Review Article

Respectful maternity care: A national landscape review

HUMAIRA ANSARI, RAJIV YERAVDEKAR

ABSTRACT

Respectful maternity care is a fundamental right of every childbearing woman. It contributes to ensuring a positive outcome for mothers as well as newborns, and aims to address health inequalities. However, studies have reported a high prevalence of disrespect and abuse in India, and have shown that the quality of care has been overlooked at all levels including research, policy, programme and practice. The lack of respectful maternity care results in failure in accessing institutional services. Thus, it is essential to design context-specific and evidence-based interventions as well as formulate policies and programmes to reduce disrespectful maternity care.

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INTRODUCTION

Pregnancy and childbirth are phases when a woman is extremely vulnerable. A woman's safety during this period is related not only to maternal mortality but also to the provision of quality of care and services.[1] 'Respectful maternity care (RMC) is a universal and fundamental right of every childbearing woman. This includes respect for women's dignity, autonomy, empathy, privacy, confidentiality, feelings, choices and preferences, including companionship during maternity care and continuous care during labour and childbirth. It ensures that there is no harm and ill-treatment.'[2] However, the quality of reproductive care remains deficient in many countries. Disrespectful care including physical abuse, non-consented care, non-dignified care, non-confidential care, discrimination, abandonment or denial of care, and detention in facilities are prevalent in many settings globally, especially among the underprivileged population.

RMC is applicable to all stages of pregnancy, including the antepartum, intrapartum and postpartum periods. A woman has the right to seek treatment and deserves the same respect during all phases.[1] In 2010, a landscape analysis traction report by Diana and Hill suggested the seven-category model of disrespect and abuse during facility-based childbirth.[2] In its support, the White Ribbon Alliance released the first consensus document 'The Respectful Maternity Care Charter: The universal rights of childbearing women' in 2011, stating that dis-RMC is a violation of human rights.[1] In 2014, WHO declared this an emerging public health problem and also published a statement on prevention as well as elimination of disrespect and abuse during childbirth at facilities.[3,4] The WHO quality of care framework states that quality of care should be safe, effective, timely, efficient, equitable and people-centred.[5] In 2014, WHO, International Federation of Gynaecology and Obstetrics and the International Confederation of Midwives endorsed RMC and collaborated to ensure 'Mother–Baby Friendly Maternities'.[1]

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PURPOSE

This review aims to further guide the debate on the formulation of policies on RMC for various health settings in India. We discuss the importance of RMC and emphasize that disrespectful care and ill-treatment are problems that need to be addressed through all domains of research including public health, quality control, management and human rights. RMC depends on multiple factors such as structural inputs, processes, policies and programmes, user and provider perspectives, as well as needs and expectations.[5] These rights are mentioned in various international rights instruments including those of the United Nations and other declarations, conventions and covenants.[1] Policy-makers and public health professionals will thus play an important role in its implementation.

IMPORTANCE OF RESPECTFUL MATERNITY CARE

Women's experiences during this vulnerable time may play a key role in empowering them or leading to negative feelings resulting in lack of confidence and self-esteem. These experiences stay with the mother throughout her lifetime. They also have consequences on the health of the mother and her newborn. Studies have reported an effect on the cognitive development of the foetus if the mother experiences ill-treatment and abuse during pregnancy.[6] RMC is a cost-effective and impactful strategy for reducing stillbirths, maternal and neonatal deaths. The WHO quality of care framework states that quality of care is important in achieving person-centric outcomes. Unscientific birth practices, non-evidence-based interventions, harm and ill-treatment weaken the innate childbirth capabilities of women, due to a feeling of guilt, anxiety and depression, thereby reducing equity and wasting resources.[3] The lack of RMC shows a major health system failure. Factors such as health system constraints and failures play an important role to ensure the quality of care.[7]

Respectful maternity care in developed and developing countries

Recent studies as well as systematic reviews have shown that women experience ill-treatment and abuse globally. A systematic

review reported the prevalence of ill-treatment from 15% to 98%.[8] It also reported that globally women experience physical abuse, verbal abuse, stigma, neglect, threats, discrimination based on certain characteristics, detainments, lack of privacy, bribery and lack of essential supplies at health facilities.[7,8] In Tanzania and Nigeria, the prevalence of disrespect and abuse was reported to be 19% and 98%, respectively.[8] The Heshima Project from Kenya showed that 1 of 5 women feel humiliated, and 9 of 10 healthcare providers have reported that women are not treated humanely.[9] A systematic review from Ethiopia reported a pooled prevalence of 49.4% for disrespect and abuse.[10] In Lebanon, women have reported that they are tied during labour. Similar findings have been reported from countries such as Iran, Italy, Tanzania, Ghana, Canada, Norway, Brazil, Sweden, Australia, Japan, etc.[7,8] A systematic review of migrant women from Europe has also reported disrespect and abuse.[11] Non-consented care, disrespect, abuse and other forms of ill-treatment have been reported from countries in Africa, Asia, America, Oceania and Europe.[8] RMC is a neglected topic and its operational definition varies across the globe.[8]

INDIAN SCENARIO OF RMC

Sub-Saharan Africa and South Asia contributed to 86% of global maternal deaths in 2013, of which the number of maternal deaths in India was estimated to be 50 000 accounting for 17% of the total deaths.[12] Institutional deliveries have been promoted to reduce maternal mortality and morbidity by providing cash incentives to the mothers. In India, the Janani Suraksha Yojana (JSY), a government scheme, which provides cash incentives to mothers, benefits 40% of women.[13–17] However, there are reports that dignity and respect are compromised at health facilities.[18] A systematic review has identified the pooled prevalence in India to be 71.31%.[19] The prevalence reported in community-based studies was 77.32% and in hospital-based studies it was 65.38%.[19] Studies have shown the prevalence of ill-treatment, disrespect and abuse at various settings including the public sector, private sector and high- and low-income settings in India. The key problems identified are lack of privacy and confidentiality, disrespect of choice to be in a comfortable position, lack of access to basic health facilities, medical care and prompt care, poor intrapartum and postpartum care and assessment, neglect, care provided by unskilled or incompetent staff, lack of communication and other infrastructural problems such as lack of cleanliness, hygiene, water, electricity and crowded rooms.[20–22] Physical abuse, verbal abuse, assault, lack of emotional and cognitive support, separation from baby, lack of food, incentives, transport, informal payments, failure to provide adequate information, non-consented care and performance of unnecessary procedures are also prevalent in different settings. Lack of dignity, equity, disrespect and detainment at health facilities are reported from the recent studies.[20–32] A study conducted in Uttar Pradesh showed that 100% of women experience some form of ill-treatment.[33] Studies have shown the prevalence of ill-treatment ranging from 20.9% to 100%.[19] Some common challenges identified by the users and providers were lack of medicine and supplies, water and electricity, availability of specialist and female doctors, poor infrastructure and post-delivery counselling. The common problems identified by providers were poor referral management, vacant positions leading to lack of human resources, inadequate incentives, poor infrastructure, absence of blood banks and poor cooperation from users.[24,34–36] Findings from a study conducted in Assam show that episiotomies are performed routinely even at times without anaesthesia, while WHO recommends that no more than 10% should be given episiotomies.[37] It is necessary to follow evidence-based practice and train healthcare providers. For all these reasons, women prefer to deliver at home or at private hospitals, and go to the health facility late or leave soon after delivery.[38–43] Studies have shown that the respect, dignity, privacy and sharing of information are not considered important and part of quality care by providers.[35,44] These studies on perception of stakeholders, infrastructural issues, JSY, quality of care and prevalence have been conducted in Jharkhand, Haryana, Gujarat, Maharashtra, Chhattisgarh, Kashmir, New Delhi, Odisha, Karnataka, Meghalaya, Andhra Pradesh, Madhya Pradesh, Rajasthan, Uttar Pradesh and Bihar. However, most of the studies are from Uttar Pradesh, the findings of which cannot be generalized to the entire country. Only a limited number of studies focus on qualitative and quantitative aspects of RMC. The prevalence estimates are inconsistent. Information on RMC from qualitative and quantitative aspects is essential for developing context-specific policies and programmes. There is a gap between the recommended quality of care and what is delivered.[20,45,46] The data show that there are limited tools for assessment of RMC[47,48] and different studies have adopted different tools of assessment.

Susceptible population

Studies have identified that women who are economically disadvantaged, illiterate, belong to the backward castes, migrants, from rural areas, suffer from comorbid conditions, adolescents and unmarried—are at a higher risk of facing dis-RMC.[34,37] Women are also discriminated on the basis of language and religion.[8] Women who are not empowered, silently accept any form of treatment, do not demand quality care, are afraid to ask questions and blame themselves for lack of knowledge.

Regulations and policies

India does not have specific policies and programmes for RMC, although these rights are mentioned in various international declarations. The Ayushman Bharat Scheme,[49,50] a new initiative to ensure universal health coverage in the country, should focus on the quality of care provided under this scheme. The interventions and policies in African countries have shown that the development of policies and simple interventions when implemented across systems help in the reduction of disrespect and abuse, and raise the standards of care and satisfaction among women.[51] Similarly, multi-component policies need to be implemented in India.

GOALS

RMC will help in achieving the Sustainable Development Goals, namely good health, well-being and reduced inequalities.

Actions required/recommendations

Some recommendations for delivering multifactorial RMC are:

1. To increase awareness about RMC among various stake-holders including women, healthcare providers, regulators and policy-makers with the involvement of public health experts as educators and advocates.
2. To seek feedback from experts to tackle the issue of disrespect.

3. To implement regulatory policies and programmes by formulating standardized protocols, operational plans and guidelines for different health settings.
4. To ensure women autonomy and empowerment by instituting mechanisms of accountability based on women's experiences.
5. To ensure outcome-based quality care that addresses concerns of stakeholders with a positive deviance approach. This will help in understanding whether or not a certain approach in the implementation of RMC will be feasible, acceptable and relevant to a specific context.
6. To address infrastructural barriers, although non-availability of resources should not inhibit the implementation of RMC through other approaches.
7. To demand greater accountability from higher authorities.
8. To have a mechanism for monitoring and evaluation to identify input, output, impact and benefit of policies and programmes.
9. To establish redressal and grievance cells at all hospitals.
10. To conduct audits and exit interviews and get feedback from clients to identify barriers and for utilization of services and quality.
11. To improve quality through partnerships and community involvement.
12. To forge joint efforts by various stakeholders, policy-makers, government authorities, United Nations, non-governmental organizations, public and private health facilities and women's groups to help achieve the desired standard of RMC.

THE PROBLEMS AND CHALLENGES

In a diverse country such as India, with a high prevalence of disrespect and abuse across settings, it is a challenge to address the concerns of stakeholders and implement context-specific programmes and policies. The term RMC has been conceptualized differently in different settings. The methodologies adopted in various studies to study RMC are inconsistent. The main barriers are the definition, assessment and measurement of RMC. Context-specific and evidence-based guidelines are lacking. Officially reported cases of disrespect, abuse and ill-treatment represent only the tip of an iceberg. Underequipped health systems, inadequate staff, insufficient supplies, lack of infrastructure and inadequate pay of healthcare personnel are barriers to the implementation of RMC.[52]

FUTURE RESEARCH

1. To develop and validate tools to assess and measure RMC for Indian settings
2. To assess the prevalence of disrespect and abuse using standardized methodologies
3. To develop appropriate policies and programmes
4. To develop evidence-based interventions
5. To examine the similarities and differences in perspectives and experiences of various stakeholders to provide evidence, based on which standards, protocols and guidelines can be designed, and policies and programmes can be implemented effectively. It will further help in identifying drivers to access of care and utilization of the care, thus helping and supporting other researchers, policy-makers and public health professionals in making informed decisions and establishing and implementing mechanisms for accountability.
6. To implement and study short-term and long-term effects of policies.

CONCLUSION

Designing tailored interventions, policies and programmes for various dynamic systems and regular monitoring and evaluation will help in achieving RMC at the national level. Only when steps are taken for implementation can the effects be studied. This will not only address maternal mortality through the delivery of care but also focus on the quality of care with a more defined and standardized approach.

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