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AN EXAMINATION OF THE CURRENT STATE OF RESPECTFUL MATERNITY CARE ON A NATIONAL SCALE

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ABSTRACT:

Every woman who is or might become pregnant has the inherent right to receive respectful maternity care. It helps to ensure a healthy result for both moms and infants, and it tries to alleviate health disparities in the process. However, studies have reported a high prevalence of disrespect and abuse in India, and they have shown that the quality of care has been overlooked at all levels, including research, policy, programme, and practise. This is a problem because disrespect and abuse are two of the most common forms of interpersonal violence. When maternity care is not provided in a respectful manner, women are unable to use institutional services. As a result, it is vital to establish interventions that are appropriate to the setting and based on data, in addition to formulating policies and programmes, in order to decrease disrespectful maternity care.

Keywords: Respectful Maternity Care, India, Maternity Care

INTRODUCTION:

The periods of pregnancy and labour are times in a woman's life when she is at her most vulnerable. Not only is there a correlation between maternal mortality and the quality of care and services that are provided during this time period, but there is also a connection between the two [1]. Every woman who is capable of carrying children has the inherent and unalienable right to receive respectful maternity care. 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. Also included in this category is the provision of companionship during maternity care. It guarantees that there will be neither injury nor inhumane treatment. 2 However, in a great number of nations, the standard of

reproductive health care is still subpar. Disrespectful care, which can include physical abuse, non-consented care, non-dignified care, no confidential care, discrimination, abandonment or denial of care, and detention in facilities is common in many settings around the world, particularly among the population that is economically disadvantaged.

The RMC may be used throughout any stage of pregnancy, including the antepartum, intrapartum, and postpartum phases. A woman always retains the right to seek medical attention and is entitled to the same level of respect throughout her life [1]. In 2010, Diana and Hill published a report on the landscape analysis traction that proposed the seven-category model of disrespect and abuse that occurs during facility-based birthing [2]. In 2011, the White Ribbon Alliance published the first consensus statement entitled "The Respectful Maternity Care Charter: The universal rights of childbearing women," in which they said that dis-Respectful Maternity Care is a violation of human rights. This was done in support of their cause. In 2014, the World Health Organization (WHO) identified this issue as an emerging public health problem and published a statement on the prevention as well as the 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-centered [5]. In 2014, the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics, and the International Confederation of Midwives all partnered to assure "Mother–Baby Friendly Maternities" and approved RMC in the process. PURPOSE The purpose of this study is to contribute to the ongoing discussion on the development of policies for RMC for a variety of health settings in India. In this paper, we highlight the significance of RMC and place an emphasis on the fact that inhumane care and treatment are issues that need to be addressed in various areas of research, including public health, quality control, management, and human rights. RMC is contingent on a wide variety of elements, including structural inputs, procedures, regulations, and programmes, the views of both users and providers, as well as needs and expectations. These rights are acknowledged in a variety of international rights instruments, such as those ratified by the United Nations as well as several additional declarations, treaties, and covenants [1]. Therefore, those responsible for making policies and experts working in public health will play a vital role in its implementation.

IMPORTANCE OF RESPECTFUL MATERNITY CARE:

The experiences that women have when they are at their most vulnerable may play a significant influence in either empowering them or contributing to negative sentiments that culminate in a lack of self-confidence and esteem. These are the kinds of things that will stick with the mother for the rest of her life. They also have an effect on the mother's health as well as the health of the newborn child. Researchers have shown that when a woman is mistreated or abused while she is carrying her child, this may have a negative impact on the cognitive development of the unborn child [6]. RMC is a method that is both cost-efficient and successful in lowering stillbirths as well as maternal and newborn mortality rates. According to the WHO quality of care framework, it is essential to provide high-quality care if one wishes to realise person-centered results. Due to feelings of shame, worry, and sadness, unscientific birth practises, non-evidence-based treatments, injury, and ill-treatment diminish the intrinsic childbearing capacities of women, hence lowering equality and squandering resources [3]. A significant flaw in the functioning of the health system is shown by the absence of RMC. [7] Ensuring the quality of medical treatment is significantly impacted by a variety of factors, including limitations and breakdowns in the healthcare system.

Respectful Maternity Care in Developed and Developing Countries:

Recent research as well as systematic reviews have both indicated that women all across the world are subjected to abusive and degrading treatment. According to the findings of a comprehensive study, the percentage of people who have been mistreated ranges from 15 to 98 percent. 8 It was also noted that women throughout the world face a variety of challenges, including physical violence, verbal abuse, stigma, neglect, threats, discrimination based on particular features, detainments, a lack of privacy, bribery, and a lack of critical supplies at health facilities [8]. It was claimed that the prevalence of disrespect and maltreatment was 19 percent in Tanzania and 98 percent in Nigeria, respectively. Tanzania is located in Africa. According to the findings of the Heshima Project in Kenya, one out of every five women experience feelings of humiliation, and nine out of ten healthcare practitioners have claimed that women are not treated in a humane manner [9]. A comprehensive study that was carried out in Ethiopia found that the overall prevalence of disrespect and maltreatment was 49.4 percent [10]. Women in Lebanon have claimed that they are restrained in some way during giving birth. Countries as diverse as Iran,

Italy, Tanzania, Ghana, Canada, Norway, Brazil, Sweden, Australia, and Japan, among others, have all reported discovering something along the same lines. A comprehensive study of migrant women from Europe found that many of them had experienced both disrespect and abuse [11]. There have been reports of nations in Africa, Asia, America, Oceania, and Europe engaging in non-consented care, disrespecting patients, abusing patients, and other sorts of illtreatment. 8 RMC is a subject that receives insufficient attention, and its practical meaning differs greatly around the world [8].

INDIAN SCENARIO OF RMC:

In 2013, Sub-Saharan Africa and South Asia were responsible for 86 percent of all maternal fatalities worldwide. It is estimated that there were 50,000 maternal deaths in India, which accounted for 17 percent of all maternal deaths worldwide. Through the provision of monetary incentives to the mothers, hospital births have been encouraged with the goal of lowering the rates of maternal death and morbidity. A government programme known as the Janani Suraksha Yojana (JSY) offers financial incentives to mothers in India [13]. This programme helps forty percent of the country's female population. On the other hand, there are complaints that dignity and respect are not always respected in health care institutions [14]. After doing extensive research, researchers found that the overall frequency in India was 71.31 percent. Research conducted in the community revealed a frequency of 77.32 percent, but studies conducted in hospitals reported a prevalence of 65.38 percent. Research conducted in India has demonstrated that poor treatment, disrespect, and abuse are all too common in a variety of contexts, including the public sector, the commercial sector, as well as high-income and low-income settings. 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 are the primary issues that have been identified. Other issues include a lack of access to basic health facilities, medical care and Abuse of different kinds, including physical abuse, verbal abuse, assault, a lack of emotional and cognitive support, separation from baby, lack of food, lack of incentives, lack of transportation, lack of formal payments, failure to provide adequate information, non-consented care, and the performance of unnecessary procedures are all commonplace in various settings.

Recent investigations have shown that people are detained at health care institutions, treated with disdain, and denied their right to dignity. According to the findings of a survey that was carried out in Uttar Pradesh, one hundred percent of women are subjected to some type of mistreatment. According to the findings of many studies, the rate of ill treatment might range anywhere from 20.9 percent to 100 percent. 19 The consumers and providers alike noted a number of similar issues, some of which were a deficiency of drugs and supplies, water and energy, the availability of specialised and female physicians, inadequate infrastructure, and post-delivery counselling. Bad referral management, unfilled jobs resulting to a lack of human resources, insufficient incentives, poor infrastructure, the absence of blood banks, and poor collaboration from consumers were the most prevalent difficulties reported by providers [15]. While the World Health Organization (WHO) advises that no more than 10 percent of women should be given episiotomies, the results of a research that was carried out in Assam demonstrate that episiotomies are done frequently, even at times without anaesthetic. It is essential to adhere to practises that are supported by research and to educate medical professionals. Because of all of these factors, most women choose to give birth at home or in private hospitals, and they often arrive to the medical institution late or depart shortly after giving birth. According to a number of studies, medical professionals do not regard respect, dignity, confidentiality, or the exchange of information to be essential components of providing effective treatment. These studies on the perception of stakeholders, infrastructural issues, JSY, quality of care, and prevalence have been carried out in the states of Jharkhand, Haryana, Gujarat, Maharashtra, Chhattisgarh, Kashmir, New Delhi, Odisha, Karnataka, Meghalaya, Andhra Pradesh, Madhya Pradesh, Rajasthan, Uttar Pradesh, and Bihar. Other states include Andhra Pradesh, Madhya Pradesh, and Uttar Pradesh On the other hand, the conclusions of the majority of the research come from Uttar Pradesh, which means that they cannot be applied to the whole nation. The qualitative and quantitative elements of RMC are only briefly discussed in a few of the available research. The estimations of the prevalence are all over the place. It is very necessary to have information about RMC, both qualitatively and quantitatively, in order to formulate policies and programmes that are relevant to the setting. There is a discrepancy between the quality of care that is suggested and what is actually provided. According to the findings, there are a limited number of techniques for assessing RMC and various research have elected to use a variety of tools for evaluation [16].

GOALS:

The RMC will contribute to the accomplishment of the Sustainable Development Goals, which include improved health and well-being as well as decreased inequality.

1. The purpose of this project is to put regulatory policies and programmes into action by developing standardised procedures, operational plans, and guidelines for a variety of health settings.
2. To ensure women autonomy and empowerment by instituting mechanisms of accountability based on women's experiences.
3. In order to guarantee outcome-based quality care that takes into account the concerns of many stakeholders and uses 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.
4. To overcome infrastructure impediments, while non-availability of resources should not limit the implementation of RMC via other ways.
5. To demand greater accountability from higher authorities.
6. To have a process for monitoring and evaluation to determine input, output, effect and benefit of policies and initiatives.
7. To create redressal and grievance units at all hospitals.
8. to carry out audits and conduct exit interviews, in addition to gathering feedback from customers, with the goal of identifying obstacles to the consumption of services and improving their quality.
9. To achieve this goal by more collaboration and participation in the community.
10. To facilitate collaborative efforts among many stakeholders, policymakers, government authorities, the United Nations, nonprofit organizations, public and private health institutions, and women's organisations in order to contribute to the realisation of the RMC standard that is wanted.

CONCLUSION:

It will be easier to achieve RMC on a national level if individualised treatments, policies, and programmes are designed for a variety of dynamic systems, and if monitoring and assessment are performed on a regular basis. The consequences can only be examined after the measures necessary for implementation have been taken. This will not only address the issue of maternal mortality via the provision of care, but it will also place an emphasis on

the quality of care provided by adopting an approach that is more clearly defined and standardised.

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