Bulletin of Environment, Pharmacology and Life Sciences
Bull. Env. Pharmacol. Life Sci., Spl Issue [4] 2022 : 38-41

Online ISSN 2277-1808
Journal's URL:http://www.bepls.com
CODEN: BEPLAD

REVIEW ARTICLE **OPEN ACCESS**

Obstacles and Standards: Respectful Maternity Care

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ABSTRACT
One of the most crucial measures to preserve women's survival is to offer labouring moms caring and respectful maternity care services. However, both in practise and study, compassionate and respectful maternity care has gotten less attention. Recent research shows that poor maternal and infant outcomes are directly and indirectly related to disrespectful/abusive/coercive service delivery by professional clinicians in institutions, which results in actual or perceived poor quality of care. Beyond preventing illness or death, safe motherhood must also protect women's fundamental human rights, such as their autonomy, dignity, sentiments, and freedom of choice and preference. The aim of this article is to identify programme opportunities and difficulties that member organisations of the RMC Council and other peer organisations run into while operationalizing certain elements.
Key Word: *RMC, obstacles, postnatal mother, quality care.*

Received 02.10.2022 Revised 29.10.2022 Accepted 24.11.2022

INTRODUCTION

Every country and culture on earth views pregnancy and labour as crucial life events for women and their families as well as vulnerable periods. Women's rights during childbirth and the ideals of care and respect during childbirth are universal. Maintaining these values depends on the interaction between women and the medical professionals who care for them during childbirth, such as midwives [1]. But an alarming picture is being painted by a growing amount of data on women's experiences throughout pregnancy and delivery. During childbirth in institutions, many women all around the world encounter rude, abusive, or inattentive treatment. This is a betrayal of women's faith in their medical professionals and can be a strong deterrent to women seeking and using maternal health care services. While disrespectful and abusive behaviour against women is possible throughout pregnancy, labour, and the postpartum period, childbirth puts women at a higher risk. This type of behaviour could directly harm the mother and the child. [1] Even though there is a focus on giving birth in a birthing centre with trained professionals, many women still opt to give birth at home, in part because of the unsanitary conditions at birthing centres or because they feel they are being abused, coerced, or neglected there. International and national organisations have documented a lack of quality care and professional accountability at birthing facilities, as well as a variety of abuses, such as physical abuse, non-consented care, and discriminatory care, that have all been referred to as discourteous care during childbirth in facilities [2]. Denigration during labour and delivery has been linked to a barrier to using health facilities, according to a number of studies. Despite universal agreement that offering each pregnant woman RMC is a vital component of high-quality intrapartum care and a fundamental human right [3].

Evidence of mistreatment and contempt during delivery at a hospital: One in five women (n=644) who were interviewed as they left the postnatal ward of 13 Kenyan health institutions as part of a study10 to ascertain the incidence of disrespect and abuse following childbirth reported feeling embarrassed at some time. The survey also revealed that during labour and the first few weeks after delivery, 18% of these women had inhumane treatment, 14% were neglected or abandoned, 9% received non-confidential care, 8% were imprisoned, 4% were subjected to physical abuse, and 1% were approached for bribes. Nine out of 10 healthcare professionals reported hearing about or seeing fellow workers mistreat women. Despite the fact that a lack of equipment and supplies is listed as a factor in D&A, the data showed that facilities really contain the majority of the necessities for assisting women during delivery, with a mean score of 31 out of 35 for essentials.

The difficulties mother confronts

A key aspect of intrapartum respectful maternity care is respecting women's beliefs, independence, sentiments, dignity, and decisions to reserve their right to have a partner or practise their cultural traditions. Disrespect and abuse (D&A) breach fundamental ethical standards, human rights, and fundamental patient care duties. Because D&A may make birth an extremely painful event for the mother, there are occasions when caring for patients in a hospital is riskier than caring for them at home [2].

Challenges at the level of Provider:

Lack of consent: Linguistic and communication problems, along with prejudice, illiteracy, and pressed for time medical staff, can result in non-consensual health intervention. Many Syrian refugee women in Greece claim to have had hysterectomies and even caesarean sections performed without them being aware or permission.

Denial or delay of care: According to women interviewed in the West Bank and Gaza, there is a rise in births at home and at military crossings, and facilities are less able to function as a result of limited resources and restricted movement. There are reports of female soldiers being refused access to hospitals, resulting in their deaths at military checkpoints, and it has been discovered that military checkpoints prevent ambulances and women giving birth [7].

Issues with the presence of temporary foreign assistance workers in the health sector: Emergency response workers on short-term missions occasionally might not be culturally competent or might not have the time or resources to treat patients in a manner that is appropriate for their culture. Even if it is not the carers' purpose, labouring women may see care as disrespectful if it does not reflect or follow their cultural standards (for example, those related to gender, language, or power). They could be deterred from using services as a result. For example, in some situations, the presence of male medical professionals—such as translators or doctors—may be viewed as disrespectful and deter women from obtaining care.

Neglect and abandonment: Due to significant limitations of both human and material resources as well as prejudice, the likelihood of neglect and abandonment is probably higher in emergency situations. Because midwives and nurses were overburdened with patients in one study, In addition, the women typically drifted away the facility within hours of giving birth and were lost to follow-up, according to reports of Palestinian women who were left alone in the hospital for prolonged periods of time during labour, without even relatives to give assistance.

Challenges at the level of mother:

Lack of information: Women's ignorance about the locations of MNH services is a major worry at times of crisis. Insufficient time or resources may prevent providers from thoroughly outlining approaches or measures. However, women who are giving birth in a hospital for the first time could be less educated or have worries related to labour or interventions. Women's worries may be lessened by initiatives to inform, counsel, and, when practical, accommodate women's preferences.

Lack of privacy: Privacy concerns can be especially troubling in camp situations, where there is limited room and clinics are sometimes housed in one-room tents [5]. Because of the lack of privacy given by institutions, women were hesitant to seek medical attention during the disasters in Haiti and Pakistan [4].

Discrimination: Regardless of their racial or cultural heritage, economic class, social standing, amount of education, or place in society, all women are entitled to fair treatment. Inequality is never acceptable. Every patient has the right to be treated equally.

Physical abuse: There is a right to be free from mistreatment and damage. Physical abuse is defined as hitting, slapping, shoving, or even rough-housing a woman.

According to a survey done in Ethiopia, more than 4/5 of the women had experienced physical violence.

Non-Confidential Care: During the provision of services, patients have a right to privacy and confidentiality. The duty of the healthcare professional is to take all reasonable steps to maintain the mother and child's safety and privacy as well as their confidentiality. Each patient has a right to confidential care. More than half of the respondents to a study in south Ethiopia received non-confidential care, it was found.

Non-Dignified Care: They appreciate and regard every woman they take care of as a person. In their words, actions, and any other nonverbal communication, they must respect the dignity of every woman. Each patient or client has the right to dignified treatment [3].

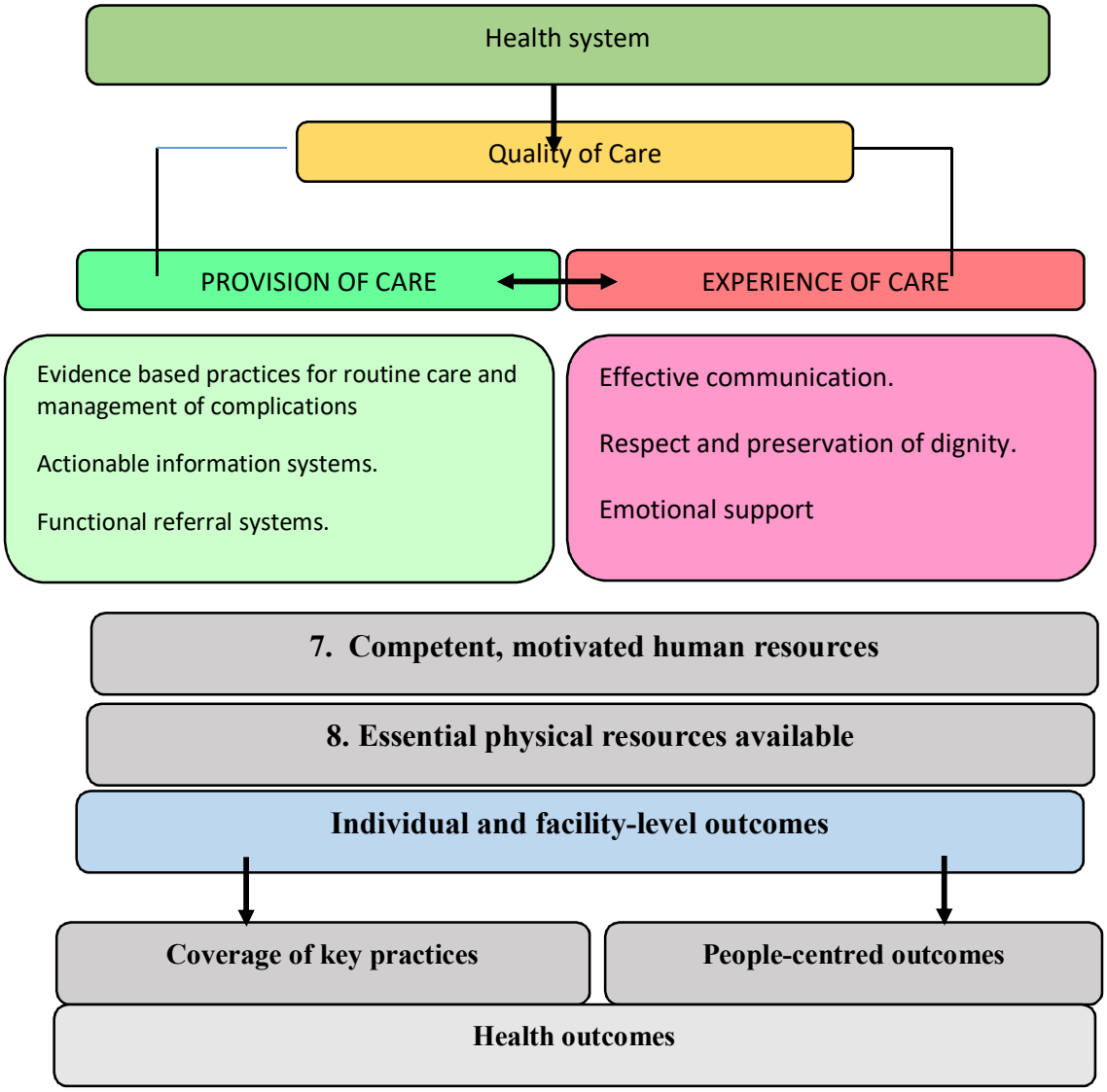
SPECIFICATIONS FOR IMPROVED MATERNAL AND NEWBORN CARE QUALITY IN A HEALTH FACILITY

Standard 1: According to WHO recommendations, each woman and infant get regular, research-based treatment and treatment of problems during labour, delivery, and the first several weeks after birth.

Standard 2: The usage of data is made possible by the health information system, ensuring that every woman and infant receive better care.

Standard 3: Each woman and new mother with a problem or conditions that cannot be adequately treated with the resources at hand are appropriately referred.
Standard 4: Efficient communication takes into account the needs and preferences of women and the families they are part of.
Standard 5: Care is given to pregnant women and babies while maintaining their integrity.
Standard 6: Every woman receives emotional assistance that is attentive to their requirements and builds the lady's capacity for her family.
Standard 7: Qualified and enthusiastic professionals are constantly accessible to give routine care and handle difficulties for every mom and infant.
Standard 8: The healthcare organization is physically suitable, has sufficient electricity, water, and sewerage supplies, as well as medications, necessary items, and equipment for managing problems and providing clinical services for pregnant women and newborns [3].

MODEL FOR WHO STANDARD PATIENT HEALTHCARE FOR MATERNAL AND NEWBORN HEALTH



CONCLUSION

In humanitarian situations, RMC is a woman's right, not a luxury. The shame, lack of respect, and isolation that certain women may encounter in humanitarian contexts should not extend beyond delivery. As an alternative, it may be a transformative event that inspires confidence in the future and creates responsive and resilient civilizations. To enable midwives to deliver RMC services, which will include emotional support, courteous care, and open communication, the government and hospital management must make the required adjustments to address current issues while enhancing the existing supporting activities. This will help in reducing the need for maternal and newborn care and also enhance the quality of care given by midwives and other healthcare professionals.

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CITATION OF THIS ARTICLE

Sonam, Banapriya Shahoo, Shalu Obstacles and Standards: Respectful Maternity Care. Bull. Env.Pharmacol. Life Sci.,Spl Issue [4] 2022 : 38-41