REVIEW ARTICLE

Protecting and Promoting Respectful Maternity Care of Every Laboring Woman in Sri Lanka beyond the Pandemic: A Narrative Review

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Received on: 02 March 2022; *Accepted on*: 22 August 2022; *Published on*: 16 November 2022

Abstract

Aim: To summarize the current status of respectful maternity care (RMC) in Sri Lanka and the way forward with the pandemic.

Background: Respectful maternity care is a human right with the capacity to improve maternal and neonatal outcomes. Promoting respect at interpersonal and health system levels attracts more women to the health facilities, gives them a positive birth experience, attenuates preventable maternal deaths, improves perinatal outcomes, and minimizes gaps and inequities in women's health. Irrespective of the personal, resource availability, cultural, or any other issue, efforts need to be taken to implement all the domains of RMC in all birthing suites.

Methodology: A comprehensive literature review was carried out on Google Scholar and MEDLINE databases to find out the relevant scientific literature on the RMC in the South Asian and the Sri Lankan context. The focus was given to identify the current concepts and the strategies to improve the RMC in the South Asian setting.

Review results: We have summarized the various aspects of the RMC, its dimensions, measurement of RMC, the impact of RMC and its importance. The RMC in the South Asian setting needs to be developed in various aspects.

Conclusion: The provision of RMC needs concern as a priority measure. The impact of COVID-19 pandemic has implications, especially in allowing a labor companion. However, promoting of RMC could be performed in micro, meso/intermediate, and macro/national levels.

Clinical significance: The present challenges and the proposed strategies in achieving this best practice need to be considered in Sri Lanka and other South Asian settings.

Keywords: Abuse, Childbirth, Disrespect, Obstetric violence, Respectful maternity care.

Journal of South Asian Federation of Obstetrics and Gynaecology (2022): 10.5005/jp-journals-10006-2117

Introduction

Childbirth is an important life event. Labor and delivery occur in the context of socio–cultural norms. This experience should be well-supported by her caregivers and the companion of choice. During labor and delivery, all women should receive respectful and dignified care.[1] However, disrespectful maternity care and abuse continues to be a major concern in both high-income and low- and middle-income countries (LMICs).[2–4]

World Health Organization (WHO) has declared a consensus statement promoting respect during childbirth, preventing disrespect and abuse, and stating the importance of women's collaboration in improving the quality of care they received. Later on, WHO expanded this statement into RMC based on basic human rights to yield a positive childbirth experience and to mitigate inequities in the healthcare system. Many countries have therefore looked into promoting RMC.[5–8]

Methodology

A comprehensive literature review was carried out on Google Scholar and MEDLINE databases to find out the relevant scientific literature on the RMC in the South Asian and the Sri Lankan context. The focus was given to identify the current concepts and the strategies to improve the RMC in the South Asian setting.

Global Maternal Morbidity and Mortality

Global maternal mortality declined substantially between 1990 and 2015, but the progress had been slower compared to the expected standard of a 75% reduction.[9] Only nine LMICs achieved the millennium development goal (MDG) 5 target of 75% reduction in maternal mortality ratio (MMR) by 2015.[3,10] The LMICs represent 99% of global maternal deaths.[10] The drivers for slow progress and lessons learned have been considered as key elements in making decisions for improving maternal health in the post-MDG era.[9] With regard to neonatal and child mortality, the same story can be repeated.[10] Consequently, United Nations introduced the 17 sustainable development goals (SGDs) to address this gap.[11] Improving universal access to high-quality reproductive health including maternal healthcare is the key to reducing maternal morbidity and mortality[12] and skilled attendance at institutions is the most critical intervention.[3]

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How to cite this article: Patabendige M, Jayawardane A. Protecting and Promoting Respectful Maternity Care of Every Laboring Woman in Sri Lanka beyond the Pandemic: A Narrative Review. J South Asian Feder Obst Gynae 2022;14(5):627–632.

Source of support: Nil

Conflict of interest: None

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Sri Lankan Maternal Morbidity and Mortality

Sri Lanka is a role model for maternity care among LMICs with exemplary achievements.[13] The MMR for Sri Lanka is 29.2 per 100,000 live births in 2019.[14] Even when compared with high-income countries, the MMR for Sri Lanka is impressive. The percentage of Sri Lankan mothers receiving the care of skilled birth attendance at delivery is over 99.5% and the percentage of institutional deliveries is over 99% with 85% occurring in a facility that has the services of a specialist obstetrician.[13,15] However, there is a dearth of studies on quality of care related to maternal and child health in Sri Lankan settings.

Maternal suicides play a significant role in maternal mortality. About 25–30 women commit suicide during the pregnancy or within 1 year after delivery in Sri Lanka annually.[16] Psychological morbidity among pregnant and postnatal mothers is an important health concern. With a previously described prevalence of 27.1%, postpartum depression is relatively common in Sri Lanka.[17] Sri Lankan survey among healthcare providers (HCPs) has revealed good overall awareness on the maternal mental health problems, but application into practice with the utilization of validated assessments needed improvement.[18]

Respectful Maternity Care

The WHO definition on the RMC has been well accepted worldwide and it mainly consists of three components. Initially, their dignity, privacy, and confidentiality need to be maintained throughout the care provided for laboring women. In addition, this care should be delivered ensuring their freedom from harm and mistreatment. Finally, it is mandatory to enable informed choice and continuous support during labor and childbirth.[19,20] At present, "disrespectful maternity care" is common and widespread worldwide.[21,22] It may include physical or sexual violence such as hitting, undue restraints, unnecessary exposure of the woman's genitalia, and rough vaginal examinations. Women at childbirth often become the victims of verbal abuse and may experience "neglectful care" consisting of restricted mobility, leaving laboring women alone, unsupportive birth attendants, and withholding of food and/or drink.[12,22,23] Women might experience serious injuries and mistreatment both physically and emotionally. Higher rates of maternal as well as neonatal and infant mortality and morbidity are associated with disrespectful maternity care in LMICs.[21] The existence of RMC improves short-term and long-term outcomes for the mother and her family.[21,24]

Global Approach Toward RMC

Woman or patient or client-centered care is a cornerstone in delivering quality healthcare.[25] The term "obstetric violence" was formally introduced from Venezuela[26] and defined as "the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, abuse of medication, and converting the natural processes into a pathological one, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women."[26] Obstetric violence is described as an "invisible wound," and can be seen even in high-income countries.[27]

Dimensions of RMC

In 2010, Browser and Hill, initially introduced seven domains of disrespectful and abusive care during childbirth – physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in health facilities.[2] This preliminary work mainly appeared to be the building block for most of the modern descriptions on the RMC.

In 2015, a mixed-methods systematic review by Bohren et al. described seven domains of RMC.[3] These qualitative findings were organized under seven domains: (1) Physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, and (7) health system conditions and constraints.[3]

In 2018, Shakibazadeh et al., concluded that the concept of RMC is broader than just reduction of disrespectful care or minimizing mistreatment of women during childbirth.[4] They also emphasized the value of inclusion of RMC as a necessary integral component of quality in maternal and child health programs. The twelve themes of RMC were described from the qualitative findings of this review, can be listed as follows:

- Being free from harm and mistreatment.
- Maintaining privacy and confidentiality.
- Preserving women's dignity.
- Prospective provision of information and seeking informed consent.
- Ensuring continuous access to family and community support.
- Enhancing the quality of the physical environment and resources.
- Providing equitable maternity care.
- Engaging with effective communication.
- Respecting women's choices that strengthen their capabilities to give birth.
- Availability of competent and motivated human resources.
- Provision of efficient and effective care.
- Continuity of care.

Measuring the RMC

In the recent years, many countries and organizations have made efforts to establish RMC. On such occasions, the initial step should be to assess the present situation in RMC. There are numerous tools and scales available to assess women's birth experience but only a handful assess RMC.[28–31]

A tool by Taavoni et al. is a long, valid, and reliable 59-item questionnaire to assess RMC.[31] The Mothers on Respect (MOR) index is a valid 14-item tool to measure quality, safety, and human rights in childbirth.[30] More recently, Sheferaw et al. published the development of a 15-item scale that assesses RMC along the following four dimensions: Friendly care, abuse-free care, timely care, and discrimination-free care.[28] Ayoubi et al. with psychometric testing, describes a 19-item scale under the following three domains: Providing comfort, participatory care, and mistreatment.[29] This 19-item scale has been developed after a thorough review of the available literature and is in line with WHO recommendations.[20,29] There is a need to validate culturally acceptable tools for the South Asian setting as well.

Importance of RMC

The concept of "safe motherhood" is generally related to the physical well-being and safety of the mother and reducing maternal morbidity and mortality.[1] However, the so-called "safe motherhood" needs to be expanded considering the psycho–social dimensions of labor and childbirth. Respectful maternity care addresses this aspect while reducing maternal morbidity and mortality. Promoting and establishing RMC is of paramount importance to uplift the quality of care during labor and childbirth. Respectful

maternity care is not only an indicator of the quality of care but also a human right.[19,32] It encourages women to utilize skilled childbirth services.[21] Labor room staff should aim to make the labor experience as comfortable and dignified as possible. Although women may appear to be happy and satisfied with a healthy baby outcome, childbirth also has a psychological dimension[33–34] and dissatisfaction with the childbirth experience is linked to a negative impact on breastfeeding, infant bonding, and future pregnancies. It is also associated with an increase in post-traumatic stress disorders, postpartum depression, and preference for caesarean delivery in future pregnancies and increases the chance of a future termination of pregnancy.[35] Respectful maternity care can give rise to a positive childbirth experience and reduce potential health inequalities.[19,32] Women who suffered from disrespect or mistreatment during childbirth are less likely to face the same scenario[32] and this could result in maternal requests for caesarean deliveries.

A recent systematic review revealed the limited availability of data on the global burden of disrespectful maternity care during institutional childbirth.[3] The need of exploring complex relationships between health system constraints, the behavior of HCPs and women's experiences of mistreatment were equally highlighted to protect the fundamental human rights of pregnant women and promote a women-centered approach in improving quality of care[3,19,36] The paucity of data is acute for exploring the association between women's experience, HCP's behavior, and health system factors toward offering RMC.[3,37]

The Sri Lankan Context of RMC

When compared to the neighboring countries, Sri Lanka is a massive success story with regard to maternal and child health.[13,15] However, studies and assessments on the quality of care and quality improvement in the Sri Lankan context are lacking. Improvement of healthcare quality is an aspect that needs more attention in Sri Lanka. So far, no tools have been validated in Sri Lankan setting to measure the RMC except for the Sinhala version of the Childbirth Experience Questionnaire.[38,39] A recent study from Colombo reporting the outcomes of person-centered maternity care has shown the poor-quality care across several domains of mistreatment during childbirth warranting broad health system reforms.[40]

Only one previous qualitative study has evaluated obstetric violence in Sri Lanka, with a cohort of public health midwives (PHMs) and antenatal mothers, carried out as field research and the target HCPs were field PHMs.[27] The study concluded that Sri Lankan obstetric care needs further improvement and reported that this sample of women had encountered obstetric violence,[27] and several human and health infrastructure factors contributing to this were identified.[27] Women from low socio–economic groups, younger women, and women with Sinhala language difficulties (Tamil/Muslim) suffered more.[27] Overall, women have explained that they felt disempowered during labor and childbirth especially by the pregnant mothers who were young, inexperienced with the healthcare system, had poor family support, and had no personal connections to staff members in the hospital.[27] This is a tragic situation and more exploration is urgently needed.

Labor Companion

Before childbirth, having moved from the home to birth facilities, it was a common practice to have female family members and friends attending on laboring mothers in addition to the traditional birth midwife/care provider. This practice empowered the laboring woman and provided her with much-needed emotional, physical, and informational support. However caring and friendly the healthcare staff may be, having to give birth alone, without a known, trusted, and supportive companion is an emotional trauma for a laboring woman. Labor companion has been mentioned as one of the essential birth practices in the WHO safe childbirth checklist.[41–44]

Women's Preference for a Labor Companion

In high-income countries, it is the general norm for laboring women to be supported by their male partners irrespective of much scientific evidence for the role of the partner as the ideal labor companion.[45,46] This may be due to socially accepted norms and in some societies, women may prefer a different labor companion than their partner. A survey in Colombo, Sri Lanka by one of the authors (AJ) revealed most primigravida (55%) would prefer their mother to provide this companionship if only one companion is allowed (Unpublished data 2017, Colombo). Women may need, choose, or prefer a different companion than their partner during their labor and this choice should be respected.

Doula

A *doula* is a professional companion who would support a person undergoing a difficult healthcare experience. This is the basis of a female labor companion, who is not part of the healthcare team. Having a labor doula to support one through labor is a common practice in high-income countries. The *doula* is an evidence-based effective obstetric intervention.[47]

In a study by Senanayake et al. from Sri Lanka, they have evaluated and reported the positive effect of labor companion in Sri Lankan hospitals.[48] The same author surveyed 140 consultant obstetricians working in Sri Lanka with a 48.5% response rate and reported a poor attitude toward implementing this evidenced-based practice.[49] According to this survey, only 58.8% of obstetricians agreed to establish labor companionship in their units.[49] Among the stated reasons for non-implementation mentioned were the lack of space (80% respondents) and the workload in the labor ward (55% respondents). Unfortunately, more than 50% of obstetricians were not aware of the potential proven advantages of labor companionship.[49] Only 16.7% ($n = 5$) of the obstetricians handling more than 300 deliveries per month had allowed a companion.[49] Labor companionship is being practiced only in very few hospitals in Sri Lanka at present. However, it has to be acknowledged that infrastructure facilities, cultural barriers, and lack of motivation from the caregivers continue to be a challenge in any setting trying to implement labor companionship. Currently, the labor companionship is a recommended intrapartum care practice in Sri Lanka.[50]

Medicalized Birth and Humanized Birth

Every woman has a right to receive RMC. Disrespectful care and obstetric violence need to be addressed in finding solutions for the global caesarean epidemic. In November 2000, the "International Conference on the Humanization of Childbirth" was held in Brazil, in response to increasing the trend of medicalized birth and rising caesarean epidemic, emphasized the value of humanization of birth including a woman-centered approach.[32,51]

COVID-19 and RMC

The adverse effect of the COVID-19 pandemic on the quality of care is enormous and further exacerbating the existing gaps

and inequities in providing RMC. This will be more prominent in LMICs with weakened health systems. A higher impact of the psychological and clinical burden on pregnant women has been reported.[52–54] As such, future health systems should be expanded and strengthened to amalgamate several initiatives to absorb major downfalls while maintaining the quality and the respectfulness of maternity care.[55] Evidence gathered during and after this pandemic will have a significant contribution in making the global health systems ready for the next crisis.

Impact of COVID-19 on Labor Companion Provision in Sri Lanka

The pandemic situation of COVID-19 had a major impact on RMC and the provision of a birth companion in Sri Lanka. None of the public sector institutions that implemented a "female birth companion in labor," their policy before the pandemic have continued this practice at the time of writing this article.

Private sector which clearly supported labor companion by allowing the partner to be with the woman in the pre-pandemic era, initially restricted the practice, citing staff exposure and safety concerns. However, this was very short-lived and with rapid antigen testing being available, currently, women are allowed to have a birth companion. This shows when women have empowered their demand and the receipt of quality labor care is the norm.

The Women-centered, Rights-based Approach to Promote RMC

A recent study discussed three levels in strengthening the health systems to promote RMC.[55]

1. Micro Level

Lack of awareness and negative mindset of the caregivers and service providers along with lack of awareness about their rights among women in the community collectively make the micro-level challenge in promoting the RMC.[55]

2. Meso-level/Intermediate Level

Space constraints in health facilities, lack of manpower, shortage of supplies, budget constraints, insufficient remunerations, poor motivation of staff, and gaps in human resource planning are intermediate challenges.

3. Macro-level/National Level

At national level, unavailability of RMC guidelines, implementation guides and training manuals, gaps in professional carrier pathways, budget constraints, inconsistent remuneration schemes, lack of research and evidence on RMC, supply chain interruptions, and weak referral system, and poor enforcement to strengthen the existing referral system.

International and local organizations such as WHO and local professional bodies, politics, culture, economy, education, and technology in a particular nation could be distant influencers.

Overcoming Barriers for RMC in Sri Lanka

Currently, Sri Lanka is struggling at all three levels. One of the key interventions in empowering women would be to allow a labor companion of choice. Our experience has shown that awareness creates a massive demand and improvements in patient care. However, the healthcare delivery system is grossly partial toward provider empowerment as opposed to client empowerment.

At meso-level, commonly cited barriers include lack of space, physical facilities, and staff workload. Available data confirm that access to hospital-based care is excellent. Sri Lanka may be unique in that the system allows free choice of a place and a lead consultant for any pregnant woman anywhere in the country. The recent developments in road network have changed the traditionally perceived difficult to access areas. The recent implementation of emergency response teams' on-call has been well received with free availability of trained response staff at doorstep and ambulance transfer to the nearest specialist unit. This level of accessible care is lacking even in high-income countries, where an ambulance call can cost a significant amount of out-of-pocket payment by the patient.

Since access is no longer a priority problem, the system must now look at the amalgamation of scattered smaller units to multi-specialist hospital units. This will allow immediate efficient utilization of available physical as well as HCPs resources. Larger multi-maternity unit hospitals including teaching hospitals must explore the feasibility of 24 × 7 on-site senior obstetric cover for the labor suite. However, this level of organization will likely place some restrictions on access choice and referral pathways for the patient.

Correction at the national level, decision-making is urgently needed emphasizing the importance of delivery of quality care. For this to be effective, a system that recognizes and responds to patient feedback and satisfaction scores is urgently needed.

The Way Forward

While increasing efforts to improve maternal mortality and morbidity, additional efforts are necessary to promoting high-quality respectful care to attract more women to the health facilities, and offering them a positive childbirth experience. Relevant governments, other responsible stakeholders and professional bodies should arrange the necessary logistics and make policies to enrich the absorption of the principles of RMC and high-quality care in a system-wide approach. Promoting respectful dignified care during labor and birth not only addresses issues around childbirth but also significantly contribute to healthier families; healthier communities; and healthier nations.

Authors' Contributions

Author MP contributed to the conception, literature search, writing, and editing of the manuscript; author AJ reviewed and contributed content and to the editing of the manuscript.

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