



**USAID**  
FROM THE AMERICAN PEOPLE



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

## Operational Guidance

**DRAFT**

February, 2018



DRAFT

MCSP is a global USAID initiative to introduce and support high-impact health interventions in 24 priority countries with the ultimate goal of ending preventable child and maternal deaths (EPCMD) within a generation. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and eHealth, among others.

This study is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.

February 2018

# Table of Contents

<b>Table of Contents.....</b>	<b>iii</b>
<b>Acknowledgments.....</b>	<b>iii</b>
<b>Abbreviations.....</b>	<b>v</b>
<b>Introduction .....</b>	<b>i</b>
<b>Background: Evidence to Date and Promising Frameworks .....</b>	<b>3</b>
Defining and Measuring RMC and Mistreatment .....	3
Promising approaches for reducing mistreatment and promoting RMC.....	6
WHO MNH Quality of Care Vision and Standards for Positive Experience of Care .....	7
<b>Designing RMC Approaches in a Comprehensive MNH Program.....</b>	<b>9</b>
First Design Phase.....	9
Second Design Phase .....	15
<b>Implementing RMC Approaches in an MNH Program .....</b>	<b>24</b>
Maintaining Stakeholder Engagement .....	24
Distilling, Applying, and Disseminating Key Learning .....	25
<b>References.....</b>	<b>27</b>
Other Resources.....	31
<b>Appendices.....</b>	<b>33</b>
Appendix 1. Types of Mistreatment and Common Drivers.....	33
Appendix 2. Promising Approaches for Promoting RMC and Reducing Mistreatment (and the Pros and Cons of these approaches based on a program context).....	35
Appendix 3. Illustrative Concept Note and Workplan for Incorporating RMC Approaches into a Comprehensive MCSP MNH Program.....	42
Appendix 4. Qualitative RMC/Mistreatment Data Collection Methods .....	48
Appendix 5. Quantitative RMC/Mistreatment Data Collection Methods.....	52
Appendix 6. MCSP RMC Formative Assessment Tools, Monitoring and Evaluation Tools, and Guidance on Ethical Review.....	63
Appendix 7: Guidance on How to Develop a Theory of Change .....	66
Appendix 7A: Template/Worksheet for Creating a Theory of Change.....	69
Appendix 7B: Examples of Theory of Change Related To Respectful Maternity Care from Tanzania .....	70
Appendix 8. RMC Working Groups and MCSP staff persons .....	71

## Acknowledgments

The MCSP Maternal Health team gratefully acknowledge the contributions of many individuals in the preparation of this document.

Key authors include Kathleen Hill, MCSP; Suzanne Stalls, MCSP; Reena Sethi, MCSP; Eva Bazant, Jhpiego; Susan Moffson, MCSP.

Special thanks go to the following people for their contributions: Debbie Armbruster, USAID; Mary Ellen Stanton, USAID; Karen Fogg, USAID; Blami Dao, Jhpiego; Myra Betron, Jhpiego; Joya Banerjee, Jhpiego; Margaret Dadian, Jhpiego; Veronica Reis, Jhpiego; Gaudiosa Tibaijuka, Jhpiego; Sheena Currie, Jhpiego; Kate Brickson, Jhpiego; Ephrem Daniel, Jhpiego; Chibugo Okoli, Jhpiego; Chioma Oduenyi, Jhpiego; Thida Moe, NanNan Aung and Khine Hay Mar, Jhpiego/Myanmar.

DRAFT

# Abbreviations

CHW	Community health worker
D&A	Disrespect and abuse
FGDs	Focus group discussions
GBV	Gender-based violence
G-RMC	Gender-respectful maternity care
HMIS	Health management information system
HSR	Human Subjects Research
HRM	Human resources management
ICU	Intensive care unit
IDIs	In-depth interviews
L&D	Labor and delivery
LMICs	Low- and middle-income countries
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal and Child Survival Program
MMEL	Measurement, Monitoring, Evaluation, and Learning
MDG	Millennium Development Goals
MMI	Model Maternity Initiative
M&E	Monitoring and evaluation
MHTF	Maternal Health Task Force
MNH	Maternal and newborn health
MOH	Ministry of Health
NGO	Nongovernmental organization
NHSR	Non-Human Subjects Research
OBD	Open birth days
QI	Quality improvement
QoC	Quality of care
RMC	Respectful maternity care
SBCC	Social and behavior change communication
TBA	Traditional birth attendant
TOC	Theory of change
VCAT	Values clarification and attitude transformation
WHO	World Health Organization
WRA	White Ribbon Alliance



# Introduction

Women's experiences of respectful maternity care (RMC) or of mistreatment during facility-based childbirth are important determinants of women's and family's choices about where to give birth and of their overall experience during this pivotal life experience. Childbirth is an experience with deep personal and cultural significance, and because "motherhood is specific to women, gender equity and gender violence are also at the core of maternity care" (RMC Charter of the White Ribbon Alliance). Mistreatment in childbirth violates women's basic human rights, violates the fundamental obligation of the health system to provide support and healing in childbirth, and can cause lasting emotional trauma.

In 2011, the White Ribbon Alliance (WRA) launched a global campaign to promote respectful maternity care as a universal human right. The WRA-led charter for the rights of childbearing women was produced as a global consensus document that drew on a landscape analysis of disrespect and abuse in facility-based childbirth, which was published by the USAID Translating Research into Action (TRAction) project in 2010 (Bowser and Hill 2010). The primary purpose of the charter was to raise awareness of the rights of childbearing women, as recognized in international human rights declarations, with respect to common manifestations of disrespect and abuse in childbirth and to highlight the importance of human rights for maternal health programs. Since 2010 there has been an explosion of publications on the topic of respectful maternity care, many focused on assessing RMC and/or D&A in childbirth across a wide range of settings. A mixed-methods systematic review of the literature on mistreatment in childbirth published by the World Health Organization (WHO) in 2015 identified seven core mistreatment themes: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints (Bohren et al. 2015). These themes and common drivers reported in the literature are summarized in Appendix 1.

The absence or lessening of mistreatment in childbirth does not, however, guarantee respectful, dignified care for women and newborns in childbirth. In 2015, as the issue of mistreatment gained increasing recognition, WHO published a Quality of Care vision for maternal and newborn health that includes eight aspirational "standards" of quality maternal and newborn health care, of which three relate directly to experience of care: effective communication, respect and dignity, and emotional support. The highlighting of a woman's and newborn's experience of care is central to the WHO Quality of Care vision and strongly supports the principles laid out in the Universal Rights of Childbearing Women charter. Elements within the other five quality standards, such as adequate supplies and medications, are also essential for the provision of respectful, compassionate, and dignified care of women and newborns in childbirth.

MCSP promotes RMC as a central element of high-quality, safe, and person-centered maternal and newborn health (MNH) care. **The purpose of this operational guidance is to provide country stakeholders and MCSP staff with a flexible process to guide design, implementation, and monitoring of efforts to**

***"Safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences."***

**Source: Reis et al. 2012**



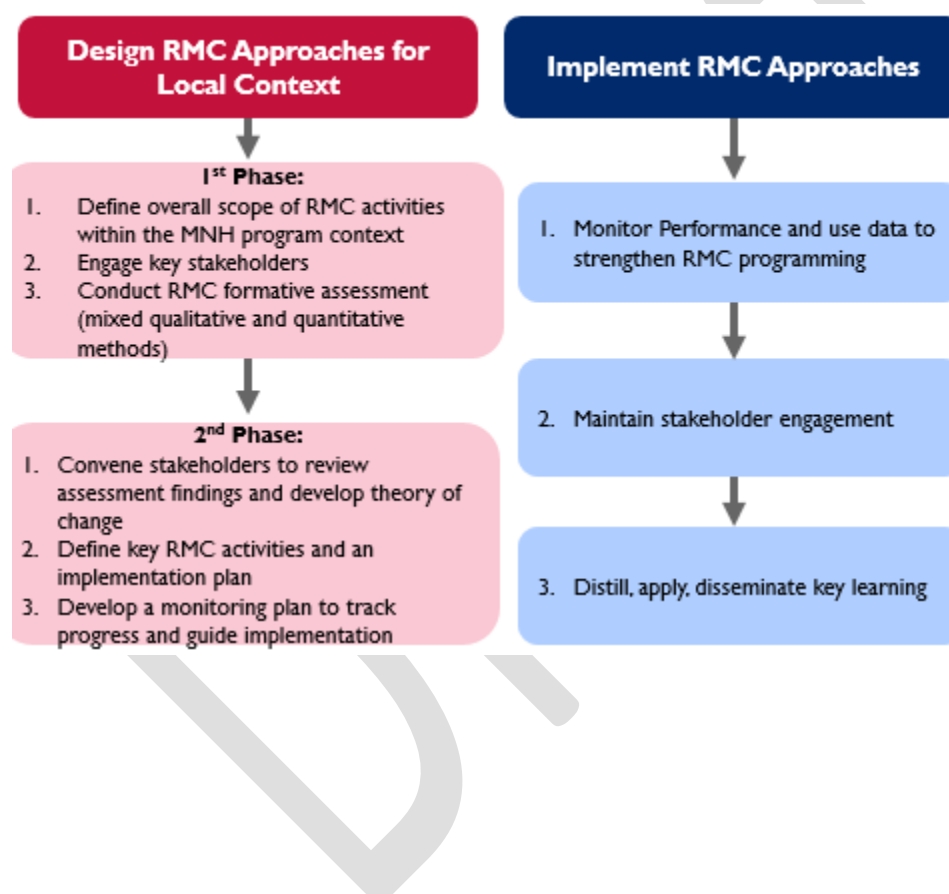
Photo by Kate Holt, Liberia

strengthen respectful maternity care and eliminate mistreatment as part of comprehensive MNH programs in MCSP-supported countries. This guidance draws on the published evidence and on the outputs from two RMC meetings organized by MCSP (one in Tanzania in 2015 and the second in Washington, DC, in 2016) that convened RMC advocates, researchers and program implementers. It

highlights key elements to consider in the design, implementation, and regular use of data in RMC and mistreatment-reduction efforts. The document includes links to resources and references that can be adapted to the specific needs of country MNH programs seeking to strengthen RMC and reduce mistreatment in childbirth. Figure 1 provides a graphic overview of the process described in this operational guidance to design and implement locally defined RMC approaches.

**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 large MNH programs.**

**Figure 1. Process for Designing and Implementing RMC approaches within a Comprehensive MNH Program**





# Background: Evidence to Date and Promising Frameworks

In order to design and implement maternal and newborn health programs that promote respectful care and diminish mistreatment in childbirth, it is important to understand underlying drivers and common manifestations of mistreatment in childbirth in the local and global context, as well as approaches that have been studied to promote RMC and reduce mistreatment. Awareness of the magnitude and characteristics of disrespect and abuse in childbirth has increased substantially in the last 5 to 10 years. As the Millennium Development Goals (MDGs) drew to a close in 2015 and MDG #5—reduction of maternal mortality by 75%—was noted to be lagging seriously behind, governments and organizations began to assess the barriers to achieving this goal. Increasing evidence demonstrated that the quality of care and the treatment that women and families experience in facilities is a significant deterrent to seeking care along with other well-documented barriers including geographic and economic access (Bohren et al, 2015; Kruk et al 2014, Abuya et al 2015a). This understanding underscored the need for formative and implementation research to better understand key characteristics, drivers of and patient-centered and health outcomes of mistreatment, as well as context-specific interventions for reducing mistreatment and promoting RMC. Recent evidence from Uttar Pradesh in India suggests that there may be an association between mistreatment during childbirth and maternal health complications (Raj et al., 2017).

Several recent publications demonstrate promising results for improving respectful maternity care and reducing mistreatment in childbirth (Abuya et al. 2015a; Ratcliffe et al. 2016a,b; Kujawaski et al. 2017). As noted, the absence or lessening of disrespect does not guarantee the provision of respectful maternity care. Approaches to promote RMC and/or reduce mistreatment may overlap or may be distinct depending on a program goals and the scope of activities feasible within a specific context. In addition to these considerations, maternal and newborn stakeholders increasingly recognize that providers themselves are often mistreated in the workplace (WHO 2016a: Midwives' Voices, Midwives' Realities). This section reviews current evidence related to defining and measuring RMC and mistreatment, promising approaches for reducing mistreatment and promoting RMC from the published literature and summarizes WHO quality of care standards and measures for improving women's and newborns' experience of care during facility based childbirth.

## Theory of Change Definition

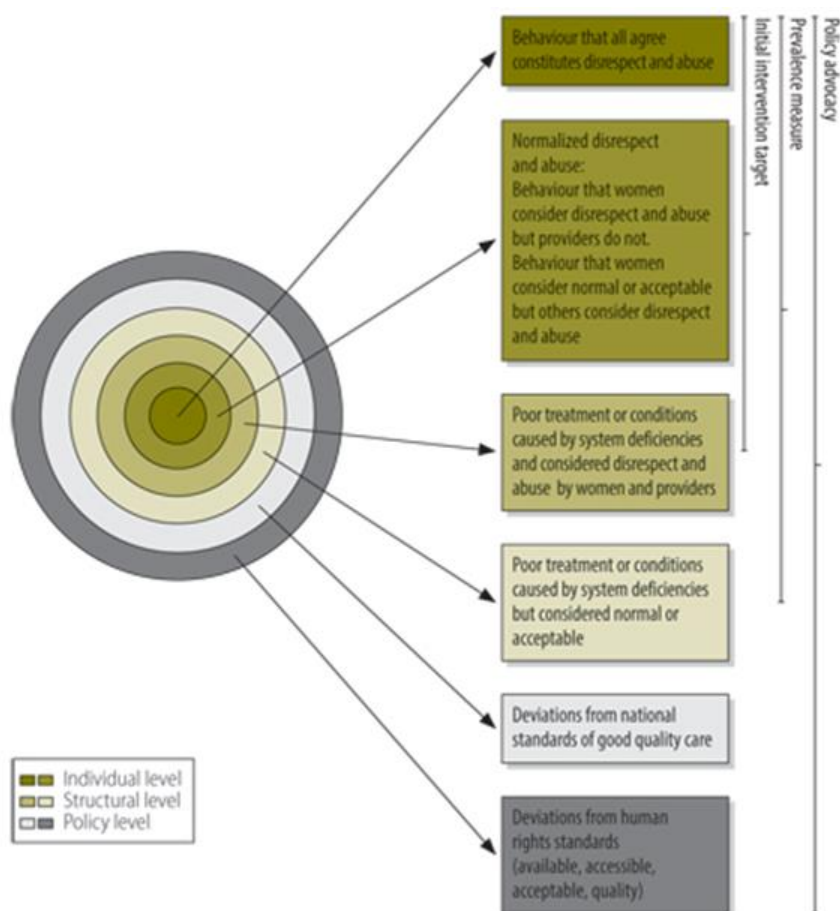
A theory of change is essentially an explanation of how a group of stakeholders expects to reach a commonly understood long-term goal.

Source: Anderson 2005

## Defining and Measuring RMC and Mistreatment

At this time, there is no widely accepted standard operational definition of mistreatment in childbirth. Because mistreatment in childbirth can manifest in many ways, its definition varies according to whose perspective and/or which normative standards are used. Freedman and coauthors (2014) propose a definition of mistreatment that includes both normative standards and experiential building blocks, as visualized in Figure 2.

**Figure 2. Defining disrespect and abuse of women in childbirth**



Source: Freedman et al, 2014.

Bohren and coauthors (2015) define seven themes of mistreatment based on a review of the quantitative and qualitative literature published in 2015:

- 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

Appendix 1 summarizes common types of mistreatment in childbirth documented in the literature, using the Bohren classification scheme, as well as associated drivers/triggers of mistreatment in the published literature. Appendix 1 can help project staff begin to think about assessing and identifying common forms of mistreatment and associated drivers in their specific context (Bohren et al. 2015). Quantitative studies published to date report prevalence rates of mistreatment in facility-based childbirth ranging from 15% to 98%, with most studies measuring mistreatment prevalence in the 12% to 20% range in Tanzania, Kenya and India (Abuya et al. 2015a; Sando et al. 2016; Okafor et al. 2015; Raj et al, 2017). Rates of client-reported mistreatment may vary according to time and place of interviews or questionnaires. In a study in Tanzania,

women's reports of mistreatment increased from 19% to 28% between maternity exit interviews and a home-based interview conducted six weeks later (Kruk et al. 2014).

Measurement challenges include inconsistent definitions of mistreatment and the use of varying tools and study designs across studies (Sando et al. 2017). The recent review by Sando et al. of methods used in prevalence studies of disrespect and abuse in facility based childbirth highlights the lack of standardized “definitions, instruments, and study methods used to date [affecting] generalizability and comparability of disrespect and abuse prevalence estimates across studies.” Furthermore, there are few instruments for measuring the characteristics of respectful/disrespectful maternity care in facility-based childbirth that have been validated in low-resource settings. Many of the instruments validated in the North America and Europe focus on specific populations or time periods that may have varying degrees of relevance for program implementers in low-resource settings depending on a program's specific RMC goals (Saraswathi et al. 2017; Sheferaw et al. 2016; Nilver et al., 2017, Vedama et al. 2017).

Given the lack of a standard operational definition, and the inherent tension between reliable, generalizable measurement methods and local validity, assessing and measuring mistreatment in childbirth is challenging for program implementers. Of particular concern for program implementers is the fact that RMC and mistreatment measurement and assessment methods in published studies to date are resource-intensive (e.g. observation of facility-based care, follow-up home-based client interviews) and are unlikely to be feasible as part of *routine* monitoring in comprehensive MNH programs operating at scale.

Given the many manifestations of mistreatment and the many aspirational goals for RMC, no single indicator can measure the entirety of RMC or mistreatment in facility-based childbirth. Although individual indicators can measure specific aspects of RMC, such as achievement of normative RMC standards (e.g. companion of choice during birth) or clients' self-reported positive or negative experiences of care, a triangulation of data combining quantitative and qualitative methods is likely to be necessary in most programs to assess and monitor RMC and mistreatment.

**“[Our] findings suggest that multiple measures may be needed to assess the diverse and potentially uncorrelated aspects of mistreatment during childbirth...”**

**Source: Raj et al. 2017**

Work is ongoing to prioritize RMC indicators for quality improvement efforts as part of the WHO Quality Equity Dignity network and this guidance will be updated as recommendations are finalized. Similarly, there are a number of research studies underway to develop and validate quantitative measurement methods (e.g., scales based on client questionnaires) and to refine qualitative assessment approaches that can be feasibly incorporated into the design and routine collection and use of data in RMC and mistreatment-reduction efforts in large comprehensive MNH programs in low resource settings.

Nilver and colleagues recently published a systematic review of validated instruments to measure women's experiences at childbirth (Nilver et al. 2017). Their review is an important and timely contribution to the literature. However, most of the instruments included in the study were validated in high-resource settings and will need to be adapted and validated for use in individual lower-resource settings as part of comprehensive MNH programs. Quantitative scales validated in low-resource settings, including Ethiopia and Senegal (see appendix 2), would likewise need to be validated in each individual program context to be considered valid for that context.

WHO is currently undertaking a mixed methods study in four countries (Burma, Ghana, Guinea, and Nigeria) with two primary aims: (1) to develop an evidence-based definition and identification criteria of how women are treated during childbirth in facilities, and (2) to develop and validate tools to measure how women are treated during childbirth in facilities (Vogel et al. 2015). The study is being conducted in two phases. The first phase consists of qualitative formative research to explore manifestations and drivers of mistreatment during childbirth using focus group discussions and in-depth interviews with women, providers and administrators to explore individual, provider, institutional and health system factors that influence respectful and

disrespectful practices during childbirth in facilities. The second phase includes the development and validation of two tools to measure prevalence of mistreatment during childbirth: 1) facility-based direct observation of women during childbirth; 2) a community-based, interviewer-administered, follow-up survey of women's self-reported experiences of facility-based childbirth. Selected results of the formative phase have been published (Balde et al. 2017). The second phase of the study to validate quantitative tools to measure the prevalence of mistreatment is underway in the four countries.

Routine assessment of mistreatment/RMC to drive effective implementation in the context of comprehensive MNH programs in low resource settings is a challenging but important area that is addressed in several sections of this guidance (formative assessment, p. 13; designing a program monitoring and evaluation framework, page 20; Quantitative and Qualitative Data collection methods and resources, Appendices 4 and 5).

Appendices 4 and 5 summarize qualitative and quantitative methods for assessing RMC and mistreatment using a range of data sources (e.g. clients, providers, managers, policymakers) and highlight the strengths and limitations of individual methods. Appendices 4 and 5 include references with tools under each assessment method that can be adapted by program managers for use as part of formative assessments and routine data collection and use to inform robust design and implementation of RMC and mistreatment reduction efforts in a comprehensive MNH program. However, further research is needed to develop, refine and validate (as appropriate) qualitative and quantitative assessment methods that are feasible and sustainable in the context of comprehensive MNH programs operating at scale in low-resource settings.

## Promising approaches for reducing mistreatment and promoting RMC

Several recent publications report positive results for improving respectful maternity care and reducing mistreatment in childbirth (Abuya et al. 2015b; Ratcliffe et al. 2016a; Kujawaski et al. 2017). Programmatic approaches to reduce mistreatment in the published and gray literature typically include a combination of interventions developed through local participatory processes based on a theory of change in a specific context.

Illustrative examples of promising approaches described in the literature at various system levels (national, subnational, service delivery, and community) include:

- Advocacy and policy work at national and local levels (e.g. national policy; district or facility charter.)
- 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
- Facility-based quality improvement processes incorporating community participation
- Interventions which support health care providers (Caring for the Carer)
- Gender-focused approaches
- Community engagement and mobilization activities (e.g. community score cards that include measures of families' reported experience of care.)

**“The reasons for mistreatment are many. Providers themselves may be treated poorly, be underpaid, or face harassment and difficult working conditions—overcrowding, understaffing—so we need to address RMC holistically and look at how to create more supportive work environments.”**

**Source: White Ribbon Alliance Blog: Every Woman Deserves Respectful Maternity Care During and After Childbirth**

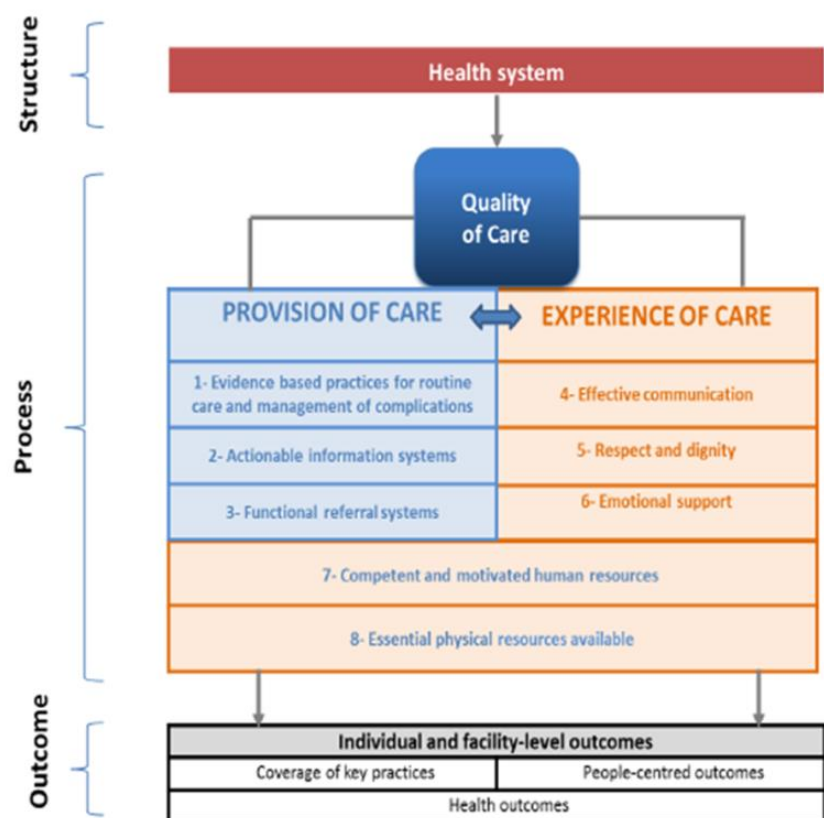
Appendix 2 summarizes promising approaches for strengthening RMC and reducing mistreatment based on recent publications and highlights potential pros and cons of implementing individual approaches within a specific program context. Unfortunately, there is no single magic bullet to reduce mistreatment and improve

respectful maternity care. The published and gray program literature demonstrate the importance of locally defined multi-faceted interventions tailored to the context.

## WHO MNH Quality of Care Vision and Standards for Positive Experience of Care

The WHO Quality of Care framework for maternal and newborn health was published in 2015 and includes eight aspirational standards to achieve high-quality care around the time of childbirth for women and newborns and to set a benchmark for measuring improvements to drive and monitor quality improvement efforts (see Figure 3).

**Figure 3. WHO Quality of Care Framework for Maternal and Newborn Health**



In 2016, WHO published standards, quality statements and measures for improving quality of maternal and newborn care in health facilities based on the WHO standards published in 2015 and the outputs of several consultations and a Delphi process to refine maternal and newborn quality of care measures (WHO, 2015 and 2016c).

Each of the eight WHO standards for improving quality of maternal and newborn care in facilities includes several *quality statements* and associated *measures*.

- *Quality statements* are concise, prioritized statements designed to help drive measurable improvements in care.
- Three measures are defined for each quality statement:
  - *Inputs*: what must be in place for the desired care to be provided
  - *Outputs* (process): whether the desired process of care was provided as expected
  - *Outcome*: the effect of the provision and experience of care on health and people-centered outcomes



Table 1 summarizes WHO standards 4, 5, and 6 related to patient experience of care and the specific quality statements identified under each standard (WHO, 2016). These quality statements and associated measures can be used by local program implementers to structure RMC quality improvement work focused on women's and newborns' experience of care and to select indicators to monitor progress toward achieving specific quality statements (i.e., improvement aims).

**Table 1. WHO Quality of Care standards and Corresponding Quality Statements for Maternal and Newborn Care**

Standard	Quality Statement
<b>Standard 4: Communication with women and their families is effective and responds to their needs and preferences.</b>	4.1 All women and their families receive information about the care and have effective interactions with staff.
	4.2: All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals.
<b>Standard 5: Women and newborns receive care with respect and preservation of their dignity.</b>	5.1: All women and newborns have privacy around the time of labor and childbirth, and their confidentiality is respected.
	5.2: No woman or newborn is subjected to mistreatment, such as physical, sexual, or verbal abuse; discrimination; neglect; detainment; extortion; or denial of services.
	5.3: All women have informed choices in the services they [and newborns] receive, and the reasons for interventions or outcomes are clearly explained.
<b>Standard 6: Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens the woman's capability.</b>	6.1: Every woman is offered the option to experience labor and childbirth with the companion of her choice.
	6.2: Every woman receives support to strengthen her capability during childbirth.

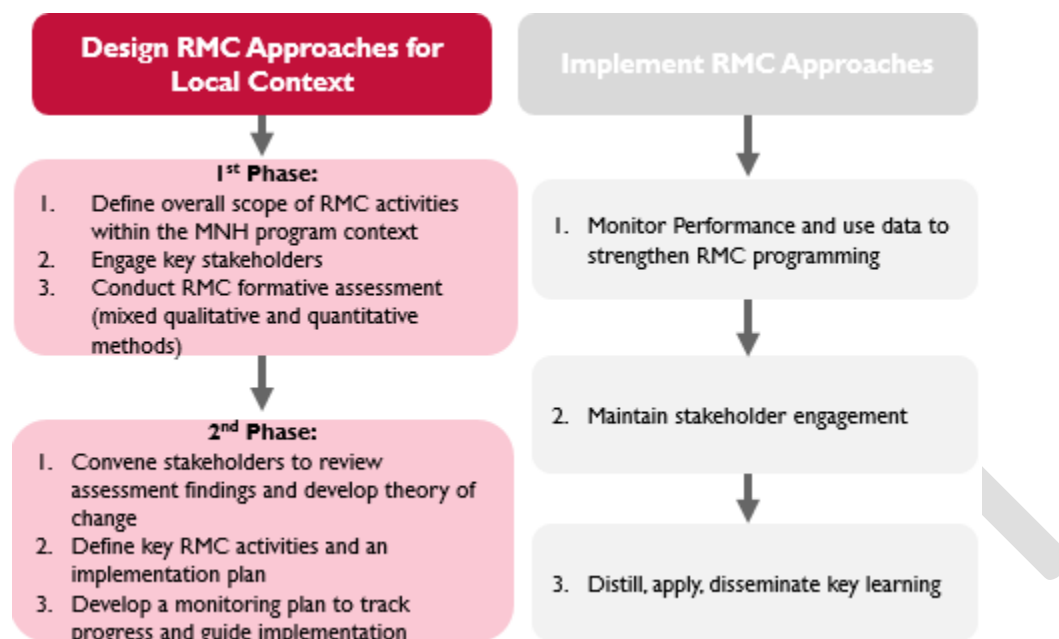
In 2017 WHO and partners launched a Quality Equity and Dignity (QED) network in nine first-wave countries to improve quality of care and outcomes for mothers and newborns during facility-based childbirth.

The goals of the QED network are to:

- Reduce maternal and newborn deaths and stillbirths in participating health facilities by 50% over five years
- Improve Experience of Care for mothers, newborns and families

As part of the QED network, efforts are ongoing to refine experience of care (RMC) indicators and feasible routine measurement methods that can be used by countries as part of continuous quality improvement to improve women's and newborns' experience of care. A monitoring framework under development for the QED network includes a flexible catalogue (menu) of quality indicators (input, process and outcome) organized by quality statements, including experience of care quality statements (Table 1). In addition to a flexible catalogue of quality indicators, the QED monitoring framework proposes approximately fourteen common quality indicators to be measured across all participating QED sites in network countries. These common indicators include three indicators related to experience of care (one for each of the experience of care standards 4, 5, 6). The proposed common indicators were reviewed by country and global stakeholders as part of recent consultations, including a multi-country QED network meeting in Tanzania in December 2017. Plans are underway to begin collecting data on the agreed common QED measures in all participating QED sites in network countries in 2018. Further information about the QED network is available on the WHO website and at: <http://qualityofcarenetwork.org>.

# Designing RMC Approaches in a Comprehensive MNH Program



## First Design Phase

### Introduction/Program Scope

Designing RMC approaches within a comprehensive MNH program can be a daunting task given the complexity of MNH programs and the many deep-seated issues related to RMC and mistreatment that reflect some of the most sensitive aspects of any culture. This section provides flexible guidance for a stepwise process to determine which aspects of RMC and/or mistreatment a program will address and how program RMC activities can be woven into a comprehensive MNH program. Appendix 3 provides an illustrative overview concept note and work plan for incorporating RMC approaches into a comprehensive MCSP MNH program, based on the design and implementation phases described below. Individual country MNH programs are encouraged to adapt the concept note based on their overall MNH program goals, RMC objectives, country context and resources.

***"We are teaching midwives to do good vaginal exams, but not to be kind."***  
**-Participant at National Stakeholder meeting on RMC in Rwanda, 2015**

It is important to recognize that a single program working within a relatively short time-frame is unlikely to be able to address or resolve the many factors that contribute to mistreatment and a positive experience of care for women and newborns in childbirth. Individuals and programs should expect to design and implement promising RMC approaches, based on the local context, and to learn, evaluate, and adapt future interventions as part of an iterative process of achieving RMC and eliminating mistreatment in childbirth, understanding that societal norms and values typically only change after long periods of effort and attention.

To date, many RMC programs have been implemented as stand-alone RMC studies focused on a set of prioritized RMC approaches in a few sites, rather than on the incorporation of RMC approaches into a comprehensive MNH program operating at scale. Such studies have generated essential learning, reflected in the proliferation of RMC publications since 2010, and are important resources for informing the selection

and adaptation of RMC approaches. However, an important next frontier is to build learning and evidence about how RMC and mistreatment-reduction efforts, which are cross-cutting, can be incorporated into comprehensive MNH programs and implemented at greater scale.

In determining how best to approach the design of RMC approaches, it is helpful to keep in mind that efforts to promote respectful care should ideally be embedded across multiple system levels, including national and subnational policy and advocacy, subnational management (e.g. district managers) provision of care by facility staff, and women's and families' experience of facility childbirth services. There will be multiple approaches and levels of the health care system that can be considered and targeted when framing the design of RMC approaches. Ultimately, the design of RMC approaches should spring from first listening to what women and health workers need and desire, followed by the creation of structures and processes that ensure their voices are heard on an ongoing basis. This initial step, embodied in the formative assessment step of this guidance, provides the foundation for the design of people-centered robust RMC approaches.

At the outset it is important to determine the overall scope of an RMC effort within a comprehensive MNH program by considering and defining:

- The overall goals of the RMC effort (e.g., relative focus on RMC promotion and/or mistreatment reduction).
- Available resources (for design and implementation of a formative assessment, programmatic RMC approaches including routine data collection and process learning (and evaluation and process learning, if resources permit)).
- Local stakeholder priorities for RMC and mistreatment reduction.
- Prior RMC advocacy, research, and implementation, and achievements in the country and local context on which program efforts can build (e.g., a national RMC charter).
- Feasibility of implementing RMC approaches at distinct system levels based on the reach and resources of a comprehensive MNH program's reach (e.g., community, primary and referral-level activities and district, regional, and national levels).
- The scale of the RMC effort based on the comprehensive MNH program coverage and scale-up plans (if any).

Depending on a program's overall scope and mandate, one or more levels of the health system may be targeted to promote RMC and reduce mistreatment. For example, if a program has a mandate to collaborate with national agencies and professional organizations to address policy, this may be one avenue to raise awareness of the issue of RMC and mistreatment and to sustain interest and ongoing advocacy efforts at a national, subnational, or local level. If a program's mandate is to collaborate with health care educational institutions, it can incorporate activities to strengthen professional codes of ethics and standards of care as part of the professional formation of health care workers during pre-service and in-service education. If a program is working to strengthen delivery of essential maternal and newborn health care services, it can incorporate RMC activities focused at district and service delivery level such as quality improvement, open maternity days, and activities targeting the values, professional ethics, and needs of health care providers.

RMC as a key component of in-service and pre-service education

**If students leave school into service delivery without witnessing first-hand the modeling of RMC, we know there will be little change.** However, when RMC and mistreatment are addressed throughout pre-service and in-service training, health care workers are more likely to value and adopt professional, caring behaviors, and to obtain the skills and knowledge to practice RMC.

Source: *Maternal Health Task Force (MHTF)*  
Blog: *Respect during Childbirth Is a Right, Not a Luxury*



If a program is working at the community and/or facility levels, it can support activities that bring community members and health care workers together to solve problems and improve client-centered care and the working conditions of providers.

## Identifying and Sensitizing Stakeholders and Engaging Key Partners

An important first step in designing RMC approaches as part of a comprehensive MNH program is to identify and raise awareness among key stakeholders involved or interested in RMC in the country and program local context. These stakeholders will be essential partners throughout the design and implementation of RMC approaches. Key stakeholders will likely include:

- Representatives of relevant departments in the Ministry of Health (MOH), including maternal, newborn/child, quality, reproductive health, community development, family, gender, infrastructure, training, and health information systems. Relevant MOH officials can be engaged at the national, regional, and/or subnational level (e.g., district), depending on the scope and mandate of a program.
- Parliamentarians, ministries of education and justice, the media, champions, and religious leaders who may have an interest in addressing the issue.
- Health facility managers and health care workers who understand and influence the day-to-day provision of care.
- A national or subnational technical advisory or working group that addresses maternal and newborn health issues.
- Implementing partners, such as nongovernmental organizations (NGOs) experienced in community-based or rights-based maternal health and gender activities, as well as partners involved in implementation at the point of service delivery and/or advocacy and operational research. For example, the White Ribbon Alliance has disseminated a charter entitled Respectful Maternity Care: The Universal Rights of Childbearing Women. Wherever a WRA national alliance exists in MCSP program countries, MCSP should explore collaboration with WRA to leverage its organizational strengths (MCSP and the WRA have a memorandum of understanding to facilitate collaboration at the country and global levels.)
- Representatives of women/clients and their companions, community leaders, traditional healers and birth attendants, adolescent groups, concerned community members and/or local NGOs that address citizens' rights to high-quality services.
- UN agencies, especially WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and UN Women.
- Donors supporting MNH, quality of care, reproductive and human rights, and other relevant policy and program work and research in the country context.

### Program Learning: RMC and Gender in Tanzania

To improve the quality of care and utilization of health facilities by pregnant women during childbirth, the Tanzania MCSP team worked with the government and stakeholders to improve RMC by linking with gender efforts including:

#### Sensitizing Stakeholders

- Implementation of a social and behavior change communication campaign (SBCC), integrating gender into SBCC messages focused on joint-decision-making, couple birth preparedness, and male engagement in maternal services.
- Distributing messages by civil society partners through cinemas, brochures, and health fairs.
- Supporting formation of gender dialogue groups for couples, reached with key messages on gender.
- Training maternal health mentors to be gender and RMC champions in their districts and facilities.

#### Engaging Key Partners

- Advocacy for Gender-RMC (G-RMC) through high-level stakeholder meetings in four districts and targeting messages to religious leaders, politicians (members of parliament (MPs), council representatives, district planning officers and facility health workers.
- Based on advocacy activities, the four program-supported districts agreed to finalize a district client service charter (with input from villages) and to reach all of their constituents with the advocacy messages.

- Professional associations, including associations of midwives, obstetricians, pediatricians, and nurses (if nurses have a significant role in providing obstetric care).
- Organizations, government agencies, or individuals with expertise in assessing and measuring the quality of service delivery, especially with a focus on respectful care. These may include local universities where faculty, staff, or students seek opportunities to hone their skills and can help manage the process of data collection, analysis, and interpretation. Local NGOs or civil society organizations may have the capacity to help support formative assessments and/or ongoing monitoring of clients' experience of care within a program's monitoring system. In some countries, there may be government-sponsored research agencies or institutes that can support formative and routine assessments to improve service delivery, including RMC.

WHO has called upon all members of the maternal health community to contribute to research, implementation, and advocacy on RMC. Building partnerships and working in collaboration at the global and country levels is essential. Context is everything, and flexibility is important; indeed, contextual realities and priorities may vary significantly by region within an individual country.

Suggestions for engaging and collaborating with key stakeholders include:

- Hold stakeholder consultations, such as a roundtable, which can gauge opinion on what should be done and how to assign roles and responsibilities.
- Identify and support champions, influencers, early adopters, and gatekeepers within the stakeholder group.
- Identify and engage actors who have a powerful role in promoting or denying opportunities for respectful, dignified, and effective maternal and newborn care.
- Frame the issue strategically with stakeholders to create buy-in. Linking mistreatment and RMC to quality of care can be convincing for many stakeholders (see Figure 3 for WHO's Quality of Care MNH framework). Linking the issue to rights-based approaches endorsed in the Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health can help national and local stakeholders to understand that RMC is a rights-based issue that is embedded within global strategies.
- Encourage women's and families' participation to ensure that cultural contexts, political sensitivities, and individual priorities and perspectives are part of the discussion to bring forward their perceptions of maternity care.
- Identify community priorities and values for quality respectful maternity services through direct dialogues between community and stakeholders in health care and the MOH.

By engaging in consultations with a range of stakeholders and partners, program designers and stakeholders will develop a better understanding of local factors related to RMC and mistreatment, including the perceptions of individual stakeholder groups (e.g., providers, women, communities, MOH officials, and facility managers). Stakeholder consultations will also begin to sensitize key stakeholder groups. During consultations with stakeholders, it may be helpful to begin discussions by reviewing any available literature or data on mistreatment and experience of childbirth in the local context. Consultations with key stakeholders are an important first step to raise awareness and deepen their understanding of the local environment.

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: MHTF Blog Respect During Childbirth Is a Right, Not a Luxury

## Assessing and Measuring RMC and Mistreatment: Formative Assessment

Once the general scope of an RMC effort has been defined as part of a comprehensive MNH program, an important next step is to understand key manifestations and drivers of RMC and/or mistreatment in the local context. Even in MNH programs with limited resources, MCSP programs should make every effort to undertake a modest formative assessment to explore mistreatment and its drivers as well as women's and health workers' perception of and priorities for maternity care in the local context. A formative assessment is important to inform the design of RMC approaches that are responsive to and more likely to be effective in the program context. Because mistreatment can manifest at all levels of the health care system, formative assessments should ideally incorporate and triangulate a range of data sources across as many system levels as feasible to inform a robust program design.

A formative assessment allows for the development of a tailored intervention based on data related to the behaviors, perceptions, norms, and beliefs of service recipients in a specific program context (Vastine et al. 2005). During the formative phase of a program, it is important to capture the perspectives of multiple stakeholders, clients, and communities in order to customize future RMC activities to the needs of women, families and health care workers. Ideally a formative assessment will employ a mix of qualitative and quantitative methods to assess key manifestations and drivers of RMC and mistreatment in the local context. The formative assessment can begin to uncover local drivers of mistreatment, such as gender inequalities and structural issues. Involving the community in planning and implementing a formative assessment and follow-on interventions can build trust and collaboration with women, families and community members to enhance the appropriateness and success of future RMC interventions. A formative assessment should be adapted and right-sized based on a program's resources and the overall scope of planned RMC activities.

Examples of illustrative priorities for information gathering during the program design or formative phase of a program include:

- The perceptions and experience of women who recently gave birth and their families, both positive and negative
- Women's and families' definitions of a positive childbirth care experience
- Community, families and healthcare workers' perception of cultural norms around the treatment of women during facility-based childbirth.
- Health workers' perceptions of women's experience in childbirth, the rights of women to certain standards of care, health workers views of their work environment and their experience of providing care in the local health system (e.g. level of support and mistreatment experienced by health workers).
- Common manifestations of mistreatment reported by women, families and health care workers and local perceptions of underlying drivers of mistreatment.
- Inequities and disparities in access to and quality of childbirth services (clinical issues, safety issues, and client-centeredness).
- District and facility managers perceptions of childbirth care, the rights of women and families, the rights of health care workers and their role and responsibility as managers to ensure a favorable childbirth environment for women, families and health care workers.

Appendices 4 and 5 summarize qualitative and quantitative methods and include references to publications and tools that can be adapted by program implementers for a formative assessment. Appendix 6 outlines and links to an illustrative set of qualitative and quantitative data collection tools developed by MCSP for use and adaptation by MCSP country programs. The MCSP formative assessment tools employ a combination of qualitative and quantitative methods targeting women, families, community members, providers, and administrators. MCSP is adapting and using the tools in Appendix 6 to support formative assessments and the design of follow-on RMC program interventions and monitoring approaches as part of large MNH programs in Guatemala and Nigeria. MCSP will update the tools in appendix 6 in late 2018 based on learning in these countries and external reviewer feedback.

## Qualitative Approaches

Formative assessments are perhaps best known for using qualitative approaches summarized in appendix 4 with a brief description of strengths and limitations of specific methods.

Qualitative methods may include:

- In-depth or semi-structured interviews with open-ended questions for individuals (e.g. women, families, health care workers.)
- Focus group discussions with members of a similar group, such as women, family members, midwives, nurses, and other cadres providing maternity care.

Despite evidence for mistreatment in childbirth across the globe, the manner in which it occurs and is perceived varies according to contextual factors such as cultural norms and local expectations and behaviors. Qualitative methods should be employed to explore cultural norms that may influence local perceptions of respectful care and mistreatment to deepen understanding of women's and families' desires for a positive birth experience and non-respectful behaviors that may be normalized in the local context. For example, physical abuse, such as slapping, may be perceived in one setting to be acceptable and/or necessary, while in another, such behavior would be condemned.

MCSP has adapted and shortened qualitative tools from the WHO multicountry study for use by MCSP country programs implementing comprehensive MNH programs (see MCSP Assessment and Monitoring tools in appendix 6). The WHO study qualitative tools include interview and focus group guides for four types of informants: women who have had a facility-based birth in the last 12 months, women who gave birth in the last 5 years, health care providers and staff, and administrators (Vogel et al. 2015). The women's interview guide includes perceptions and experiences of care provided at their birth, including treatment by health care workers and the facility environment; elements and experiences of mistreatment; perceived factors that affect treatment received; and acceptability of the treatment of women in childbirth. The provider and administrator interview guides are similar to those for the women, but also ask how providers and staff are treated.

Qualitative approaches used in a formative assessment may, in some cases, be modified for use as part of periodic monitoring during program implementation (see section on designing a program monitoring framework, page 20). It is important to note that the collection and analysis of rich information using qualitative methods requires skills that are often lacking among program implementers and providers. It is important for program implementers to identify local sources of expertise to support robust qualitative components of a formative assessment. Please see appendix 4 for a further discussion of qualitative methods.

## Quantitative Approaches

Quantitative approaches can also be used in formative assessments, as part of a baseline assessment, and as part of routine monitoring during implementation of RMC activities. Selected quantitative methods and their strengths and limitations, including specific references and tools, are summarized in appendix 5. Although routine health management information systems (e.g. service registers and client forms) will not include information on respectful care or mistreatment, they may provide useful complementary information such as monthly volume of births, provision of selected clinical interventions, and patient-level health outcomes.

Examples of quantitative data collection methods to measure RMC and/or mistreatment include:

- Structured surveys with women clients, their families, or community members.
- Structured surveys with health care workers and managers/administrators.
- Direct clinical observations with a focus on RMC and/or mistreatment

Ideally, health care workers' perspectives and broader health system factors that influence quality of care and women's and newborns' experience of care should be incorporated into health worker surveys and health facility readiness surveys. Such surveys and assessments can inform an understanding of underlying contributors to mistreatment experienced by women and providers such as infrastructure constraints and/or lack of basic support for providers. Structured observations of simulated client-provider interactions can help to assess provider interpersonal communication skills, for example after training and as part of supportive supervision. Each of the quantitative methods has strengths and limitations (see appendix 5), particularly in settings where mistreatment is normalized.

### *Planning for Data Collection*

As data collection plans are being made, it is important to consider the available capacity for the proposed activities. A leader who has some background in measurement and assessment methods should be identified to direct the assessment activities. Sometimes, hiring a local research firm or university students or faculty will help the assessment team collect and analyze the data in a timely way. In some cases, data may be collected by providers themselves. If the program has the resources to implement a baseline and endline survey to support a program evaluation, it will be important to pretest and validate tools beforehand within the local context (refer to Sheferaw et al. 2016).

The mode of data collection also needs to be considered as part of the planning and budgeting process. Increasingly, data are being collected on tablets, phones, or computers, and this requires more up-front planning for hardware, software, and internet-based solutions for collecting and presenting data, as well as staff expertise in information technology. For more information, MCSP's Digital Health and Measurement, Monitoring, Evaluation, and Learning (MMEL) teams may be able to provide assistance. For qualitative data collection, consider whether data will be recorded and then transcribed and coded in a qualitative data management software, as this will need to be included in the program budget. Contact MCSP for more information on digital tools.

### *Ethical Considerations*

RMC and mistreatment are sensitive topics, and all information collected must be kept private and confidential and be collected in an ethical and careful way. The example of the WHO multi-country study of violence against women is instructive about how to collect sensitive data ethically (WHO 2005). The WHO ethical and safety recommendations for intervention research on violence against women includes recommendations for anyone intending to research domestic violence against women and also for those initiating or reviewing such research, such as donors and research ethics review committees (WHO 2016a).

Please remember that data collected as “not human subjects’ research” or for program purposes only do not necessarily need be submitted to ethical review boards in the United States, but MCSP teams need to apply for and obtain a determination letter for the activity. Ask MCSP MMEL for more information and to receive the determination template form. Please also consider the local data collection regulations in the country where the program is collected. Also, if the program wishes to publish (or present externally) the data that is collected, please work with the MMEL advisor and/or the MCSP Institutional Review Board (IRB) Help Team as the plan is designed. All data collected under MCSP will eventually be shared publicly under the terms of the USAID MCSP cooperative agreement and will need to be de-identified (with any identifying information removed) prior to sharing. Again, contact MCSP MMEL for the latest guidance as this is evolving.

## **Second Design Phase**

### **Engaging Key Stakeholders and Partners**

After involving stakeholders and partners in the initial sensitization and other aspects of the program's formative assessment, the program can now begin designing activities and interventions to promote RMC



and reduce mistreatment. The program should convene key stakeholders to review the formative assessment findings and to define specific program goals and a theory of change to guide selection of RMC activities.

## Defining Program Goals and Developing a Theory of Change

### Defining Program Goals

The treatment women receive in childbirth spans a continuum from outright abuse, such as hitting or humiliating a woman in labor or withholding care, to the provision of person-centered care that is deeply responsive to the emotional and physiological needs and individual preferences of women during labor and childbirth. Many forms of RMC or mistreatment may fall in between these two ends of the continuum. Programs should define their RMC goals based on the overall scope of the RMC effort (discussed above) and the results of the formative assessment in order to target key manifestations and drivers of mistreatment in a given context. MCSP recommends that program goals be clearly linked to a results framework and theory of change. The design of specific RMC approaches within a comprehensive MNH program will depend on the overall MNH program scope and resources, the results of the formative assessment, a clear theory of change, and the levels at which the MNH program is able to intervene (e.g. national, regional, district, facility, and/or community). The feasibility of implementing prioritized RMC approaches across MNH program geographic sites at different system levels will influence the scale of the program's RMC interventions.

### Developing the Theory of Change

A theory of change is essentially a comprehensive description and illustration of how and why programs expect to make a desired change happen within a specific context. It is particularly important to map out the steps between the activities and interventions of the program and explain how these activities will help to achieve the desired goals based on the theory of change. Program staff and stakeholders must clearly identify the short and long-term goals for achieving RMC and eliminating mistreatment and must explore and articulate what conditions must be in place and what changes must occur to achieve the defined goals.

A program's theory of change should include information about contextual factors related to RMC and mistreatment and proposed program inputs, outputs, and outcomes, both short-term and long-term. The program should also highlight key assumptions underlying the theory of change. Local stakeholders and actors should work together to define the problem of mistreatment and the program's RMC goals based on the program's scope and resources and formative assessment results. The theory of change should define RMC approaches that address contextual drivers of mistreatment elicited in the formative assessment and the hypothesized changes that will occur when prioritized RMC approaches are implemented. The expected effect of the program's RMC activities on women's health, experience of childbirth care, providers' work satisfaction, and other long-term outcomes for the health system should be clearly articulated as part of the theory of change.

See Appendices 7, 7A and 7B for guidance on how to develop a theory of change and for two examples of theories of change from implementation research that demonstrated reductions in mistreatment in Tanzania and Kenya (Ratcliffe et al., 2016; Kujawaski et al. 2017).

As stakeholders develop a theory of change, they may find it useful to review promising RMC approaches and results from the published literature. Appendix 2 summarizes promising RMC approaches, including the pros and cons of selected approaches based on specific program contexts. To align a program's theory of change with emerging global maternal and newborn quality of care standards, inclusive of experience of care, stakeholders developing a theory of change may also find it useful to review the WHO *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities* (WHO 2016c; see Figure 3, Table 1). Several of the standards are particularly relevant to respectful care, including standards 1, 4, 5, 6, and 7.

## Defining Key RMC Activities across System Levels

The prioritization of RMC activities should ideally be guided by the program's theory of change based on the formative assessment results and a program's overall scope and goals related to improving women's and newborns' experience of care and eliminating mistreatment of women and newborns in childbirth. Given that the formative assessment is likely to identify facilitators of RMC and drivers of mistreatment operating at multiple system levels, prioritized RMC approaches are likely to target as many system levels as is feasible within the overall MNH program scope.

Programs may choose to address broad systemic factors or single or local issues, depending on the overall program scope, RMC goals, resources, and theory of change. Given that mistreatment is multifactorial and is perpetuated through both individual and collective actions, engagement and advocacy of multiple stakeholders at many organizational and governmental levels may be essential to effect durable change. Addressing mistreatment on all fronts and across all system levels may or may not be feasible within a single program and should be carefully considered as part of the theory of change and prioritization of RMC approaches within an individual MNH program.

This section outlines considerations for program implementers designing and prioritizing RMC activities across system levels in a comprehensive MNH program. See Appendix 2 for a summary of promising RMC programming activities and the pros and cons of selected approaches based on specific program contexts from the published literature to date.

## National and Subnational

### Policy and advocacy

Advocating for policies at any level of the health care system means stakeholders are requesting that a change or redirection in behavior of individuals or governmental and organizational entities be instituted in the form of policies. Those policies are then applied by organizational or governmental entities as a result of the influence exercised by advocates. Just as advocacy for RMC is essential at national and subnational levels, the complementary development of national policies that communicate an unequivocal expectation for and favorable environment for RMC, including zero-tolerance for mistreatment, is essential for fostering short- and long-term change.

For effective identification and implementation of solutions at the policy and national level, stakeholders must see mistreatment as a significant problem and must value respectful care as an essential component of health service delivery. Including national, subnational and local stakeholders in a formative assessment and engaging them in discussions of program approaches builds awareness of the issue and helps programs to identify opportunities for success and to gauge feasibility in their context.

If the program chooses to address a broad systemic issue, an important consideration is to decide *which* stakeholders to engage at *which* level of governance. While specific RMC interventions may often be targeted at the community and/or facility level, program designers reviewing assessment results may conclude that

### Caring for the Carers

It is imperative to understand the complex challenges that even highly motivated health workers face in their work environment and lives. Many midwives and maternity providers work in situations of adversity, with negative effects on wellbeing, morale and retention. Preventing and eliminating mistreatment during childbirth requires a “systems approach” to address underlying drivers of mistreatment, including gender inequalities, shortages of staff, and disempowerment of midwives and other providers. Special consideration needs to be given to health worker needs in fragile over burdened health systems and /or in conflict settings where mistreatment triggers are greater and women and their providers are especially vulnerable.

Examples of RMC activities focused on providers include:

- Values clarification and attitude transformation training which supports health care providers to reflect on how they work and cope with working in under-resourced facilities.
- Mediation provided to process challenging situations
- Recognition of providers and their services
- Facility-sponsored tea and snacks for providers taking call overnight and on weekends
- Supportive mentoring and opportunities for professional advancement

national advocacy for respectful care is imperative for bringing about desired changes. Greater impact can be achieved by collaborating with stakeholders with deep advocacy expertise and knowledge of the local context (e.g., the White Ribbon Alliance and other civil society organizations) and by building on prior or ongoing advocacy and policy efforts. It will be important to engage key stakeholders or institutional and governing structures during all stages of program design and implementation, including the formative assessment when feasible.

### Pre-service Education and Professional Standards: Developing a Caring Workforce

Effective advocacy and policy formation at national level can help pre-service educational institutions embed support for RMC within their institutions and education materials. In a favorable advocacy and policy environment, educational institutions are more likely to be able to model why kindness, compassion, and respect matter in maternity care and what educators, health care workers and program implementers can do to promote RMC. During training, respectful care is either modeled for providers or engrained in their learning and perceptions of their future role as providers, or the opposite occurs and providers are left without exposure to respectful care or, even worse, are exposed to mistreatment as part of the “normal” workplace. Curricula and aligned teaching/learning materials should be based on the best evidence for provision of respectful patient-centered care. However, one of the most challenging components of graduating “fit for purpose” respectful providers is the regular provision of and exposure to clinical practice settings in which respectful care is modeled at all times.

Challenges include a lack of role models and teachers who possess appropriate interpersonal communication and caring skills and attitudes. Recent publications note that exposure to disrespectful patient care during midwifery training can be common (Moyer et al. 2016) and eventually becomes justified by students (Rominski et al. 2016), contributing to the “normalization” of mistreatment in facility-based childbirth. Illustrative program activities that can enhance RMC during pre-service education and as part of locally endorsed professional standards include:

- Assessing attitudes and behaviors in pre-service education institutions and programs) is important to ensure that the process of teaching/learning is respectful and gender sensitive, uses principles of adult learning, and promotes the development of professional, caring behaviors (see text box “USAID Strengthening Human Resources for Health Program in Ethiopia”).
- Collaborating with medical, nursing, and midwifery councils to embed principles of respectful care within professional standards, including mechanisms that support and enforce implementation of respectful care standards.

### USAID Strengthening Human Resources for Health Program in Ethiopia

**Subgoal:** Improve the retention of female students in health science programs in higher institutions, universities, and medicine, midwifery, and nursing schools.

**Strategies:** Promote gender responsive pedagogy by integrating effective teaching skills training for professors and clinical preceptors. The **Gender Responsive Pedagogy** is a two-day orientation designed to equip faculty members with knowledge, skills, and attitudes to promote, create, and mainstream a gender-responsive academic environment that ensures the equal participation of all genders. The pedagogy helps instructors to consider and address gender and its impacts on learning in several ways:

- Encouraging female students to speak and participate in class more often;
- Ensuring that the institution has a sexual harassment policy in place and that it is enforced;
- Putting in place safety mechanisms to protect female students (e.g. transport late at night);
- Ensuring that classrooms, lessons plans, and course materials are free of gender-stereotyping and bullying language;
- Ensuring there is a balance in the gender breakdown of instructors and the institution’s leadership;
- Addressing the needs of vulnerable students (e.g., providing small stipends or sanitary napkins to poor girls, ensuring gender balance in student leadership positions);
- Tracking enrollment, retention, and performance of female vs. male students, and rewarding students who have made the most progress over time;
- Engaging male students to challenge harmful norms and behaviors and to support female students to excel.

Source: Jhpiego/Ethiopia



## Local Health Systems

The sociocultural and health system characteristics of each country will vary (including often by subregion) and will influence the optimal design of local system and service delivery approaches. Key stakeholders involved in implementing RMC approaches will need to grapple with universal human rights to respectful maternity care and local cultural norms and expectations, which may sometimes represent divergent world views.

The geographic scope of RMC activities and selection of sites in a comprehensive MNH program will be determined by the program's overall geographic coverage and resources, including the availability and capacity of staff and local stakeholders to support program RMC activities. A program's theory of change should address the geographic coverage and feasibility of proposed RMC interventions in the context of the overall MNH program.



A midwife holds the hand of a woman in labor at a hospital in Gusau, Nigeria. Photo by Karen Kasmauski/MCSP.

Ideally, RMC approaches should be embedded in and leverage local health system assets and structure. RMC approaches are more likely to be sustainable when they are embedded in the local system and designed by key actors in the local health system. For example, ongoing local human capacity development activities (e.g., training, supervision, mentoring, continuous professional development) can be leveraged to incorporate a stronger focus on RMC and reduction of mistreatment (e.g., competency-based interpersonal communication skills). When present, local quality improvement (QI) efforts can be leveraged to incorporate a focus on client-centered care as part of ongoing QI efforts, including participation of community members on QI teams, supportive local leadership, and the routine measurement of client experience of care. Maternity open days can be implemented to help promote better communication and to break down the walls that often exist between clients, families, and health care workers (see box, “Maternity Open Days”).

The provider, who is most often a midwife, may herself or himself experience disrespect and abuse in the work environment. “Caring for the Carer” interventions, when incorporated into local health system structures and processes, can help to address the barriers and lack of an enabling work environment faced by many providers. “Caring for the Carer” interventions are increasingly recognized as a vital component of improving RMC and reducing mistreatment given the major stresses that many health care workers face in the local health system and service delivery environment.

The cross-cutting theme of gender and gender bias is also a key consideration in design and implementation. While both sexes may experience mistreatment in clinical settings, women of reproductive age seeking childbirth services are particularly vulnerable. Providers who deliver services to women are often midwives and women themselves. Inequity and power imbalances are often present within the provider–client relationship but also commonly determine the provider’s experience of working and providing care in a local health system environment (see text box, “Quality of Care (QoC) Assessment in Nigeria: selected gender results”). See appendix 2 for additional examples of promising RMC activities at the local system and service delivery level.

## Community

An important consideration for design of RMC approaches is the engagement of the community, to ensure that the essential perspectives, needs and priorities of women, families and community members are represented in the program’s goals, theory of change and program design. The active, valued participation of community stakeholders is important for all strata of society and all levels of the health system. When program designers place as much emphasis on community and local service delivery systems as they do on national advocacy and policy efforts, they are more likely to help “level the playing field,” which is often fraught with inequity and power dynamics. RMC programs described in the literature have usually included efforts to influence change at national, local, and community levels (Ratcliffe et al., 2016; Sando et al. 2014; Abuya et al. 2015a; Kujawaski et al. 2017).

Programs may support community-level activities that bring community members and health care workers together to improve client-centered care and as well as the working conditions of providers. Some examples of collaboration are mediation as a mechanism for dispute resolution and quality improvement teams with members from both the community and the facility (Ndwigwa et al. 2014. Respectful Maternity Care Resource Package: Facilitator’s Guide). (Please see appendix 2 for a description of promising RMC approaches, including pros and cons, at community and local health system level).

## Designing a Program Monitoring and Evaluation Framework

Once the program has defined its RMC program goals and program activities based on the formative assessment and theory of change, the program must consider how it will define, monitor and evaluate key measures and outcomes and use data on a regular basis to strengthen program RMC activities. The main purposes of ongoing monitoring and evaluation (M&E) are to systematically gather, analyze, and use information from various sources about a program; measure program outcomes to improve the results of the intervention; and inform stakeholders (including key decision-makers) about the contributions and effects of the program. An M&E plan should follow the program objectives, with both performance-related measures and outcome measures. This plan should align with the program’s theory of change and resource and time constraints.

Quantitative and qualitative methods used in the formative assessment can be selectively adapted to support monitoring during implementation of program RMC activities. For example, a short quantities questionnaire

### Quality of Care (QoC) Assessment in Nigeria: selected gender results

MCSP Nigeria conducted a maternal and newborn Quality of Care assessment in 40 health facilities in Kogi and Ebonyi states. The QoC assessment assessed provider skills, performance and availability of physical infrastructure and supplies and assessed gender-related barriers and experiences of mistreatment in childbirth.

Key findings of a gender analysis of the QoC assessment results include:

1. The majority of service providers have not received any training on gender and human rights.
2. Health facilities lack gender-based violence services, and there is no knowledge of GBV response by health workers.
3. There is limited involvement of male partners as birth companions
4. Service providers lack infrastructure and capacity to engage men in maternal services, limiting men’s participation and support for women during pregnancy and childbirth.
5. The majority of interviewed service providers expressed the view that a woman should not be able to choose a family planning method on her own; this view undermines women’s decision-making autonomy as well as their reproductive empowerment.

Source: MCSP/Nigeria

for women, families and providers used in the formative assessment can be administered on an intermittent basis during program implementation to assess progress, including patient-reported outcomes.

However, in contrast to implementation research, the methods and data sources available for routine RMC monitoring in comprehensive MNH programs are likely to be much more constrained. For example, direct observation of childbirth care and home-based follow-up client interviews used in many RMC studies to date are unlikely to be feasible as part of *routine* monitoring of RMC interventions in comprehensive MNH programs operating at scale (WHO, multicountry study protocol; Ratcliffe et al., 2016; Sando et al. 2014; Abuya et al. 2015a; Kujawaski et al. 2017). Monitoring methods will need to be tailored to the program goals, theory of change, activities and budget.

### Indicator Selection

Program indicators should be developed to monitor inputs, activities, outputs, outcomes, and impact of program RMC activities in line with a program's overall goals and scope. In WHO's Standards for Improving Quality of Maternal and Newborn Care in Health Facilities (WHO 2016c), each quality statement is linked to a menu of potential indicators categorized under inputs, outputs, and outcomes (WHO, 2016c.) Examples of indicators at the input level include the existence of a health facility policy, educational materials, trained health care providers, and supervision. At the level of short-term outcomes, examples include providers' skill levels and the proportion of women clients who receive certain items, information, or practices from providers. Illustrative longer-term outcome measures include women's satisfaction with the care provided and providers' satisfaction with the work environment. The forthcoming multi-country QED network monitoring framework includes a flexible streamlined catalogue (menu) of experience of care indicators that is likely to be a useful resource for MNH policy makers and program implementers prioritizing experience of care indicators in their local context (reference forthcoming; <http://qualityofcarenetwork.org>).

When feasible, these indicators may be included as part of the ongoing monitoring and assessment of RMC activities. Indicators should be "SMART": specific, measureable, attainable, relevant, and time-bound. There are many efforts underway to prioritize and refine RMC and experience of care indicators including as part of the WHO QED network; however, there is not yet global consensus on a small set of priority RMC indicators for use by programs seeking to improve women's and newborns' experience of care as part of comprehensive MNH programs. The Ending Premature Maternal Mortality working group has identified the development of RMC indicators as a priority area for future result (Moran et al. 2016).

Since mistreatment and RMC are multifaceted, and often context specific, a combination of indicators and data collection methods is likely to be most useful for programs implementing RMC programs. Using the definition developed by Freedman and colleagues (Figure 2; Freedman et al. 2014), program indicators should ideally measure both disrespect and abuse at the *individual* level (provider and client experience of care outcome levels) and *structural* or systemic disrespect and abuse (i.e., deficiencies in the health system that are drivers of disrespectful and abusive environment). Additional inputs measures may focus on policy and legal factors as appropriate to the program.

### Identification of Data Collection Methods

As with the formative assessment, a combination of qualitative and quantitative data (see appendix 4 and 5) can be adapted and used for ongoing monitoring and evaluation of program implementation. The types and quantity of data needed will vary depending on the program's RMC goals, approaches, resources, and focus of the intervention and on how much is known about RMC/mistreatment in the program's setting. The selection of different data collection methods and tools will be based on the program's interventions. The program can adapt the formative assessment (and other tools) to meet its monitoring needs, capitalizing on learning from implementation of the formative assessment tools as part of the program design phase. The monitoring tools, including data source and method and frequency of data collection, should be described for

each indicator or concept to be assessed. The frequency of data collection and analysis (e.g. monthly, quarterly, semi-annually) should be specified as part of the program monitoring plan.

All planned M&E activities should be feasible and covered in the program budget. The following questions should be answered for all data sources included in the program monitoring plan:

- What are the sources of data?
- What are the data collection methods?
- Who will collect the data?
- How often will the data be collected?
- What are the cost and difficulty of collecting the data?
- Who will analyze the data?
- Who will report the data?
- Who will use the data?

The program monitoring plan should also specify how the data will be shared with stakeholders through defined feedback mechanisms.

### *Quantitative Approaches*

Quantitative data collection methods can be used at all stages to monitor program implementation. Rapid surveys of involved actors should be done at baseline to determine the baseline of respectful care, and can be conducted during the course of program implementation. Monitoring of mistreatment or RMC will likely come from repeated, rapid, structured surveys yielding quantitative data (e.g., structured patient exit interviews), or by open-ended questioning techniques or observations and other data collection modalities (e.g., focus group discussions, open-ended individual interviews). If resources permit, periodic structured observations of clinical care or simulated client-provider interactions may be done to assess observable incidents of mistreatment using normative standards (direct clinical observation) or to assess provider interpersonal communication skills.

A survey can quantify perceptions of factors related to or triggers of mistreatment or RMC using the program's theory of change. A survey can quantify health workers' and managers' perceptions of the work environment over time. A survey can document the fidelity of implementation of prioritized program approaches (e.g. Caring for the Carer, accountability, QI). This can be done alongside monitoring of institutional facility birth rates in given catchment areas from the health information system or from facility registers and other sources. Please note that in aligning tools and indicators with the theory of change, program designers will want to reflect carefully on whether or how these indicators can measure either improvement in respectful care and/or reduction of mistreatment.

Each quantitative method has its own advantages and disadvantages (see appendix 5). The most appropriate methods depend on a clear definition of what needs to be measured. Standardized approaches for routine monitoring of RMC and mistreatment are in their early stages of development. Demonstration projects and research studies have used the methods described in appendices 4 and 5. Validated quantitative tools for assessing RMC prevalence and incidence will be available once the WHO multicountry study is completed in early 2018. Unfortunately, however, the measurement methods used in the WHO study (direct observation of care and follow-up home-based interviews) are unlikely to be feasible in large MNH programs. Building the evidence for quantitative RMC and mistreatment measurement methods that can be employed on a routine basis in comprehensive MNH programs operating at scale is an important learning priority.

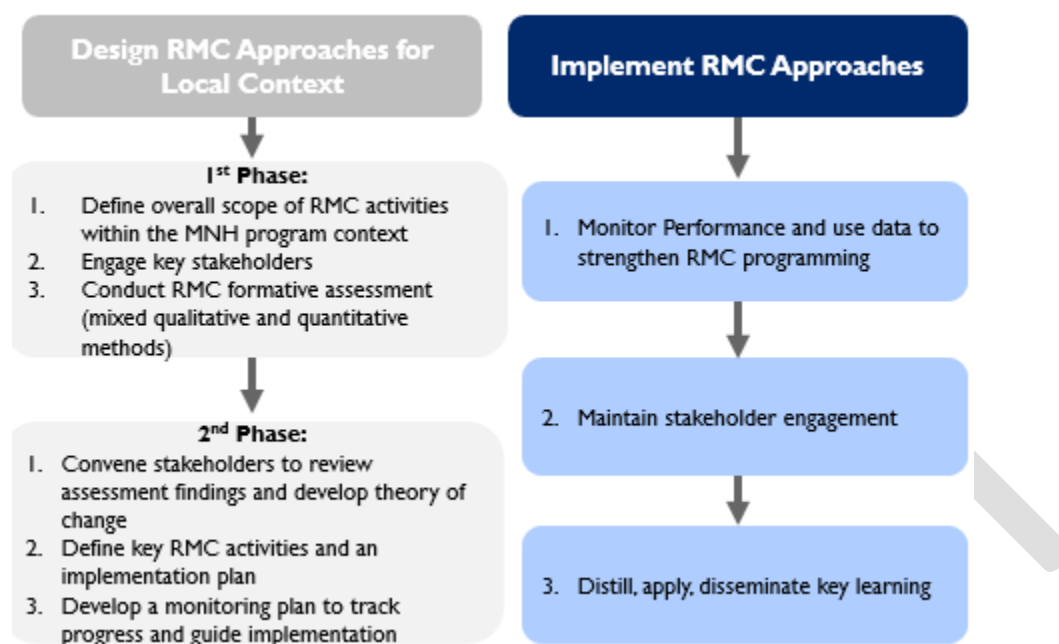
### *Qualitative Approaches*

Qualitative data can be collected as a part of routine program monitoring to gain a deeper understanding of how the program is actually implemented and is affecting stakeholders. These data can be useful for process evaluation and for learning whether the stakeholders, including clients, community members, and health workers, believe that changes have occurred or that the situation has improved. Qualitative methods can be used before development of quantitative tools, or can be deployed simultaneously or afterward to help understand quantitative findings. Selected qualitative methods used in the formative assessment such as focus groups and structured in-depth interviews can be modified for periodic use during program implementation. . User manuals are available to help guide data collection since qualitative methods require specific expertise (Bohren et al. 2016; Mack et al. 2005; Rosen et al. 2015). Many of the methods mentioned earlier in the guide for formative assessments can also be adapted for routine monitoring during implementation of the program RMC approaches. Some of the tools measure only mistreatment; others measure both mistreatment and respectful care. The theory of change will help to determine which methods and tools are most appropriate for carefully reflecting changes or improvements.

Please refer to the section on page 13 about assessing and measuring RMC and mistreatment, and see p. 15 and appendix 6 for a discussion of the ethical considerations that must be addressed when planning data collection as part of the formative assessment and the program monitoring plan.



# Implementing RMC Approaches in an MNH Program



## Implementing and Monitoring RMC activities in a comprehensive MNH program

Once the program has established its RMC goals, key approaches and a monitoring plan program staff should develop a detailed implementation plan and timeline with key roles for program staff and local stakeholders. It may also be helpful to prepare a matrix (e.g., Gantt chart) indicating the planned tasks, frequency, timeline, financial and human resources needed for implementation and monitoring activities. The work plan should include steps to be taken for each phase of implementation and assessment with clear roles, responsibilities, and resources. Data collection, analysis, sharing, and use should be a part of the implementation and monitoring plan. During program implementation, data will be needed on a continual basis to understand whether adjustments need to be made to the intervention and whether the program is being implemented as planned.

## Maintaining Stakeholder Engagement

Recently Ratcliffe and colleagues (Ratcliffe et al. 2016b) described a participatory approach adopted to engage key stakeholders throughout the planning and implementation of a focused RMC program. They concluded that a visible, sustained, and participatory intervention process, committed facility leadership, management support, and staff engagement throughout the project contributed to a positive change in the hospital culture that values and promotes respectful maternity care.

MOH colleagues and other key stakeholders engaged by the program should be kept regularly informed of the program's progress as it unfolds. In many programs, key stakeholders will have been engaged during the program design phase and may include representatives of women's groups, clients, and the community, as well as health workers and professional associations (see page 11 for a description of important categories of stakeholders). Program monitoring results (quantitative and qualitative) should be communicated clearly and in a way that is understandable to all stakeholders, including graphic depictions or visualizations of results for community participants. As needed, information should be translated into local languages. Community

members or other stakeholders may want to form a local advisory group or national advisory group that can track the program monitoring results and help recommend adjustments to program activities.

Key stakeholders are often the future champions of RMC in the local setting and it is important to share learning with these stakeholders and to be open and frank about setbacks and failures. Positive stories from women and providers may be an important mechanism to maintain interest and motivation of key stakeholders and can be shared with local media as appropriate.

In some countries, the MOH may be ready to expand or scale up promising program RMC approaches before ensuring a positive national policy and leadership environment to support successful scale up of emerging best practices. Stakeholders who support the expansion of program activities should continue to advocate for needed national policy frameworks and legal safeguards and should continue to advocate for the broad engagement of local MOH officials, health workers, women and families to expand and help sustain program gains.

## Distilling, Applying, and Disseminating Key Learning

There are many important learning questions and outstanding evidence gaps related to RMC programming and monitoring in comprehensive MNH programs operating at scale. 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. During the design and early implementation phases program designers and managers should ask themselves:

- What can be learned from the implementation of program RMC approaches?
- How should program learning be structured?

Due to the limited evidence base for implementation and monitoring of RMC approaches as part of comprehensive MNH programs operating at scale, a concrete plan for program documentation should be developed to facilitate real-time course-correction and to support future dissemination of key learning to local and global stakeholders. One resource developed under MCSP that provides a systematic approach to documenting and understanding how interventions are designed, implemented, and operated in a specific context includes the [Documenting Program Processes \(DPP\) Quick User's Guide](#), part of [a larger toolkit](#). The *Quick User's Guide* briefly describes the tools for planning, collecting, synthesizing, organizing, and presenting the DPP data for a public health program being implemented or scaled up. The purpose of the DPP approach is to produce evidence that:

- Supports efforts to scale up and transfer successful programs to different settings;
- Facilitates real-time program learning for all MCSP projects during the course of the project cycle, which helps identify bottlenecks and track all program adaptations and unintended consequences;
- Helps to interpret outcome results, such as what worked or did not work and how and why it worked or did not work, which helps to make recommendations for program improvement.

Program documentation should assess program fidelity to planned interventions: Was the program that was implemented consistent with the one that was planned based on the program's theory of change, or were

### Maternity Open Days

Maternity Open Days provide an opportunity for pregnant women and their families to interact with health care providers and visit the maternity unit to demystify birthing practices and mitigate any fears regarding childbirth in a facility. Maternity Open Days are designed to:

- promote mutual understanding between community members and service providers
- Improve knowledge and demystify procedures during labor, childbirth, and the immediate postnatal period

Source: Population Council Brief, Maternity Open Days (Population Council/TRAction, 2015).

there significant changes in planned activities? Any deviation from what was planned, as well as reasons for the changes, are important to document.

Program dissemination materials should be designed to address the priorities and information needs of key stakeholders and decision-makers. During the program design phase, the program team and partners should identify priority information needs of key actors and stakeholders and develop a program documentation and dissemination plan that addresses the information needs of these stakeholders (e.g., policymakers, program implementers.) The program should intentionally use communication formats that will resonate with identified stakeholders. Some stakeholders may prefer to read a short brief or to attend an interactive presentation of program findings, while others may prefer a journal article or a longer report with detailed information on program activities and results. Others may prefer a visual video or to hear the voices of program participants and beneficiaries. Learning and dissemination activities should be clearly defined and should be included in the program's budget.

During the last decade, the global maternal and newborn health community has witnessed a rapid expansion of advocacy, research and program implementation focused on improving women's and newborns' experience of care during facility-based childbirth as well as health care workers' experience of providing care. Those concerned with respectful maternity care have blossomed from a small community of concern with a handful of stakeholders to a universal movement with multiple organizations working on this issue across six continents. In focusing attention on the care that surrounds mothers and newborns during the critical moment of childbirth in the human life cycle, many individuals, organizations and governments have taken on the challenge to ensure that all women and newborns' are provided compassionate, dignified and respectful childbirth care as a fundamental human right. It is hoped that this operational guidance can help local stakeholders and program implementers to realize this commitment to women and newborns.

### **What is Documentation of Program Processes?**

The documentation of program processes (DPP) is a structured, systematic approach for project staff and other stakeholders to assess and document interventions exactly as they were implemented, and the implementation processes (i.e., description of activities and how they were implemented), contextual changes that include key events, and actions implemented within specific contexts to achieve the desired results. Through the DPP, program teams develop and regularly revise a description of the process details—**who, what, how, and why**—of all program activities. Source: DPP Guidance Manual



# References

- Abuya T, Warren C, Miller N, Njuki R, Ndwiga C, Maranga A, Mbehero F, Njeru A, Bellows B. 2015a. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS One* DOI: 10.1371/journal.pone.0123606.
- Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N, Warren C. 2015b. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. *BMC Pregnancy and Childbirth* 15:224.
- Alufani, PA, Diamond-Smith N, Golub G, Sudhinaraset M. 2017. Development of a tool to measure person-centered maternity care in developing settings: validation in a rural and urban Kenyan population. *Reprod Health* 2017 Sep 22; 14(1):118. DOI: 10.1186/s12978-017-0381-7.
- Anderson, A. 2005. The community builder's approach to theory of change: a practical guide to theory development. The Aspen Institute Roundtable on Community Change.
- Arnold R, van Teijlingen E, Ryan K, Holloway I. 2014. Understanding Afghan healthcare providers: a qualitative study of the culture of care in a Kabul maternity hospital. *Bjog* 2014; DOI: 10.1111/1471-0528.13179.
- Asefa, A, Bekele, D. 2015. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. *Reprod Health* 2015; 12:33; DOI: 10.1186/s12978-015-0024-9.
- Balde DB, Diallo BA, Bangoura A, Sall O, Soumah AM, Vogel JP, Bohren M.A. 2017. Perceptions and experiences of the mistreatment of women during childbirth in health facilities in Guinea: a qualitative study with women and service providers. *Reprod Health* 2017 14:3. DOI: 10.1186/s12978-016-0266-1.
- Bardach, E. 2012. A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving Fourth Edition. Sage/ CQ Press, Thousand Oaks, CA, USA.
- Beebe J. 2001. Rapid Assessment Process: An Introduction. Walnut Creek, CA: Altamira Press. Volume 3, No. 4, Art. 33.
- Bohren MA, Vogel J, Hunter E, Lutsiv O, Makh S, Souza J, Aguiar C, et al. 2015. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Med* 12(6): e1001847. doi:10.1371/journal.pmed.1001847.
- Bohren MA, Vogel J, Tunçalp O, Fawole B, Titiloye M, Olutayo A, Oyeniran A, et al. 2016. "By slapping their laps, the patient will know that you truly care for her": A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria. *SSM-Population Health* 2 (2016) 640–655.
- Bowser D, Hill K. 2010. *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*. Washington: USAID.
- CARE Malawi. 2013. The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services. Cooperative for Assistance and Relief Everywhere, Inc.
- Carquillat P, Venditelli F, Perneger T, Guittier MJ, 2017. Development of a questionnaire for assessing the childbirth experience (QACE). *BMC Pregnancy and Childbirth* (2017) 17:279. DOI 10.1186/s12884-017-1462-x.
- Cindoglu D, Unal D. 2017. Gender and sexuality in the authoritarian discursive strategies of 'New Turkey.' *European Journal of Women's Studies* 24 (1): 39-54, <http://journals.sagepub.com/doi/abs/10.1177/1350506816679003>.
- D'Oliveira AF, Diniz SG, Schraiber LB. 2002. Violence against women in health-care institutions: an emerging problem. *Lancet*. May 11;359 (9318):1681-5.

- Donabedian A. 1980. Methods for deriving criteria for assessing the quality of medical care. *Med Care Rev.* 37: 653-698.
- Filby A, McConville F, Portela A. 2016. What prevents quality midwifery care? A systematic mapping of barriers in low and middle income countries from the provider perspective. *PLoS One*, May 2.
- Fogarty L, Johnson P, Bluestone J, Drake M, Rawlins B, Fullerton J. 2012. The health impacts of pre-service education: An integrative review and evidence-based conceptual model. Baltimore, Jhpiego.
- Freedman LP, Ramsey K, Abuya T, Bellows B, Ndwiga C, Warren C, Kujawski S, Moyo W, Kruk M, Mbaruku G. 2014. Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. *Bull World Health Organ.* 92(12): 915-917.
- Ganle JK, Parker M, Fitzpatrick R, Otupiri E. 2014. A qualitative study of health system barriers to accessibility and utilization of maternal and newborn healthcare services in Ghana after user-fee abolition. *BMC Pregnancy and Childbirth* 14: 425, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4307897>.
- J. F. Jensen, T. Thomsen, D. Overgaard, M. H. Bestle, D. Christensen, I. Egerod, 2015. Impact of follow-up consultations for ICU survivors on post-ICU syndrome: a systematic review and meta-analysis. *Intensive Care Medicine*, Volume 41, Issue 5, pp 763–775.
- Jewkes R, Penn-Kekana L. 2015. Mistreatment of women in childbirth: time for action on this important dimension of violence against women. *PLoS Medicine.* 12(6):e1001849.
- Jha P, Larsson M, Christensson K, Svanberg AS. Satisfaction with childbirth services provided in public health facilities: results from a cross-sectional survey among postnatal women in Chhattisgarh, India. *Global Health Action* 2017; 10(1): 1386932. DOI: 10.1080/16549716.2017.1386932.
- Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman L. 2014. Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. *Health Policy Plan* doi: 10.1093/heapol/czu079.
- Kujawski SA, Freedman LP, Ramsey K., Mbaruku G, Mbuyita S, Moyo W, et al. 2017. Community and health system intervention to reduce disrespect and abuse during childbirth in Tanga Region, Tanzania: A comparative before-and-after study. *PLoS Med.* 14(7): e1002341. Doi.org/10.1371/journal.pmed.1002341.
- Mack M, Woodsong C, MacQueen KM, Guest G, Namey E. 2005. *Qualitative Research Methods: A Data Collector's Field Guide*, Family Health International, Research Triangle Park, NC.
- Magoma M, Requejo J, Campbell OM, Cousens S, Filippi V. 2010. High ANC coverage and low skilled attendance in a rural Tanzanian district: a case for implementing a birth plan intervention. *BMC Pregnancy Childbirth* 10:13. ISSN 1471-2393 DOI:10.1186/1471-2393-10-13, <https://researchonline.lshtm.ac.uk/3895/1/1471-2393-10-13.pdf>
- Maternal and Child Health Integrated Program (MCHIP), 2015. Mozambique: Final Report April 12, 2011–June 30, 2015.
- Maternal and Child Health Integrated Program (MCHIP), 2015. Respectful Maternity Care: A Field Aspiration.
- Maternal and Child Health Integrated Program (MCHIP) and Maternal Child Survival Program (MCSP), 2015. A Review of the Maternal and Newborn Health Content of National Health Management Information Systems in 13 Countries in Sub-Saharan Africa and South Asia.
- Montesinos-Segura, R, Urrunaga-Pastor D, Mendoza-Chuctaya G, Taype-Rondan A, Helguero-Santin LM, Martinez Ninanqui FW, et al. 2017. Disrespect and abuse during childbirth in fourteen hospitals in nine cities of Peru. *Int J Gynecol Obstet* DOI: 10.1002/ijgo.12353.
- Moran AC, Jolivet RR, Chou D, Dalglish SL, Hill K, Ramsey K et al. 2016. A common monitoring framework for ending preventable maternal mortality, 2015–2030: phase I of a multi-step process. *BMC Pregnancy and Childbirth* (2016) 16:250. DOI 10.1186/s12884-016-1035-4.

- Moyer CA, Adongo PB, Aborigo RA, Hodgson A, Engmann CM. 2014. ‘They treat you like you are not a human being’: Maltreatment during labour and delivery in rural northern Ghana. *Midwifery* 30(2):262–268.
- Moyer CA, Rominski S, Nakua EK, Dzomeku VM, Agyei-Baffour P, Lori JR. 2016. Exposure to disrespectful patient care during training: Data from midwifery students at 15 midwifery schools in Ghana. *Midwifery* 41(10): 39-44.
- Mselle LT, Moland KM, Mvungi A, Evjen-Olsen B, Kohi TW. 2013. Why give birth in health facility? Users’ and providers’ accounts of poor quality of birth care in Tanzania. *BMC Health Services Research* 13:174, <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-174>.
- Ndwiga C, Warren C, Abuya T, Kanya L, Maranga A, Ochieng C, Wanjala M. et al. 2014. Respectful Maternity Care Resource Package: Facilitator’s Guide. New York, Population Council.
- Nilver H, Begley C, Berg M 2017. Measuring women’s childbirth experiences: a systematic review for identification and analysis of validated instruments. *BMC Pregnancy and Childbirth* 17:203.
- OECD/Development Assistance Committee (DAC). 2002. Glossary of Key Terms in Evaluation and Results Based Management. Paris, France. <https://www.oecd.org/dac/evaluation/2754804.pdf>.
- Okafor II, Ugwu EO, and Obi SN. 2015. Disrespect and abuse during facility-based childbirth in a low-income country. *Int J Gynaecol Obstet* 128:110–113.
- Paul S. Holding the State to Account: Citizen Monitoring in Action. Bangalore, India: Public Affairs Centre, 2002. [http://www.pafglobal.org/about-us/publications/Lessons\\_BRCs\\_7Oct05.pdf](http://www.pafglobal.org/about-us/publications/Lessons_BRCs_7Oct05.pdf).
- Perrin B .2012. Linking Monitoring and Evaluation to Impact Evaluation. Impact Evaluation Notes. No. 2. InterAction and Rockefeller Foundation. Washington DC. <https://www.interaction.org/sites/default/files/Linking%20Monitoring%20and%20Evaluation%20to%20Impact%20Evaluation.pdf>.
- Population Council/TRAction. 2015. “Maternity Open Days: Clarifying misconceptions about childbirth.” Promoting Respectful Maternity Care Resource Package.
- Rahmani Z, Brekke M. 2013. Antenatal and obstetric care in Afghanistan – a qualitative study among health care receivers and health care providers. *BMC Health Services Research* 13:166, <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-166>.
- Raj A, Dey A, Boyce S, Seth A, S Bora, D Chandurkar et al. 2017. Associations Between Mistreatment by a Provider during Childbirth and Maternal Health Complications in Uttar Pradesh, India. *Maternal and Child Health Journal*, 21: 1821. <https://doi.org/10.1007/s10995-017-2298-8>.
- Rani M, Bonu S, Diop-Sidibe N. 2004. An empirical investigation of attitudes towards wife-beating among men and women in seven sub-Saharan African countries. *African Journal of Reproductive Health*, 8 (3) (2004).
- Ratcliffe H, Sando D, Lyatuu GW, Emil F, Mwanyika-Sando M, Chalamilla G, Langer A, McDonald KP . 2016a. Mitigating disrespect and abuse during childbirth in Tanzania: an exploratory study of the effects of two facility-based interventions in a large public hospital. *Reproductive Health* 13:79.
- Ratcliffe H, Sando D, Mwanyika-Sando M, Chalamilla G, Langer A, McDonald KP. 2016b. Applying a participatory approach to the promotion of a culture of respect during childbirth. *Reproductive Health* 13:80.
- Reis V, Deller B, Carr C, Smith J. 2012. Respectful maternity care: country experiences. Survey Report. Washington DC: United States Agency for International Development.
- Rominski-DS, Lori J, Nakua E, Dzomeku V, Moyer C. 2016. “When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out”: Justification of disrespectful and abusive care during childbirth among midwifery students in Ghana. *Health Policy and Planning* Mar 1;32(2): 215-224.
- Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, Bartlett LA, and on behalf of the Quality of Maternal and Newborn Care Study Group of the Maternal and Child Health Integrated Program. 2015.

- Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy and Childbirth* 15:306, <http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4>.
- Sando D, Abuya T, Asefa A, Banks KP, Freedman, LP, Kujawski S. 2017. Methods used in prevalence studies of disrespect and abuse during facility based childbirth: lessons learned. *Reproductive Health* (2017) 14:127 DOI 10.1186/s12978-017-0389-z.
- Sando D, Kendall T, Lyatuu G, Ratcliffe H, McDonald K, Mwanyika-Sando M, Emil F, Chalamilla G, Langer A. 2014. Disrespect and abuse during childbirth in Tanzania: Are women living with HIV more vulnerable? *J Acquir Immune Defic Syndr* 67(4):S228–34.
- Sando D, Ratcliffe H, McDonald K, Spiegelman D, Lyatuu G, Mwanyika-Sando M, Emil F, Nell Wegner M, Chalamilla G, Langer A. 2016. The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania, *BMC Pregnancy and Childbirth* 16:236.
- Saraswathi V, Stoll K, Rubashkin N, Martina K, Miller-Vedame Z, Hayes-Kleine H, Jolicoeur G, the CCinBC Steering Council. 2017. The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth. *SSM-Population Health* volume 3 p. 201-210.
- Sheferaw ED, Mengesha TZ, Wase SB. 2016. Development of a tool to measure women's perception of respectful maternity care in public health facilities. *BMC Pregnancy and Childbirth*, 16(1) p. 67.
- Smith L. 2001. Development of a multidimensional labour satisfaction questionnaire: dimensions, validity, and internal reliability. *Quality in Health Care* 10:17–22.
- Tunçalp Ö, Were WM, MacLennan C, Oladapo OT, Gülmezoglu AM, Bahl R, Daelmans B, et al. 2015. Quality of care for pregnant women and newborns—the WHO Vision. *BJOG* 122(8):1045–9.
- Vastine A, Gittelsohn G, Ethelbah, B, Anliker J, Caballero B. 2005. Formative research and stakeholder participation in intervention development. *Am J Health Behav.* 29(1): 57-69.
- Vedama S, Stollb K, Rubashkinc N, Martina K, Miller-Vedame Z, Hayes-Kleine H, Jolicoeur G, and the CCinBC Steering Council. The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth. *SSM - Population Health* 3 (2017) 201–210.
- Vogel JP, Bohren MA, Tuncalp O, Oladapo OT, Adanu RM, Balde MD, et al. How women are treated during facility-based childbirth: development and validation of measurement tools in four countries - phase 1 formative research study protocol. *Reprod Health.* 2015; 12:60.
- Warren C, Njuki R, Abuya T, Ndwiga C, Maingi G, Serwanga J, Mbehero F, et al. 2013. Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya. *BMC Pregnancy Childbirth* 13:21.
- White Ribbon Alliance. 2011. Respectful Maternity Care: The Universal Rights of Childbearing Women. White Ribbon Alliance, Washington, DC. [http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final\\_RMC\\_Charter.pdf](http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final_RMC_Charter.pdf)
- World Health Organization. 2001. Putting women first: Ethical and safety recommendations for research on domestic violence against women. Department of Gender and Women's Health Family and Community Health, <http://www.who.int/gender/violence/womenfirtseng.pdf>.
- World Health Organization. 2005. WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses. Geneva, World Health Organization.
- World Health Organization. 2014. *The prevention and elimination of disrespect and abuse during facility-based childbirth*. Geneva, WHO.
- World Health Organization. 2015. Strategies toward ending preventable maternal mortality (EPMM). Geneva, WHO.

World Health Organization. 2016a. Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication *Putting women first: ethical and safety recommendations for research on domestic violence against women*. Geneva, WHO. February.

World Health Organization. 2016b. Midwives' voices, midwives' realities. Findings from a global consultation on providing quality midwifery care. Geneva, WHO.

World Health Organization. 2016c. Standards for improving quality of maternal and newborn care in health facilities. Geneva, WHO.

## Other Resources

(These include references relevant to RMC promotion and mistreatment reduction efforts which have not been directly referenced in this document.)

Afaya A, Yakong VN, Afaya RA, Salia SM, Adatara P, Kuug AK et al. 2018. A Qualitative Study on Women's Experiences of Intrapartum Nursing Care at Tamale Teaching Hospital (TTH), Ghana. *Journal of Caring Sciences* 6(4):303-314; DOI:10.15171/jcs.2017.029.

Alzyoud F, Khoshnood K, Alnatour A, Oweis A. 2018. Exposure to verbal abuse and neglect during childbirth among Jordanian women. *Midwifery* 2018; <http://dx.doi.org/10.1016/j.midw.2017.12.008>.

Asefa A, Bekele D, Morgan A, Kermode M. 2018. Service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. *Reprod Health* 2018; 15:4; <https://doi.org/10.1186/s12978-017-0449-4>.

Austad K, Chary A, Martinez B, Juarez M, Martin Y J, Ixen EC et al. 2017. Obstetric care navigation: a new approach to promote respectful maternity care and overcome barriers to safe motherhood. *Reproductive Health* (2017) 14:148.DOI 10.1186/s12978-017-0410-6.

Banks, KP, Karim AM, Ratcliffe HL, Betemariam W, Langer A. 2017. Jeopardizing quality at the frontline of healthcare: prevalence and risk factors for disrespect and abuse during facility-based childbirth in Ethiopia. *Health Policy and Planning*, czx180, <https://doi.org/10.1093/heapol/czx180>.

Bohren MA, Hunter E, Munthe-Kaas H, Souza J, Vogel J, Metin Gülmezoglu A. 2014. Facilitators and barriers to facility-based delivery in low- and middle-income countries: A qualitative evidence synthesis. *Reprod Health* 11:71.

Boulkedid R, Alberti C, Sibony O. 2013. Quality indicator development and implementation in maternity units. *Best Pract Res Clin Obstet Gynaecol*. 27(4):609-19.

Devkota HR, Clarke A, Murray E, Groce M. 2017. Do experiences and perceptions about quality of care differ among social groups in Nepal? : A study of maternal healthcare experiences of women with and without disabilities, and Dalit and non-Dalit women. *PLoS ONE* 12(12): e0188554, <https://doi.org/10.1371/journal.pone.0188554>.

Downe S, Lawrie TA, Finlayson K, Oladapo OT. 2018. Effectiveness of respectful care policies for women using routine intrapartum services: a systematic review. *Reproductive Health* 15:23 DOI 10.1186/s12978-018-0466-y.

Freedman LP, Kruk ME. 2014. Disrespect and abuse of women in childbirth: Challenging the global quality and accountability agendas. *Lancet* 384:e42-4.

Hussein S, Hons MN, Dahlen HG, Ogunsiji O, Schmied V. 2017. Women's experiences of childbirth in Middle Eastern countries: A narrative review. *Midwifery* 2017 DOI: <http://dx.doi.org/10.1016/j.midw.2017.12.010>.

International Federation of Gynecology and Obstetrics; International Confederation of Midwives; White Ribbon Alliance; International Pediatric Association; World Health Organization; International Federation of Gynecology and Obstetrics. 2014. Mother-baby friendly birthing facilities. *Int J Gynaecol Obstet* 128(2): 95–9.

Ishola F, Owolabi O, Filippi V. 2017. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. *PLOS One*, 12(3): e0174084.

Karanja S, Gichuki R, Igunza P, Muhula S, Ofware P, Lesiamon J, Leshore L et al. 2018. Factors influencing deliveries at health facilities in a rural Maasai Community in Magadi sub-County, Kenya. *BMC Pregnancy and Childbirth* 18:5, <https://doi.org/10.1186/s12884-017-1632-x>.

*Lancet* Midwifery Series, 2014. Volume 384, No. 9948.

Mafuta E, Buning T, Lolobi DL, Mayala PM, Mambu TMN, Kayembe PK et al. 2018. Factors influencing the capacity of women to voice their concerns about maternal health services in the Muanda and Bolenge Health Zones, Democratic Republic of the Congo: a multi-method study. *BMC Health Services Research* 18:37, <https://doi.org/10.1186/s12913-018-2842-2>.

Marshall M, Campbell S, Hacker J, Roland M, eds. 2002. *Quality indicators for general practice*. London: Royal Society of Medicine.

McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RN, Winch PJ. 2014. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. *BMC Pregnancy Childbirth* 14:268.

Morgan R, Tetui M, Kananura RM, Ekirapa-Kiracho E, George AS, 2017. *Health Policy and Planning*, Volume 32, Issue suppl\_5, 1 December 2017, Pages v13–v21, <https://doi.org/10.1093/heapol/czx011>.

Mukamurigo J, Dencker A, Ntaganira J, Berg M. 2017. The meaning of a poor childbirth experience – A qualitative phenomenological study with women in Rwanda. *PLoS ONE* 12(12): e0189371, <https://doi.org/10.1371/journal.pone.0189371>.

Munawar A, Hassan ZU, Ayub A, Shaikh BT, Buriro NA, Ahmed F et al. 2017. Womens perceptions about quality of maternity care at tertiary care hospital Karachi, Pakistan. *Pakistan Journal of Public Health* [S.L], v. 7, n. 2, p. 109-112, November 2017. ISSN 2226-7018, <https://www.pjph.org/index.php/pjph/article/view/46>.

Oladapo OT, Bohren MA, Fawole B, Mugerwa K., Ojelade OA, Titiloye MA. 2017. Negotiating quality standards for effective delivery of labor and childbirth care in Nigeria and Uganda. *Int J Gynecol Obstet*, 139: 47–55. doi:10.1002/ijgo.12398.

Savage V, Castro A. 2017. Measuring mistreatment of women during childbirth: a review of terminology and methodological approaches. *Reproductive Health* (2017) 14:138 DOI 10.1186/s12978-017-0403-5.

Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Nogueira Pileggi et al. 2017. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *Bjog* 2017 DOI: 10.1111/1471-0528.15015.

Shimoda K, Horiuchi S, Leshabari S, Shimpuku Y. 2017. Midwives' respect and disrespect of women during facility-based childbirth in urban Tanzania: a qualitative study. *Reproductive Health* 15:8, <https://doi.org/10.1186/s12978-017-0447-6>.



# Appendices

## Appendix I. Types of Mistreatment and Common Drivers

Prevalent Type of Mistreatment	Common drivers reported in the literature
Physical abuse <ul style="list-style-type: none"> <li>• Use of force</li> <li>• Physical restraint</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse-midwives justified their mistreatment of women by claiming that they were attempting to ensure safe outcomes for mothers and babies and excused the perpetration of physical abuse as a “necessity” to ensure compliance and safe birth outcomes, believing that they were “forced by circumstance” (Bohren et al. 2015).</li> <li>• Nurses and midwives from South Africa and Cambodia confirmed the urge to use physical aggression to deal with anger or frustration at a noncompliant woman (Bohren et al. 2015).</li> </ul>
Sexual abuse <ul style="list-style-type: none"> <li>• Sexual abuse</li> </ul>	
Verbal abuse <ul style="list-style-type: none"> <li>• Harsh language</li> <li>• Threats and blaming</li> </ul>	<ul style="list-style-type: none"> <li>• Workers “overstretched,” “tired,” or “overworked” (Bohren et al. 2015).</li> <li>• “Hierarchical authority in health system” legitimizes control of health workers over women (Bohren et al. 2015).</li> <li>• Some women “aggressive and arrive primed for confrontation.”</li> <li>• Where societies accept and tolerate violence against women, eradication is complex, as those perpetrating abuse may not recognize their actions as abusive (Rani et al. 2004).</li> <li>• Some providers view such behavior as a necessary practice to have a safe outcome for the baby (Bohren et al. 2016).</li> </ul>
Stigma and discrimination <ul style="list-style-type: none"> <li>• Discrimination based on sociodemographic characteristics</li> <li>• Discrimination based on medical condition</li> </ul>	<ul style="list-style-type: none"> <li>• In settings with a rigid social hierarchy, menial tasks that are associated with providing good care to women may be seen as low-class activities, and thus may not be valued by health professionals (D’Oliveira et al. 2002). This may lead to such behaviors as midwives asking women to clean up after themselves following their childbirth (Moyer et al. 2016).</li> <li>• Women reported feeling shamed by health workers who made inappropriate comments to them regarding their sexual activity. Adolescent or unmarried women may experience insensitive comments more frequently, since many communities view pregnancy and childbirth as appropriate only in marital relationships (Bohren et al. 2015).</li> <li>• In one study, women with obstetric fistula who delivered at an urban municipal hospital in Dar es Salaam recounted feeling unwelcomed by health care staff and reported experiencing abandonment as well as physical and verbal abuse during labor and delivery (Sando et al. 2016).</li> </ul>

Prevalent Type of Mistreatment	Common drivers reported in the literature
<p>Failure to meet professional standards of care</p> <ul style="list-style-type: none"> <li>• Lack of informed consent and confidentiality</li> <li>• Physical examinations and procedures</li> <li>• Neglect and abandonment</li> </ul>	<ul style="list-style-type: none"> <li>• Providers overworked (women's perspectives, McMahon et al. 2014).</li> <li>• Providers do not feel obligated to provide care when women are "non-compliant" (<i>global reviews</i>).</li> <li>• Providers and women may consider mistreatment to be justifiable, such as when women cry out or fail to comply with a provider's requests (Bohren et al. 2016).</li> <li>• Providers commonly blamed a woman's "disobedience" and "uncooperativeness" during labor and delivery for her experience of mistreatment (Bohren et al. 2016).</li> <li>• In a maternity hospital in Afghanistan, neglect and suboptimal care were unlikely to be deliberate but were the result of conflicting priorities, the heavy workload, poor clinical skills, and the struggle for survival (Arnold et al. 2014).</li> <li>• In pre-service training, students often witness disrespectful and abusive behavior and, in turn, copy that behavior.</li> <li>• Students usually model both good and bad behaviors during preservice education (D'Oliveira et al. 2002). D'Oliveira reported the experience of students witnessing mistreatment of women by a resident and how they modeled it, suggesting that it is important to focus beyond the immediate cause of mistreatment, improve teaching on professional ethics, and work towards producing respectful health care providers.</li> </ul>
<p>Poor rapport between women and providers</p> <ul style="list-style-type: none"> <li>• Ineffective communication</li> <li>• Lack of supportive care</li> <li>• Loss of autonomy</li> </ul>	<ul style="list-style-type: none"> <li>• Providers may fear being humiliated in public, losing their job and the consequences for their family, and being blamed for a professional error. In a culture of fear and blaming, "surviving might mean blame someone else before you are blamed" (Arnold et al. 2014).</li> <li>• Violence against women in obstetric settings results from gender inequalities that place women in subordinate positions compared with men, thereby enabling the use of violence and promulgating disempowerment of women (Jewkes and Penn-Kekana, 2015).</li> </ul>
<p>Health system conditions and constraints</p> <ul style="list-style-type: none"> <li>• Lack of resources</li> <li>• Lack of policies</li> <li>• Facility culture</li> </ul>	<ul style="list-style-type: none"> <li>• Social, cultural, economic, and professional barriers to quality care provision among midwives include gender inequality, extremely low wages for long hours worked, poor training opportunities, and the challenges associated with working in remote regions with minimal chance for continuing education (Filby et al. 2016).</li> <li>• In settings where abusive care has been normalized (e.g., as part of midwifery education during training), it becomes routine, accepted, and expected (Kruk et al. 2014; Moyer et al. 2016).</li> <li>• Many urban hospitals have extremely high patient flow and yet are faced with significant resource and staff shortages, which is likely to be one of the key drivers of disrespect and abuse (Sando et al. 2016).</li> </ul>



## Appendix 2. Promising Approaches for Promoting RMC and Reducing Mistreatment (and the Pros and Cons of these approaches based on a program context)

Evidence-Informed Approaches (including purpose/goal) for Promoting RMC and Reducing Mistreatment	Pros (works well if...)	Cons (may not work well if...)
<b>National Policy/Advocacy</b>		
<b>1. Strategic advocacy and policy efforts</b> to create favorable policy and leadership, including client-centered and human-rights-based policy and funded national MNH operational plans that address critical system weaknesses and quality-of-care gaps.	<p>There is advocacy for RMC inclusion in national policy and in relevant guidelines, training materials, quality standards, job aids, etc. (national, regional, and facility).</p> <p>Advocacy work is supported for the creation of a conducive environment for RMC to be implemented (i.e., addressing issues on client privacy).</p> <p>Civil society organizations are engaged and their role is maximized in implementation and the learning side of RMC approaches.</p>	<p>Cultural context limits access to facility based care</p>
<b>2. Strengthening local health systems</b> to overcome structural barriers (lack of commodities, lack of basic infrastructure). Preventing and eliminating mistreatment in childbirth requires a “systems approach” to address underlying triggers.	<ul style="list-style-type: none"> <li>• Women are empowered through participatory accountability mechanisms that promote the status of women as providers and receivers of health care.</li> <li>• Barriers that prevent midwives from providing high-quality care to mothers and newborns are addressed in the local context. Some barriers include:             <ul style="list-style-type: none"> <li>• Social (gender inequality/economic/professional) — Midwifery seen as female profession; because of this, it is not valued. Midwives may have a lack of voice within profession and are often absent from policy dialogues, and therefore unable to contribute to decisions. This may result in moral distress and burn out.</li> <li>• Providers often overworked. This creates safety concerns in facilities. One outcome is poor quality of care.</li> </ul> </li> </ul>	<p>More information needs to be gathered on the issues around structural drivers of mistreatment, such as human resources, the challenges of the work environment, infrastructure, and gender-related issues.</p>

Evidence-Informed Approaches (including purpose/goal) for Promoting RMC and Reducing Mistreatment	Pros (works well if...)	Cons (may not work well if...)
<p>3. <b>Continuous Quality Improvement (QI)</b> focused on overcoming critical barriers and regular measurement (with consideration of community and efforts focused on identifying and overcoming critical barriers to RMC, linked to regular measurement/assessment of women's and families' experience of care). Continuous QI may involve maternity QI teams composed of health care workers, and community members.</p>	<p>RMC is addressed as a key aspect of QoC as part of ongoing and future QI efforts in targeted regions.</p>	
<p>4. Heighten emphasis on <b>professional ethics</b> and standards of care through involvement of professional associations and regulatory frameworks, including efforts to influence professional ethics and regulations linked to explicit professional standards of care (requires further testing).</p>		
<b>Local System and Service Delivery</b>		
<p>1. <b>Provider Training — Values Clarification and Attitude Transformation (VCAT)</b>            Help providers and managers conduct a self-evaluation of their behaviors and attitude in relation to RMC and mistreatment. This VCAT training is part of a comprehensive package called <b>The Respectful Maternity Care Resource Package</b>: This package is a set of manuals, tools, and resources to ensure high-quality, respectful maternal and newborn health care services. The resources help program managers, health care workers, and technical advisors set up workshops and trainings for facility-based providers and community health workers. The workshops provide practical, low-cost, and easily adaptable strategies to improve respectful care.</p>	<p>Individuals recognize that behavior and attitude change is self-driven.</p>	<p>There is an unsupportive environment for behavior change such as group thinking that incorrectly evaluates a situation/action in a way that magnifies the negative or minimizes the positive.</p>

Evidence-Informed Approaches (including purpose/goal) for Promoting RMC and Reducing Mistreatment	Pros (works well if...)	Cons (may not work well if...)
<p><b>2. Caring for the Carers</b> (providing supportive services for health workers). Provide opportunity for providers to deal with work-related pressures and develop sustainable processes within the MOH systems. More specifically, may help address health system factors that negatively affect health care workers in the workplace, support health care workers (e.g., provide tea and biscuits on night shift), and help health care workers to process work-related stress (e.g., set up peer support groups).</p>	<ul style="list-style-type: none"> <li>• Providers themselves nominate or identify the people they think would be good counselors: make sure it is confidential. Providers need to be able to offload their stress.</li> <li>• Mentoring opportunities exist in the local system: Somebody in the facility is available to provide more regular mentoring; serves as a “go to” resource when something happens (e.g., stillbirth).</li> <li>• Certificates for training: There is often burn out, and not enough rotation. Train people as teams. Providing certificates for training (if not remuneration) is motivating. Where management is supportive, conditions improve.</li> <li>• Work to build empathic communication skills among providers; reinforce over time through mentoring; not just one-off trainings. Feedback from clients is so powerful that it becomes a huge motivation for providers.</li> <li>• Community representatives are in the facility, giving the community a voice, so that they understand issues and lobby for providers’ needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Counselor is either too familiar or in a management position. Providers perceive management as a stressor.</li> <li>• Confidentiality is a concern</li> </ul>

Evidence-Informed Approaches (including purpose/goal) for Promoting RMC and Reducing Mistreatment	Pros (works well if...)	Cons (may not work well if...)
<p><b>3. Open Birth Days (OBD)<sup>1</sup></b>, also referred to as <b>Maternity Open Days<sup>2</sup></b>  A birth preparedness and antenatal care education program (designed to increase knowledge of patient rights and birth preparedness; increase and improve patient–provider and provider–administrator communication; and improve women’s experience and provider attitudes). Provide an opportunity to discuss birth planning with male partners. Gives mothers and community members a chance to contribute to women centered care.</p> <p>Maternity Open Days are also an opportunity for pregnant women and their families to interact with health care providers, visit the maternity unit to help understand what to expect during labor and delivery, and quell any fears they may have about giving birth in a facility. They are an opportunity to understand how communities and health facility staff can learn to support each other and see how some challenges can be overcome. For example, if a facility does not have a good supply of water, the community may offer to support the facility by harvesting rain water. Maternity Open Days aim to:</p> <ul style="list-style-type: none"> <li>• Promote mutual understanding, accountability, and respect among community members and service providers.</li> <li>• Improve knowledge and demystify procedures during labor, childbirth, and the immediate postnatal period.</li> </ul>	<p>There are effective community facility linkages and adequate community interest in improving maternity care services.</p>	<ul style="list-style-type: none"> <li>• Facility management is not willing to let the community in the facility.</li> <li>• There is poor community mobilization and/or cultural barriers, such as preventing the presence of males during child birth.</li> </ul>

<sup>1</sup> Used in the Uzazi Bora Project in Tanzania.

<sup>2</sup> Used in the Heshima project in Kenya. For more detail on pros and cons of Heshima approaches, please refer to Heshima Lessons Brief.

Evidence-Informed Approaches (including purpose/goal) for Promoting RMC and Reducing Mistreatment	Pros (works well if...)	Cons (may not work well if...)
<p><b>4. A Respectful Maternity Care (RMC) workshop</b> for health care providers based on the Health Workers for Change curriculum. The workshops are for health care providers and they engage providers in reflection about their own values and aspirations, client needs and priorities, and their local health care realities. Workshops are designed to increase knowledge of patient rights and birth preparedness, increase provider empathy, increase and improve patient-provider and provider-administrator communication, and improve women's experience and provider attitudes.</p>	<p>There is a facility-wide action plan (as an outcome of the workshops) to generate conversation about creating a culture of respect at the hospital. In addition to addressing facility barriers to respectful care, the action plan can be designed to empower health care providers and to improve their feelings of self-efficacy and ability to enact change within their workplace. The action plan can be used as a tool at department meetings, and provide opportunities for staff of all cadres to discuss issues of patient care. Items in the action plan should be constrained to activities that staff could conduct on their own, through teamwork and active involvement, without substantial additional resources. These activities will vary according to context and might include staff recognition events to improve staff motivation; repairing or procuring curtains and screens to ensure that all beds have a functioning partition for privacy, etc. (For more illustrative activities, access the following link: <a href="#">Uzazi Bora Project Article</a>).</p> <p>There is a sustained presence of project staff in the facility, working in close collaboration with facility leaders, to allow for the coordinated delivery of these multifaceted efforts.</p>	
<p><b>5. Development or Adaptation of a Client Charter</b>, (e.g., adaptation of a national charter): This charter would be complemented by such enforcement and change management mechanisms as "client questionnaires," anonymous client complaint mechanisms, and regular support to a maternity QI team to achieve the core principles of a client charter. This charter may be complemented by regular support to a QI team in a district hospital, which focused on identifying and overcoming obstacles to achieving RMC.</p>	<p>There is a local "adaptation process" of the national charter as part of the intervention. This will vary according to context, but in the case of Staha project, local adaptation involved a systematic dialogue between representatives of the district health system and communities.</p> <p>The final client charter is approved by local authorities and is centered on the value of mutual respect and consensus on key rights and responsibilities for patients and providers to ensure respectful care.</p> <p>There is leadership and facility readiness; both were important elements in the intervention's success; some leaders emerged later in the process and highlighted the need for continual engagement.</p>	<p>If mistreatment is normalized and/or there are ineffective structures for redress.</p>

Evidence-Informed Approaches (including purpose/goal) for Promoting RMC and Reducing Mistreatment	Pros (works well if...)	Cons (may not work well if...)
<p><b>6. Patient Satisfaction Surveys:</b> They are easy to do; the hospital analyzes the data. Questions focus on RMC, not MISTREATMENT. Answers are put in a box and analyzed every week, so there is regular frequency. Questionnaires provided motivation for providers to serve with respect. These questionnaires can be used to regularly elicit clients' experience of care and priorities for care to inform and assess efforts to improve RMC and reduce mistreatment in childbirth.</p>	<p>Participants are assured of confidentiality or anonymity and that their participation will not affect their (or their families') access to services or quality of services received.  Women can feel comfortable sharing their perspectives.  The box is not a complaint box that women have to walk up to; the surveys must be directed at all women.</p> <ul style="list-style-type: none"> <li>• Literacy in context will determine use of paper surveys and putting them in a locked box.</li> <li>• Every woman fills out the questionnaire.</li> <li>• Complaints are verbal, on phone, and have an intermediary.</li> <li>• Suggestion boxes – not effective</li> <li>• Issue – determine whether to have exit survey done in community or facility.</li> </ul> <p><b>In surveys, look at most common concerns of women:</b></p> <ul style="list-style-type: none"> <li>• Do clients feel that they have a choice of facilities?</li> <li>• Do clients feel that they can talk about facilities' care and not feel retribution?</li> <li>• Did anything happen that made you feel bad? Humiliated? And then follow up with specifics. Ask about overall satisfaction as a starting point.</li> <li>• Verbal abuse, physical abuse (slapped), neglect (deliver alone).</li> <li>• Ask about respectful care received, and whether they were treated well.</li> <li>• &lt;5 questions?</li> <li>• Hospital management may suggest an exit survey to monitor QI process – ratings of QoC elements.</li> <li>• Use yes/no responses; easier to analyze. Add "I don't know," as an answer choice.</li> </ul>	
<p><b>7. Promoting mutual accountability:</b> rights and responsibilities of health care providers and clients.</p>	<p>Behavior change is addressed as part of MCSP programming because behavior change among service providers is key to addressing D&amp;A at the facility level.</p>	
<p><b>8. Local participatory approaches</b> are focused on iterative refinement of locally defined priorities and program approaches.</p>	<p>National, regional, and district ownership is prioritized for setting strategies for participatory approaches from the beginning of the project.</p>	<p>Further research is needed on local participatory implementation design and processes that can be adapted and sustained locally to reduce D&amp;A and sustain RMC—with a focus on iterative learning and adaptation.</p>



Evidence-Informed Approaches (including purpose/goal) for Promoting RMC and Reducing Mistreatment	Pros (works well if...)	Cons (may not work well if...)
<p><b>1. Community sensitization and participatory action planning workshops</b> develop community-owned action plans to hold health system accountable for RMC in line with “Citizens Charters,” and to strengthen positive male involvement by discussing the importance of birth planning and finances with men/elders.</p>	<p>Utilizing existing community channels for meetings (e.g., chief/tribal leaders meeting, women’s groups, religious gatherings).</p>	<p>Communication on rights do not result in observable outcomes. Community health volunteers may focus on easy targets such as referrals for antenatal care, deliveries, malaria, and cases, but should not discuss rights issues.</p>
<p><b>2. Alternative dispute resolution for mistreatment</b> establishes joint facility and community mechanism to resolve and seek redress for mistreatment incidents, including continuous Quality Improvement Teams (cQITs), community score cards, or community “rights watch groups.”</p>	<p>If community is willing to report cases and there are effective Community–facility linkages. Must be managed well to ensure mutual respect between communities and facilities.</p>	
<p><b>3. Approaches that break down barriers between providers and clients</b> (e.g., regular facilitated community–facility dialogue, QI teams comprising community and health care workers who engage in continuous work to improve people-centered care, and Maternity Open Days).</p>		
<p><b>4. Social accountability approaches:</b> Social accountability is an approach towards building accountability that relies on civic engagement, in which citizens participate directly or indirectly in demanding accountability from service providers and public officials. Social accountability may involve the mobilization of civil society to put pressure on government or providers to deliver quality, respectful services. Examples of social accountability tools and mechanisms include participatory budgeting, public expenditure tracking, citizen report cards, community score cards, social audits, citizen charters, and right-to-information acts. May involve use of media and social media to drive policy change: one goal may be to gain attention nationally about mistreatment and/or respectful care. One benefit of participatory accountability is a sense of ownership and sustainability (because citizens drive this), as well as cultural sensitivity, since these approaches capture issues that women care about.</p>		

# Appendix 3. Illustrative Concept Note and Workplan for Incorporating RMC Approaches into a Comprehensive MCSP MNH Program

## Background and Objective

As part of MCSP's on-going efforts to promote respectful care and reduce mistreatment as a central element of quality MNH care, MCSP has developed process-oriented RMC operational guidance based on current evidence for use in MCSP country programs.

The **overall objective of proposed activities** in this concept note is to implement a process-driven, locally designed set of interventions to promote RMC and reduce mistreatment in facility-based childbirth services in MCSP-supported sites in *COUNTRY*. Increasingly evidence demonstrates that when childbirth care is respectful women and families are more likely to use facility maternity services and that obstetric complications may be reduced (Kruk et al. 2014; Bohren et al, 2015; Raj et al, 2017.)

*COUNTRY-SPECIFIC BACKGROUND INFORMATION ABOUT RMC/D&A: Include a brief summary of relevant country background information (e.g. national policy, program efforts supported by national government, partners, MCSP) including key findings from any RMC studies or assessments or program implementation efforts (by MCSP or partners) completed in the COUNTRY.*

*BACKGROUND INFORMATION ON MCSP's WORK IN COUNTRY: MCSP is working in selected health facilities and/or communities in COUNTRY to end preventable maternal and neonatal deaths. In the past two years, MCSP has collaborated with the MOH to deploy evidence-based interventions including skills-based trainings to enhance the provision of quality care during childbirth. Include an overview of MCSP MNH program work in COUNTRY. Briefly summarize any previous MCSP activities to address RMC/mistreatment on which the proposed program interventions will build.*

## OVERVIEW OF PROPOSED RMC ACTIVITIES FOR SUPORT BY MCSP AS PART OF MNCH PROGRAM ACTIVITIES IN COUNTRY

Using a participatory, co-design approach MCSP will apply this RMC operational guidance as part of established MNH work to improve women-centered and newborn-centered care in *COUNTRY* and to generate learning across USAID-supported countries.

This note outlines next steps for building on current and interlinked RMC, Gender, and QoC client-centered work in *COUNTRY* for discussion with *COUNTRY* USAID Mission and eventually other stakeholders if approved by the USAID Mission.

Based on MCSP global RMC operational guidance, the proposed work in *COUNTRY* will be conducted in three phases beginning in quarter X of PY Y and extending through the life of the MCSP program in *COUNTRY*:

- Phase 1: a modest RMC formative assessment (qualitative and quantitative data collection) in selected sites [building on earlier X assessments] with added focus on client experience of care as a key dimension of quality
- Phase 2: development by local stakeholders of a context-specific theory of change and selection of priority RMC gender-sensitive approaches with a corresponding implementation and monitoring plan
- Phase 3: implementation and ongoing program monitoring (and endline assessment if resources permit.)

In line with the MCSP *COUNTRY* PY 3 work plan, MCSP will also work with the HSS/Equity and gender teams to incorporate equity and gender factors into the proposed formative assessment and follow-on interventions and routine measurement of RMC as applicable based on the results from the formative assessment.

The formative assessment is expected to build on and complement on-going PY X RMC-related activities and to help refine PY Y RMC follow-on activities for implementation in selected sites. Current RMC and related activities in progress in YR 3 include: *COUNTRY*.

### **Implementation Approach**

For **Phase I**, MCSP- *COUNTRY* will undertake a modest mixed methods (qualitative and quantitative) formative and baseline assessment to understand local characteristics and drivers of mistreatment and assess clients' experience of care in selected facilities in order to tailor the implementation approach to the country's context. In-country and remote support will be provided by MCSP HQ, with the support of the broader MCSP *COUNTRY* team. The formative assessment will include key informant interviews and potentially focus group discussions with key stakeholders, including community members, women clients, health facility staff, health facility and district managers to obtain qualitative information about RMC within the anticipated intervention areas (See appendix 6 in the MCSP RMC operational guidance for a set of formative assessment tools that can be adapted based on local context and local program needs.)

Key informant interviews will be conducted with community members (women of reproductive age who have delivered in the past one year in the formal and informal health sectors); formal health care workers who provide labor and delivery services; and the leadership in those facilities and sub-districts or districts.

Qualitative data will be supplemented by baseline quantitative surveys/questionnaires with key stakeholders, including women who have recently delivered in facilities and managers and providers.

Phase I will be implemented in ## selected MCSP supported facilities. The criteria for selecting these facilities will include: XX

It may involve

- I. Key informant interviews with the Health Facility Managers using the formative assessment in depth interview guide/tool

2. Key informant interviews with X selected health care workers from targeted facilities using the formative assessment in-depth interview guide/tool and structured interviews with health providers using a quantitative survey tool.
3. Interviews with selected women post-delivery using the quantitative exit interview tool.
4. Individual interviews and/or Focus group discussions (FGD) with women of reproductive age who have delivered in the past one year in the formal and informal health sectors. The women will be from the catchment area of selected facilities and a “snow ball” methodology will be used for selection. The formative assessment in-depth interview guide for women of reproductive age in the community will guide the Focus group discussion. The recruitment process for the FGD will use the community structure to identify the first set of women before these women identify other women who meet the criteria.
5. Other potential data sources/interviewees for discussion:
  - a. Civil society groups? (E.g. WRA, etc.)
  - b. Professional associations
  - c. Government policy-makers and actors at different levels of the health system
  - d. Selected community committees

In **Phase 2** (end of YR X or early Q Y), results from the mixed methods formative and baseline assessment, including clients’ reported experience of care, will be used by MCSP and key stakeholders to develop the program’s theory of change. Based on the theory of change and using MCSP’s RMC Operational Guidance as a reference, the program will design context-specific activities and interventions, to be embedded within MCSP-COUNTRY MNH program YR X activities in selected sites to promote RMC and reduce mistreatment in facility based childbirth services as a core element of quality MNH care.

In **Phase 3** (in program YR X) MCSP will implement and monitor the interventions and approaches identified through the phase-one formative assessment and design processes described in the MCSP RMC operational guidance. If resources permit an endline assessment will be implemented after approximately 12 months of implementation.

As part of the initial formative assessment the program would, ideally, like to conduct baseline and subsequent endline assessments to measure changes in provider and client experience of care during the implementation and monitoring phase. The baseline and endline assessment will be primarily done through interviews with clients and providers to be able to measure post-intervention changes in the selected facilities. This information will help MCSP COUNTRY and stakeholders understand whether measureable changes have occurred and which program activities contributed most to any observed positive changes.

## **Baseline and Formative Assessment Objectives**

- Assess clients, health workers, and managers perceptions of the quality of childbirth services with respect to clients' experience of care (respectful and non-respectful) provided during childbirth, including key manifestations of, and potential drivers of, mistreatment in the local context
- Determine the extent to which health facility users and providers/managers (clients, providers, and administrators) are satisfied with the services provided during childbirth; explore what women characterize as a positive facility childbirth experience (i.e. their priorities and expectations)
- Assess health care workers views on factors that may contribute to their attitude towards their clients and the specific stresses that they experience in the workplace, including what they identify as their priority needs related to their work as maternal health providers.
- Examine equity and gender factors related to experience of care at the facility level, looking at critical demographic/equity information.

## Outputs

MCSP will document successes and lessons learned for key stakeholders to improve programming and strengthen respectful maternity care as well as eliminate mistreatment. MCSP seeks to obtain feedback from clients, providers, and health facility administrators about their experience and satisfaction as health facility providers and users to improve their experience providing and receiving care. Their input will assist providers, managers, and policy-makers to improve services in response to the needs of clients, and may help identify bottlenecks to the provision of quality, client-centered care. This information will also help MCSP Country and stakeholders understand whether the approaches used are feasible and acceptable.

The proposed RMC and gender activities in this document, summarized in timeline below, directly responds to the primary mandate of the MCSP MNCH program in COUNTRY to improve quality of MNCH services, of which client-centered gender-sensitive care is a core component of quality care. MCSP will develop a dissemination plan to ensure that findings are fed back to the community, managers and providers and other key stakeholders at various levels of the health system. MCSP will also share findings with district and lower geographical levels and advocate for quality improvements. Based on learning from implementation of MCSP RMC operational guidance in COUNTRY, MCSP will continue to test and refine formative assessment and routine measurement approaches and tools to capture progress and inform implementation of RMC and mistreatment reduction efforts. MCSP will continue to update and improve the MCSP RMC operational guidance based on learning from COUNTRIES with the goal of building evidence about how RMC approaches can be mainstreamed into comprehensive MNH programs operating at scale (to augment findings from RMC-focused implementation research studies which constitute most of the evidence to date.)

## Illustrative Timeline (for adaptation)

	Activity	Time Frame	Responsibility
<b>PHASE I: Formative Assessment (April-July, 2017)</b>			
1.	Development of RMC Assessment/patient satisfaction Objectives and Program Monitoring Document	April	
2.	Tool Development and Adaptation	April/May	

3.	Development of detailed formative assessment/patient satisfaction plan and protocol	April/May	
3.	Share tools with HSS/Equity, Gender, and others	Mid-June	
4.	Translate tools and consent forms	June-July	
5	Solicit IRB approval and local approval per protocol	June-July	
6.	Identify local consultant to manage formative and baseline assessment	June	
7	Stakeholders advocacy meeting in implementation areas to raise awareness of the formative assessment/patient satisfaction survey	July	
8	Recruitment of Data collectors	July-August	
9	Training of Data Collectors	August (2-day training) Third week of August (work planning for MCSP 1st and second week)	
10	Data collection and analysis of results	September - October	
<b>PHASE 2: Development of a theory of change and implementation monitoring approach September-November 2017)</b>			
1.	Preparation for in-country Stakeholder meeting	September-November	
2.	Stakeholder meeting to design theory of change	Oct-Nov	
3.	Selection of implementation approaches and development of implementation plan	Oct-Nov	
3.	Development of detailed monitoring approach	Oct-Nov	
4.	Identification of HFs to be included	Oct-Nov	
<b>PHASE 3: Implementation and routine program monitoring (November 2017-October 2018)</b>			
3.	Program implementation (further details to be described as part of PY 4 WP.)	February	
4.	Conduct End-line Assessment	October to November 2018 (2weeks)	



5.	Data entry and analysis	November 2018 (2weeks)	
6.	Report writing and dissemination	September-October (1 month) November/Dec 2018	
	Preparation of manuscript for publication?	Dec 2018-Feb 2019	

## Appendix 4. Qualitative RMC/Mistreatment Data Collection Methods

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Description
1. Focus group discussion (FGD)	Elicits group norms and opinions, which is facilitated by the group dynamic. In a short amount of time, a range or many different stories or nuances on a topic can emerge. (a) For Regular RMC assessment: Many studies use FGDs. It is acceptable and feasible to hold FGDs with women on experiences with and access to care. Can reach many women (or men, community members or others who are comfortable gathering as a group) in a short period of time. Group members' comments build off each other.	Sensitive personal information or experiences may not be shared. Mistreatment experiences may not be discussed unless participants feel safe and comfortable with the members and the moderator of the group. Dominant participants can influence other participants to be quiet.	a. Cindoglu and Unal, 2016 <a href="https://www.ncbi.nlm.nih.gov/pubmed/20390649">https://www.ncbi.nlm.nih.gov/pubmed/20390649</a>	Turkey	FGDs with clients and separately midwives, physicians
			b. Ganle et al. 2014 <a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-014-0425-8">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-014-0425-8</a>	Ghana	FGDs with women
			c. Magoma et al. 2010 <a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-13">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-13</a>	Tanzania	FGDs with women
			d. Moyer et al. 2014 <a href="http://www.sciencedirect.com/science/article/pii/S0266613813001514">http://www.sciencedirect.com/science/article/pii/S0266613813001514</a>	Ghana	3 FGDs with grandmothers, 2 FGDs with compound heads, and 2 FGDs with household heads
2. In-depth interview or key informant interview	Elicits individual opinions, experiences, and feelings. Greater confidentiality for participants to describe personal or sensitive views. Ability to explore the relationships or connections between phenomena, events, beliefs. Ability to gain information from professionals and staff in certain positions. Can be	In general: Sometimes, responses on personal experiences are short.  For regular RMC assessment: The variety (range) of mistreatment experiences may not emerge unless many interviews are done.	a. Heshima <a href="http://www.popcouncil.org/research/Measuring-disrespect-and-abuse-to-promote-respectful-maternity-care">http://www.popcouncil.org/research/Measuring-disrespect-and-abuse-to-promote-respectful-maternity-care</a>		
			b. Staha <a href="https://www.mailman.columbia.edu/research/averting-maternal-death-and-disability-amdd/respectful-maternity-care">https://www.mailman.columbia.edu/research/averting-maternal-death-and-disability-amdd/respectful-maternity-care</a>		

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Description
	semi-structured or in-depth interviews. For regular RMC assessment: Many studies use interviews. It is acceptable and feasible to hold them with women and with health care providers.				
3. Observations (unstructured, ethnographic)	This is done in ethnography and sociology to understand the cultural context, actors, processes, constraints, and phenomena as they unfold. Researchers can see care processes with their own eyes. "Observation can be a powerful check against what people report during interviews and focus groups." After a few days, the Hawthorne effect may be minimized. Unstructured observation can be used initially to develop other structured data collection methods.	Unstructured observation may be done less often in public health. Takes much time to observe, document in field notes, and expand and analyze notes. Observer needs to commit to objectivity.  Open-ended comments added to structured surveys may yield brief responses.	a. Beebe J. 2001. Rapid Assessment Process: An Introduction. Walnut Creek, CA: Altamira Press. Volume 3, No. 4, Art. 33 <a href="http://www.qualitative-research.net/index.php/fqs/article/view/773/1678#gl">Rapid Assessment Process in Qualitative Inquiry</a> <a href="http://www.qualitative-research.net/index.php/fqs/article/view/773/1678#gl">http://www.qualitative-research.net/index.php/fqs/article/view/773/1678#gl</a>	NA	For RMC assessment related to government and also clients. The book introduces readers to rapid methods of inquiry in ethnography that offer field-based findings to implementers and policymakers.
			b. Magoma et al. 2010 <a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-13">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-13</a>	Tanzania	For regular RMC assessment. Helped authors understand and interpret data from interviews and FGDs. Used for triangulation purposes and to give perspective. Principal investigator noted observations each day in a field diary
			c. Arnold et al. 2014 <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4489341/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4489341/</a>	Afghanistan	For regular RMC assessment. 6 weeks of daily observations of staff with field notes taken and discussed with interpreter.
			d. Rosen et al. 2015 <a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4</a>	5 African countries	Structured (quantitative) observation tool had open-ended questions to document phenomena not mentioned in quality-of-care tool/standards. Structured observational tool had open-ended fields for comments.
4. Participatory methods	Possibly can engage providers or clients/community members in data generation activities (ranking, sorting, mapping) and later on in policy or service delivery	Few examples to date; may require certain expertise to organize and analyze data from participatory methods.	Community-based participatory research (CBPR) (US); participatory rural appraisal (PRA) (low-resource settings); participatory action research (PAR)		

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Description
	changes. Possibly can be added to focus groups or dissemination meetings with stakeholders.	An example of a participatory method is "Rich Picture."	Examples relevant to RMC still need to be identified.		
			a. <a href="http://www.who.int/workforcealliance/knowledge/toolkit/33.pdf">Stakeholder Analysis Guidelines by Kammi Schmeer.  http://www.who.int/workforcealliance/knowledge/toolkit/33.pdf</a>	NA	For RMC assessment related to government and also clients. This 8-step guide covers planning the process, selecting and defining a policy, identifying stakeholders, adapting tools, collecting information, filling in and analyzing a stakeholder table, and using the information for decision-making. Examples are given.
			b. <a href="http://www.mspguide.org/tool/stakeholder-analysis-importanceinfluence-matrix">Influence and importance matrix  http://www.mspguide.org/tool/stakeholder-analysis-importanceinfluence-matrix</a>	NA	For RMC assessment related to government and policy. This website gives a brief 7-step description of how to assess influence and importance, including listing stakeholders, drawing out interests in relation to the problem, assessing the influence or power of the stakeholders, brainstorming, completing the matrix diagram, identifying risks and assumptions for stakeholder cooperation, and determining how and which stakeholders should participate in project activities.
			c. Rich Picture <a href="http://www.managingforimpact.org/tool/rich-picture-0">http://www.managingforimpact.org/tool/rich-picture-0</a>	NA	For RMC assessment related to clients. This describes a group exercise to develop a drawing of a situation that addresses a problem and illustrates the main elements and relationships that need to be considered in trying to intervene to create some improvement.
			d. Bardach E. 2012. A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving Fourth Edition. Sage/ CQ Press, Thousand Oaks, CA, USA.	NA	For RMC assessment related to government and policy. The path involves initial steps of defining the problem, assembling some evidence, and constructing alternatives. Next steps include selecting the criteria for solutions, projecting the outcomes, and confronting the trade-offs. The steps culminate with "Decide!" and telling your story.
			e. <a href="#">Net-Map (social networking mapping tool)</a>	NA	Quality of care (structure, process, community-reported outcomes related to L&D services and RMC)
			f. Community Score Card <a href="http://www.care.org/sites/default/files/documents/FP-2013-">http://www.care.org/sites/default/files/documents/FP-2013-</a>		For perspectives of RMC and D&A from community members. Developed by CARE, the community score card approach brings together community members, service providers, and local government to identify service utilization and provision challenges, to mutually generate solutions, and work in partnership to implement and track the effectiveness

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Description
			<a href="#">CARE CommunityScoreCard Toolkit.pdf</a>		of those solutions in an ongoing process of quality improvement.

## Appendix 5. Quantitative RMC/Mistreatment Data Collection Methods

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
I. Client exit interview	<ul style="list-style-type: none"> <li>-May be done routinely for each client if self-administered.</li> <li>-Text message or phone follow-up may be feasible in some settings.</li> <li>- Clients can directly report on their own experiences.</li> <li>-May be administered to a sample of clients</li> </ul>	<ul style="list-style-type: none"> <li>-Household surveys may be more accurate but are not feasible as part of routine program implementation.</li> <li>-Exit interviews probably tend to underestimate mistreatment in childbirth</li> <li>-Text message or mailed written surveys or questions require a minimum level of literacy.</li> <li>-Text message or phone follow-up excludes poorer women without access to a phone.</li> <li>-Possible loss-to-follow-up if not administered while the client is still in the facility.</li> <li>-Self-administered questionnaires are challenging in low-literacy populations.</li> <li>-Possible response bias (e.g., courtesy bias) depending on who administers survey.</li> <li>-May not be able to measure negative experiences that have been normalized.</li> </ul>	a. Sando et al. (2014): n=1,954 client interviews (single large referral hospital). <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251905/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251905/</a>	Tanzania	N	Mixed methods study that included interviews with postpartum women	Assesses satisfaction and quality with specific focus on experience of disrespect and abuse in childbirth, including physical abuse, nonconsented care, and nonconfidential care, lack of privacy, nondignified care, and abandonment during or after labor and delivery, and detention in facilities.
			b. Kruk et al. (2014): Interviews with women upon discharge (n=1,779) and then follow-up with subset 5-10 weeks later at home (n=593) <a href="https://academic.oup.com/heapol/advance-article/doi/10.1093/heapol/czu079/2907853">https://academic.oup.com/heapol/advance-article/doi/10.1093/heapol/czu079/2907853</a>	Tanzania	N	Interviews with women using a structured questionnaire.	Categories of D&A included: non-confidential care, non-dignified care, neglect, non-consented care, physical abuse and inappropriate demands for payment
			c. Abuya et al. (2015a): Exit survey with n= 641 women <a href="http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0123606">http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0123606</a>	Kenya	N	Pre-post interviews with women about D&A as part of the Heshima Project.	Questionnaire included D & A in general as well as six typologies, including physical and verbal abuse, violations of confidentiality and privacy, detainment for non-payment, and abandonment.
			d. Asefa (2015): Exit interviews prior to discharge with n=173 women	Ethiopia	N	Cross-sectional interviews with women immediately prior to discharge	Levels of disrespect and abuse during childbirth were measured using seven performance standards (categories of disrespect and abuse) and their



Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
			<a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4403719/">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4403719/</a>				respective verification criteria developed by the Maternal and Child Health Integrated Program (MCHIP) as part of their respectful maternity care tool kit
			e. Scheferaw et al. (2016): n=509 postnatal clients interviewed to develop a scale <a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0848-5">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0848-5</a>	Ethiopia	Y	Development of a tool to measure women's perception of RMC in public health facilities, BMC 2016	Dimensions included friendly care; abuse-free care; timely care; and discrimination-free care.
			f. Women's Views of Birth Labour Satisfaction Questionnaire (WOMBSQ) <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743424/pdf/v010p00017.pdf">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743424/pdf/v010p00017.pdf</a>	UK	Y	For RMC and D&A related to patients. Developed by Smith (2001), this questionnaire assesses women's satisfaction with their labor care.	The 10 dimensions included in this questionnaire include professional support in labor; expectations of labor; home assessment in early labor; holding the baby; support from husband/partner; pain relief in labor; pain relief immediately after labor; knowing labor carers; labor environment; and control in labor.
			g. <a href="#">Staha Study Facility Exit Questionnaire</a>	Tanzania	N	For RMC and D&A related to patients. This questionnaire was used as part of the Staha study in Tanzania; this questionnaire includes a section on women's reported experience of disrespect and abuse; the length of this questionnaire may make it prohibitive for routine use of the entire questionnaire but it could	Perceived quality and satisfaction; experience of disrespect and abuse.

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
						be used to collect baseline/endline data.	
			h. <a href="#">Maternity Ward Survey for Magunga Hospital (Staha project in Tanzania)</a>	Tanzania	N	For RMC and D&A related to patients. This self-administered questionnaire was used for the QI process at the hospital, which asks women to rate a number of aspects regarding quality of care. Women placed these in a locked box and the responses were analyzed by facility staff.	Nine question exit survey asking about respect from providers; physical privacy; availability of drugs and equipment; cleanliness of facility.
			i. Pregnancy- and maternity-care patients' experiences questionnaire/PreMa PEQ (Sjetne et al. 2015). <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4546178/pdf/12884_2015_Article_611.pdf">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4546178/pdf/12884_2015_Article_611.pdf</a>	Norway	Y	Purpose of the survey was "to describe the development and psychometric properties of a pregnancy- and maternity-care patients' experiences questionnaire." From 17 weeks of birth.	Birth one of 4 questionnaire sections – 3 subscales: personal relationships in delivery ward, resources and organization of ward; attention to partner in ward.
			j. Survey of Bangladeshi women's experience of maternity services (Duff et al. 2001).	Bangladesh	Y	72 items (3 subscales: ANC 33; peri-15; postnatal 24). Timeframe: 2 months postpartum.	"Model for developing instruments for minority ethnic populations"

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
			<a href="https://www.ncbi.nlm.nih.gov/pubmed/11476146">https://www.ncbi.nlm.nih.gov/pubmed/11476146</a>				
			o. Questionnaire for Assessing Childbirth Experience (QACE). Carquillat et al., BMC Pregnancy and Childbirth 2017. <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5577741/pdf/12884_2017_Article_1462.pdf">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5577741/pdf/12884_2017_Article_1462.pdf</a>	Switzerland, France	Y	13 item scale 4 sub-scales: relationship with staff (4), emotional status (3), first moments with NB (3) feelings at 1 month pp (3).	Expectations, perceived control, relationship with caregivers and father, emotions, first moments baby was born.
			p. Citizens Report Cards <a href="http://siteresources.worldbank.org/INTPCEN/G/1143380-1116506267488/20511066/reportcardnote.pdf">http://siteresources.worldbank.org/INTPCEN/G/1143380-1116506267488/20511066/reportcardnote.pdf</a>	No published results from use of this tool for RMC/D&A	N	For perspectives of RMC and D&A from community members and clients. Developed by the Public Affairs Center in 1994, citizen report cards are client feedback surveys.	User perceptions of quality, efficiency and adequacy of different public services.
			q. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; <a href="http://www.hcahpsonline.org/home.aspx">http://www.hcahpsonline.org/home.aspx</a>	No published results from use of this tool for RMC/D&A	Y—in multiple countries	For RMC assessment related to patients. The HCAHPS survey contains 21 patient perspectives on care and patient rating items. The survey also includes four screener questions and seven demographic items, which are used for adjusting the mix of patients across hospitals and for analytical purposes.	The survey covers nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
			r. The Mothers on Respect (MOR) Index Measuring Quality, Safety, and Human Rights in Childbirth (Note: the tool referenced does not explain the scoring/weighting). <a href="http://www.sciencedirect.com/science/article/pii/S2352827317300174">http://www.sciencedirect.com/science/article/pii/S2352827317300174</a>	British Columbia USA	Y	Developed and validated in British Columbia, this paper presents results from the psychometric analysis of survey with 14 questions that measured aspects of patient-provider communication.	Items in MORi assess the nature of respectful patient-provider interactions and their impact on a person's sense of comfort, behavior, and perceptions of racism or discrimination.
			s. Afulani et al. 2017, <i>Reproductive Health</i> . Development of tool to measure person-centered maternity care in developing settings: validation in rural and urban Kenya <a href="https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0381-7">https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0381-7</a>	Kenya	Y	30 item scale with 3 sub-scales to measure <i>positive and negative aspects</i> of person-centered maternity care (PCMC); validated in a rural and urban setting in Kenya	3 sub-scales measure PCMC: -Dignified and respectful care (6 items, positive and negative) -Communication and autonomy (9 items) -Supportive care (15 items; time, labor and delivery support, emotional support; pain control, facility infrastructure)
			t. Montesinos-Segura, R et al. 2017. Disrespect and abuse during childbirth in 14 hospitals in 9 cities of Peru <a href="http://onlinelibrary.wiley.com/doi/10.1002/ijgo.12353/abstract">http://onlinelibrary.wiley.com/doi/10.1002/ijgo.12353/abstract</a>	Peru	N	Cross-sectional survey of D&A based on Bowser and Hill categories	

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
			u. Paridhi Jha et al. 2017. <i>Global Health Action</i> . Satisfaction with childbirth services provided in public health facilities: results from a cross-sectional survey among postnatal women in Chatisgarh, India <a href="http://www.tandfonline.com/doi/full/10.1080/16549716.2017.1386932">http://www.tandfonline.com/doi/full/10.1080/16549716.2017.1386932</a>	India	N		
2.Interview with birth companion	-May be done routinely for each client's companion if self-administered. -Text message or phone follow-up <i>may</i> be feasible in some settings. -Companions may be able to report on witnessed behavior that was not recognized by the client herself.	-Text message or mailed written surveys or questions require literacy. -Text message or phone follow-up excludes poorer birth companions without access to a phone. -Possible response bias (e.g., courtesy bias) depending on who administers the survey.	No published studies on RMC/mistreatment using this method identified in low- and middle-income countries (LMICs).	NA	NA	NA	NA
3.Provider/ staff confidential questionnaire	-May be a relatively more feasible approach that can be triangulated with patient self-report if confidentiality is ensured. -Possible to collect information on issues related to organizational culture. -Because staff are always present, can observe	-Possible response bias (e.g., social desirability bias). -Mistreatment may have become normalized for many staff.	No published studies on RMC/mistreatment using this method identified in LMICs  a. Hospital Survey on patient safety culture <a href="https://psnet.ahrq.gov/resources/resource/5333/surveys-on-patient-safety-culture">https://psnet.ahrq.gov/resources/resource/5333/surveys-on-patient-safety-culture</a>	NA	Y	For RMC assessment related to organizational culture. Developed by the Patient Safety Group of the US Agency for Healthcare Research and Quality (AHRQ): This staff survey was developed in 2004 to help hospitals assess their culture of	This tool can assess support to providers; management/supervision of providers; communications within the facility; provider background information

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
	patterns of RMC and mistreatment. -Can measure health workers' experience of providing care					safety. This link includes survey tools and a user's guide.	
			<b>b.</b> <a href="https://www.capacityplus.org/files/resources/hrm-assessment-approach.pdf">Human Resources Management Assessment Approach</a> <a href="https://www.capacityplus.org/files/resources/hrm-assessment-approach.pdf">https://www.capacityplus.org/files/resources/hrm-assessment-approach.pdf</a>	NA	N	For RMC assessment related to organizational culture and work environment. This document from the Capacity Plus Project describes an assessment approach that is intended to help users identify and address human resources management (HRM) systems issues. It promotes the collection and analysis of information on defined key HRM challenges, and informs the development of effective policy, strategy, systems, and process interventions to respond to these challenges. The approach also helps generate the evidence base needed to determine the most appropriate solutions and interventions to address HRM challenges in a systemic, integrated, and holistic manner.	Organizational culture; work environment; management systems
			<b>c.</b> <a href="https://med.uth.edu/chqs/surveys/safety-attitudes-and-safety-climate-questionnaire/">Safety attitudes and safety climate questionnaire</a> <a href="https://med.uth.edu/chqs/surveys/safety-attitudes-and-safety-climate-questionnaire/">https://med.uth.edu/chqs/surveys/safety-attitudes-and-safety-climate-questionnaire/</a>	NA	Y	For RMC assessment related to organizational culture and work environment. This survey can be used to measure health care provider attitudes related to six domains: teamwork climate, safety climate, perceptions of management, job satisfaction, working conditions, and stress recognition. This link includes the survey tool, permission letter to	This tool can assess teamwork climate, safety climate, perceptions of management, job satisfaction, working conditions, and stress recognition



Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
						use the short form of the questionnaire, and a scoring key.	
			d. Health Workforce Productivity Analysis and Improvement Toolkit  <a href="https://www.capacityplus.org/productivity-analysis-improvement-toolkit/">https://www.capacityplus.org/productivity-analysis-improvement-toolkit/</a>	NA	N	For RMC assessment related to organizational culture and work environment. Developed by the Capacity Plus Project, The Health Workforce Productivity Analysis and Improvement Toolkit describes a step-wise process to measure the productivity of facility-based health workers, understand the underlying causes of productivity problems, identify potential interventions to address them, improve health service delivery, and achieve health goals. This toolkit focuses specifically on the productivity of facility-based health care workers and not that of the health system as a whole.	This tool can assess health workforce productivity problems, including health facility inefficiencies; health worker absenteeism; and low patient demand.

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
			<p>f. Employee Satisfaction Survey</p> <p><a href="https://www.k4health.org/sites/default/files/Employee_Satisfaction_Tool.pdf">https://www.k4health.org/sites/default/files/Employee_Satisfaction_Tool.pdf</a></p>	NA	N	For RMC assessment related to organizational culture, work environment, and employee satisfaction. Developed by the Management and Leadership Program (M&L), Management Sciences for Health, this survey tool can be used to establish a baseline on employee satisfaction. Managers are encouraged to use this questionnaire to establish baseline data prior to implementing improvements to the HRM system.	This tool assesses fair treatment of employees; employees' understanding of expectations; employee's feelings about performance feedback, their value to the organization, and opportunities for career development.
5.Observation of care during childbirth	Can provide objective measures for tasks that are easier to observe or less subjective (e.g., physical violence, birth companion presence, etc.)	<p>Resource intensive so not feasible as part of routine programming but could be done as part of quality assurance (e.g. periodic supervision visits)</p> <p>More subjective tasks may require more interpretation</p>	<p>a. MCHIP Quality of Care Surveys. Rosen et al. (2015) : n=2,164 L&amp;D observations. <a href="https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4">https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4</a></p>	Ethiopia, Kenya, Madagascar, Rwanda, Tanzania	N	For RMC and D&A related to patients. The purpose of the survey is to generate information to quantify the need for and guide the content of quality improvement activities for maternal and newborn care at facility, district, and national levels. The surveys provide documentation of the appropriate use, quality of implementation, and barriers to performance of key preventive, screening, and treatment interventions during facility-based maternal and newborn care.	Bowser and Hill (2010) categories of D&A: physical abuse, non-consented clinical care, non-confidential care, non-dignified care, and detention in health facilities
			<p>b. Adaptation of the MCHIP Quality of Care labor and delivery observation tool. Sethi et al.</p>	Malawi	N		

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
			(2017) : n=2,109 L&D observations. <a href="https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0370-x">https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0370-x</a>				
			c. <a href="#">Staha Observation Tool</a>	Tanzania	N	For RMC and D&A related to patients. This observation tool was used at endline in the Staha study. The tool was based on MCHIP's Quality of Care surveys as well as modifications made by the Population Council.	
6.Simulation of care and provider–client interactions	<ul style="list-style-type: none"> <li>-Could provide objective measures for tasks that are easier to observe.</li> <li>-Does not require availability of L&amp;D case, so could potentially be used in low caseload settings.</li> <li>-Permits assessment of simulated provider communication skills (not performance)</li> <li>-May help simultaneously build provider skills.</li> </ul>	<ul style="list-style-type: none"> <li>-Could be conducted as part of quality assurance process:</li> <li>-More subjective tasks may require more interpretation.</li> <li>-Some aspects of care are difficult to observe during simulation (e.g., discrimination/bias).</li> <li>-Possibility of Hawthorne effect.</li> <li>-Does not measure provider actual performance (only skills)</li> </ul>	-No published studies on RMC/mistreatment using this method identified in LMICs.	NA	NA	NA	NA
7. Routine Health Management Information System (HMIS)	Data could be collected for each patient rather than a sample.	Further information required to correctly interpret results (e.g., was birth position choice denied or not requested;	-No published studies/reports currently available related to data use.	NA	NA	NA	NA

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Validated? (Y/N)	Description	Dimensions covered
		were birth companions denied or not requested). -There is a limit to how many indicators can be collected through HMIS and which dimensions of care can be covered.	-Indicators are currently collected in Mozambique HMIS: Birth companion & Delivery position (specifically, vertical or semi-vertical positions) (MCHIP HMIS Review 2014) -Ghana HMIS includes presence of male during birth.				
8. Interviews with family			a. Questionnaire on family experiences of ICU quality of care. Jensen et al, 2015.	Denmark, The Netherlands	Y	For RMC and D&A related to families of patients. Developed by Jensen et al. (2015), the euroQ2 was designed to evaluate families' experiences of quality of care for critically ill patients in the intensive care unit (ICU). However, questions in this questionnaire may be considered for adaptation to understand family members' experiences with care.	Quality of care including interpersonal care (structure, process, family-reported outcomes related to L&D services and RMC

# Appendix 6. MCSP RMC Formative Assessment Tools, Monitoring and Evaluation Tools, and Guidance on Ethical Review

*For adaptation by country programs*

The MCSP RMC formative assessment tools listed below have been adapted from several sources and can be further modified by MCSP program implementers as part of the first design phase described in the RMC operational guidance. **The tools intentionally include only data collection methods likely to be feasible and sustainable in the context of comprehensive MNH programs operating at relative scale in low-resource settings. Thus, resource-intensive data collection methods that may be considered by some a gold standard in RMC research, such as direct observation or post-discharge follow up in-home client interviews, are not included.**

Tools are summarized into two tables below: 1) qualitative tools including in-depth interviews with administrators, providers, women, policy-makers and CSO representatives (Table 2); and 2) quantitative tools including client, manager and provider surveys (Table 1). The tools listed below are available on the MCSP SharePoint at [RMC Measurement Tools](#).

The qualitative formative assessment tools in Table 2 include modified versions of the WHO Multi-country study field guides and other sources cited in individual tools for further adaptation and use by MCSP country programs. The original WHO tools were used in an in-depth multi-country study to develop and validate tools to measure how women are treated in childbirth (study ongoing). As part of this study, WHO is also validating a survey tool that will be incorporated into this guidance once available (Vogel et al. 2015). The revised WHO qualitative tools included here (for further adaptation) are meant for a more condensed formative assessment likely to be more feasible for use in large MNH programs with limited resources in low-resource settings.

Baseline and endline quantitative data collection tools in Table 1 include adaptations of existing survey tools from the Heshima Project, the Staha Project, MCHIP Quality of Care Surveys, a paper from Sheferaw et al. (2016) and additional sources cited in the individual tools. The client exit survey and provider survey can be used as part of baseline and endline data collection to inform the design and the evaluation of program RMC interventions. The provider survey tool is adapted in part from the MCHIP Quality of Care Surveys.

Country programs are encouraged to adapt the tools to their local context as needed based on the program's overall scope and specific RMC goals and, as needed, to review and adapt additional data collection tools from studies relevant for their specific program and local context (see references). In some cases, the number of questions in a particular tool can be reduced or questions can be modified or even added using the resources listed in appendices 4 and 5 of the RMC operational guidance. For example, programs may want to use a subset of questions from the client exit survey and provider survey for periodic monitoring of women's experience of care in the context of program RMC interventions.

Because institutional Review Board (IRB) review is required for assessment and external reporting of self-reported client and health worker/provider experience and/or opinion it is important that programs

determine whether they need to apply for IRB approval before initiating data collection. See further guidance on ethical considerations below, including resources available to MCSP staff.

**Table 1: Baseline and Endline Quantitative Data Collection Tools**

<b>Baseline and endline data collection tools to inform design and evaluation of RMC interventions</b> (include adaptations from Heshima and Staha projects, MCHIP Quality of Care Surveys, a paper from Sheferaw et al. 2016 and other sources cited in tools)	
Tool 1A: <a href="#">Provider Survey</a>	Collects information from facility-based <b>health care providers</b> as key informants about how women in general are treated during labor and delivery in facilities and how their colleagues are treated.
Tool 2A: <a href="#">Client Exit Survey</a>	This survey tool adapted from the Staha Project and Heshima Project client exit interview tools, asks women to reflect on how they should be treated during delivery, as well as their own personal experiences during facility-based childbirth. If possible, this longer, comprehensive survey tool should be used at baseline, prior to the introduction of interventions, and then again at endline to measure changes in key indicators.

**Table 2: Formative Assessment Qualitative Tools**

<b>Formative Assessment tools: to understand local context and inform design of local RMC interventions</b> (adapted from WHO multi-country study and other tools.)	
Tool 3A: <a href="#">In-depth interview guide for women of reproductive age (WRA)</a>	Collects information from <b>women in the community</b> who are of reproductive age and who have delivered in a health facility. They are key informants regarding experiences that they have heard about or experienced individually during labor and childbirth.
Tool 4: <a href="#">In-depth interview guide for women receiving antenatal care (ANC)</a>	Collects information from pregnant <b>women in the community</b> who are receiving antenatal care (ANC). They are key informants regarding their experiences of receiving ANC and their opinions regarding how women in their community are treated during ANC visits.
Tool 5: <a href="#">In-depth interview guide for administrators</a>	Collects information from <b>health facility administrators</b> as key informants about perceptions of how women in general are treated during labor and delivery in their facilities and the facility environment.
Tool 6: <a href="#">In-depth interview guide for providers</a>	Collects information from facility-based <b>health care providers</b> of pregnancy and birth care as key informants about how women in general are treated during labor and delivery in facilities from a provider perspective, how their colleagues are treated and individual provider self-reported values, perceptions and needs
Tool 7: <a href="#">In-depth interview guide for policymakers and CSOs</a>	Collects information about how <b>civil society organizations (CSOs), professional associations and policymakers</b> are promoting RMC in communities and health facilities. *Note: May also be used for HSR.
Tool 8: <a href="#">In-depth interview guide for TBAs</a>	Collects information from <b>traditional birth attendants (TBAs)</b> as key informants about how women in general are treated during pregnancy, labor and birth at home, the TBAs' interactions with the facility and TBA perceptions of women's experience at the facility.
Tool 9: <a href="#">FGD Guide for women in the community</a>	This Focus Group Discussion (FGD) guide collects information about <b>women in the community</b> about how they think women should be treated during labor and delivery, as well as their own facility-based maternity care experiences.

Tool 10: <a href="#">RMC Facility Readiness Assessment Tool</a>	This observation-based tool collects information about the readiness of facility labor, delivery, and postnatal spaces to provide respectful quality care during labor, delivery and the postpartum period (e.g. privacy for clients, availability of minimum commodities, client consent protocols, etc.).
---	---

### Guidance on Ethical Reviews:

- Generally, Institutional Review Board (IRB) review may be required for programs intending to measure self-reported client and provider experience. More specifically, if the assessment tools/in-depth exit interviews ask about a person's own individual experiences (for women, health workers, and other stakeholders), whether through individual interviews or through Focus Group Discussions (FGD), *and the program wishes to disseminate widely the findings*, then IRB review may be necessary, since this type of data collection may be considered human subjects research (HSR). That said, the JHSPH IRB's made a recent determination of a protocol (that used the tools above) as being not human subjects research because the activity was described as a quality improvement approach/project. The JHSPH IRB determined that the activity did not qualify as human subjects research defined by DHHS regulations 45 CFR 46.102. Some formative assessment tools collect key informant information on perceptions of general experiences and community norms, and should qualify for non-human subjects research (NHRSR). However, you should work with your MMEL backstop and IRB Help to confirm before beginning any data collection.
- For HSR, IRB approval is required prior to data collection and the dissemination of results outside of MCSP. There is a rule against publishing without IRB review in peer reviewed journal publications and possibly conference presentations, whereas publication of aggregated program data or reports via MCSP program websites, submission to USAID or ministries of health, or at informal meetings is generally acceptable. Again, please work with your MMEL backstop and IRB Help to confirm that the results can be shared.
- Efforts must be made to protect the privacy and confidentiality of participants from whom data are collected, regardless of how the data are collected and disseminated, and data should be stored securely.
- Even if the Johns Hopkins Bloomberg School of Public Health's IRB does not consider your data collection methods to be HSR, it is advisable to determine whether the same data collection methods will be considered HSR in the country and follow correct in-country submission/review procedures. Some local IRBs may still want to review protocols that are NHRSR in the US. Therefore, it is important to comply with local regulations and at a minimum, to inform the appropriate point people that the program will be collecting NHRSR data to avoid potential issues later on. Consult [IRBHelp@jhpiego.org](mailto:IRBHelp@jhpiego.org) with any questions or for a consultation.

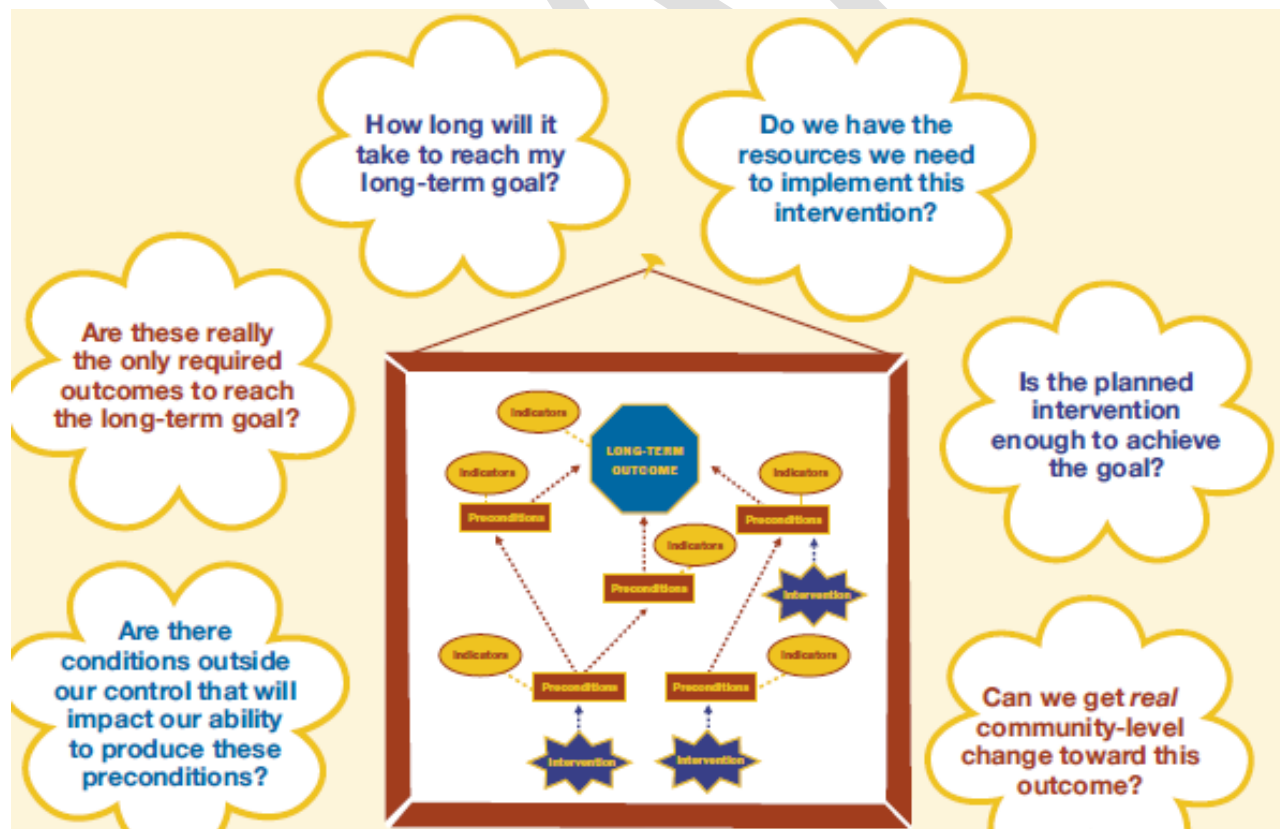


## Appendix 7: Guidance on How to Develop a Theory of Change

Why should I care about developing a theory of change?

- A theory of change helps avoid implementing a mistake.
- Creating a theory of change raises new questions for stakeholders to consider while developing a strategic plan or evaluation (see Figure 1 below).
- The process of creating and critiquing a theory of change forces stakeholders to be explicit about how resources will be used to bring about the preconditions of the long-term goal they are pursuing.
- Theories of change also help a group build consensus on how success will be documented.
- Finally, creating a theory of change helps program stakeholders develop a shared understanding of what they are trying to accomplish by making everything clear to everyone involved.

**Figure 1. Examples of the type of questions that may be raised as the group works through the process**



Illustrative example of tasks involved in creating and refining a theory of change (TOC)

1. Identifying long-term goals

In the first stage of theory development, TOC participants discuss, agree on, and get specific about the long-term goal or goals.

DRAFT

## 2. Backwards mapping and connecting outcomes

After the first step of laying out the long-term goals and a simple change framework, a more detailed stage of the mapping process takes place. Building upon the initial framework, we continue to map backwards until we have a framework that tells the story we think is appropriate for the purposes of planning.

## 3. Completing the outcomes framework

To complete the framework, the preconditions are fleshed out all the way back to the initial condition; explaining preconditions remains important.

## 4. Identifying assumptions

Any initiative is only as sound as its assumptions. Unfortunately, these assumptions are too often unvoiced or presumed, frequently leading to confusion and misunderstanding in the operation and evaluation of the initiative. To address that problem, TOC documents assumptions to ensure agreement for planning and posterity.

## 5. Developing indicators

In the indicators stage, details are added to the change framework. This stage focuses on how to measure the implementation and effectiveness of the initiative. By collecting data on each outcome, the initiative can identify what is or is not happening and find out why.

Each indicator has four parts: population, target, threshold, and timeline.

## 6. Identifying Interventions

After laying out the near-complete change framework, we now focus on the role of interventions (what the program (or initiative) must do to bring about outcomes).

Source: What is a theory of change? Center for Theory of Change.

Reference Materials for Developing a Theory of Change  
(Located on MCSP SharePoint):

[Theory of Change: A Practical Tool for Action, Results and Learning](#)  
(Annie E. Casey Foundation, [www.aecf.org](http://www.aecf.org))

[The Community Builder's Approach to Theory of Change: A Practical Guide to Theory Development](#)  
(Andrea Anderson, the Aspen Institute Roundtable on Community Change)

[What is Theory of Change? Center for Theory of Change](#)



# Appendix 7B: Examples of Theory of Change Related To Respectful Maternity Care from Tanzania

This framework focuses on the right-hand side of the logic model in the worksheet in Appendix 8A. It could be a useful starting point for an RMC-related program and the stakeholders working on it. Some other sample theories of change for the Staha project (in Tanzania) can be found at the following link (view figures 1 and 2): [Sample Theories of Change from Staha Project](#)

Ratcliffe et al. *Reproductive Health* (2016) 13:79  
DOI 10.1186/s12978-016-0187-z

Reproductive Health

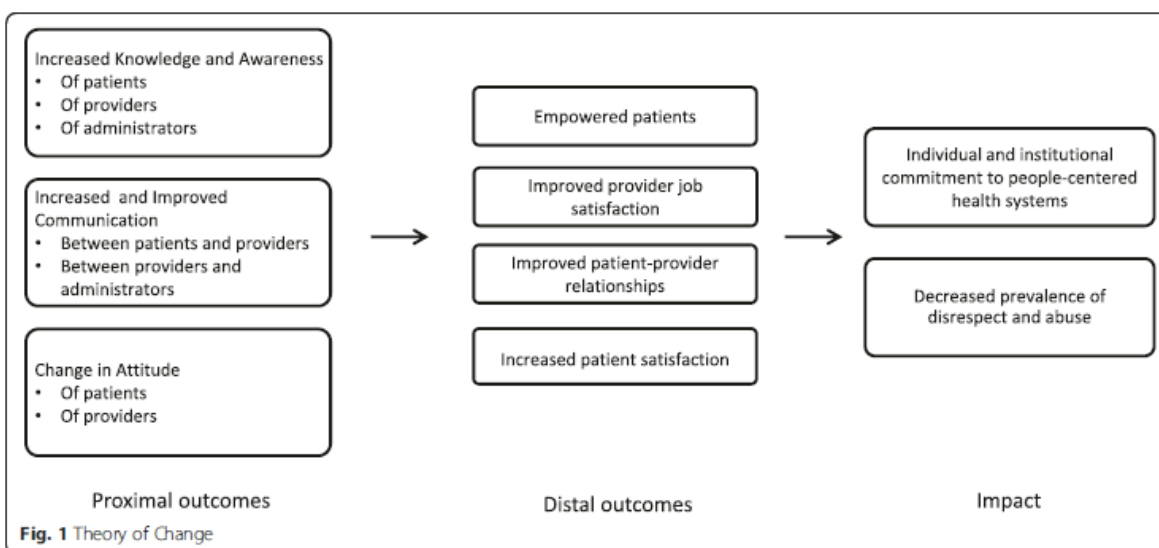
RESEARCH

Open Access



## Mitigating disrespect and abuse during childbirth in Tanzania: an exploratory study of the effects of two facility-based interventions in a large public hospital

Hannah L. Ratcliffe<sup>1,2\*</sup>, David Sando<sup>1,3</sup>, Goodluck Willey Lyatuu<sup>3</sup>, Faida Emil<sup>3</sup>, Mary Mwanyika-Sando<sup>4</sup>, Guerino Chalamilla<sup>3,4\*</sup>, Ana Langer<sup>1</sup> and Kathleen P. McDonald<sup>1,5</sup>



## Appendix 8. RMC Working Groups and MCSP staff persons

Topic	Contact	Title	Contact Information
<b>MCSP</b>			
Maternal Health (MH) Team lead	Kathleen Hill	Maternal Health Team Lead, MCSP	Kathleen.Hill@jhpiego.org
Technical implementation	Suzanne Stalls	Senior Technical Advisor, GLO (Global Learning Office)	Suzanne.Stalls@jhpiego.org
Program management	Kate Brickson	Senior Program Officer, MCSP	Kate.Brickson@jhpiego.org
Program management	Susan Moffson	Senior Program Officer, MCSP	Susan.Moffson@jhpiego.org
Pre-service Education)	Sheena Currie	Senior Maternal Health Advisor, MCSP	Sheena.Currie@jhpiego.org
Gender	Myra Betron	Director, Gender, TLO (Technical Leadership Office)	Myra.Betron@jhpiego.org
	Joya Banerjee	Senior Technical Officer, TLO	Joya.Banerjee@jhpiego.org
Monitoring and Evaluation/ Assessment	Eva Bazant	Research Team Lead, Monitoring, Evaluation and Research	Eva.Bazant@jhpiego.org
	Reena Sethi	Senior Research Manager, MCSP	Reena.Sethi@jhpiego.org
<b>RMC Council</b>			
White Ribbon Alliance (WRA)	Betsy McCallon	Executive Director, WRA	bmccallon@whiteribbonalliance.org
	Elena Ateva	Maternal and Newborn Health Policy and Advocacy Advisor, WRA	eateva@whiteribbonalliance.org
	Kristy Kade	Advocacy Director, WRA	kkade@whiteribbonalliance.org
<b>Subcommittee for Evidence-Informed RMC Approaches (EIA2RMC)</b>			
University Research Co., LLC (URC) – Center for Human Services (CHS)	Emily Peca	Implementation Research Scientist, Translating Research into Action (TRAction) and Health Evaluation and Applied Research Development (HEARD)	epeca@URC-CHS.COM
Averting Maternal Death and Disability (AMDD) – Columbia University	Shanon McNab	Associate Director, AMDD	sem2173@cumc.columbia.edu
Management Sciences for Health (MSH)	Kate Ramsey	Kate Ramsey, Principal Technical Advisor, MSH	kramsey@msh.org

Advocacy Subcommittee			
White Ribbon Alliance	Elena Ateva	Maternal and Newborn Health Policy and Advocacy Advisor	eateva@whiteribbonalliance.org
Averting Maternal Death and Disability (AMDD) – Columbia University	Marta Schaaf	Deputy Director, AMDD	mls2014@cumc.columbia.edu

DRAFT