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RESEARCH ARTICLE

ENCOURAGING THE PROVISION OF CONSIDERATE RESPECTFUL MATERNITY CARE ON A GLOBAL SCALE-AN ESSENTIAL HUMAN RIGHT

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Abstract

The majority of women and their families see pregnancy, labour, and delivery as life-altering physiological events, hence cooperation between medical professionals providing maternity care is beneficial. When it comes to providing the best care possible for women and infants, particularly those who are at risk of obstetrical or neonatal difficulties, multidisciplinary education and teamwork—which includes consultation, communication, collaboration, and referral—are crucial.

Aim: To promote the provision of thoughtful, respectful maternity care worldwide i.e. a fundamental human right.

Methodology: Relevant literature was identified through a search on Medline and PubMed, National Health library. several maternal health modules.

Outcomes: Professional emergency and routine care delivered in a pleasant, safe, and economical manner should be a frequent resource for all pregnant mothers.

Conclusion: More than simply having access to treatments, medications, and supplies is necessary for providing high-quality maternity and neonatal care. Care that is inclusive and courteous is essential to providing high-quality treatment.

Introduction:-

Pregnancy and delivery are life-changing experiences for women and families everywhere, and they represent a period of extreme vulnerability. The idea of "safe motherhood" is typically limited to physical safety, but childbirth is also a vital rite of passage for a woman and her family, with deep personal and cultural importance. Because parenthood is unique to women, gender equity and gender violence are important to maternity care. As a result, the concept of safe motherhood must be enlarged beyond the avoidance of sickness or death to include respect for women's essential human rights, such as autonomy, dignity, sentiments, choices, and preferences, as well as companionship during maternity care.

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Pregnancy, delivery, and the complications that follow remain the top causes of mortality, sickness, and disability among women of reproductive age in poor nations. In 2011, about 275,000 maternal fatalities occurred worldwide as a result of curable diseases during pregnancy and delivery. Almost majority of these incidents occurred in underdeveloped nations.[1]

In 2010, the subject of abuse during delivery gained significant international attention. Following a landscape analysis, Bowser and Hill classified the following seven manifestations:
• Abuse of force
• Non-consented treatment
• Non-confidential treatment
• Inhumane treatment
• Discrimination
• Carer abandonment
• Facility detention[2].

Bohren et al. (2015)[3] defined seven "third order themes" of abuse as follows in a more recent publication:
The following are examples of abuse: physical, sexual, verbal, stigmatising, discriminatory, failure to give care in accordance with professional standards, lack of consent and confidentiality, poor relationship between women and providers, inefficient communication, unsupportive care, loss of autonomy, loss of autonomy and supporting care.

Complications during labour and delivery account for about one-third of maternal fatalities[4], around 42·3% of stillbirths [5], and 11.6 percent of newborn deaths [6]. Most of these fatalities take place in low-resource environments and can be largely avoided with prompt interventions[7]. Complications can be reduced with good treatment and avoiding needless procedures. The prevention of unfavourable delivery outcomes depends critically on early detection and care of problems, as well as monitoring of the health of the mother and foetus and the status of labour. The approach with the most potential impact on lowering stillbirths and maternal and infant mortality across the continuum of care has been shown to be enhancing the quality of care during childbirth and in the immediate postpartum period [8].

WHO developed the WHO Labour Care Guide (LCG) and an accompanying WHO labour care guide: user's manual in order to enhance the quality of care during labour and delivery, facilitate the effective implementation of the WHO recommendations: Intrapartum care for a positive childbirth experience, published in 2018, and encourage a shift towards improving the experience of childbirth. Within the framework of a more comprehensive, rights-based approach, the WHO LCG is a tool to support the implementation of high-quality, evidence-based, woman-centered care for a pleasant delivery experience. This policy brief aims to give decision-makers and stakeholders in maternal and newborn health an overview of the WHO LCG and its guiding principles, highlight the benefits of switching from the WHO partograph to the WHO LCG, and outline the necessary steps to create an environment that will support the WHO LCG's sustainable introduction.[9,10]

Respectful maternity care (RMC) is a human right as well as an essential part of high-quality healthcare. "Every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth," the World Health Organisation (WHO) declared in a statement made in 2014. The statement called for the prevention and eradication of disrespect and abuse during childbirth. WHO also demanded that governments, programmers, academics, activists, and communities rally around RMC. A stronger emphasis on respect and dignity preservation was one of the new guidelines that the World Health Organisation (WHO) released in 2016 to improve the quality of care for mothers and babies in healthcare facilities.

The following categories of infractions are more common in humanitarian settings:

1. Lack of information: In an emergency, medical professionals might not have the time or means to thoroughly explain operations or procedures. However, efforts to inform, counsel, and, when feasible, accommodate women's desires may help to allay women's concerns when it comes to giving birth in a hospital or in a Western health care setting for the first time, having fears about childbirth or interventions, or having little education (Fink et al., 2014).[11]
2. Lack of privacy: Since there is limited area and one-room tents are frequently utilised as clinics in camp settings, privacy concerns might be especially problematic (Women's Commission, 2004; Krause et al., 2015).

Women were reluctant to seek medical attention during the disasters in Haiti and Pakistan due to the lack of privacy that the facilities offered.[12]

3. Lack of consent: Emergencies can lead to migration, which puts groups of individuals in unfamiliar or non-welcome environments where they don't know the language or customs. Non-consensual health intervention can result from a combination of factors such as language and cultural difficulties, prejudice, inadequate education, and time constraints faced by medical staff. For instance, in order to restrict their ability to procreate, women in SWAPO refugee camps in Namibia during the 1980s had secret sterilisations after caesarean sections (Lindsay, 1986). Many Syrian refugee women in Greece report that they were not informed or given their permission for caesarean sections or even hysterectomies (Ahmetasevic, 2016; Gill, 2016a).[13]
4. Denial or postponement of care: Women interviewed in Gaza and the West Bank revealed that inadequate resources and movement restrictions result in a reduction in the efficiency of facilities and an increase in deliveries at military checkpoints and at home. There are stories of women dying at military checkpoints because they were refused access to the hospital; these checkpoints have been shown to impede ambulances and labouring women (Aswad, 2007; Bosmans et al., 2008). Syrian refugees in Greece must rely on the Greek healthcare system, which puts the needs of its people first, when camp health services close at night. It may take an ambulance up to twelve hours to arrive (Ahmetasevic, 2016). In institutions, shortages of staff, equipment, medication, or expertise can also result in delays in care (Hynes et al., 2012). Patients who lack the financial means to pay for care may experience delays or denials of care even in the presence of appropriate resources (Women's Commission, 2004). For instance, in Malaysia, Rohingya who do not have a valid UNHCR registration card are not allowed to enter government or private hospitals, even in cases of emergency when these facilities are mandated by law to treat them; even with the cards, which provide subsidised healthcare, costs are frequently unaffordable, particularly for services related to pregnancy and childbirth, forcing families to seek other sources of funding (Sullivan, 2016).[14]
5. Neglect and abandonment: Because of acute shortages of both human and material resources as well as prejudice, there is a larger chance of neglect and abandonment during catastrophes. In one study, Palestinian women reported that because midwives and nurses were overworked, they would frequently leave the hospital within hours of giving birth, leaving them unfollowed (Wick, 2002). The women also described being left alone in the hospital for extended periods of time during labour, without even family to offer support.[15]
6. Concerns about the use of temporary foreign assistance health workers: When it comes to providing culturally appropriate treatment, short-term mission personnel working in emergency response may occasionally lack the necessary time and resources or lack cultural competency.Labouring women may view care as disrespectful if carers do not share or follow their cultural norms (e.g., regarding gender, language, power), even if this is not always the case with D&A. As a result, they may be discouraged from using services. For instance, in some situations, women may feel disrespected and be discouraged from obtaining care if male healthcare professionals or auxiliary staff, such translators, are present (Women's Commission, 2004; Bloem & Miller, 2010; Krause et al., 2015).[16,17]

Suggestions and Measures:-

A statement issued by the World Health Organisation (WHO) has received support from more than ninety international organisations, such as the International Federation of Gynaecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM), which calls on governments, healthcare institutions, and healthcare providers to prevent and end abuse and disrespect during facility-based childbirth. The goal is for "every woman to have access to the best possible standard of health, including the right to dignified and respectful medical care."[18]

Measures to stop and get rid of mistreatment and disregard during in-hospital deliveries

The following steps should be followed in order to stop and eradicate disrespect and abuse during facility-based deliveries worldwide:

1. Governments and development partners should provide more funding for studies and initiatives addressing disrespect and abuse.
2. Create, implement, and maintain initiatives aimed at raising the standard of maternity healthcare, placing a special emphasis on the importance of respectful treatment.
3. stressing a woman's right to courteous, dignified medical treatment throughout her pregnancy and delivery
4. Systems of accountability, effective professional assistance, and the generation of data on respectful and disrespectful care practices are necessary.
5. Involve women as well as other stakeholders in initiatives to increase care quality and get rid of abusive and disrespectful behaviours.[18]

When abuse of women during childbirth has been the norm, it presents extra hurdles to creating respectful and inclusive maternity care. Research has revealed, for instance, that certain medical personnel view abuse of women during labour and delivery as normal, essential, and appropriate in order to obtain the woman's consent and produce a healthy baby[19]. For other women, mistreatment is simply a fact of life when giving birth in a medical institution.[20] Women, their families, healthcare professionals, and researchers must all approve of a change-making process that identifies, confronts, and declares such behaviours intolerable.[21] In order to empower healthcare practitioners to effect change, this will create or improve the enabling environment.

The WHO's advice on respectful care during labour and delivery emphasises how crucial it is to adapt locally and execute changes via a consensus-building, inclusive process. It is crucial that local adaptation takes into account international norms and standards to prevent the process of adaptation from normalising abusive behaviour that already exists simply because it is "the way things are done here." The ideal way to approach adaptation is as a component of larger projects or activities aimed at evaluating and raising the standard of care for expectant mothers and newborns.[22]. In addition to community participation and awareness, effective implementation must take organisational, systems, and health policy factors into account. These initiatives also aim to redefine the expectations of respect in society and the workplace and to reframe access to high-quality healthcare as a fundamental right for all women.

Enacting rules and practices that promote respectful care: health policy implications[23]

1. Regardless of social, economic, racial, cultural, or other characteristics, the government must firmly commit to expanding access to maternity care for all expectant mothers giving delivery in medical facilities. It is important to obtain national backing for the entirety of the package of proposals, rather than simply individual parts.
2. Participants in training facilities and professional organisations should be included at all phases of the process to define the agenda, ensure wide grounding, and guarantee progress in policy formation and decision-making.
3. Information related to the circumstances surrounding the anticipated effects of the new intrapartum care model on providers, service consumers, and costs should be gathered and distributed in order to aid in discussions and planning.
4. In the context of universal health coverage (UHC), policies for increasing public funding for health care will need to be revised in order to fully assure access for all women to high-quality maternity care. Donors may be able to help low-income nations accelerate their implementation efforts.

Things to consider at the organisational or health system level

1. In order to address the scarcity of qualified midwives, enhance facility infrastructure and referral channels, and maintain and enhance high-quality maternity care, long-term planning is required for resource generation and budget allocation.
2. To ensure that preservice and in-service training curricula can be updated as fast and seamlessly as feasible, training institutions and professional bodies should be involved in the model's introduction.

3. To make sure that all healthcare providers: comprehend the fundamental ideas behind what defines normal and abnormal labour and labour progress, and the necessary support; and apply the standardised tools, a revised partograph and other standardised labour monitoring tools will need to be developed. [24,25]
4. The national Essential Medicines Lists will have to be revised, for example, to add medications that should be accessible for pain management after childbirth.
5. The WHO intrapartum care model must be the basis for the creation or modification of national guidelines and/or facility-based protocols. A higher level of care must be transferred to in a timely and appropriate manner in the event that complications during childbirth arise, and healthcare facilities lacking caesarean sections will need to develop context- or situation-specific guidelines (e.g., accounting for travel time to the higher-level facility).
6. The establishment of effective referral routes requires the provision of high-quality oversight, communication, and transportation connections between primary and higher-level facilities.
7. In order to meet local needs, strategies for improving supply chain management will need to be developed. For example, standards for acquiring and keeping products in stock should be developed.
8. To support the WHO intrapartum care model and lessen the exposure of healthy pregnant women to needless interventions common in higher-level institutions, consideration should be made to the care provided at alternative maternity care facilities (e.g., on-site midwife-led birthing units).
9. Settings where non-evidence-based intrapartum care practices are well ingrained may need to implement behaviour modification methods directed towards healthcare practitioners and other stakeholders.
10. Effective tactics for implementation ought to be recorded and disseminated to other implementers as models of optimal performance.

User-level factors

It is important to carry out community-level sensitization campaigns to spread knowledge regarding:

1. Respectful maternity care (RMC) for expectant mothers and their unborn children in institutions is a basic human right.
2. Facility-based techniques (e.g., RMC, labour and delivery companionship, effective communication, birth position selection, and pain relief method selection) that enhance women's childbearing experiences
3. Superfluous delivery methods that are no longer used in institutions and are not advised for healthy expectant mothers (such as regular amniotomies, fundal pressure, or the widespread use of episiotomies

Suggestions:-

1. Every expectant mother should have regular access to professional emergency and routine care that is provided in a courteous, safe, and cost-effective way.
2. Healthcare institutions must provide women with privacy by using drapes or dividing walls and letting them select the support person of their choice.
3. Pregnancy should not be met with any kind of prejudice or physical, verbal, or sexual abuse of any kind for any woman.
4. When it comes to taking care of themselves and their children, women have a right to information and communication.
5. When women are included in the decision-making process and their preferences are honoured, their ability to give birth is strengthened.
6. In addition to being valued and appreciated, maternity health workers should have access to sufficient training, mentoring, and support, as well as work environments that allow them to treat patients with dignity and justice.

Conclusion:-

More than simply having access to treatments, medications, and supplies is necessary for providing high-quality maternity and neonatal care. Care that is inclusive and courteous is essential to providing high-quality treatment. It is also crucial that the patient and her family feel comfortable both emotionally and mentally. Care must be given with consideration, taking into account the beliefs and knowledge of the community, being individualised to meet the needs of women, and—most importantly—being delivered by healthcare professionals who are able to integrate clinical expertise with interpersonal and cultural competency. In every nation, providing maternity care should include providing respectful maternity care, which includes all of these components as well as others.

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