Training course in adolescent sexual and reproductive health 2021

Antenatal, intrapartum and postnatal care

Maisara Alrayyes, M.D., MSc

King's College London, United Kingdom

Maisara.alrayyes@gmail.com

Question 1.1

Identify three actions that could be taken to ensure that adolescents have access to antenatal care, intrapartum care and postnatal care in the context of disruptions to service provisions due to COVID-19.

The impact of the COVID-19 on adolescents' lives, including their sexual and reproductive health (SRH), is profound. The COVID-19 pandemic and the ensuing disruption of service provision and movement restrictions hinder adolescents from accessing health services. Antenatal care, intrapartum care, and postnatal care have been primarily affected. Therefore, countries should continue to prioritise and maintain these essential core health services to all adolescents. Data has shown a decline in facility-based care with an expected rise in maternal mortality (1). Many pregnant women delay health-seeking due to fear of contracting the infection (2, 3). Therefore, countries have to implement outreach strategies to encourage adolescents and women to continue seeking health services while ensuring that safety measures are available in all facilities to prevent adverse pregnancy outcomes. Governments should also utilise digital media (television, radio, or social media) to inform adolescents about the availability and access to maternity care services.

In the context of COVID-19, countries should also consider some modifications in service provision. When appropriate, telemedicine (using telephone or video) could be an alternative method to provide counselling and screening for adolescents during the antenatal and postnatal period (1). Telemedicine is appropriate to minimise overcrowding in clinics, decrease the risk of virus transmission, and maintain continuous service provision to all pregnant women, including adolescents.

It worth mentioning that a healthy workforce is a cornerstone for the provision of high-quality maternity care services. Therefore, countries should also ensure that maternity care providers have full access to all personal protective equipment (PPE) and that the working environment is respectful and safe (1).

Question 1.2

Were there disruptions to maternal health services in your country due to COVID-19? If so, what were the consequences. Please back up your answers with references, where possible.

The impact of COVID-19 on SRH services, including maternal health, is outrageous in Palestine. The pandemic is placing additional strain on already under-resourced and overwhelmed health system. Although no significant outbreak have been reported yet, all primary health care providers, including the Ministry of Health and United Nations Relief and Works Agency (UNRWA), have scaled-down SRH services. Routine antenatal, postnatal, and preconception care have been stopped. Though, facility-based delivery and antenatal and postnatal care for identified high-risk pregnancies continue as usual (4). In April 2020, it was estimated that 210,000 pregnant and lactating women were in Palestine (4). To mitigate the risks of disruptive services, health care providers used alternative care modalities, including hotlines and phone consultations, in an attempt to detect high-risk

pregnancies (4, 5). However, high-risk pregnancies may not be detected as health care providers are not well trained to provide telemedicine for maternal services. Although no data are available yet on the consequences of services disruption, nondetection of high-risk pregnancies could result in several adverse outcomes, including increase risk for maternal morbidity and mortality.

Question 2.1

What were the two primary determinants of mistreatment during childbirth in the four-country study reported in the article titled: "How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys"?

Although the World Health Organisation (WHO) recommends respectful maternity care for all women (6), women worldwide experience mistreatment during childbirth (7). A study in four countries (Ghana, Guinea, Myanmar, and Nigeria) found that 41.6% of observed women during labour have experienced mistreatment (either physical abuse, verbal abuse, stigma, or discrimination) (8). Age and lack of education were the two main determinants of mistreatment during childbirth. For instance, younger women (aged 15-19 years) with no or some education were more likely to encounter verbal abuse than older women (aged ≥30 years) (8).

Question 2.2

Why do you believe that girls/young women and those with less education were more affected by mistreatment?

During childbirth, respectful care is a universal right for each woman regardless of age, level of education, or socioeconomic status. Several studies suggested that women are not equally treated during childbirth, with adolescents and uneducated women being more vulnerable to unfavourable childbirth experience (8, 9). Adolescents are more prone to experience mistreatment because of healthcare providers' attitudes and perspectives, who may judge adolescents for being sexually active and pregnant at a young age (9, 10). Health care providers also suggested that adolescents are unaware of the childbirth process, less prepared to engage with the health system, and less cooperative, making them more vulnerable to mistreatment (9). Many healthcare providers use slapping to encourage and gain cooperation from uncooperative women to ensure positive health outcomes (11).
Women with no prior birth preparedness education are more likely to experience mistreatment (12). Uneducated women and adolescents are less able to communicate or advocate with health care providers and less likely to be aware of their rights. They also cannot express their satisfaction or dissatisfaction with services. Healthcare providers attitudes toward uneducated women also render their ability to get high-quality care. In a report from South Africa, health workers stated that ‘’providing explanations to less educated women is not a good use of time as they just can‘t understand’’(13). Yet, educated women are aware of their rights, have a high level of self-confidence, and have greater confidence to

report mistreatment, reducing the likelihood of mistreatment (14).
Mistreatment during childbirth can potentially discourage women from seeking medical care in future, leading to adverse maternal and neonatal outcomes (7). Therefore, interventions to promote high-quality and respectful health care services is substantial to ensure good health for women and their infants.

Question 3.1

What are the proven clinical benefits of labour companionship?

Quality of care during labour and childbirth has a high impact on both women and their infants. During labour, a companion of choice is an effective intervention to support women and improve maternal and perinatal outcomes (15). In addition to its psychological impact, labour companionship results in improving clinical outcomes. Research has shown that women accompanied by a labour companionship have a shorter labour duration. Moreover, women with continuous support are more likely to have a spontaneous vaginal birth and less likely to undergo a caesarian section. The presence of labour companionship also results in a decline in intrapartum analgesia and increased satisfaction with childbirth (15). In addition to improving maternal outcomes, labour companionship also improves neonatal outcomes. Infants born to a woman with continuous support are less likely to have a low five-minute Apgar score (15).

Question 3.2

What were the three principal findings of the research study in three public tertiary hospitals in Egypt, Lebanon and the Syrian Arab Republic on labour companionship in each of these contexts?

The research study's findings show that labour companionship can be successfully integrated into the context of public tertiary hospitals in Egypt, Lebanon and Syria. The feasibility of this practice was grounded on engaging healthcare providers and considering their needs and concerns, and involving hospital management in the study activities. Moreover, the study also showed that the labour companionship model is acceptable for both women, families, and health care providers. It was compatible with women’s and their families’ needs, and it changed healthcare providers' perception toward labour companionship.
In terms of the costs, it was observed that the benefits of the model (reducing the rate of cesarean section and low Apgar score) outweighed the costs in all three countries. For every 1 US dollar spent on developing and implementing the model, the benefits were as high as 29.86 US dollars in Egypt, up to 11.79 US dollars in Lebanon, and up to 6.17 US dollars in Syria (16).

Question 4.1

Identify three ‘delays’ that contribute to high maternal and infant mortality in the Eastern Mediterranean region.

Between 2000 and 2017, the Maternal mortality ratio (MMR) in the Eastern Mediterranean Region (EMR) has been reduced by 50.3%, though the EMR has the second-highest MMR globally (164 per 100,000 live births) (17). Generally, three identified delays in accessing and receiving care contribute to maternal and infant mortality in the EMR (18). First, delay in deciding on seeking care. Pregnant women might lack decision-making to determine seeking care. They might also lack knowledge about the warning signs and symptoms of pregnancy and labour and when and where to seek care. Second, delay in reaching an adequate health care facility. Even when women have the autonomy and awareness of the need to seek care, they might not access health facilities. The underdeveloped transportation infrastructure and the high transportation cost or other financial constraints render women from acquiring health care. Third, delay in receiving adequate care at the health care facility. The under-resourced health system across many countries across the EMR critically affect care-seeking. Healthcare providers might lack the appropriate knowledge and skills to provide high-quality care. Staffing shortages and shortage of equipment and supplies also affect the quality and availability of the care.

Question 4.2

Identify two priorities for improving maternal healthcare - with a focus on adolescents - in your country.

The health care system in Palestine is under-resourced and facing several challenges. Conflict, increasing poverty, and unemployment have affected access to maternal health services (19). In Palestine, the continued Israeli military occupation, the Separation Wall, Israeli army checkpoints have limited Palestinians' access to healthcare services (20). During the heightened conflict, antenatal care services are most likely to be affected (21). Adequate access to maternal healthcare also requires an uninterrupted supply of reachable and affordable services (22). However, since 2007, the Gaza strip's health care system has been suffering from a significant shortage of essential health care services. Maternal pharmaceuticals have been mainly affected due to the blockage. A mapping study showed that all the assessed primary healthcare (PHC) facilities reported that all necessary medications and life- saving drugs were either unavailable or interrupted for the last six months (23). These include iron, folic acid, antibiotics, and methyldopa.
Accordingly, in my opinion, the two most important priorities for improving maternal healthcare in Palestine are: 1) Developing community health care facilities. These facilities will ensure maintained access to maternal health services, espically during conflict. These facilities should be adolescent-friendly, and care providers should be well trained to meet adolescents' needs, 2) Maintain a continuous supply of essential drugs. All the governmental and non-governmental organisations should make every effort to advocate with the Israeli authorities to facilitate the transportation of drugs to the Gaza Strip to cover the needs for all women.

Question 5.1

Based on the study's findings, identify two reasons that young Iranian women accepted a pregnancy even if they were not ready for it?

Although some young Iranian women are unwilling to become pregnant, they might compulsory accept it. Some women might agree to childbearing either because their religion forbids abortion or because they are afraid that abortion could affect their future fertility. Others might accept it because of facing pressure from their families or because they believe that having a child means a more stable and healthier marriage.

Question 5.2

Based on the study's findings, identify two causes for the frustration and regret the young pregnant Iranian women who were studied felt.

Some young Iranian women experience a sense of frustrations and regret concerning their pregnancy. Lack of preparedness to take maternal responsibilities due to lack of information about childcare led to a feeling of uncertainty and despair. For other women, their sense of frustration was due to limited financial resources and economic barriers.

Question 5.3

Name one thought that came to your mind when you read this study.

Every time I read about adolescent marriage and childbearing, I feel pain for them. Girls of this age should think about their education and future rather than about their families and children. The psychological impact of early marriage is hard to imagine. Adolescents are not aware of their responsibilities as mothers and are usually unable to make decisions. Even when it comes to pregnancy, they cannot determine whether they want to become pregnant or not. We all should protect adolescents and help them to live safe and desired life.

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