

Review Article

Dignity and respectful maternity care as an essential step towards universal health coverage

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Received: 29 July 2022

Revised: 08 September 2022

Accepted: 09 September 2022

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ABSTRACT

Most women experience disrespect and abuse in delivery rooms instead of support, and respect. Disrespect and abuse of women seeking maternity care are becoming an urgent problem and creating a growing community of concern that spans the domains of healthcare research, quality, and education; human rights; and civil rights advocacy. Deprivation of respectful mother care is an important cause of traumatic childbirth experiences as much as inadequate care make mothers feel that they are forced to be in the delivery bed, exposed, and left with no help. Good communication between parturient and care provider is associated with higher patient satisfaction with care and safety. All maternity care personnel should take cognizance of the issue of respectful maternity care and take appropriate corrective measures. By providing respectful maternity care we will take a concrete step ahead toward the attainment of universal health coverage.

Keywords: Respectful maternity care, Parturients, Maternity care provider, Disrespect and abuse

INTRODUCTION

Most women experience disrespect and abuse in delivery rooms instead of support, and respect.^{1,2} In different studies, the prevalence ranges from 15 to 98%.^{3,4} Lack of respectful mother care is an important cause of traumatic childbirth experiences. Mothers feel that they are forced to be in the delivery bed, exposed, and left with no help. Women perceive such care with fear and helplessness. They also experience a lack of proper communication from caregivers during labor and childbirth as a feeling of loneliness, fear, lack of support, and violence along with insecurity.⁵ A remarkable amount of research evidence, sharing of experience, and several case reports regarding maternity care systems from the wealthiest to poorest nations worldwide show a different and disturbing scenario. The disrespect and abuse of women seeking maternity care is becoming a pressing issue. Its concern is

growing in field of healthcare research, quality, and education; human rights; and civil rights advocacy. The disrespect and abuse mothers face during maternity care can take many forms as subtle disrespect and humiliation to overt violence; they include physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), and discrimination based on specific patient attributes, abandonment or refusal of care, and confinement in facilities.⁶ These episodes prevent the achievement of complete physical, mental and social wellbeing among parturients and lead to ill health and its consequences presenting as major hindrance to universal health coverage (UHC). Evidence suggest that in the absence of quality care, increasing institutional delivery alone is insufficient to reduce maternal mortality and other negative health consequences.⁷ We discuss here some of the factors associated with disrespect and abuse during care of parturients.

METHODS

This study is based on a comprehensive literature search on PubMed and Google scholar utilizing the keywords respectful maternity care (RMC), disrespect and abuse, parturients and a combination of related terms. We searched and explored for valuable information in research papers that discussed the information about maternity care related issues. Only English language, free access, full text articles were included in the study.

DISCUSSION

There is now enough evidence on mistreatment of women during labour and childbirth from low as well as high income countries across the globe.⁸⁻¹⁰ Mistreatment has been described as disrespect and abuse, scolding and violence during childbirth, abandonment, lack of privacy, examination without prior information and proper consent and at times inhumane treatment of parturients. In a study conducted in India, mistreatment was found both in public and private sector.¹¹ Another study found 74.7% of the participants reporting one or more types of disrespect and abuse.¹²

Underlying causes

Beck et al identified the factors such as lack of proper communication between healthcare providers and mothers, limited or no attention to women's feelings, lack of privacy, inability to instill a sense of security in women, lack of empathy, lack of sufficient resources and high patient load responsible for lack of RMC.¹³ Poor and rural women who deliver in hospitals face ridicule because of poverty, sub-standard clothing, poor personal hygiene, and cries of pain. Women complained about feeling rushed by midwives and doctors to deliver within a certain time frame and often having their cultural wishes denied, such as upright birthing positions and having a trusted family member present.¹⁴ Providers' knowledge at times become a barrier in providing RMC.¹⁵ In a study conducted in Tanzania, disrespect was reported by more educated and poor women.¹⁶

Impact of failure to provide respectful mother care

The negative behavior of health workers towards women in the delivery room increases the fear of vaginal birth and cesarean section. Disrespect and abuse can also cause long-term injuries and emotional traumas.¹⁷ As women are more physiologically, socially, and psychologically vulnerable during the childbirth process, neglect and abuse could exacerbate maternal psychological problems including sleep difficulty and post-traumatic stress disorder (PTSD).¹⁸⁻²⁰ Postpartum psychological trauma can occur for various reasons, e.g. psychological distress (fear) during labor and delivery, obstetric complications (dystocia and emergency C-section), or the negative outcomes of pregnancy and childbirth (stillbirth and infant death). These traumas can result from physical or mental

injuries after childbirth.^{21,22} Fear of neglect and abuse by health workers sometimes prevents parents from using the necessary facilities for birth care.²³ Women, especially in rural areas, place particular trust in traditional birth attendants, who often play a respectful role in local births for many years and are seen as an integral part of motherhood.²⁴ These factors hinder institutional deliveries and contribute to poor perinatal outcomes.

Management strategies and coping mechanisms

Equal and fair access to healthcare was the center of debate in past but now a greater emphasis is focused on dignity, respect and autonomy for women who do utilize healthcare facilities. All childbearing women need and deserve respectful care and protection of their autonomy; this includes special care to protect the mother-baby in a context of marginalization or heightened vulnerability (e.g., adolescents, ethnic minorities, and women living with physical or mental disabilities or HIV). Furthermore, disrespect and abuse during maternity care is a violation of women's basic human rights. In 2018, the World Health Organization (WHO) published some recommendations on how to ensure adequate and correct intrapartum care for positive birth experiences, emphasizing the importance of respectful maternity care.²⁵ A study in Nepal found that women who discussed family planning with their partners and had higher levels of education were more likely to receive skilled prenatal and delivery care.²⁶ This can contribute to obtaining better health services, including maternity care. Good communication between mother and care provider was found to be associated with higher patient satisfaction with care and safety.²⁷ All maternity care staff should be aware of the issue of RMC and take appropriate corrective measures. There should be regular scrutiny and feedback from parturients availing maternity services to know their concerns and tailor management strategies accordingly. Vyas et al in their narrative review focused on determinants of maternal satisfaction and stressed on provision of quality maternal care.²⁸ It should be emphasized that providing RMC to parturients is a moral, social and professional responsibility of service provider. By providing respectful maternity care, we will take a concrete step towards universal health coverage.

CONCLUSION

The concept of safe motherhood, therefore, needs to be expanded beyond the prevention of morbidity or mortality during child birth. It must include respect for women's basic human rights, including women's autonomy, dignity, feelings, choices and preferences, including accompaniment during maternity care. A good relationship and communication between the mother and health professional is essential for achieving RMC. Appropriate informed consent should be obtained before doing any intervention to parturient. Education and empowerment of women can be helpful in providing respectful maternity care. Universal health coverage would be possible only by providing respectful maternity care.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

REFERENCES

- Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, Aguiar C, Coneglian FS, Diniz AL, Tunçalp Ö, Javadi D. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med*. 2015;12(6):e1001847.
- Abuya T, Warren CE, Miller N, Njuki R, Ndwiga C, Maranga A, Mbehero F, Njeru A, Bellows B. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PloS One*. 2015;10(4):e0123606.
- Sando D, Ratcliffe H, McDonald K, Spiegelman D, Lyatuu G, Mwanyika-Sando M, Emil F, Wegner MN, Chalamilla G, Langer A. The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. *BMC Pregnancy Childbirth*. 2016;16(1):1-10.
- Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. *Int J Gynecol Obstet*. 2015;128(2):110-3.
- Schroll AM, Kjærgaard H, Midtgaard J. Encountering abuse in health care; lifetime experiences in postnatal women-a qualitative study. *BMC Pregnancy Childbirth*. 2013;13(1):1-1.
- Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth: report of a landscape analysis. USAID-TRAction Project. 2010.
- Randive B, Diwan V, De Costa A. India's conditional cash transfer programme (the JSY) to promote institutional birth: is there an association between institutional birth proportion and maternal mortality? *PloS One*. 2013;8(6):e67452.
- Vedam S, Stoll K, Rubashkin N, Martin K, Miller-Vedam Z, Hayes-Klein H, Jolicoeur G. The mothers on respect (MOR) index: measuring quality, safety, and human rights in childbirth. *SSM-population health*. 2017;3:201-10.
- Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: a systematic review. *PloS One*. 2017;12(3):e0174084.
- Warren C, Njuki R, Abuya T, Ndwiga C, Maingi G, Serwanga J, et al. Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya. *BMC Pregnancy Childbirth*. 2013;13(1):1-9.
- Sharma G, Penn-Kekana L, Halder K, Filippi V. An investigation into mistreatment of women during labour and childbirth in maternity care facilities in Uttar Pradesh, India: a mixed methods study. *Reprod Health*. 2019;16(1):1-6.
- Hajizadeh K, Mirghafourvand M. Relationship of post-traumatic stress disorder with disrespect and abuse during childbirth in a group of Iranian postpartum women: a prospective study. *Ann Gen Psychiatry*. 2021;20(1):1-8.
- Beck CT. Birth trauma: in the eye of the beholder. *Nursing Res*. 2004;53(1):28-35.
- Kwagala B. Birthing choices among the Sabiny of Uganda. *Culture, Health Sexuality*. 2013;15(3):S401-14.
- Afulani PA, Buback L, Kelly AM, Kirumbi L, Cohen CR, Lyndon A. Providers' perceptions of communication and women's autonomy during childbirth: a mixed methods study in Kenya. *Reproductive Health*. 2020;17(1):1-7.
- Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP. Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. *Health Policy Planning*. 2018;33(1):26-33.
- Hajizadeh K, Mirghafourvand M. Relationship of post-traumatic stress disorder with disrespect and abuse during childbirth in a group of Iranian postpartum women: a prospective study. *Ann Gen Psychiatry*. 2021;20(1):1-8.
- Kruk ME, Paczkowski M, Mbaruku G, De Pinho H, Galea S. Women's preferences for place of delivery in rural Tanzania: a population-based discrete choice experiment. *Am J Public Health*. 2009;99(9):1666-72.
- Madeira S, Pileggi V, Souza JP. Abuse and disrespect in childbirth process and abortion situation in Latin America and the Caribbean—systematic review protocol. *Systematic Rev*. 2017;6(1):1-5.
- Swahnberg K, Schei B, Hilden M, Halmesmäki E, Sidenius K, Steingrimsdottir T, Wijma B. Patients' experiences of abuse in health care: a Nordic study on prevalence and associated factors in gynecological patients. *Acta obstetrica et gynecologica Scandinavica*. 2007;86(3):349-56.
- Stramrood CA, Wessel I, Doornbos B, Aarnoudse JG, Van den Berg PP, Schultz WW, Van Pampus MG. Posttraumatic stress disorder following preeclampsia and PPRM: a prospective study with 15 months follow-up. *Reprod Sci*. 2011;18(7):645-53.
- Beck CT, Driscoll J. Postpartum mood and anxiety disorders: A clinician's guide. Jones & Bartlett Learning. 2006.
- Anastasi E, Borchert M, Campbell OM, Sondorp E, Kaducu F, Hill O, Okeng D, Odong VN, Lange IL. Losing women along the path to safe motherhood: why is there such a gap between women's use of antenatal care and skilled birth attendance? A mixed methods study in northern Uganda. *BMC Pregnancy Childbirth*. 2015;15(1):1-5.
- Dantas JA, Singh D, Lample M. Factors affecting utilization of health facilities for labour and childbirth: a case study from rural Uganda. *BMC Pregnancy Childbirth*. 2020;20(1):1-0.
- World Health Organization. WHO recommendations: intrapartum care for a positive

- childbirth experience. Geneva: World Health Organization. 2018.
26. Furuta M, Salway S. Women's position within the household as a determinant of maternal health care use in Nepal. *International family planning perspectives*. 2006;17-27.
27. Oliveira VC, Refshauge KM, Ferreira ML, Pinto RZ, Beckenkamp PR, Negrao Filho RF, Ferreira PH. Communication that values patient autonomy is associated with satisfaction with care: a systematic review. *J Physiotherap*. 2012;58(4):215-29.
28. Vyas H, Mariam OJ, Bhardwaj P. Maternal satisfaction among mothers delivering at public health facilities in India: a narrative review. *Int J Comm Med Public Health*. 2022;9(7):1.

Cite this article as: Khan IA, Aditya V, Mishra R, Tiwari HC. Dignity and respectful maternity care as an essential step towards universal health coverage. *Int J Community Med Public Health* 2022;9:3898-901.