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ECOFEMINISM, ITS PERSPECTIVES AND SAFE MOTHERHOOD

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Abstract:

Ecofeminism is a term that links feminism with ecology. Its advocates say that paternalistic/capitalistic society has led to a harmful split between nature and culture. It is also an activist and academic movement that sees critical connections between the exploitation of nature and the domination over women both caused by men.Ecofeminism describes movements and philosophies that link feminism with ecology. This movement seeks to eradicate all forms of social injustice, not just injustice against women and the environment

Keywords

Eco-femeinsm, Oppression, motherhood

Perspectivesof Ecofeminism

Mann associates the beginning of ecofeminism not with feminists but with women of different race and class backgrounds who made connections among gender, race, class and environmental issues. Woman have been subjected to oppression, domination, exploitation, and colonization from the Western patriarchal society that emphasizes and values men.

Ecofeminism was coined in 1970s.Women participated in the environmental movements, specifically preservation and conservation, "Land Ethic" (1949).
Vandana Shiva, Maria Mies and Evan Bondi on ecofeminism considered modern science and its acceptance as a universal and value-free system. Instead, they view the dominant stream of modern science as a projection of Western men's values.The privilege of determining what is considered scientific knowledge has been controlled by men, and for the most part of history restricted to men. Bondi and Miles list examples including the medicalization of childbirth and reproduction.

Bondi argues that the medicalization of childbirth has marginalized midwife knowledge and changed the natural process of childbirth into a procedure dependent on specialized technologies and appropriated expertise. A common claim within ecofeminist literature is that patriarchal structures justify their dominance through binary opposition, these include but are not limited to: heaven/earth, mind/body, male/female, human/animal, spirit/matter, culture/nature and white/non-white. Oppression is reinforced by assuming truth in these binaries and instilling them as 'marvellous to behold' through religious and scientific constructs.

Safe Motherhood

Safe motherhood encompasses a series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high-quality gynaecological, family planning, prenatal, delivery and postpartum care, in order to achieve optimal health for the mother, fetus and infant during pregnancy.
The inauguration of the Safe Motherhood Initiative in Kenya in 1987 marked the beginning of concerted international efforts to reduce maternal mortality. Since that time, reducing maternal mortality has continued to be the aim of many international health programs. Over time, policies and strategies to achieve safe motherhood have changed as knowledge and understanding about the determinants of maternal health have become clearer.

Improving maternal health was included as the fifth Millennium Development Goal (MDG), which calls for a 75 percent reduction in maternal mortality between 1990 and 2015. And reducing maternal mortality by 30 percent across assisted countries is one of the targets for USAID's Global Health Initiative (USAID, 2011).
Although safe motherhood has remained high on the political agenda, the scope of what constitutes "safer" motherhood has changed considerably. A major factor has been the incorporation of a human rights approach into the definition of Safe Motherhood following the agenda set at the International Conference on Population and Development (ICPD). By defining maternal death as social injustice, programs for "Safer Motherhood" are able to invoke a much broader range of political, social, and economic initiatives than was previously possible (UNFPA et al., 1997).

Policies and strategies to achieve safe motherhood have also changed as knowledge and understanding about the determinants of maternal health lack of education for girls; early marriage; lack of access to contraception; poor nutrition; and women's low social, economic, and legal status (Starrs, 2006).

Maternal death or maternal mortality is defined by the World Health Organization (WHO) as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental cause.
There is a distinction between a direct maternal death that is the result of a complication of the pregnancy, delivery, or management of the two, and an indirect maternal death,[9] that is a pregnancy-related death in a patient with a pre-existing or newly developed health problem unrelated to pregnancy. Fatalities during but unrelated to a pregnancy are termed accidental, incidental, or nonobstetrical maternal deaths.

According to a study published in the Lancet which covered the period from 1990 to 2013, the most common causes are postpartum bleeding (15%), complications from unsafe abortion (15%), hypertensive disorders of pregnancy (10%), postpartum infections (8%), and obstructed labour (6%). Other causes include blood clots (3%) and pre-existing conditions (28%). Indirect causes are malaria, anaemia, HIV/AIDS, and cardiovascular disease, all of which

may complicate pregnancy or be aggravated by it.

According to a 2004 WHO publication, sociodemographic factors such as age, access to resources and income level are significant indicators of maternal outcomes. Young mothers face higher risks of complications and death during pregnancy than older mothers, especially adolescents aged 15 years or younger. Adolescents have higher risks for postpartum haemorrhage, puerperal endometritis, operative vaginal delivery, episiotomy, low birth weight, preterm delivery, and small-for-gestational-age infants, all of which can lead to maternal death. Structural support and family support influences maternal outcomes. Furthermore, social disadvantage and social isolation adversely affects maternal health which can lead to increases in maternal death. Additionally, lack of access to skilled medical care during childbirth, the travel distance to the nearest clinic to receive proper care, number of prior births, barriers to accessing prenatal medical care and poor infrastructure all increase maternal deaths.

Unsafe abortion is another major cause of maternal death. According to the World Health Organization in 2009, every eight minutes a woman died from complications arising from unsafe abortions. Complications include hemorrhage, infection, sepsis and genital trauma.

By 2007, globally, preventable deaths from improperly performed procedures constitute 13% of maternal mortality, and 25% or more in some countries where maternal mortality from other causes is relatively low, making unsafe abortion the leading single cause of maternal mortality worldwide

Four elements are essential to maternal death prevention, according to UNFPA. First, prenatal care. It is recommended that expectant mothers receive at least four antenatal visits to check and monitor the health of mother and fetus. Second, skilled birth attendance with emergency backup such as doctors, nurses and midwives who have the skills to manage normal deliveries and recognize the onset of complications. Third, emergency obstetric care to address the major causes of maternal death which are hemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour. Lastly, postnatal care which is the six weeks following delivery. During this time bleeding, sepsis and hypertensive disorders can occur and newborns are extremely vulnerable in the immediate aftermath of birth. Therefore, follow-up visits by a health worker to assess the health of both mother and child in the postnatal period is strongly recommended.

Maternal Death Surveillance and Response is another strategy that has been used to prevent maternal death. This is one of the interventions proposed to reduce maternal mortality where maternal l deaths are continuously reviewed to learn the causes and factors that led to the death. The information from the reviews is used to make recommendations for action to prevent future similar death. Maternal and perinatal death reviews have been in practice for a long time worldwide and the World Health Organization (WHO) introduced the Maternal and Perinatal Death Surveillance and Response (MPDSR) with a guideline in 2013. Studies have shown that acting on recommendations from MPDSR

can reduce maternal and perinatal mortality by improving quality of care in the community and health facilities.

Medical technologies:

The decline in maternal deaths has been due largely to improved asepsis, fluid management and blood transfusion, and better prenatal care.

Technologies have been designed for resource poor settings that have been effective in reducing maternal deaths as well. The non-pneumatic anti-shock garment is a low-technology pressure device that decreases blood loss, restores vital signs and helps buy time in delay of women receiving adequate emergency care during obstetric hemorrhage.It has proven to be a valuable resource. Condoms used as uterine tamponades have also been effective in stopping post-partum hemorrhage.

Public health

Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. Improving access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth will reduce maternal deaths significantly. It is particularly important that all births be attended by skilled health professionals, as timely management and treatment can make the difference between life and death. To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system. Recommendations for reducing maternal mortality include access to health care, access to family planning services, and emergency obstetric care, funding and intrapartum care.Reduction in unnecessary obstetric surgery has also been suggested.

Family planning approaches include avoiding pregnancy at too young of an age or too old of an age and spacing births. Access to primary care for women even before they become pregnant is essential along with access to contraceptives.

Policy

The biggest global policy initiative for maternal health came from the United Nations' Millennium Declarationwhich created the Millennium Development Goals. The fifth goal of the United Nations' Millennium Development Goals (MDGs) initiative is to reduce the maternal mortality rate by three quarters between 1990 and 2015 and to achieve universal access to reproductive health by 2015.

The Millennium Development Goals (MDGs) are eight international development goals that were officially established following the Millennium Summit of the United Nations in 2000.

Trends through 2010 can be viewed in a report written jointly by the WHO, UNICEF, UNFPA, and the World Bank

maternal health depends on three key factors: 1. reviewing all maternal health-related policies frequently to ensure that they are internally coherent; 2. enforcing standards on providers of maternal health services; 3. any local solutions to problems discovered should be promoted, not discouraged.

In terms of aid policy, proportionally, aid given to improve maternal mortality rates has shrunken as other public health issues, such as HIV/AIDS, have become major international concerns. Maternal health aid contributions tend to be lumped together with new born and child health, so it is difficult to assess how much aid is given

directly to maternal health to help lower the rates of maternal mortality. Regardless, there has been progress in reducing maternal mortality rates internationally.

Maternal deaths and disabilities are leading contributors in women's disease burden with an estimated 275,000 women killed each year in childbirth and pregnancy worldwide. In 2011, there were approximately 273,500 maternal deaths (uncertainty range, 256,300 to 291,700).Forty-five percent of postpartum deaths occur within 24 hours.Ninety-nine percent of maternal deaths occur in developing countries.

Conceptual Model

The "Three Delays Model" identifies the points at which delays can occur in the management of obstetric complications at the community and facility level.

The first "delay" (delay in deciding to seek care) may relate to a number of factors, including the lack of knowledge about obstetric danger signs, community perception of poor quality facility care, or the lack of health services availability which increases the opportunity costs and therefore reduces the likelihood of care seeking.

The second "delay" (delay in identifying and reaching a medical facility) relates to the geographical proximity and accessibility of health services and includes factors such as the availability of transportation.

The third "delay" (delay in receiving appropriate care at health facilities) is related to factors in the health facility, including the availability of staff, equipment, and resources as well as the quality and (in some cases) the cost of services.

Motherhood Interventions

In addition to the changes in the definition, policies, and strategies as well as the emergence of new public health problems that drive the need for an increasingly wide range of indicators, monitoring and evaluating safe motherhood programs

Safe motherhood outcomes need to be measured for two individuals: the mother and baby

Under most circumstances interventions that benefit or harm the mother similarly affect the baby and vice versa. Some exceptions are notable. For example, a caesarean section for fetal distress may be critical to ensure a good neonatal outcome

Interpreting whether outcomes are attributable to program interventions is difficult, because most interventions consist of "bundled" services

Demonstrating change because of a safe motherhood program is difficult because programs usually provide a package of care to communities rather than providing one single intervention.

The provision of appropriate maternity care is a complex process that requires multiple indicators to monitor

The occurrence of an emergency sets into motion a complex chain of events to ensure that a woman receives adequate care. First, the family needs to recognize the problem and be able to access the appropriate services. Second, the equipment, supplies and medicines must be available at the facility to enable the care provider to make the correct diagnosis and to provide appropriate treatment promptly. If definitive care cannot be provided at the first level, then transport needs to be available quickly to take the woman to a higher level of care that must also deliver the appropriate services.

A series of indicators is required to reveal whether a problem occurs on the "demand" or "supply" side of the equation, and hence, whether the interventions need to address community mobilization, behaviour change, health system performance, or a combination of these factors.