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Achieving Respectful Maternity Care for Women, Newborns and Families

Flexible Operational Guidance

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www.mcsprogram.org

The purpose of this operational guidance for respectful maternity care is to guide maternal and newborn health program implementers through a flexible, stepwise process to design, implement, and monitor efforts in their local context to improve women’s, newborns’ and families’ experience of care and eliminate mistreatment in facility-based childbirth.

Introduction

There is growing commitment among local and global stakeholders to address people’s experience of care as an essential component of quality of care. The quality of childbirth care in facilities, including women’s, newborns’ and families’ experience of this care, is an important determinant of families’ decision to use, or not to use, facility childbirth services (in addition to other geographic and economic factors).^{1,2,3} In many countries, women experience mistreatment during childbirth and are unable to make choices that put them in control of their own experience.^{1,4,5} Efforts to increase women’s and families’ utilization of facility-based childbirth services will not succeed unless mistreatment is reduced and women and families trust that they will receive respectful maternity care (RMC). This understanding has underscored the need to better understand the local forms and drivers of both RMC and mistreatment to guide the design and implementation of interventions to improve RMC and reduce mistreatment.

Despite the many published studies assessing manifestations, prevalence, and, to a lesser extent, drivers of RMC and mistreatment, there is still limited evidence to inform the local design, implementation and monitoring of RMC interventions as part of comprehensive maternal and newborn health (MNH) programs. Studies demonstrate that there is no single magic bullet to improve RMC and illustrate the importance of a local multi-stakeholder process to develop and test interventions based on the local context. To date, most RMC interventions have been implemented in stand-alone RMC studies rather than as part of comprehensive MNH programs.

The Respectful Maternity Care Operational Guidance

Moving Respectful Maternity Care into Practice in Comprehensive MCSP Maternal and Newborn Programs
Operational Guidance

March 2020

Available at:
https://dec.usaid.gov/dec/content/Detail_Presto.aspx?vID=47&ctID=ODVhZjk4NWQtM2YyMi00YjRmLTkxNjktZTcxMjM2NDNmY2Uy&rID=NTU5ODAy

The target audience for this RMC operational guidance is MCSP staff and country stakeholders seeking to incorporate a stronger focus on RMC within the context of larger MNH programs.

Drawing on the published and gray literature, USAID's flagship Maternal and Child Survival Program (MCSP) developed the RMC Operational Guidance to help program managers incorporate RMC as a core element of comprehensive MNH programs. The purpose of the operational guidance is to guide MNH program managers and local stakeholder counterparts through a flexible process of designing, implementing, and monitoring RMC efforts based on a deep understanding of the local context.

Box 1. RMC Operational Guidance Table of Contents

- Introduction
- Background: Evidence to Date and Promising Frameworks
- Design and Implement RMC Approaches in a Comprehensive MNH Program
- Appendices (Tools and Resources)

This brief summarizes key components of the guidance including resources available in the published and gray literature. As shown in Box 1, the RMC Operational Guidance includes four main sections: an introduction; a background section; a section on how to design, implement, monitor and document RMC approaches in a comprehensive MNH program; and a final section of appendices that link to useful references and tools.

RMC Operational Guidance

Introduction to the RMC Operational Guidance

The introductory section reviews the overall purpose of the guidance and outlines the rapid increase in advocacy, research and implementation efforts to reduce mistreatment of women in facility-based childbirth. Awareness of the magnitude and most common manifestations of mistreatment of women in childbirth has increased substantially in the decade since the publication of the Bowser and Hill Landscape Analysis of Disrespect and Abuse in Facility-based Childbirth.⁶ In 2011, the White Ribbon Alliance launched a global campaign to promote RMC as a universal human right, culminating in a charter for the rights of childbearing women, subsequently updated in 2019 to include the rights of childbearing women and newborns. In 2015, Bohren and colleagues published a mixed-methods systematic review of mistreatment of women in childbirth which identified seven core mistreatment themes:

Box 2. Seven themes of mistreatment identified in WHO's systematic review

- Physical abuse
 - Sexual abuse
 - Verbal abuse
 - Stigma and discrimination
 - Failure to meet professional standards of care
 - Poor rapport between women and providers
 - Health system conditions and constraints
- Bohren et al. 2015

physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and health care providers, and health system conditions and constraints¹ (see Box 2).

As the issue of mistreatment has gained increasing recognition in the last decade, the World Health Organization (WHO) and others have incorporated RMC (or experience of care) into many global recommendations and strategies, including standards related to a positive experience of childbirth care for women and newborns. For example, the WHO Quality of Care framework for MNH includes eight aspirational standards to achieve high-quality care around the time of childbirth.⁷ Three of these standards (four, five and six) address experience of care, including effective communication; respect and dignity; and emotional support.

It is important to note that the absence or lessening of disrespect does not guarantee the provision of RMC. For example, the absence of a negative behavior such as verbal abuse does not assure positive caring behaviors such as asking a client for her consent before conducting a vaginal examination. Respectful maternity care and mistreatment in childbirth occupy two extremes of a continuum and studies demonstrate that women and newborns may experience a mix of both positive RMC and negative mistreatment along this continuum.

The absence or lessening of disrespect does not assure the provision of RMC; simultaneous program efforts to promote RMC and reduce mistreatment may yield the best results.

Background: Building the evidence and frameworks for understanding mistreatment and respectful care

The background section of the operational guidance describes current frameworks and evidence for defining and measuring RMC and mistreatment and reviews approaches that have been tested in studies across different contexts to strengthen RMC and reduce mistreatment. Recent evidence demonstrates that in addition to the common mistreatment of women in childbirth across geographic settings, maternity health workers themselves are often mistreated and work within health systems that fail to meet their basic needs.⁸ Understanding and reducing the local drivers of mistreatment of both clients and health workers requires a health systems and social lens along with a commitment to address health system weaknesses, structural social and economic inequalities and power asymmetries between women and health workers.

Studies demonstrate that there is no single magic bullet to reduce mistreatment and improve RMC. **Rather, the published and gray program literature illustrates the importance of locally defined, multi-faceted interventions tailored to each program context.**

There is no one-size-fits-all approach when it comes to ensuring respectful childbirth care. MCSP works with country partners to identify and test solutions for preventing mistreatment and promoting RMC tailored to each country's context.

Source: Respect during Childbirth Is a Right, Not a Luxury (MCSP, published on the MHTF Blog)

Illustrative examples of various approaches to improve RMC and reduce mistreatment applied in studies across different contexts and at various system levels (national, subnational, service delivery, community) are summarized in Appendix 3. Examples include:

- National and local advocacy and policy work (national policy, district or facility charter)
- Facility-based quality improvement processes incorporating community participation
- Open maternity days to increase informal interaction between pregnant women, families and health care workers and to increase families' familiarity with and, potentially influence over, maternity services
- Interventions that support health care workers (Caring for the Carer)
- Incorporating a strong focus on professional ethics and communication and interpersonal skills into pre-service and in-service education, supportive supervision and professional development
- Strengthening local health systems to overcome structural barriers (e.g., lack of commodities, lack of basic infrastructure)

Design and implementation of RMC approaches in a comprehensive MNH program

The third section of the operational guidance outlines a flexible sequence of steps to guide the design, implementation, and monitoring of RMC interventions in a comprehensive MNH program. Figure 1 provides a graphic overview of this stepwise process within two consecutive stages: a design stage and an implementation stage. The first phase of the design stage focuses on defining the overall scope of RMC activities, engaging key stakeholders and understanding drivers and manifestations of mistreatment and positive experience of childbirth care in the local context (via a situational analysis). Phase two of the design stage focuses on reviewing findings with local stakeholders and using those findings to prioritize a set of RMC activities across system levels and to design a program monitoring framework. The second implementation stage focuses on implementing the RMC activities prioritized in stage one, monitoring performance and using quantitative and qualitative data to strengthen and adapt program activities as needed, maintaining stakeholder engagement and regularly distilling applying and disseminating learning.

Design of RMC approaches: first phase

- 1. Define overall scope of activities:** The guidance highlights two phases during the design of RMC approaches. In the first phase program implementers define the overall scope of an RMC effort within a comprehensive MNH program, considering available local evidence, local stakeholder priorities, program resources and other key considerations outlined in the guidance.

- 2. Identify and sensitize key local stakeholders; engage key partners:** These stakeholders are essential partners throughout the design and implementation of local RMC interventions and

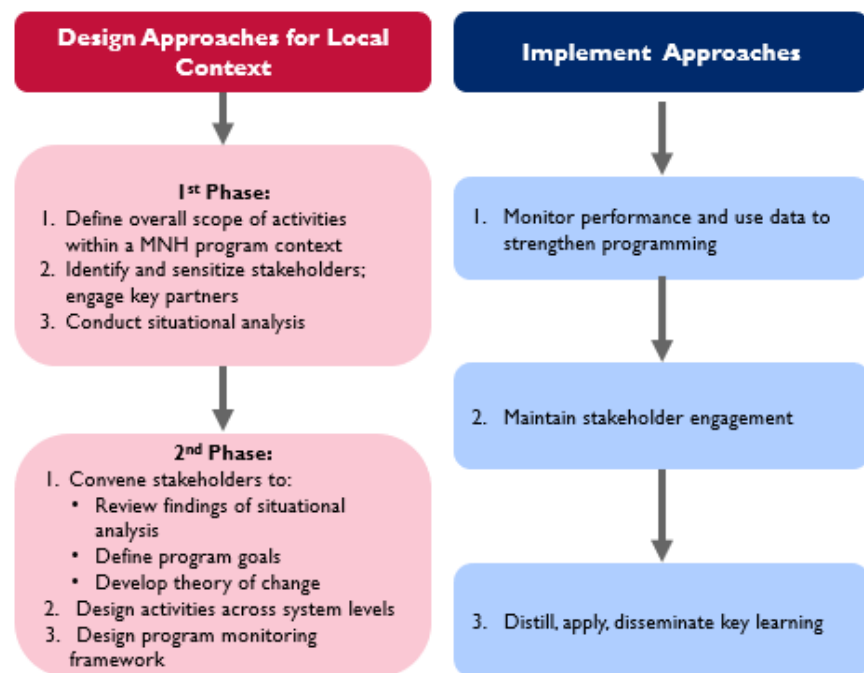
contribute to the sustainability of a program's interventions. By engaging consultations with a range of stakeholders and partners, program managers will develop a better understanding of local factors related to RMC and mistreatment, including the perceptions and priorities of important stakeholder groups (e.g., women, families, communities, health workers, and ministries of health, and facility managers.) Consultations will also begin to sensitize key stakeholder groups.

- 3. Conduct situational analysis:** Once the general scope of an RMC effort in a comprehensive MNH program has been defined, it is important to explore and understand the key manifestations and drivers of RMC and/or mistreatment in the local context. Even in MNH programs with limited resources, programs should undertake a modest situational analysis to explore mistreatment and its drivers (e.g., gender inequities) and women's, families' and health workers' experience of and priorities for maternity care in the local context. Ideally, a situational analysis will include a mix of qualitative and quantitative methods. MCSP developed and applied a set of situation analysis tools, adapted from the literature, in Nigeria (Ebonyi and Kogi States) and Guatemala (Western Highlands). These tools, linked in Appendix 7 and revised based on learning in each country, include a combination of qualitative and quantitative methods to assess and triangulate the perspectives, experiences and priorities for maternity care among women, families, community members, and health care workers and managers.

Design of RMC approaches: second phase

- 1. Convene key stakeholders to review situational analysis findings, define program goals and develop a theory of change:** During the second phase of designing RMC approaches, key stakeholders have an important role to play to help program managers review the findings of the situational analysis, define program RMC goals, and develop a theory of change based on findings. A theory of change is a helpful tool for defining and mapping how prioritized activities are expected to achieve the desired program goals in the local context. Illustrative examples of theories of change from RMC studies in Tanzania and Kenya are included in Appendix 8b of the RMC Operational Guidance.

Figure 1. Process to design and implement RMC approaches within a comprehensive MNH Program



2. **Design key RMC activities across systems levels:** The situational analysis is likely to identify facilitators of RMC and drivers of mistreatment operating at multiple system levels. Ideally, program RMC approaches will target as many relevant system levels as feasible within the program’s scope and resources. The operational guidance outlines considerations for defining and prioritizing RMC activities across system levels in a comprehensive MNH program (e.g., national and subnational policy, legislation advocacy; subnational managerial support to frontline maternity services and health workers; quality improvement processes that engage community members and facility health workers). Appendix 3 reviews various approaches for strengthening RMC and reducing mistreatment that have been tested in studies across different contexts and outlines potential facilitators and barriers to applying specific approaches in an individual program context.
3. **Design of program monitoring framework:** Once a program has defined its RMC program goals and activities based on findings and its theory of change, the program must define how it will monitor its performance (including regularly assessing women’s and families’ experience of care) and how it will use this data to continuously adjust and strengthen program RMC activities. Quantitative and qualitative methods used in the situational analysis can be selectively adapted to support monitoring during implementation of program RMC activities. For example, a short quantitative questionnaire for women, families and providers adapted from the tools utilized for the situational analysis can be used periodically to measure women’s and families’ experience of care. This section reviews indicator selection and quantitative and qualitative data sources that can be used by program managers to develop a program monitoring plan and describes measurement approaches being tested in the WHO multi-country Quality of Care Network.

Implementation and monitoring of RMC approaches

1. Monitor performance and use data to strengthen RMC programming:

Once the program has defined its RMC goals, key approaches and a monitoring plan, program staff should develop a detailed implementation plan and timeline that clearly specifies roles and responsibilities for program staff and local stakeholders, including implementation resources. The implementation and monitoring plan should specify the program milestones and indicators that will be monitored, including how data will be collected and analyzed on a regular basis to assess program performance and make adjustments when needed.

2. Maintain stakeholder engagement:

For sustainability, impact and potential scale up, it is important for program staff to collaborate with, communicate progress and maintain strong engagement of key stakeholders, including ministry of health representatives, representatives of women’s groups and professional groups, clients, community and health workers and managers. Ideally, key stakeholders will have been engaged during the program design phase and may

RMC Operational Guidance Appendices	
Appendix 1	Summarizes WHO maternal and newborn quality of care standards four, five, and six related to patient experience of care and the specific quality statements defined for each standard. ⁹
Appendix 2	Describes the seven core mistreatment themes identified by the WHO in 2015 and the common drivers reported in the literature.
Appendix 3	Summarizes promising RMC approaches in the published literature, including the potential pros and cons of individual approaches in specific program contexts.
Appendix 4	Provides an illustrative concept note and work plan for incorporating RMC approaches into a comprehensive MNH program.
Appendices 5 & 6	Summarize qualitative and quantitative methods for assessing mistreatment and positive experience of facility-based childbirth care; includes references to publications and tools that program implementers may adapt.
Appendix 7	Outlines and links to a set of qualitative and quantitative situational analysis tools developed by MCSP that program implementers can adapt based on local context and program needs.
Appendix 8, 8a, 8b	Provides guidance on how to develop a theory of change and illustrative examples of RMC theories of change.

help lead some program activities. The program may benefit from forming a local and/or national advisory group to help monitor the program's performance and recommend adjustments to program activities when needed.

- 3. Distill, apply, and disseminate key learning:** There are many important learning questions and outstanding evidence gaps related to designing, implementing and monitoring RMC approaches in comprehensive MNH programs in low-resource settings. This section outlines the importance of developing a program monitoring and documentation plan to inform program adaptations and support dissemination of learning for local and global stakeholders. Program learning should be action-oriented and focused on feeding back practical information to key stakeholders to improve programming, contribute to local and global RMC learning, and fill important evidence gaps. This section includes links to two resources that can help structure documentation and learning and highlights several priority learning questions for programs implementing RMC activities

Conclusion

Despite many recent policy, program, and research efforts to advance respectful maternity care for women and newborns, there is still limited evidence to inform the local design, implementation and monitoring of interventions to promote RMC and reduce mistreatment in comprehensive MNH programs in low-resource settings.

MCSP hopes that the RMC Operational Guidance will be useful for country stakeholders, program managers and partners to advance RMC implementation efforts and learning across a range of settings. MCSP has worked with local stakeholders in Nigeria and Guatemala to apply the first phases of the operational guidance and is helping to design, implement and monitor interventions to improve person-centered care and reduce mistreatment as part of the WHO multi-country Quality of Care Network for improving MNH (www.qualityofcarenetwork.org).



Photo by Kate Holt

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⁵ Abuya T, Warren C, Miller N, Njuki R, Ndwiwa C, Maranga A, et al. 2015a. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS One* DOI: 10.1371/journal.pone.0123606.

⁶ Bowser D, Hill K. 2010. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis. Washington: USAID.

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