Despite differences in culture, US and India fall short in childbirth in similar ways

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Woman in labor, shown with monitors. Credit: Shutterstock

After eight years of practicing obstetrics and researching childbirth in the United States, I know as well as anyone that the American maternal health system could be better. Our way of childbirth is the costliest in the world. Our health outcomes, from mortality rates to birth weights, are far, far from the best.

The reasons we fall short are not obvious. In medicine, providing more care is often mistaken for providing better care. In childbirth the relationship between *more* and *better* is complicated. Texan obstetricians, when compared to their counterparts in neighboring New Mexico, are 50% more likely to intervene on the baby's behalf by performing a cesarean section. Nonetheless, Texas babies still have a lower survival rate than New Mexican babies.

I long assumed that our most puzzling American health care failures were idiosyncrasies–unique consequences of American culture, geography, and politics. But a trip to India for the 2017 Human Rights in Childbirth meeting led me to a humbling realization: when it comes to childbirth, both countries fall short in surprisingly similar ways.

Human rights in childbirth

I take care of patients in at a well-funded teaching hospital in Boston, where pregnant women seem well-respected and have clear, inviolable rights.

I've read about the gender-based violence, the profoundly disturbing cases of disrespect and abuse that too many women in India and around the world experience. But these are not things I have deep experience with.

I initially hesitated when I received an invitation to speak at a human rights meeting. Still, the opportunity to scrutinize my profession alongside international experts from a broad range of disciplines was compelling. Over 200 activists and scientists, midwives and physicians, journalists and attorneys planned to discuss strategies to advance justice, dignity, and respect for pregnant women. So I got on the long flight from Boston to Mumbai.

The meeting began with Indian women describing their experiences of care gone wrong. Many were heartbreaking stories of women receiving *too little care too late* – failures to provide antibiotics, blood and other forms of resuscitation in a timely way. Others were equally heartbreaking examples of women receiving *too much care too soon* – unnecessary inductions of labor, episiotomies and C-sections. Beyond instances of clinically measurable harm, the stories illustrated routine misappropriations of care that these women felt deprived them of basic dignity.

Throughout, I was conscious of the fact that Indian clinicians have different training and face different constraints than I do. Indian women often have less agency to advocate for themselves compared to American women. Nearly half of Indian women are married before the age of 18 and have limited

capacity to make independent decisions regarding reproduction. Indian women also have less access to basic social services than American women, though they are far more likely to require them. Higher rates of chronic and infectious diseases, higher rates of illiteracy, higher rates of abject poverty are all factors contributing to avoidable suffering in childbirth.

But as I sat there, listening to case after case, aware of the differences between the American and Indian context, much of what I was hearing also sounded uncomfortably familiar. Fundamentally, providing too little care too late or too much care too soon are challenges that all maternal health systems are confronting, including the American system. And in America, India, and many other countries, the standard approach to address these challenges is similarly limited.

The principal way my profession aims to improve care is by issuing guidelines that spell out the things we should be doing more of. But simply advocating that we start to do more things may be inadequate. In many cases doing more can actually be harmful.

The balance between too much care and too little

In a recent Lancet commission on maternal health, 77 researchers from around the world, including me, concluded that our primary struggle in maternal health care is to find the appropriate balance – to provide the right patient with the right care at the right time.

The testimonies during the conference revealed a startling set of facts. In India, as in the United States, the biggest risk factor for getting an avoidable and potentially harmful c-section appears to be which facility a woman goes to for care, not her personal preferences or medical risks.

In India, as in the United States, those facilities that are better at achieving the right balance of interventions rarely share best practices with others. And in India, as in the United States, efforts to elicit and attend to the legitimate preferences women may have during childbirth are the exception rather than the rule.

These parallels have their limits. On average, health outcomes in the United States are significantly better than those in India. But this mode of comparison misses a critical point. Dignity is a consequence of appropriate care, and appropriateness cannot be easily determined by population statistics. In our intense focus on mortality rates, we often overlook the obvious fact that childbearing women have goals other than emerging from birth alive and unscathed.

Childbirth is a moment of identify formation as a mother. It is a moment of profound self-agency (or lack thereof). It is a moment that nearly all my patients tell me has long-lasting and nuanced effects on their lives, though we do not have good ways of measuring such things.

Appropriate care is about more than safety

The stories of care gone wrong in India gave me an uncomfortable feeling that even the routine, seemingly respectful and safe care I provide in Boston may occur in a system that may not be designed to prioritize the dignity of my patients.

A large part of the challenge is that many women may not know what they deserve when it comes to the experience of having a baby.

An impoverished Indian woman who treks to civil hospital, only to give birth through an avoidable episiotomy, with minimal labor support, on a dirty metal cot, in a room crowded with other patients, may see that as normal. She may even expect it.

Of course, an American woman who labors in a clean, private room, within a state of the art hospital, only to receive an avoidable c-section will often see that as normal as well. In both cases, as long as the baby is healthy, women are almost always grateful.

Those of us in the birth community could do better in helping women understand what they deserve, and in developing systems of care that deliver on this promise. But first we have to be willing to link the ideas of appropriateness and justice, of patient

experience and dignity. In other words we have to be willing to see childbirth through the lens of human rights.

As an obstetrician, I understand the hesitation. There's a part of me that still bristles at this framing. In practice, knowing when to intervene in the course of an otherwise healthy woman's labor can be incredibly difficult. Perfect accuracy may actually be impossible.

Yet there are certainly broad ways that the American maternal health system can do better. About 50 percent of U.S. counties lack any qualified childbirth provider, limiting access to necessary care. Paradoxically, when we do provide access to care, we tend to provide too much. In the case of unnecessary c-sections, the error margin is again about 50 percent.

While perfection may not be a reasonable goal, delivering appropriate care with the same success rate as a coin flip is not reasonable either. In fact, it is unjust.

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