



Why Experience of Care Matters for Maternal Health Outcomes: Early Learning from Guatemala and Nigeria

Suzanne Stalls, MA, CNM, FACNM
Jhpiego/MCSP

Declaration of Good Standing and Conflict of Interest Disclosure

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Learning Objectives

1. Present the Respectful Maternity Care Operational Guidance (RMC OG), sharing promising approaches for RMC promotion and mistreatment reduction efforts
2. Demonstrate mechanisms for integration of RMC into Maternal and Newborn Health (MNH) programs
3. Present early learning from Guatemala and Nigeria

Background

- A growing body of evidence on mistreatment in facility-based childbirth has emerged (close to 200 articles published since 2010)
- However, evidence on implementation approaches to promote respectful maternity care (RMC) and reduce mistreatment in facility childbirth is more limited
- MCSP identified a need to support evidence into action in MNH programs through the development of the RMC Operational Guidance



Methods

- Maternal Child Survival Program (MCSP) developed Operational Guidance (OG) to support the design, implementation, and monitoring of RMC promotion and mistreatment reduction efforts
- MCSP supporting respectful care efforts in Guatemala and Nigeria, utilizing the process suggested in the guidance

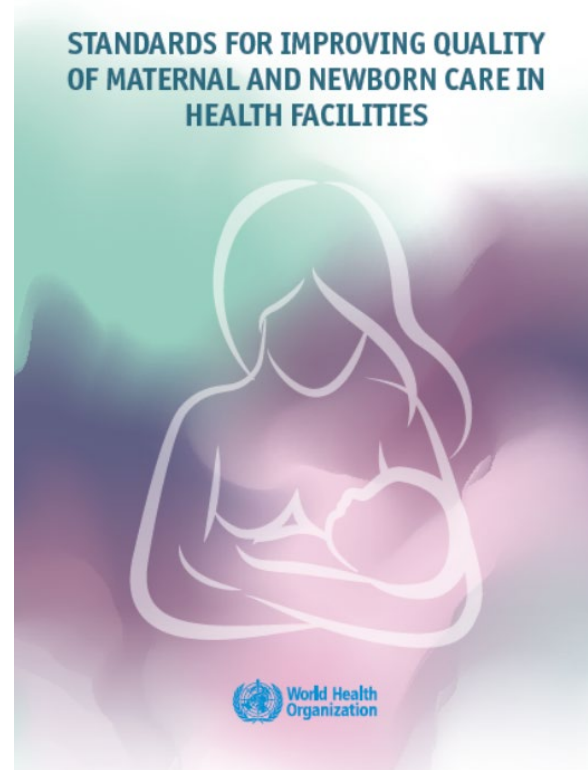
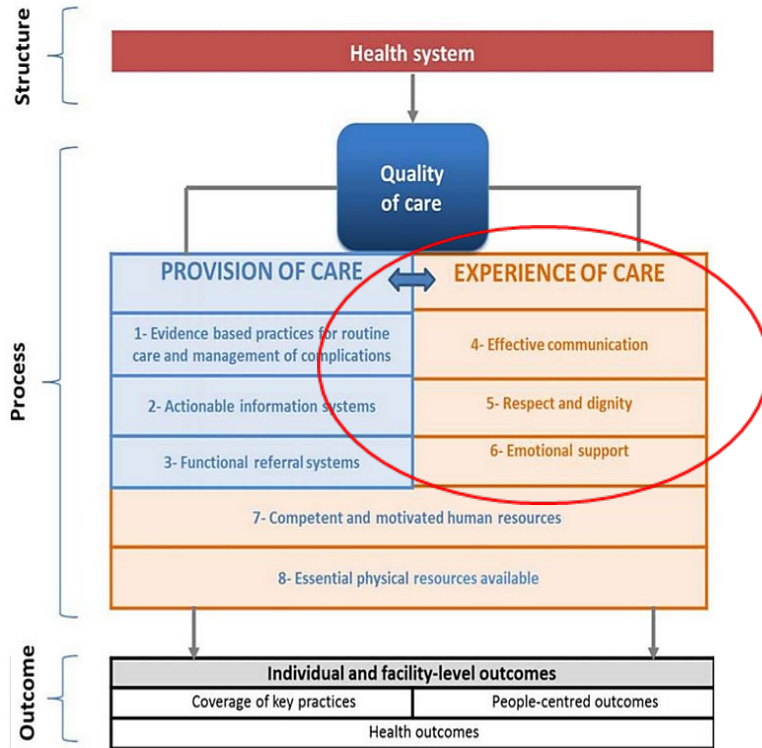


Midwife Elizabeth Mpunga assists a woman and her newborn baby.

Respectful Maternity Care & Experience of Care in Recently Published Global Guidelines

- 2015 WHO MNH Quality of Care (QoC) Framework
- 2016 WHO Standards for Improving Quality of Maternal and Newborn Care in Health Facilities
- 2016 WHO Recommendations on Antenatal care for a positive pregnancy experience
- 2018 WHO Recommendations on Intrapartum care for a positive childbirth experience
- 2018 WHO MNH Quality Equity and Dignity (QED) Network Monitoring Framework
- 2018 Lancet series on Quality (“Putting quality and people at the center of health systems”)

WHO MNH Quality of Care Framework and Network



MCSP RMC Operational Guidance: Purpose

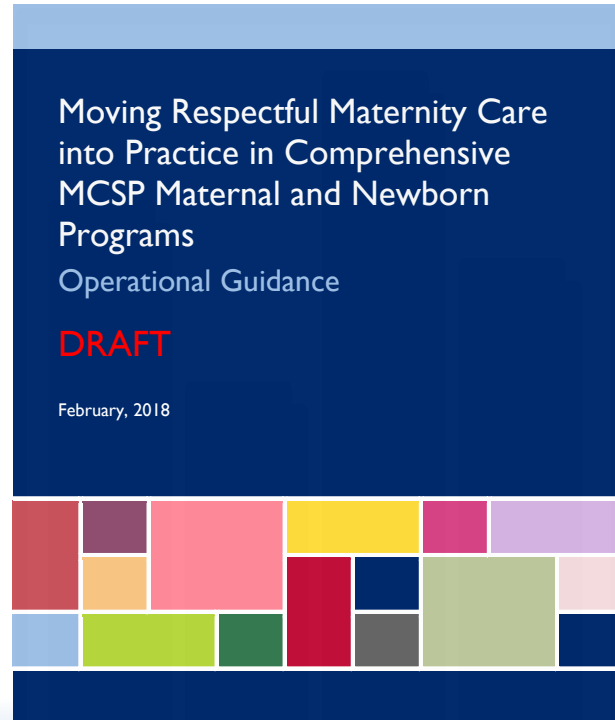
- To provide country stakeholders with a flexible process to guide design, implementation, and monitoring of efforts to strengthen RMC and eliminate mistreatment in comprehensive country MNH programs supported by MCSP



Photo by Kate Holt, Liberia

Mainstreaming RMC into Comprehensive MCSP Maternal and Newborn Health (MNH) programs

- Available in draft form on [MCSP website](#)
- Shared with WRA Global RMC Council, expert reviewers
- RMC Operational Guidance Table of Contents:
 - Introduction
 - Background: Evidence to Date and Promising Frameworks
 - Designing and Implementing RMC Approaches in a Comprehensive MNH Program
 - Appendices (Tools and Resources)



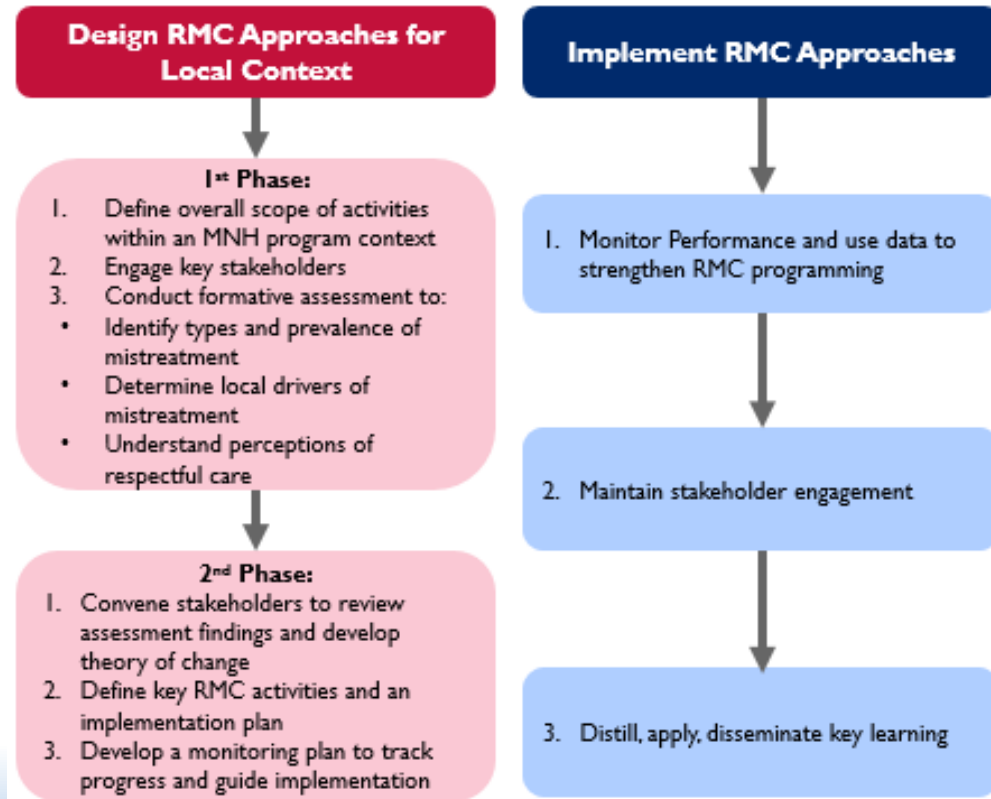
MCSP RMC OG: Guiding Principles

- No magic bullets
- Emphasis on process
- Absence of mistreatment does not imply respectful care
- Complex, requiring systems approach across multiple levels of the health system
- Emphasizes experience of both providers and recipients of care
- Rigorous documentation is needed to contribute to country, regional and global learning

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.

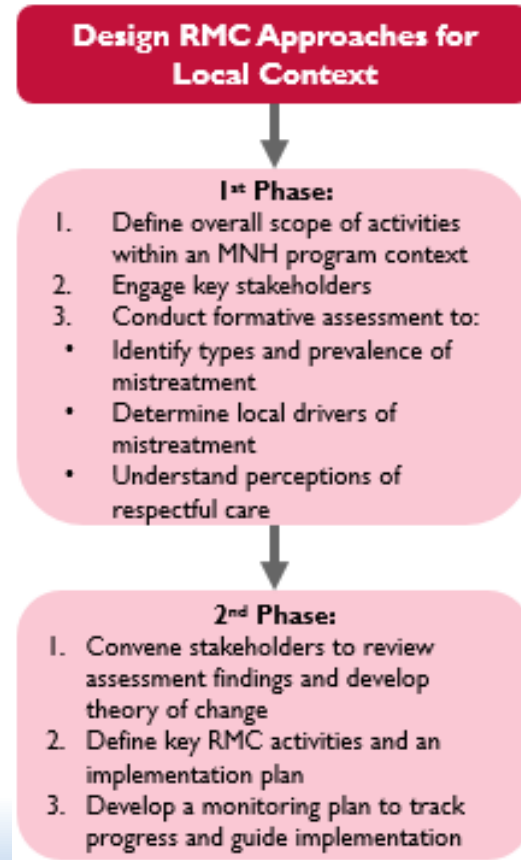
Source: MHTF Blog - Respect During Childbirth Is a Right, Not a Luxury

Phased Approach to Designing and Implementing RMC Interventions



Design Process – Phase I

- Emphasis on process in order to avoid “cookbook responses”
- Determine scope of RMC activities within scope of larger MNH program
 - Timeline
 - Resources
 - Scope of activities and involvement of varying levels of health system
- Engage with key stakeholders
- Plan for and conduct formative assessment

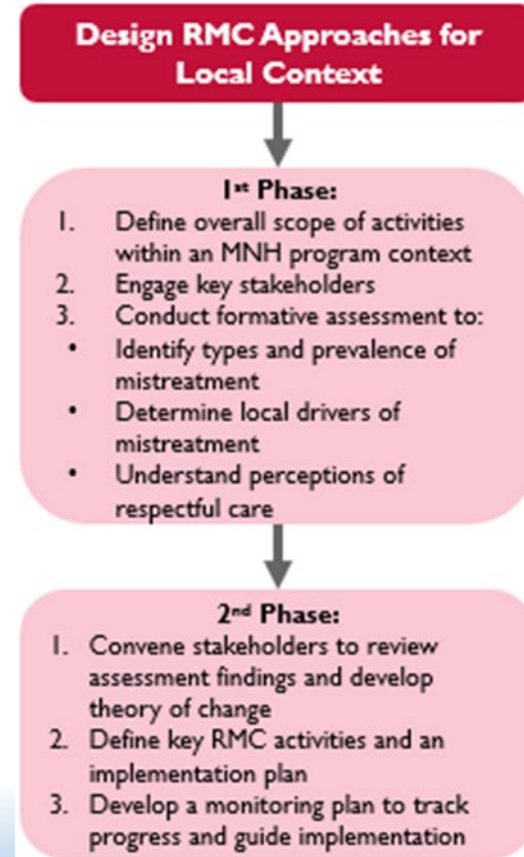


Design Process – Formative Assessment

- Essential to understanding key drivers and priorities in local setting
- Suggests a mixed method formative assessment using qualitative and quantitative tools

Design Process – Phase 2

- Convene stakeholder consultation to:
 - Review and analyze results of formative assessment
 - Develop program goals and theory of change
 - Define activities and co-design implementation plan with relevant stakeholders
- Establish a monitoring plan - consider using/adapting tools from formative assessment



Methodology: Nigeria and Guatemala

- Engage key stakeholders (MOH, Hospital Directors, Relevant Community members, etc.)
- **Conduct formative assessment to determine local drivers of mistreatment (mixed qualitative & quantitative methods, refer to tool summary table, right)**
- In Guatemala, conduct stakeholder workshop to present results, develop theory of change and co-design RMC interventions
- Develop a monitoring plan to track progress and guide implementation, including adapting tools for routine measurement

Tool Summary – Formative Assessments (Nigeria and Guatemala)
Tool 1 – Provider survey
Tool 2 – Client survey
Tool 3 – In-Depth Interview (IDI) WRA Community
Tool 4 – IDI Women @ ANC
Tool 5 – IDI Administrators
Tool 6 – IDI Facility providers
Tool 7 – IDI Policy Makers
Tool 8 – IDI Traditional Birth Attendants (TBAs) (Guatemala only)
Tool 9 – Focus Group Discussion (FGD) Community
Tool 10 – Facility Assessment (Guatemala only)

- Primarily qualitative data (in-depth interviews and focus group discussions with stakeholders)
- Quantitative survey of health workers
- Quantitative survey of women who have given birth in MCSP-supported facilities

Results from Guatemala Formative Assessment

- At all three hospitals, staff in Quiché (Western Highlands) are providing some level of respectful care
- Women's unwillingness to return to hospital for next delivery is closely associated with mistreatment
- Most mistreatment is centered around verbal abuse and poor communication
- Physical abuse is rare, and sexual abuse was not mentioned at all
- Other sources of disrespect include: unsupportive (inattentive) care; providers often dismissing women's concerns; women left exposed and unattended with a lack of concern for women's sense of modesty; a lack of sensitivity about keeping women warm (strong cultural preference)
- There were several complaints about unequal treatment of women, and a bias against those not speaking Spanish
- Providers reported feeling unappreciated

Results from Nigeria Formative Assessment

- The most common forms of disrespectful maternity care experienced were verbal abuse, unsupportive (inattentive) care, discrimination, physical abuse and especially detention.
- A number of barriers to respectful maternity care mentioned across urban and rural localities were health system inadequacies, clients' socioeconomic status, a perception among providers that clients were not complying with instructions; and a lack of motivation among health care providers.
- Health system inadequacies was the most common barrier mentioned in all locations, including: an insufficient number of health care providers of all cadres, lack of hospital equipment, and a lack of available space in facilities to ensure privacy.

Guatemala Assessment Results Continued:

Key findings from quantitative data

Prevalence of disrespectful care

- Disrespectful maternity care was present at three hospitals in Quiché: Nebaj, Uspantán and Santa Cruz
- The overall prevalence: 36%
- Disrespectful maternity care was higher in one facility than others
- 50% of the women who had given birth in a facility and who had experienced mistreatment stated they would not return to the facility for another pregnancy.

Nigeria Assessment Results Continued:

Key findings from quantitative data

Prevalence of disrespectful care

- Disrespectful maternity care was present in both Kogi and Ebonyi states.
- The overall prevalence: 32.0%
- Ebonyi State: 36.0%
- Kogi State: 28.0%
- Disrespectful maternity care was higher in Ebonyi compared with Kogi, although the difference was not statistically significant ($p=0.078$).
- By study location, it was higher in urban (36.4%) compared with rural (27.6%) and the difference was statistically significant ($p=0.046$).

Assessment Results Continued: Client and Provider Quotes

Guatemalan women's experience of mistreatment during childbirth:

- “When I entered the emergency room, the doctor took off my clothes in the presence of my family members... there was my mom, my dad, my spouse, my grandmother and my sisters-in-law. It gave me great shame...the truth is that they made me feel very bad. I would not return to the hospital. What they did caused me shame in front of the family.”
- “They tell you not to shout; say that because you opened your legs you have to endure (the pain).”
- “I have seen them (providers) make fun of people that can't speak Spanish, or speak it poorly...they tell them to speak better and then they laugh...they don't treat indigenous people well.”

Some reasons for mistreatment according to Guatemalan providers:

- “I think it is not so much a lack of respect, but the women can not understand a situation, either due to language or something (e.g. education, rural women who do not know hospital routines), but it is not disrespect.”

Assessment Results Continued: Client and Provider Quotes

Nigerian women describing why women choose to give birth outside the facility:

- “(At the hospital when a woman is unable to pay), the person is asked to run around and raise the money. They will detain you; you will not go until you have paid your bill.”
- “My first child was delivered at a hospital. They operated on me with razor blade and scissors. I felt the pain was so severe that I vowed never to go to a health facility for child-bearing. So, subsequent births were at home...”

Some reasons for lack of job motivation among Nigerian providers & for mistreatment:

- “This problem of salary is affecting our job... if you are not paid, you cannot give attention or come to work. Non-payment of salary is affecting our job because you cannot leave your house for work if you don't have money.”
- “Staff attitudes also affect respectful care. Staff overload also affects the patient respectful care because it leads to reduced attention given to the patient.”

Assessment Results Continued: Client and Provider Quotes

Nigerian women's experience of mistreatment during childbirth:

- “...a woman came in direct from the farm, and didn't bring the necessary things for labor, so the nurse shouted at her saying, “Didn't you know... was there no sign of labor before you went to the farm, there is no way you will tell me that there was no sign of labor.”
- “If you have money they will attend to you on time, if you are poor like me they will not even answer you. Some patients self where I went to visit someone, the patient was in labor and she was left and she died in that hospital.”
- “There is more respect when you come with your husband or your mother-in-law. When you are about to deliver and they demand for anything, there is someone to provide those things. So, coming to deliver with a relative enhances the respectful care you receive. It makes a big difference.”

Conclusions

- In both countries, women attributed mistreatment or inequitable treatment to the following key factors:
 - socioeconomic factors, such as wealth
 - Ethnicity/tribe/language (e.g. in Guatemala, indigenous women may not speak Spanish).
 - personal relationships (when the perception is that providers treat patients who are friends or relatives better)
 - religion (in Nigeria)
- While mistreatment took several forms, the most common in Guatemala was verbal abuse and in Nigeria it was detention of the patient until their bill was paid (and this mentioned as was a major reason that women don't seek health care in facilities)
- Verbal abuse was relatively common and normalized among providers in both countries who felt justified using harsh language and insults when their patients were uncooperative or not complying with instructions, in particular during women's contractions
- Both providers and women pointed to health system inadequacies as key reasons for mistreatment (lack of staff, lack of medicines/equipment, providers not being paid regularly, cramped facilities, etc.)

Key Messages

1. The assessment findings should be disseminated to district, national and community level stakeholders to ensure that the design of RMC interventions are locally driven and context-specific.
2. After dissemination in Guatemala, MCSP will undertake co-design of activities with local stakeholders, based on assessment findings.
3. MCSP has laid out programmatic processes in the RMC OG for reducing mistreatment and promoting RMC in comprehensive MNH programs. In Guatemala, we will validate these processes in the coming year. Due to time and program constraints, we are unable to validate all these processes in Nigeria.

Thank you



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

For more information, please visit
www.mcspprogram.org

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