



Facilitator copy (see separate Delegate copy)

Instructions for the facilitator

Ask everyone to introduce themselves briefly (3 minutes).

Ask one of the group to be the scribe for the case study.

Read the first three sections to the group (2 minutes).

Please ask a member of the group to read out the case study (2 minutes).

Once it has been read out, turn to the 'Discussion'. The blue notes are there as prompts if you require them to engage people in discussion but do not feel you have to use them if the group engage in the discussion. Try to ensure all members of the group are included and encouraged/invited to share their thoughts and ideas.

Spend 15-20 minutes discussing the questions.

Introduction

This case study is set in Uganda. It explores the responsibility of health professionals in providing respectful care towards women in labour.

Note on the case study

This case study has been written by Dr Helen Allott FRCOG, trainer for the RCOG Emergency Obstetric Skills programme.

Learning Objective

To encourage health professionals to consider how to provide respectful, compassion care to women (especially young women and girls) who are in labour and the importance of privacy and dignity of care to those who may be frightened and unable to pay for services as this may result in severe consequences including birthing injury or death of the mother and her baby.

Case study

Mary, a young Ugandan woman, became pregnant aged 17 following a rape and attended her local Health Centre 4 for Antenatal Care. There were many women at the clinic and she had to wait for several hours to be seen by the midwife. The midwife told Mary that she should bring her husband with her to her next appointment. Mary had a rapid diagnostic test for HIV which was positive. The midwife told her that she had HIV and would need to go to the ART at the hospital for medication. Mary said she had no money for transport but the midwife said she would have to find it somehow. She said Mary should have thought about that before she slept around and became infected.

Mary never went back for further antenatal care or to the ARV clinic. At 35 weeks, she went into labour. Although she was afraid she might see the same midwife again, she managed to walk the 4 miles to the Heath Centre whilst in labour. When she arrived she was told to wait to be seen. There was nowhere private to wait, just the corridor. There was a wooden bench but several others were sitting there and there was no room for Mary.

Eventually Mary was seen by the midwife who told her to open her legs so that she could examine her. Mary was frightened and clamped her knees together and the midwife roughly pulled them apart. Mary was not given a sheet and there were no curtains around the bed so women, other staff and students could all see Mary being examined. The examination was rough and very painful. When Mary cried out the midwife slapped her and told her that she had not cried in such a way when she conceived. After that the midwife left Mary alone. The other women in the labour ward delivered their babies and were moved to the postnatal ward. Night fell and no-one returned to see Mary. She was very frightened but she was in too much pain to get up and look for someone to help. She developed an urge to push but there was no one to tell her what to do. At 04:00 she delivered a baby alone. The baby did not cry or move. Shortly afterwards, Mary started to bleed. By the time staff came back in the morning, Mary was unconscious, lying in a pool of blood.

Discussion

1. What are your first impressions of this case?

Allow time for delegates to give their views on the case, which may reveal different levels of understanding about quality respectful care towards women in labour.

2. What should health professionals have identified as priority risk factors in this case?

Allow time for delegates to respond but if required, prompt them with:

The fact Mary has been the victim of rape

Mary's age

HIV status

Mary's lack of follow-on antenatal care visits

Single

Poverty

3. How could the midwives have behaved differently?

If required, prompt delegates with:

With gentle questioning found out the circumstances of the conception and provided support

Appreciated how frightened she was

Made sure that PMTCT was provided in an accessible way for Mary

Treated Mary with kindness and compassion, especially as a victim of rape

Offered counselling/support or where she could get this if available for both rape and HIV infection

Made sure Mary had tests and/or treatment for other STIs and she understood why

Not discriminated against Mary on the basis of having not money for transport

Created a private space

Not physically abused Mary when conducting an examination

Shown patience and awareness of how frightened Mary is

Treated Mary as a high risk patient

Monitored Mary using EWS and partograph

Not left Mary alone during the night (abandonment)

4. What system changes could be made to reduce the risk of this happening to anyone else?

Prompt: institutional guidelines for treatment of Rape victims in place

Integrated ANC and HIV treatment in place

Policy on non-discriminatory treatment

Zero tolerance for violence to patients with notices and pictures so patients know what to do if this happens and who to complain to

Labour ward staffing policy

Care in labour policy

Disciplinary process for negligent care

Process for serious incident investigation

Adequate labour ward staffing

Compulsory training on respectful care for all staff

5. What are the key learning points from this case?

Refer to the learning objective

Invite the group to review the Checklist for Respectful Care in Women's Health and ask them to contribute their ideas to put the actions into practice in their workplace.

[End of case study].