary Care." Administrative personnel in both clinics answered the survey questions and were present during on-site inspections.

Patient survey: We used a list of all pregnant patients seen at the clinic to identify women who fit our eligibility criteria of at least four prenatal consultations between June and October 2011. We identified 36 women who met study criteria, but we were able to find only 27 of these women. To evaluate their experiences, we used a survey entitled "Questionnaire for Women who have received Prenatal Care."

Observation: Additional observations made by the authors during their visits to the clinics were included in the dataset.

Data analysis: Data was inputted into Excel and analyzed using descriptive statistics (primarily frequencies and percentages).

Ethical analysis: The study followed the regulations governing research as stipulated in the "General Health Law."[5] Informed consent was obtained from all subjects. Measures were taken to protect their anonymity and privacy. Participation in the study was entirely voluntary.

Results

The prenatal period

Content of prenatal care: The following lab tests are ordered at the first prenatal visit: CBC (complete blood count), glucose, syphilis, HIV, blood type/Rh, and urinalysis. While these tests were ordered at the health units, patients had to go to secondary or tertiary centers to provide blood and urine samples. Similarly, neither unit had an ultrasound machine, so patients were also required to go to a higher-level center for ultrasounds.

Women receiving prenatal care were given a tetanus shot and supplements containing folic acid and iron. Mexican health regulations require units to perform a minimum of five prenatal consultations for low-risk pregnant women.

Patients' perceptions: Eighty-nine percent of respondents had been seen more than five times at their respective clinics. 40% of the women seen at Unit 1 had incurred some expense during the pregnancy. Examples included: paying private doctors for care at night (the public clinics did not provide nocturnal services); purchasing drugs which were not available at the clinic; and paying for diagnostic tests ordered by the doctors but not available in the unit, including ultrasound, urinalysis, and beta-HCG. Our subjects noted that going to referral centers in the public system meant incurring travel-associated costs, long waiting times to obtain appointments, and the need to return for the needed test or study after getting the appointment. In Unit 2, 35% of the women noted that the unit did not have the necessary medications and they were forced to purchase these themselves. This was a particular issue for urinary tract infections.

Forty percent of women in Unit 1 stated that they waited more than three hours to be seen; this was an important cause of dissatisfaction. In Unit 2, 60% of women stated the wait was between 10 and 15 minutes (when they had an appointment).

Fifteen percent of subjects had sought emergency prenatal care and not received it. Causes for this included: the clinic was closed; the attending physician was not present; or the clinic guard did not consider the matter as urgent enough.

Seventy percent of the women were able to mention at least three indications for seeking emergency attention. This measure of health literacy is considered an important quality indicator in prenatal care. Red flag symptoms are specifically sought for during the history and physical examination.[6]

Eighty-eight percent of women said the health information they received was clear; the remainder found it confusing. In a few cases, women reported receiving no health information. These women said that they had had questions but did not ask them because but they were embarrassed or felt that they would be scolded for asking.

Health education is closely related to perceptions of the quality of health care. 56% reported receiving good treatment, 30% felt their care was acceptable, and 14% felt their care was bad. Comments regarding quality of care focused on their interactions with the nurses, the receptionist, and the security staff at the clinic.

When asked about the services offered by the clinics, 12% of the women did not know they could deliver in their unit and 33% did not know that the unit provided emergency obstetrical care.

Labor and delivery

All of the women had chosen to come to the units voluntarily and they typically came to visits accompanied by a relative. 19% had premature rupture of membranes and had used the emergency services at the clinic. The remaining 81% had a normal vaginal delivery.

Forty-eight percent reported being allowed to walk around the unit during labor; 52% were either sent home or allowed to walk outside of the unit due to insufficient space for walking within the unit.

Eighty-one percent reported having sufficient privacy on the labor and delivery unit; the remainder felt the coming and going of medical personal made them uncomfortable. 26% of patients were allowed to have a companion present when they were walking; this was limited to the waiting room, as companions were not allowed in the delivery room. 74% of the women were left alone in the waiting area prior to being brought into the delivery room. One woman reported giving birth in the waiting area; the doctor had apparently not realized she was ready to deliver because a pelvic examination had not been performed. 89% of the women were not allowed to drink on the labor unit.

During Stage 1 of delivery (cervical dilation), 67% of the women were informed prior to pelvic or other types of physical examination; 22% reported that they were not informed prior to exams and 11% could not remember. 93% stated that fetal heart monitoring was performed by the physician every 30 minutes during Stage 1 as per established guidelines. The remaining women (n=2) said this had not been done; in one case, the mother had a precipitate delivery and in the other the woman gave birth in the waiting area without medical assistance.

Sixty-seven percent of the women reported they had received less than three exams during Stage 1; 19% reported more than 3 exams; the remaining women (14%) reported either not being examined or could not remember. Those women who were examined reported that they had been examined by more than three different people. Only a third of the women reported that they were free to move, adopt different birthing positions, and use the bathroom during the labor process. 51% of women reported receiving intravenous medications during labor. 38% received no medications and 11% did not remember. 67% of subjects reported that medications were administered without any explanation; 22% stated they were given medications to speed up contractions and to decrease labor pains. The remaining 11% could not remember. Shaving the pubic area prior to delivery and the use of enemas was not routinely performed in the health units.

Use of episiotomy: 44% of the women reported they had received an episiotomy during the second stage of labor (cervical dilation to delivery); 44% reported that they had not received an episiotomy, and 11% did not know if they had received an episiotomy or not. One of the women in the latter group reported that she was not sure if she had had an episiotomy or a tear. No one had told her what happened. Her wound eventually became infected and she needed treatment.

Contact with newborn before leaving delivery room: 67% of the women reported that they had physical contact with the newborn in the delivery room; 33% did not have contact with the newborn until they were in the waiting area. Clinic staff explained delays in contact by the need to clean and weigh the child or by the need for an episiotomy. In some cases the women did not understand why they could not hold their child.

Delay in cutting the umbilical cord: 77% of women reported the cord was cut immediately; 15%

said it took more than five minutes; 8% did not remember.

Care in Stage 3 (delivery of baby to delivery of placenta): Care in Stage 3 was evaluated by the following indicators: use of a maneuver to deliver the placenta; explanation of any maneuver utilized; and examination of the uterine cavity. 44% reported that no maneuver was used to expel the placenta. 41% said that their abdomens had been massaged to help remove the placenta. 7% could not remember if anything was done because they were too tired at the time. 63% reported that the procedure was explained to them in advance; 30% said it was not ("they just did it") and 7% did not remember. 56% reported their uterine cavity had been examined, 26% said it had not, and 18% did not remember.

Puerperium

The puerperium is the six-week period after childbirth. Quality of care is evaluated by the presence of complications (early, middle, and late), the date of the first follow-up visit, attendance at follow-up visits, and screening for congenital hypothyroidism.

Complications: In the immediate post-partum period, 15% of women reported complications; these included vaginal tears, bleeding from the episiotomy site, and falls. During the mid puerperium, 4% of women reported an infected episiotomy site and pelvic pain, which led to chronic dyspareunia.

Follow-up visits: 56% of women had their first post-partum visit within seven days of discharge; 22% were given appointments more than a week after discharge. 22% never received post-partum appointments. 11% of women did not have a post-partum check-up. 11% had one post-partum check-up; and the remaining 78% had an average of 2-3 visits.

Health education: 78% reported that they had been given information about newborn care. When asked to provide an example of what they had learned about the post-partum period, 60% of this group could not give us an example, reporting that they had received information about the baby, not their own care.

Intercultural Care

A third of respondents spoke an indigenous language (Mixtec, Zapotec, and/or Chatina). Guidelines exist on the units regarding the provision of intercultural care, but when asked, unit personnel told us such guidelines did not exist. The majority of the non-Spanish speaking patients were in Unit 1, where none of the staff speak an indigenous language.

Accessibility

We learned from the administrators that Unit 1 had a functioning, fueled ambulance and driver available 24 hours a day; Unit 2 had no transportation. 22% of women did not know that their unit had an ambulance. They wondered if the ambulance was functioning because they had always come to center on their own, either taking a taxi or walking. 78% of the women knew the unit had an ambulance but did not realize it could be used for emergency transportation.

Both units had functioning telephones which could be used to contact other health units in case of an emergency. 80% of the women were aware of this.

Access to the units: During the night, both units are locked. This is done to prevent unauthorized use of the unit parking lot and the entry of indigent or intoxicated persons. 80% of the respondents noted that the security guards, nurses, and receptionists controlled access to the clinic. Patients must first explain the reason for their visit. The security guard, nurse, or receptionist would then decide if the matter is an emergency and if they can enter the unit. If not they will be asked to wait.

Free service

Within the Seguro Popular system (Mexico's public health insurance), all pregnancy-related services are supposed to be free. Despite this, the Municipality has placed a sign at the entrance of Unit 1 indicating that all consultations cost 20 pesos. Women noted that, in reality, the unit does not charge for consultations, but 85% of them reported having to pay for laboratory tests and ultrasounds. They also noted that going to a referral center for these tests cost them both money (for transportation) and significant time (scheduling the tests).

Information and educational materials

In both units we examined the availability of materials regarding maternal health. The following documents were not available: information on where the delivery would occur; materials from the "Healthy Pregnancy" program; materials on obstetrical warning signs; audiovisual material illustrating warning symptoms; posters and

information on what to do in case of bleeding, pre-eclampsia, or eclampsia; posters on what to do in case of an abortion (fetal loss); informational material on the Seguro Popular insurance program and its eligibility criteria (both for the mother and child); posting of clinic hours and personnel; forms for assessing women during labor; names of personnel who spoke an indigenous language.

It should be noted that neither the patients nor the clinic staff have access to the above materials. The Labor Assessment form was kept under lock and key, and the only person with a key was not present at the clinic.

Delivery equipment and infrastructure

Both units have functioning delivery rooms. These are equipped with a table, stirrups, and an examination lamp, all in good condition. Both had adequate sterilization units. Antiseptic solutions and sterile gowns were available, as well as all needed instruments. These materials were all in good condition. However, the bag containing sterile clothing did not have the date of sterilization marked on it, nor was there an indication of its contents. Neither unit had an adequate space for women in labor to walk.

Medicines and supplies

Both centers lacked the necessary medications and supplies that are legally mandated for institutions caring for obstetrical emergencies. Medications for urinary tract infections were not available, nor were medications to inhibit uterine contractions, to control blood pressure or – in emergency cases – to control hemorrhage. Plasma expanders were among the missing medications.

Comments about care

Suitability of the unit: 56% of the women interviewed responded to the question as to whether or not they would recommend the unit to a family member. 15% said they did not plan to return to the unit; 33% would not recommend it because of ill treatment by the nurses; 8% did not think the unit was an appropriate place to get maternal care.

Discussion

The results of our survey highlight several issues. Mexican health regulations require units to perform a minimum of five prenatal consultations for low-risk pregnant women. The goal is to prevent and screen for obstetrical risks, such as anemia, preeclampsia, and vaginal/cervical infections. Our observations showed that the majority of women came to appointments and received tetanus toxoid as well as iron and folic acid supplementation. In addition, tests were ordered at the first prenatal consultation. However, in order to obtain these tests women were obliged to spend their own money and invest significant time. This led many women to have the studies done in the private sector. As a result, their care was not really free.

There was dissatisfaction with long waiting times. In one clinic, waiting times reached three hours. Ministry of Health guidelines for quality monitoring in primary care use waiting times as an indicator of respectful care.[5] Users (patients, family members, or companions) are questioned about their satisfaction over waiting times. These are measured from the time a patient is given an appointment (or registered for an existing appointment) to the time when s/he enters the doctor's office. The standard of care is that 85% of users are satisfied with the wait time. Therefore, both units are deficient by this measure.

We also found that women who sought emergency care at the units were unable to obtain it. It is important to put this in the context of the WHO's recommendation from 1985 that "[e]very woman has the right to proper prenatal care."[8] The ten Principles of Perinatal Care endorsed by WHO include: "Care should be family-centered. ... Care should be culturally appropriate. ... Care should involve women in decision making. ... Care should respect the privacy, dignity and confidentiality of women."[9] Additionally, "[b]irth is a natural and normal process, but even 'no risk' pregnancies can give rise to complications. Sometimes intervention is required to obtain the best result."[8]

It is, therefore, alarming that 15% of women were unable to get care at a time of "crisis"; this may have potentially endangered the lives of both mother and child. The National Center for Gender Equity and Reproductive Health has published a "Comprehensive strategy to accelerate the reduction of maternal mortality in Mexico." This strategy emphasizes that adequate material and human resources for the health system are necessary to provide primary and emergency care. 24-hour coverage of obstetrical emergencies should be available year-round at the primary and secondary levels of the health system.

Health education during prenatal visits seems to be focused on warning signs as most women could

identify at least three of these. The care manual for the Healthy Pregnancy, Safe Childbirth, and Healthy Newborn emphasizes knowledge of warning signs as a key measure of good prenatal care, and they are emphasized during both history and physical examination of the pregnant woman.[6] Consquently, women who can name the warning signs are potentially in a position to seek out emergency care.

Women should also be informed about both delivery and emergency services; 85% of our respondents knew that the unit offered obstetrical services. This percentage meets the standards designated by the SICALIDAD program (Sistema Integral de Calidad en Salud: Comprehensive Healthcare Quality Control System). We would note that this quality data should be publicly available and that health education can be reinforced at each prenatal visit.[8]

A bit over half of our respondents (56%) were satisfied with the care they received. The remaining patients classified the care as acceptable or poor. Their complaints were primarily directed at the nursing staff, the receptionists, and the security staff. The General Health Law (articles 51 and 83) and the Regulations pertaining to the General Health Law (articles 25 and 48) both specify that patients should receive appropriate and respectful care from the doctor, the nurse, and other healthcare personnel. Patients' standards of personal privacy and decency, especially those related to their socio-economic status, gender, modesty, and privacy should be taken into consideration. The standards set in the SICALIDAD guidelines require that at least 90% of patients be satisfied with their prenatal care. The units did not meet this quality measure.

It should be noted that the authors reviewed the operational requirements of the "SICALIDAD" and "Aval Ciudadano" (a program allowing inspection of healthcare facilities by community organizations). We found that there were no quality measures for delivery and post-partum care. In addition, we cannot ignore the sociocultural characteristics of users, most of whom are indigenous. Guidelines exist in the units on providing appropriate intercultural care. But we did not find translators in the clinics, nor was clinic administration aware of the guidelines on intercultural care.

The shortcomings identified in this study should not be interpreted as a result of failure of the medical staff. Rather, they result from a system that is not patient-friendly and tacitly lays the blame for deficiencies on the staff.

This study is limited by several factors. Though it used structured instruments and techniques from ethnographic research, the information obtained is based on patient self-report; information may be inaccurate due to forgetfulness, poor understanding, fear, or shame. In addition, there was no control group. Thus we cannot say if the conditions we found in the two units can be generalized to other centers or reflect poorer care provided to the participants in our study. Despite these limitations, we believe our data suggests serious deficiencies in both clinics.

In conclusion, we emphasize the importance of studying the reality of obstetric care at all stages and not relying solely on levels of compliance with norms or standards; the truth is more complex. Furthermore, our results document how women perceived the care they received in the units under study as well as specific violations of their human and reproductive rights, including the rights to equality, non-discrimination, information, physical integrity, health, and reproductive autonomy. This is the end result of a multifactorial framework in which institutional violence and gender violence interact.

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