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Rethinking trust in the context of mistreatment of women during childbirth: a neglected focus

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> Health systems are also human systems. At their heart is a personal encounter, the interaction between the patient and the health provider—sometimes tenuous, often contested, but always with the potential for humanity and compassion (Sheikh *et al*, 2014, p. 1).

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The mistreatment of women during childbirth is a global phenomenon.[1] Mistreatment includes physical and verbal abuse, violations of privacy, stigma and discrimination, and neglect and abandonment. To date, much of the focus has been on measuring this phenomenon and the interpersonal relationships between women and health workers and the role of and abuse of power by these workers.[2] However, more recently, there have been increasing calls for widening the lens on underlying drivers of mistreatment of women during childbirth to include the considerations of social, gender and economic inequalities,[3] and systemic failures both at health facility and the health system levels.[1 4 5]

This recognition and renewed attention on the wider social, economic and political systems in which health systems are embedded is important for two reasons. First, while much of the mistreatment is often carried out by health workers and especially those at the frontline, it is important to recognise that many of these health workers are located lower in the organisational hierarchy, themselves overworked and abused in under-resourced and poorly supervised environments and overall dysfunctional health systems.[6–9] This recognition has underpinned nascent investigation of the role of workplace and institutional trust in some settings.[10–13]

Second, mistreatment does not affect all women equally.[14 15] Similar to the vulnerability that health workers lower in the organisational hierarchy experience as *kick-down* (ie, overwork and abuse), the tendency of those same providers to *kick-out* (ie, abuse socially marginalised patients)[16] follows the fault-lines of gender, race, social and economic inequalities, marginalisation and discrimination. In all settings, mistreatment and abuse is disproportionately experienced by women lower down in the social, economic and political hierarchy (ie, adolescents, migrant women, women with disabilities, ethnic minorities, unmarried women and others).[15] Such neglect, mistreatment and abuse not only contribute to eroding trust but may also deepen overall mistrust in state institutions and the health system. At the same time, since not all groups will experience the same level of neglect, mistreatment and abuse, differing levels of trust based on both personal experiences and received wisdom may lead to further polarising groups in society and undermining social solidarity.[17]

Trust is well recognised as an essential component of effective health system functions from the macro to the micro levels. The implications of trust for healthcare access, treatment adherence and health outcomes have been widely explored[18 19] with particular focus on the way patients' interpersonal trust in health workers influences their health outcomes. Importantly, an inquiry into addressing mistreatment of women in childbirth through addressing mistrust is incomplete without revisiting the role of health workers, who are often at the interface between patients and communities and the healthcare system. Giddens[20] reminds us that "Although everyone is aware that the real repository of trust is in the abstract system, rather than the individuals who in specific contexts 'represent' it, access points carry a reminder that it is the flesh-and-blood people (who are potentially fallible) who are its operators" (p. 85). By 'access points', Giddens refers to the social situations in which health workers are located and work, while the 'individual' (ie, health worker) are representatives of the social system. Representatives who believe that the health system works in their

best interests are more likely to be motivated to fulfil their professional responsibilities and provide people-centred care.[10 13] Recognition of the central role that health workers in the health system is increasingly driving much needed research not only into understanding the factors and mechanisms that erode trust but also opportunities for building trust through improved working conditions, inclusive organisational culture and human resource practices.[10–13]

Gille and colleagues[21] also remind us that 'high levels of public trust in state institutions *beyond health* are generally associated with system legitimacy, low transaction costs and improved health, and higher levels of social cohesion' (emphasis added). This resonates with the current global context in the wake COVID-19 pandemic. The COVID-19 pandemic has spurred interest—conceptual, policy and programme—in the sphere of public trust in health systems and state institutions more widely, including that for respectful maternity care.[4] The pandemic has served to remind us of the importance of the role of citizens in health and related policies that affect them.[22] It has also turned the public eye back on the significance of accountability of state institutions and the need to embody and demonstrate values of care and acting in the best interests of all their citizens particularly the vulnerable and marginalised. Sreedar and Gopal[17] reflecting on the USA—but relevant for other countries and economic settings across the globe—identify two important consequences of government budget cuts; that of increasing privatisation of basic services, and overall poor access to healthcare: '[f]irst, people are unlikely to trust institutions that do little for them' and 'second, public health is no longer viewed as a collective endeavour, based on the principle of social solidarity and mutual obligation'. Experiences of social exclusion, disempowerment and 'feeling let down' by state institutions erode trust, particularly for socially marginalised and vulnerable groups.[13 19]

What are the implications of this for how we understand and examine the role of trust in maternal health and specifically mistreatment of women during childbirth? Despite a few studies,[23–25] trust in the context of mistreatment during childbirth and quality of care and maternal health more widely continues to be neglected both conceptually and programmatically. Within the existing body of work, moreover, trust is often conceptualised and analysed at the interpersonal level and framed as just one more 'determinant' (alongside health worker attitudes, distance from facility, costs of delivery kits, etc) of women's ability and willingness to access facility childbirth. This approach fails to recognise the dynamic and reconstitutive nature of trust in the health system. That is, trust as an *input* into women's access to care but also an *output* of that healthcare experience which may inform future evaluations of health system trustworthiness.

With few exceptions, childbirth represents one of the most critical encounters between women and their communities, and the health system. During childbirth, trust and quality of care are paramount. Where those encounters are positive, trust in providers and the broader system may be reinforced but conversely, a poor experience may damage trust in ways that impact on more than just the women's access and engagement with care at that point in time. Despite growing recognition of such links, however, theory-driven research exploring how trust can be strengthened, not just between women and their individual providers but in facilities and the broader health system, remains lacking.

Can inquiry of mistreatment through the lens of trust be the tide that lifts some if not all boats towards ensuring that women are treated with respect and dignity? If yes, what are the lines for inquiry for examining mistreatment through a lens of trust? The starting point is the recognition that health systems are social institutions and that the trust across all its dimensions and types (ie, interpersonal, social, public) is dynamic, both a process and an outcome that needs to be explored and investigated in context.

We propose a set of preliminary questions here to guide discussion and future inquiry in this area:

- How does inclusion of trust within conceptual framing of drivers of mistreatment extend and deepen theoretical understanding of abuse and mistreatment and what would be the implications of this for the design and implementation of interventions to reduce mistreatment and improve respectful care?
- How do experiences of mistreatment in childbirth influence community trust in healthcare and how does this differ across communities divided along, for example, social, economic and ethnic lines?
- What are the specific challenges arising from pre-existing (dis)trust, rooted in historical and political marginalisation (eg, indigenous populations) and institutional racism and discriminatory health policies for access to services and what are the consequences for how different groups experience and express trust in the health system?
- What are the underlying health systems and institutional factors that either build or erode the trust of women particularly during pregnancy and childbirth?
- What governance, design and delivery features, including social accountability mechanisms, promote sustained improvements in systems-level trust and by what processes and structures?
- How does workplace (mis)trust differentially influence performance and quality among different health worker cadres, and in the context of different healthcare services?
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These set of questions while not exhaustive, and subject to being adapted for different health systems contexts, provide a point of departure for conversations and research that will deepen understanding of the

relationship between trust and mistreatment of women during childbirth. Inquiry in this area is important not only because of the potential to reduce mistreatment through policy and programmatic changes, but also from a conceptual perspective. Alongside the inquiry, equally relevant is the approach. Co-design approaches to identifying both the problems and interventions demand that researchers and decision-makers step aside for women, communities and health workers to better understand their needs and what changes are needed in the health system to build and earn their trust. This is especially timely given that despite global and regional commitments to ensuring women's right to dignified, respectful healthcare, mistreatment remains a global reality for too many who give birth in facilities.

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