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CASE MANAGEMENT BASED ON THE PREVENTION OF GENDER–BASED VIOLENCE IN THE PROVISION OF ANTENATAL CARE TO PREGNANT WOMEN AND THE MANAGEMENT OF REPRODUCTIVE HEALTH CARE FOR WOMEN OF CHILDBEARING AGE

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Abstract
In the article, the issues of strengthening the reproductive health of the population, maintaining the statistical indicators of women of childbearing age in an embodied/integrated manner, reducing maternal and infant mortality through regular case management, and protecting motherhood and childhood are discussed.
This case–management healthcare system is intended for primary midwives, patronage nurses, heads of OP/OShP, KTPP, UASh specialists, reproductive specialists, internal pharmacy managers, chief specialists of district and city OB and BMQ, chief obstetrician–gynecologists and specialists of regional OB and BMQ management. and intended for social workers.

Keywords: case management, antenatal care, integration, contraception, vertical lines, regionalization, gender violence, sexual exploitation, oppression and violence, social service, rehabilitation center, shelter, victimization, autoaggression, rumination.

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Introduction

THE URGENCY OF THE PROBLEM

When we analyze the demographic indicators of the population living in all regions and cities of the Republic of Uzbekistan year by year, we can see that the number of births and birth rates is increasing. In particular, the increase in the number of people, including young people and the population of fertile age, creates the basis for an increase in the number of marriages and, accordingly, births.

Youth marriages, primary registration of pregnant women, increases in births and birth rates, and unwanted pregnancies among women of childbearing age may indirectly lead to increased rates of disability and death among mothers and infants.

According to the WHO, more than 500,000 mothers die each year worldwide, and 8,000,000 women suffer from pregnancy–related complications each year. Millions of women suffer from disability as a result of complications related to pregnancy. 80% of all maternal deaths are associated with four obstetric causes (hypertension, hemorrhage, septic complications, and extragenital diseases). But they can be prevented with simple, effective and inexpensive measures.

The main purpose of antenatal care is to support and inform future parents, as well as to solve problems that arise during pregnancy. Help should be aimed at eliminating the specific problem that has arisen, not at risk. The important issue is not more or less antenatal visits to health workers, but health care services and management that work and women can be satisfied with care [1, p. 3–5].

In this process, the activities of general practitioners and nurses have a special place. However, in the development of complicated pregnancy, there is a special need for the support of not only medical personnel, but also representatives of other fields[2, p. 2].

MATERIALS FOR RESEARCH

During the medical analysis of maternal deaths that occurred in cities and districts in 2018–2023 in the perinatal center of Surkhandarya region, it was found that in addition to the medical services that are always provided to the population, various social problems arose in these families, they were not solved in time, and such problems led to the increase of severe complications of the patients' diseases. or we were convinced that it created a predisposition to pathological conditions. It is desirable to study the indirect existing causes of such social problems, to prevent them, and to implement case management of women's reproductive services and primary medical services provided to babies and their control. Among them, we recommend the tables developed based on the order of the Ministry of Health of the Republic of Uzbekistan No. 137 of February 2016 to clarify the case management, using national standards and protocols in the health care system[4]. On the basis of this schedule, 100% coverage is provided in the individual cards of pregnant women, and visit dates are set for each pregnant woman to be covered with targeted patronage service and preventive examinations during antenatal monitoring. 16 points are indicated in this procedure, which are intended to provide individual, high–quality antenatal care and targeted patronage of a pregnant woman in the postpartum period. The time of delivery of a pregnant woman is estimated in advance, and her risk group is determined at the initial visit or during antenatal follow–up.

In cities and districts of the region, inventory reports, ie statistics, of women of childbearing age are conducted on the last days of every month. Indicators of women of childbearing age in the area

of the women's consultation office of the city and all districts are kept monthly according to the schedule.

Table 2. The midwife of the women's consultation room, patronage nurse, obstetrician–gynecologist attached to the site or UASh doctor works with table 2. Once a month, the head of the senior nurse, OP/OShP, KTMP checks the correctness of the indicators. In this case, the employee responsible for filling out this table will inform the head of OP/OShP, KTPP. The final report of cities or districts is received once a month by the chief experts on the territory.

Table 2 is filled in as follows:

"D" counts the number of pregnant women under control and is placed in the 4th vertical row of column III (women who do not temporarily need contraceptive coverage) in Table 2. From month to month, this indicator changes and represents the number of pregnant women in antenatal care during a certain period of time, who are then transferred to the vertical row of those who should be covered by contraception, that is, to vertical row 1 of column V.

In this table, 4 large groups are distinguished. In particular, column I shows the months of the year and subgroups of women of all reproductive ages II, III, IV, V, and the total number of women of fertile age in column VI. Column II is the number of women who are currently covered by contraceptives: intrauterine devices (IBS), users of oral contraceptives (OC), users of injectable contraceptives (IC), those who are under "Dispensary" monitoring for contraceptives, and the number of women who used primary contraceptives (KP) during one month The number of primary BIS, OK, IK is added to the vertical row of the table from the journal maintained on the basis of the order No. 168 of the Ministry of Health of the Republic of Uzbekistan dated 08.05.2014 [5]. Voluntary surgical contraception under "D" control, uterine hysterectomy (uterine amputation and extirpation) and the number of women who underwent obstetrics/gynecology, other city/district, VPM, uterine hysterectomy surgery during this month are also shown in vertical rows. BIS, OK, IK, IJK+womb amputation are written off and those under "Dispensary" control are indicated in the contraception columns in table 18 of the women's consultation room of each institution.

BIS, OK, IK contraceptives are monitored by "Dispensary" 2 times a year (case status). Month–by–month sales of contraceptives, "Dispensary" out of control, balances are reflected in the columns of this table, and contraceptives are carried out numerically in the same way as the logistics system. Contingents in this group mainly require medical observation.

Column III Women who do not temporarily need contraception coverage: This column includes general girls (adolescent+unmarried), primary+secondary infertility, single mother (widows), pregnant women, young brides+those planning to give birth, climactic (menopause) age, self and/or the number of women whose husbands temporarily went abroad is entered. Women who have gone abroad (migrant women) are on the list of the passport desk of the Regional Internal Affairs Department (IIB) by asking other close relatives in the woman's house to clarify. Women in this column are assigned to one or another group depending on the situation/case. If pregnant, giving birth, needing contraception after giving birth, or girls getting married, women of fertile age at the age of climax are excluded from the general calculation, and hz.

Women in this group will need medical and psychological support in the family. For example, special attention should be given to teenage girls in puberty, infertile women to prevent 3rd party intervention in their spouse, mother–in–law or family, social assistance to single mothers, etc.

Column IV other categories: those who refused contraception, disabled from childhood (with disabilities due to mental and other acquired diseases), and +immigrants, –immigrants, users of

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other (natural, rubber products..) methods, temporary residents or renters, and deceased number of women (including the number of maternal deaths) are included. Immigrant women must be registered at the IIB passport desk. And women who have moved should be deregistered from the passport desk of their place of residence.

It is because of unstable living conditions among women, discord in the family, in–law relations, that brides, pregnant women and women with children are forced to temporarily live with their parents or family separation. In such situations, the regularity of the monitoring of a pregnant woman by the patronage nurse, the number of active patronages decreases, and various obstetric pathologies that threaten the life of the woman in labor develop[4].

Such social case situations can cause pregnant women to be brought to maternity hospitals in critical situations, and timely medical assistance is delayed, and this situation can become one of the factors that cause the death of mothers. To the people in this group, it is determined in which category they are included, and medical services are provided according to their instructions or needs. Depending on the situation of the case, the medical worker should refer to other social workers in a timely manner for impartial assistance.

Column V Women who should be covered by contraception: in this column, a separate list of women who have given birth after pregnancy and are breastfeeding (during lactation), who have extragenital disease found during medical examinations, and who have absolute or relative impediment to childbirth, will be formed. In particular, women with absolute infertility must be diagnosed, the number of children is indicated, and they must be covered by contraception. Based on the criteria for artificial termination of pregnancy in accordance with social and medical guidelines of the newly revised and supplemented national standard of the Order No. 312 "On Approval of Standards for Artificial Termination of Pregnancy" dated 10.09.2013 of the Republic of Uzbekistan SSV, pregnancy is terminated in pregnant women with absolute obstruction to childbirth [5].

Column I shows the total number of women of childbearing age month by month. In this case, the number of women in all available column vertical rows is summed up. This number should change at the beginning of the months of the year, and the vertical row indicators in the column will be interchanged. The numbers in this column are also variable, including adolescent girls, excluding women of menopause (climax), emigration, and deaths.

Based on these tables presented to you, the following brief analysis follows. For example: the number of women in the risk group who must be covered by column V, the number of women in the risk group, who are neglected during the provision of medical services and patronage in column IV, young pregnant brides who live in rented accommodation or from socially troubled and conflicted, low–income families, go to their mothers without temporary medical care, and their lives Pregnant women whose risk symptoms remain uncontrolled are considered. In most cases, due to gender–based violence in the family, the work of conducting primary medical patronage service and its control among pregnant women in this group is weakened. Untimely preventive measures such as edema, anemia, kidney diseases, high blood pressure, etc., are complicated during the delivery process, and lead to the disability of pregnant women and newborn babies, and the death of mothers and babies in severe conditions.

Through the table, networks or some isolated micro–sites should be collected and include a single systematic statistical indicator. However, it is necessary to form a separate list of women with relative and absolute obstacles to childbirth from extragenital diseases detected during general medical examinations. The chief therapist is responsible for these indicators and receives

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information from the reproductive specialist, heals and keeps track of unhealthy women identified during medical examinations in outpatient or inpatient conditions.

The midwife and senior nurse of the women's clinic manage the input and output supply–logistics system of contraceptives, the report is compiled by the city/district reproductive specialist on the 1st–2nd of every month, and 1 copy is presented to the chief obstetrician–gynecologist of the district. Taking into account the contraceptives in the reserve of the regional internal pharmacy, the reproducologist ensures monthly supply of contraceptives from the reproductive health center of the region. Chief specialists of the district (chief obstetrician–gynecologist and person responsible for O and BMQ) control this schedule and supply logistics[5].

Adolescent girls' gynecologist at the women's clinic should also submit a report to a reproductive specialist.

Infertile women who do not temporarily need contraceptive coverage in column III, gynecological diseases in women who need protection alone should be detected in time. We can also calculate the estimated number of births expected in the district based on the number of newly married brides and grooms. In order to give birth to a healthy child, information about young people getting married will be obtained from the head of the Ministry of Health, and a health plan will be drawn up[13].

About the women who moved to the neighborhood and moved out of the neighborhood, activities are carried out in cooperation with the neighborhood assets and internal affairs officers. The identification of the young bride's marriage registered by the FXDYo through the passport system and the residence information will eliminate the discrepancies regarding the residence register in cases of maternal death. The quality implementation of the passport system leads to the timely elimination of problems not only in the medical field, but also in other social fields.

The women in the groups separated from each other in the columns are constantly changing in terms of quality and quantity. People in this group are monitored as a result of observations, patronage and medical examinations. At the end of the year, as a result of these inventories (calculation), general conclusions/results are formed about women of childbearing age in the region and specific conclusions/results for each section. Based on the analysis of these conclusions, it is possible to plan the quality and scope of medical services. According to the options in this table, medical and non–medical social cases that have gone out of control or are left out of control for no reason (not detected in time, not patronized, not cured or allowed to get pregnant, with high risk factors, etc.) are combined.

As a result of such cases, the poor quality of primary medical care provided to pregnant women, the mistakes of the obstetric care provided in the inpatient service become the cause of disability, critical situations and, finally, the death of babies and mothers during childbirth. In severe cases, the legal responsibility falls on the medical staff, especially the doctors on night duty in the maternity hospital. Lack of qualified personnel in the province, physical and mental fatigue of doctors on night shifts, delivery of sufficient blood and its reserves at all maternity and resuscitation posts in critical cases, (especially blood with a negative rhesus factor), interruptions in hospital material equipment, narcotics, psychotropic drugs supply from all sides has a negative impact on the quality of medical services.

Maternal mortality rate in the health care system is not only the unsatisfactory condition or lack of medical services in all areas of treatment and prevention institutions under the control of the city or district, but also the lack of full and reliable guarantee of the reproductive rights of citizens and, as a result, one of the main reasons for their complaints.

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If all of the above categories of women are seen by patronage and OShP/OP doctors and their medical problems are solved step by step in a timely manner, in regional preventive treatment institutions, using the guidelines, standards and protocols developed by the Ministry of Health of the Republic of Uzbekistan, targeted and high–quality medical midwives will be provided to the population. – if gynecological, intensive care and neonatal services are provided, the number of deaths of mothers and babies will be reduced.

To clarify our goal, let's take a specific case, for example, an unwanted pregnancy and childbirth in a minor (15–17) teenager who does not have a civil passport. Child marriage is the formal or informal marriage of boys and girls under the legal age limit. Usually girls suffer from these conditions more. In this case, a problem arises that must be solved by all social spheres. In this regard, a solution of one situation is required in the areas of health, justice, internal affairs, prosecution, education and neighborhood women, religious affairs and Youth Union and similar areas. In such cases, first of all, we have to ensure that the problem of termination of pregnancy and the delivery process goes without complications. For this, first of all, we must provide social and psychological support to the minor and his close relatives in the family and put an end to gender violence in the family. Otherwise, it is natural for a teenage pregnant woman to develop conditions for negative consequences such as depression and subsequent suicide. In such a case, the events related to the issuance of a civil passport by the internal affairs, the organization of sexual violence by the prosecutor's office, or the occurrence of criminal acts such as abduction on purpose will be clarified.

ANALYSIS AND RESULTS

Sexual violence – inflicting physical injuries of varying degrees of severity on women, putting them in danger, failing to provide assistance to a person whose life is in danger, committing other violent crimes, exerting physical influence or threatening to use other measures of such influence. is a form of violence that attacks girls' life, health, freedom and other rights and freedoms protected by law.

The judicial adviser decides the issues related to the writing of a document in civil cases after the birth of the fetus. Also, neighborhood women's advisers, representatives of education and Youth Union take preventive measures. Thus, one problematic case must find a solution according to its relevance within the framework of mutual social spheres. The approach to the problem in this direction guarantees a high–quality, short and effective case. Such an approach should serve to clearly indicate the number of women within the primary system of districts and urban areas, to provide them with appropriate medical care based on the case, and to solve the problems completely together with social workers in rare cases with a collective comprehensive approach. This kind of approach is to show the number of women as accurately as possible within the primary system of districts, cities and regions, to provide them with not only medical care, but also to provide them with a systematic and comprehensive approach in rare cases, or with social workers (social service providers). serves to solve problems together [14, p. 33–39].

Social service providers are state institutions and civil society entities, including non–governmental non–profit organizations, which provide a set of measures to meet the social needs of victims of gender violence (and their families) in order to prevent them from leaving difficult situations, marginalization and social exclusion.

Case management (or case management) is a recognized method of providing integrated services in which the victim of gender–based violence is placed in the focus of support services with a

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commitment to help solve problems in a crisis situation. In this case, it is mandatory to maintain consistency of case management steps such as assessment of needs, planning, provision and coordination of services, evaluation of positive changes achieved, and those steps are carried out together with support service workers and the victim of gender violence.

A victim of gender–based violence is a person who is under the threat of harassment or violence, or has suffered as a result of harassment or violence, including a female person under the age of 18.

Sexual partner violence is the most common form of violence experienced by women in the world and consists of coercive sexual, psychological and physical acts against women and adolescent girls by a current or former sexual partner without their consent.

Prevention of harassment and violence – a system of economic, social, legal, medical and other measures aimed at identifying and eliminating the causes and conditions that lead to harassment and violence against women, raising awareness of women's rights to be free from violence in society .

Basic services for victims of gender–based violence are the minimum set of services required to ensure the rights, safety and well–being of any woman, girl or child experiencing violence against women.

Providers of law enforcement services are state/government officials who provide legal services to victims of gender violence, prosecutors, employees of internal affairs bodies, consultants on legal issues, court administration, lawyers and their assistants, lawyers of organizations providing social services.

Psychological service providers are individuals or institutions that have special training (specialization) in the field of practical psychology and provide regular psychological services. A counselor psychologist, psychotherapist, or any other specially trained person with expertise in helping women in crisis situations can be an individual psychological service provider.

Medical service providers are individuals or legal entities that regularly provide medical services. An individual health care provider may be a physician, health worker, or other health care professional, or any other trained person with expertise in health matters. Institutions offering medical services include hospitals, clinics, family medicine centers, urban and rural family polyclinics, Reproductive Health Center, perinatal centers, obstetrics–gynecology and traumatology, emergency medical centers and other service points. Primary health care providers include nurses, midwives, family physicians, and other professionals.

Providing comprehensive medical services for victims/individuals of gender–based violence includes:

first aid

anamnesis and examination

Clinical treatment of injuries and urgent medical problems

assessment and management of psychological support

gather evidence

risk assessment and management.

Crisis center or rehabilitation center for victims of gender violence – public or private institutions, non–governmental non–profit organizations designed to provide comprehensive assistance to women and their children in difficult living conditions, including those who are subjected to various forms of gender violence or persons at high risk of violence. .

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A protection order is a document that provides state protection to a victim of harassment and violence, which causes the use of legal measures against a person or a group of persons who harass women or commit violence against them.

A shelter is a temporary place of residence for women who want to escape from all forms of gender–based violence, often organized on the basis of state institutions or public organizations, in order to protect their children.

Victimization (from the Latin word "victim" means "victim") is the process or end result of becoming a victim of criminal aggression. It is impossible to "blame the victim" in the incident.

Autoaggression is a person's actions against himself. Adverse actions include suicide, self–harm, alcoholism, drug addiction, self–blame, self–harm.

Post–traumatic syndrome–JKS or JK stress state–a serious mental illness caused by external factors. Clinical symptoms of mental illness appear as a result of acts of violence, disruption of the central nervous system, humiliation, fear for the lives of loved ones.

The aforementioned violence, family turmoil, third–party intervention, and social deprivation, lack of medical care in families may indirectly cause increased rates of maternal, infant, and maternal mortality.

CONCLUSIONS AND SUGGESTIONS

Summary data and recommendations of case management based on the prevention of gender–based violence in the provision of antenatal care to pregnant women and the management of reproductive health care for women of childbearing age:

1. Tables No. 1 and No. 2 attached above are proposed for vertical introduction from the bottom up to the medical staff of the primary link of the health care system. Healthcare is designed to provide control and targeted medical care in the vertical management of maternity and child care.
2. On the basis of tables No. 1 and No. 2 (as a questionnaire), it is possible to carry out vertical monitoring of medical services in antenatal care and reproductive health care for pregnant women in institutions of the system.
3. Representatives of public service bodies and organizations are called "social worker" or "social representative" in case management, regardless of the type of service. Service delivery should be considered as a "social work" method of solving any complex problems that arise in the population area. For example, socio–medical, socio–psychological, social education, social legal, social moral, etc.
4. The resolution of any violence between women, pregnant women, adolescents, disabled people and other similar population groups in the neighborhood, family, pre–school education, school and other similar organizations is the solution of the problem between "social workers" .
5. The social worker concerned with the most urgent problem causing social work is considered as "case management" i.e. "case management worker" and additional social workers provide timely assistance to him.
6. It is necessary to start the implementation of case–management within the smallest part of the society – the family, and raise it to the neighborhood, district, region and higher levels. In particular, it is necessary to establish proper and high–quality use of the assistance of other social workers in the patronage service of primary medical institutions in providing medical assistance to pregnant women and maintaining the reproductive health of women of childbearing age, ensuring gender rights for women, preventing and reducing the number of deaths of mothers and babies.

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7. Increasing the number of demographic indicators of the population, maternal and infant mortality rates, ensuring gender equality in women's health care and increasing legal literacy is not only the guaranteed service and responsibility of medical personnel, but also the responsibility of representatives of the social sphere, as a result of maintaining the reproductive health of the population.

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