Respectful maternity care

A cross-sectional study with labour observations and community-based surveys carried out by Borhen et al found that 41·6% of women had experiences of physical abuse, verbal abuse, or stigma or discrimination, most commonly occurring from 30 min before birth until 15 min after birth. Women who were younger and less educated were most at risk, suggesting inequalities in how women are treated during childbirth. Furthermore, observation and survey data show that many women have vaginal examinations and procedures (caesarean section, episiotomy, induction) done without their consent. 4·5% of observed and 2·0% of surveyed women gave birth without the presence of a skilled attendant, and 5·0% of women reported detainment because they were unable to pay the hospital bill.[1] In another study, Afulani and colleagues measured person-centred care in Ghana, India, and Kenya, and reported that providers did not explain the purpose of examinations or procedures for two-thirds of women.[2]

Jenson and colleagues[3] under the title, "First Do No Harm" in Journal of Perinatal Education. The go on to list a number of interventions during childbirth procedures; enforced bedrest, electronic fetal monitoring, limited oral intake during labour, frequent vaginal examination, induction of labour, artificial rupture of membranes, regional anesthesia, catheterization, ineffective pushing, routine episiotomy and cesarean surgery which are considered unnecessary in several instances.

Quality of maternal and newborn health care is crucial for the future of the present generation and for the generations to come. Although medical and technological advances in maternity care have drastically reduced maternal and infant mortality, used appropriately, many of these procedures can be life-saving. But routine use, without valid indications, can transform childbirth from a normal physiologic process and family life event into a medical or surgical procedure as well as escalating cost of health care. Jenson et al go on to suggest that interdisciplinary collaboration can ensure that intrapartum caregivers "first do no harm" and reminds us of Nightingale's admonition to ". . . do the sick no harm" is especially pertinent for maternity nurses. This is even more relevant with the increase in technology and interventions available today.

It is also disrespectful to women and children if preventive measures are held from them which can do a great damage to their survival and optimal growth. Many women in poverty and those in rural and remote areas are especially deprived of the basic reproductive health services. Today, health professionals providing basic care have access to a number of interventions that are guaranteed to improve the health of both mother and the newborn. They include family planning advice and contraceptive needs and termination services where indicated (*Pre-pregnancy*); at least four quality antenatal care visits, knowing HIV status of pregnant women and prevention of mother-to-child of HIV, and availability of retroviral treatment, treatment of anemia and malaria where indicated (*During pregnancy*); skilled attendant at birth and appropriate referral for emergency obstetric care including cesarean section (*Birth*); early initiation of breast feeding and postnatal visits for both mother and the newborn (*Postnatal*); exclusive breastfeeding for six months, appropriate nutritional advice and

weaning through Under-5s growth monitoring programmes, routing immunisations, vitamin A supplementation (*Infancy*); and sleeping under insecticide treated nets for Malaria, diagnosis and treatment of pneumonia and diarrhea and oral rehydration, safe drinking water and adequate sanitation facility (*Childhood*). Furthermore, universal health coverage requires adequate monitoring of these primary health care services.

Tracking coverage of interventions proven to reduce maternal, newborn, and child mortality is central to global monitoring efforts.[4] Brizuela and colleagues[5] matched WHO quality standards and found difference in the quality measures covered ranged from 62% for the service provision assessment to 12% for the World Bank's Service Delivery Indicator. Although the broadest tool addressed parts of each of the 31 quality statements, 68 (25%) of 274 input and process quality measures were not measured at all. Horton commenting on General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP) describes a catalogue of extraordinary negligence and missed opportunities. Global health needs more independent accountability, not less. It's time not only to resuscitate the IAP, but also to examine how independent accountability can be applied to other domains within the SDGs.[6]

Advancement in information technology and artificial intelligence has made the task of monitoring much easier now than what was possible a decade or so back. Use of routine data collection electronically, its periodical analysis and auditing primary health care is the key to improving the health of masses.

Incorporation of these principles into Primary Health Care and District Health Services will enable quality Universal Health Coverage in the world.

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