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Respectful Maternity Care and its outcome

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Abstract: *Every woman around the world has a right to receive respectful maternity care. The concept of "respectful maternity care" has evolved and expanded over the past few decades to include diverse perspectives and frameworks. In November 2000, the International Conference on the Humanization of Childbirth was held in Brazil, largely as a response to the trend of medicalized birth, exemplified by the global cesarean section epidemic, as well as growing concerns over obstetric violence. Advocates emphasized the need to humanize birth, taking a woman-centered approach.*

India remains one of the most high-risk places in the world to give birth, accounting for 15% of total maternal deaths worldwide. Annually, over 44,000 women die in India of maternal causes, despite over 80% delivering in health facilities. Almost all these deaths are preventable, suggesting that quality of care needs attention at multiple levels. India has seen progress around maternal health in recent years but the rush to bring women to facilities has grown without investing enough on the experience they have once they are there. The best way to continue decreasing India's maternal mortality rate is to focus on realizing women's rights for quality, respectful healthcare.

Key Words: *maternity, childbirth, Respectful, cesarean section, epidemic, obstetric, violence, maternal mortality rate, healthcare.*

1. INTRODUCTION:

The concept of "obstetric violence" gained momentum in the global maternal health community during the childbirth activism movement in Latin America in the 1990s. The Network for the Humanization of Labour and Birth (ReHuNa) was founded in Brazil in 1993, followed by the Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN) during the 2000 conference. In 2007, Venezuela formally defined "obstetric violence" as the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalization and pathologization of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life.

Disrespect and abuse (D&A), a concept closely related to obstetric violence, has been documented in many different countries across the globe. In a 2010 landscape analysis, Bowser and Hill described 7 categories of disrespectful and abusive care during childbirth: physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment and detention in health facilities. A 2015 systematic review updated this framework to include:

- Physical abuse
- Sexual abuse
- Verbal abuse
- Stigma and discrimination
- Failure to meet professional standards of care
- Poor rapport between women and providers
- Health system conditions and constraints

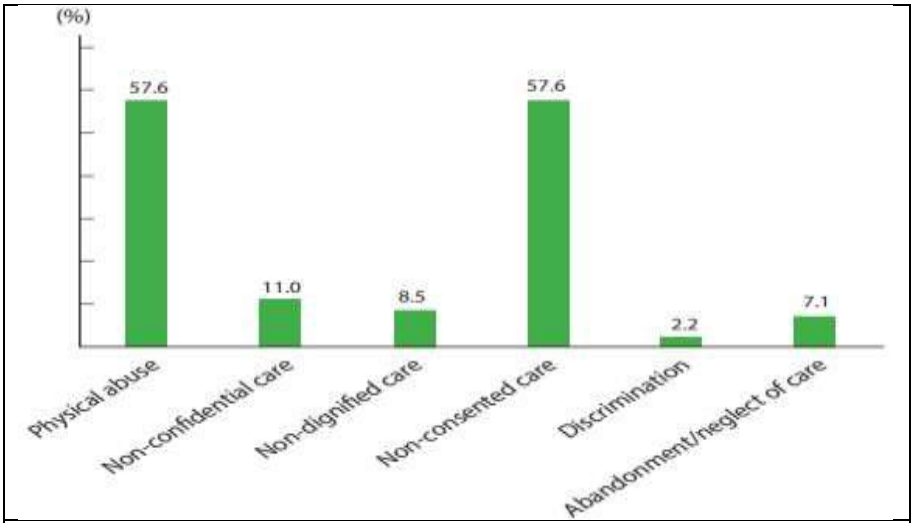


Fig: Frequency of disrespect and abuse by category during facility based childbirth in Bahir Dar Town, North west, Ethiopia[1]

2. INDIAN SCENARIO:

The number of maternal deaths remains large in India with 45,000 estimated deaths in 2013 [2]. Since 2006, the Government of India has promoted skilled attendance at birth and rapidly expanded the Janani Suraksha Yojana (JSY) programme that now benefits approximately 40% of India's birth cohort [3]. The JSY is a cash transfer programme that provides a monetary incentive to women attending institutions for birth [4]. Since 2013, JSY guidelines have been revised and conditionality's associated with parity and minimum age of the mother for institutional deliveries in high and low performing states and union territories have been removed.

However, recent evidence from JSY has been cautionary and highlights the need to improve Quality of Care (QoC), concomitantly, with efforts to increase utilization of institutional births [5]. Ensuring high QoC at the time of birth encompasses the application of evidence- based obstetric and neonatal care and efforts to ensure positive birth experiences for pregnant woman [6]. Respect, dignity and emotional support, although, integral to ensuring positive birth experiences have been overlooked in research, policy, programmes and practice [7, 8].

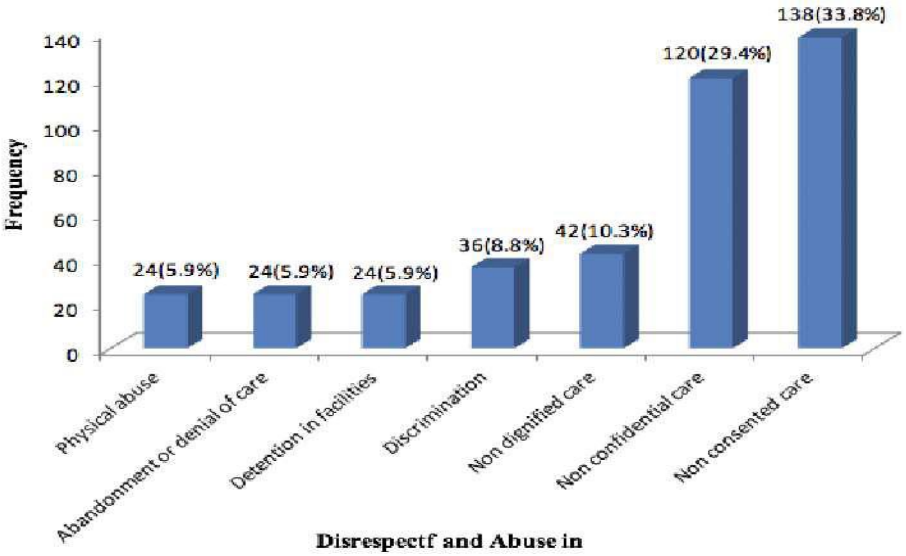


Fig: Disrespect and abuse during facility-based childbirth, Uttar Pradesh[9]

3. EVIDENCES:

There is now increasing research evidence on mistreatment of women during labour and childbirth from both high [10, 11, 12, 13, 14] and lower income settings [15, 16, 17]. Mistreatment has been previously described as disrespect and abuse [18], obstetric violence [19] and dehumanized care [20]. However, conceptualizing what constitutes mistreatment, and therefore, how to measure mistreatment are both complexes. A comprehensive definition of mistreatment needs to capture the health, human rights and socio-cultural dimensions of mistreatment, while,

measurement efforts need to capture what, where, how and why mistreatment occurs [21]. Freedman et al. have highlighted that measurement efforts should also be able to capture whether mistreatment was intentional or not, and the role of local societal norms (for example- women's status, patient-provider dynamics) that influences women's perceptions of mistreatment in different contexts [22].

Given these challenges, a recent WHO systematic review tried to establish the evidence-base for mistreatment globally [13]. They found that most studies use different operational definitions and measurement approaches [13]. Amongst the quantitative studies, only three studies reported a prevalence of mistreatment at maternity facilities, which varied from 15 to 98% [13]. This review also proposed a typology of items considered mistreatment and identified the following: physical, verbal or sexual abuse, stigma and discrimination, lack of informed consent, breaches of confidentiality, neglect and abandonment, refusal to provide pain relief, lack of supportive care, detainment in facilities, bribery and extortion [13].

However, a phenomenon often overlooked in the disrespect and abuse discourse relates to the overuse of inappropriate or unnecessary interventions for care at normal birth. There are examples of health workers in both high and low-income settings under using simple, inexpensive interventions (for example, birth companionship or counseling on breastfeeding) and overusing ineffective interventions that are more technical, lucrative or convenient despite potential for harm (for example: labour augmentation without indications or caesarean sections)

Some evidence suggests that ethnic minorities are at greater risk of experiencing D&A during facility-based childbirth. Other factors that might influence a woman's risk include parity, age and marital status. Women who have experienced or expect mistreatment from health workers may be less likely to deliver in a facility and to seek care in the future.

4. CARE FOR THE MOTHER:

The principles of care and respect during childbirth, and of women's rights during childbirth, are universal (McConville. *Midwifery* 2014:30:154–7). The relationship between women and the doctors, midwives and other birth attendants who care for them is crucial in upholding these principles. However, a WHO statement in 2014 points out that across the world, many women experience treatment that is neglectful, abusive and disrespectful, which violates their human rights and their rights to care. Such treatment infringes on the trust between women and healthcare providers and may deter women from accessing healthcare services Respectful maternity care (RMC) is not only a crucial component of quality of care; it is a human right. In 2014, WHO released a statement calling for the prevention and elimination of disrespect and abuse during childbirth, stating that "every woman has the right to the highest attainable standard of health, including the right to dignified, respectful care during pregnancy and childbirth." WHO also called for the mobilization of governments, programmers, researchers, advocates and communities to support RMC. In 2016, WHO published new guidelines for improving quality of care for mothers and newborns in health facilities, which included an increased focus on respect and preservation of dignity?

While a number of interventions have aimed to address this issue, many women around the world, including those living in high-income countries, continue to experience aspects of disrespectful and abusive care during childbirth. As facility-based birth and the use of skilled birth attendants continue to rise, a focus on quality and RMC remains critical for improving global maternal health.

5. CONCLUSION:

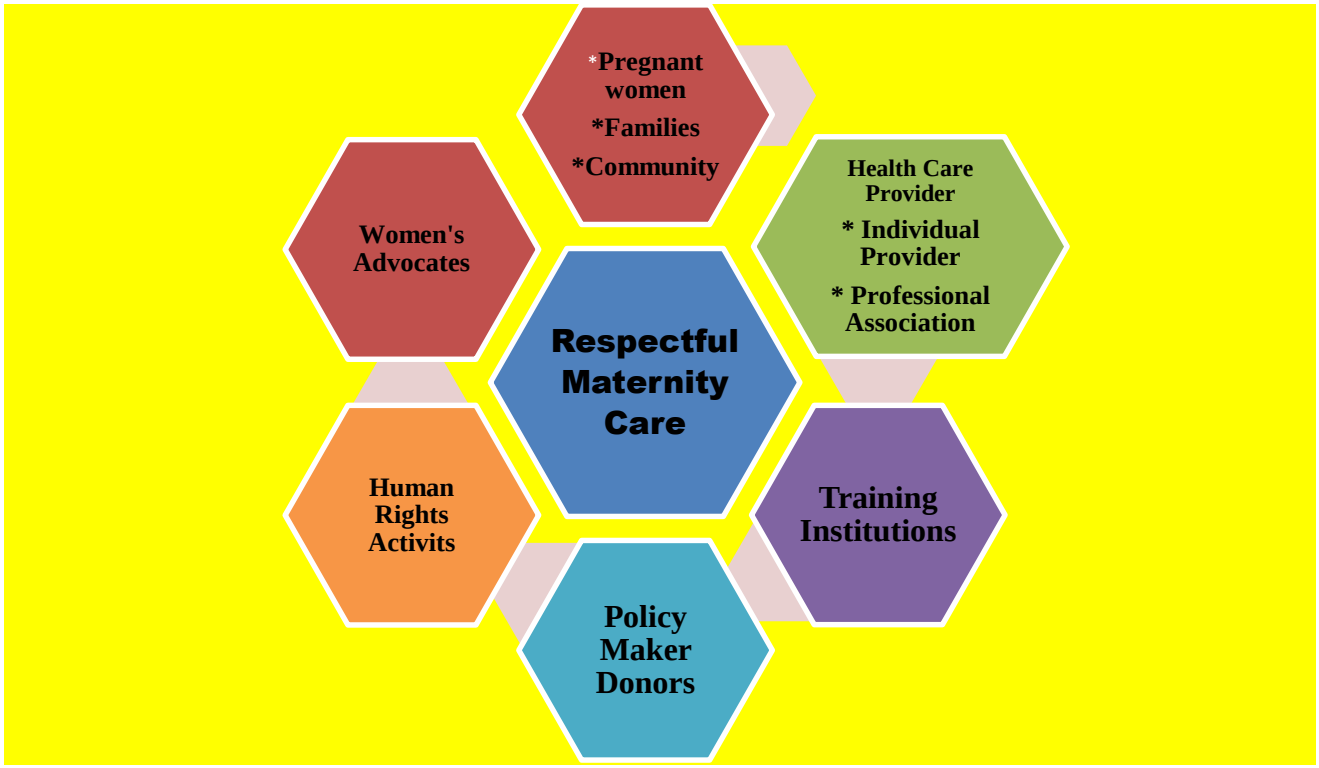
Mistreatment is common in both private and public sectors, albeit of different types. Efforts to expand institutional births in Uttar Pradesh and other high maternal and perinatal mortality settings would benefit from strengthening the quality of maternity care in both sectors so that evidence-based maternity care is provided, and positive births experiences are ensured. There are at least five specific recommendations emerging from this work. First, there needs to be a systematic and context-specific effort to measure mistreatment in high burden states in India in both public and private sectors. Second, a training initiative to orient all maternity care personnel to the principles of respectful maternity care would be useful. Third, systems to promote accountability for the application of respectful, woman-centred, maternity care pathways are needed. Fourth, participatory community and health system interventions need to be designed to articulate norms, standards of care and support the implementation of respectful maternity care standards. Lastly, we note that there needs to be a long-term, sustained investment in health systems so that supportive and enabling work-environments are

RESPECTFUL MATERNITY CARE

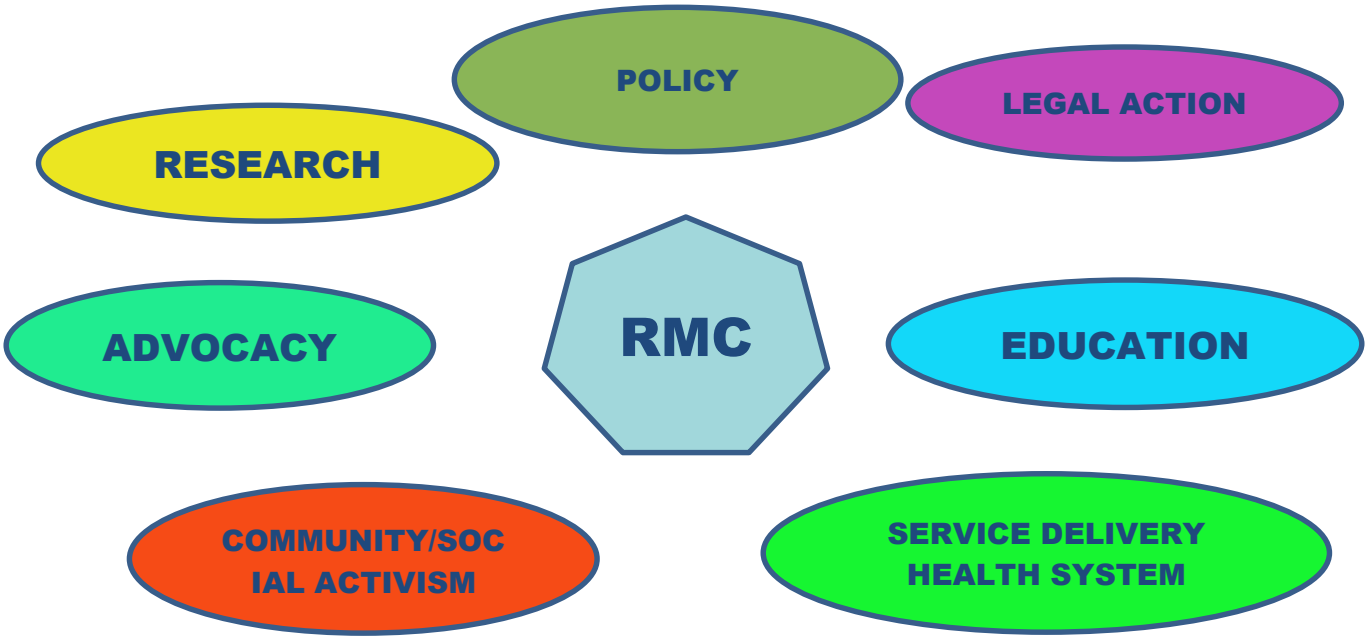
DIGNIFIED CARE
CONSENTED CARE
CONFIDENTIAL CARE

NON ABANDONMENT IN CARE
NO PHYSICAL ABUSE
NO ABUSE RELATED TO COST, INCLUDING DETENTION
EQUITY IN ACCESS

KEY STAKE HOLDERS IN RMC



KEY ACTION POINTS



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