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

Operational Guidance

March 2020

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Acknowledgments

Abbreviations

CHW	Community health worker
D&A	Disrespect and abuse
FGDs	Focus group discussions
GBV	Gender-based violence
HMIS	Health management information system
HSR	Human subjects research
HRM	Human resources management
L&D	Labor and delivery
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal and Child Survival Program
MNH	Maternal and newborn health
MNCH	Maternal, newborn and child health
MOH	Ministry of health
NGO	Nongovernmental organization
NHSR	Non-human subjects research
QI	Quality improvement
QoC	Quality of care
RMC	Respectful maternity care
TBA	Traditional birth attendant
WHO	World Health Organization
WRA	White Ribbon Alliance

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Introduction

Women's and families' experiences of childbirth care in health facilities is fundamental to their overall experience of childbirth and to their decision about where to give birth. Childbirth is an experience with deep personal and cultural significance and women and families want, and have the right to, respectful dignified care during childbirth. Studies from around the world, however, describe the mistreatment of women during facility childbirth (Bohren et al. 2015, 2019; Afulani et al. 2019). Mistreatment in childbirth violates women's and newborns' 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 (RMC) as a universal human right. A WRA-led charter for the rights of childbearing women, published in 2010 and updated in 2019, draws on a 2010 landscape analysis of disrespect and abuse in facility-based childbirth published by the USAID Translating Research into Action (TRAction) project (Bowser and Hill, 2010). The primary purpose of the charter, in the face of growing evidence of mistreatment, is to raise awareness of the rights of childbearing women and newborns as recognized in international human rights declarations. In 2014, WHO issued a statement calling for the elimination and prevention of disrespect and abuse during facility-based childbirth (WHO 2014).

"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

Since 2010 there has been an explosion of publications on the topic of RMC from around the world. The majority of these studies have assessed manifestations, prevalence and, to a lesser extent, drivers of mistreatment in facility childbirth. A four-country study of mistreatment in childbirth using common methods across countries documented a mistreatment prevalence of 41.6% based on direct observation and of 35.4% based on a community survey of women in Nigeria, Ghana, Myanmar and India (Bohren et al. 2019). A mixed methods systematic review of the literature on mistreatment in childbirth 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 selected common drivers described in the literature are summarized in Appendix 2.

The absence or lessening of mistreatment in childbirth does not, however, guarantee RMC for women and newborns in childbirth. For example, the absence of a negative behavior such as verbal abuse does not assure positive caring behaviors such as asking a client for her consent before conduct a vaginal examination. RMC and mistreatment in childbirth occupy two extremes of a continuum and studies demonstrate that women and newborns may experience a mix of both positive RMC and negative mistreatment along this continuum (Afulani et al. 2018). In 2015, WHO published a quality of care vision for maternal and newborn health that outlines 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 (see Figure 1). The other five standards, related to provision of evidence-based (clinical care) and essential health system functions (commodities, human resources, referrals and information systems), are also essential for

the provision and experience of RMC. The 2018 WHO intrapartum care recommendations for a positive childbirth experience and the updated charter on the Universal Rights of Childbearing Women and Newborns published in 2019, both reinforce the central importance of RMC for women and newborns (WHO 2018, WRA 2019). In its 2018 intrapartum care recommendations, WHO defines RMC as "care that is organized for and provided to all women in a manner than maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth" (WHO 2018).

Despite the many published studies assessing manifestations, prevalence, and, to a lesser extent, drivers of RMC and mistreatment, there is still limited evidence to inform the local design, implementation and monitoring of interventions to promote RMC and reduce mistreatment as part of comprehensive maternal and newborn health (MNH) programs. A handful of studies have generated important early learning on interventions to reduce mistreatment that has helped to inform this operational guidance (Abuya et al. 2015b, Ratcliff et al. 2016a; Kujawski et al. 2017).

The purpose of this operational guidance is to provide country stakeholders (including policy-makers, program managers and civil society members) and Maternal Child Survival Program (MCSP) staff with a flexible process to guide the design, implementation, and monitoring of efforts to strengthen RMC and eliminate mistreatment as part of comprehensive MNH programs. This guidance draws on the published literature and on the outputs of two RMC meetings organized by MCSP (one in Tanzania in 2015 and the second in Washington, DC, in 2016) that convened RMC policy-makers, advocates, researchers and program implementers. It highlights the importance of local context and process and key elements to consider in the design, implementation, and routine monitoring of RMC and mistreatment reduction efforts. Organized around a design and implementation stage (see Figure 3), the guidance outlines a flexible sequence of steps informed by local context and continuous implementation learning. The document and appendices include links to many practical resources and references that can be adapted by MNH program managers based on their specific needs and local context.

> 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.

Background: Building the Evidence

This background section describes current frameworks and evidence for defining and measuring RMC and mistreatment and reviews promising approaches that have been tested in various settings to strengthen RMC and reduce mistreatment. The section begins with an overview of RMC frameworks and measurement considerations followed by an overview of mistreatment frameworks and measurement considerations. The section concludes with a brief overview of promising approaches to improve RMC and reduce mistreatment that have been tested in various settings in a small number of studies.

Understanding and Measuring Respectful Maternity Care and Mistreatment

Respectful Maternity Care

A systematic qualitative review of what matters to women in childbirth found, unsurprisingly, that most women want a positive experience that fulfils or exceeds their prior personal and sociocultural beliefs and expectations, including "giving birth to a healthy baby in a clinically and psychologically safe environment with practical and emotional support from birth companions, and competent, reassuring, kind clinical staff" (Downe et al. 2018).

The WHO vision for quality of facility-based childbirth care for women and newborns, published in 2015, includes eight aspirational standards to achieve high-quality care around the time of childbirth for women and newborns, of which three relate directly to experience of care: effective communication; respect and dignity; emotional support (see Figure 1).

Figure 1. WHO quality of care framework for maternal and newborn health
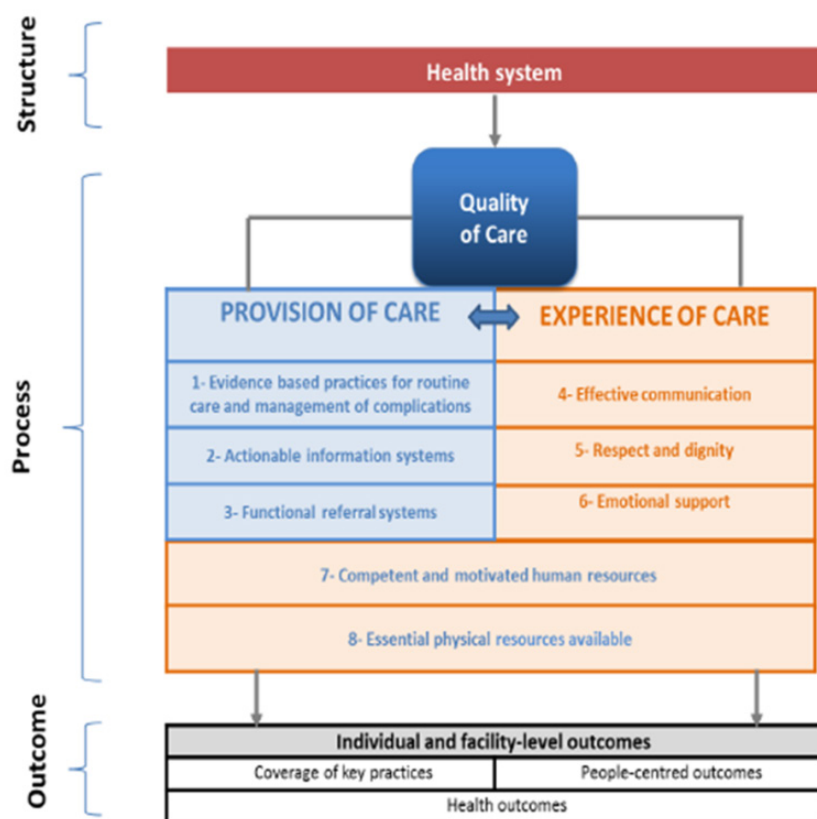
As a follow-up to its vision for quality childbirth care, WHO published a set of standards, quality statements and measures to help guide efforts to improve and monitor quality of maternal and newborn care in health facilities (WHO, 2015 and 2016c. Please refer to [Standards for Improving Quality of Maternal and Newborn Care in Health Facilities](#)). 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. Appendix 1 summarizes the WHO quality statements for each of the three aspirational standards related to experience of care. A monitoring framework for the WHO Quality of Care (QoC) Network includes illustrative indicators for each quality statement (WHO 2019. Please refer to [WHO Monitoring Framework Network Countries](#)). In 2017 WHO and partners launched a QoC 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 QoC 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

A quantitative client person-centered maternity care (PCMC) scale developed and validated in Kenya, India and Ghana by Afulani and colleagues measures both positive and negative attributes of maternity care categorized within three sub-scales that reflect the three experience of care standards (domains) in the WHO QoC framework: dignity and respect; communication and autonomy; supportive care (Afulani et al. 2019). Positive care attributes in the 30-item PCMC scale include questions ranging from being treated with respect to being asked for consent before procedures. Afulani and colleagues characterize person-centered maternity care as "maternity care that is respectful of and responsive to individual women and their families' preferences, needs and values [and includes] system and provider responsiveness, patient–provider communication, and interpersonal communication" (Afulani et al. 2019).

Efforts are ongoing to refine RMC indicators and measurement methods (quantitative and qualitative) to assess and monitor women's, newborns and families' experience of childbirth care as part of quality improvement efforts in countries participating in the QoC Network and as part of MNH program implementation and research in countries beyond the network.

Mistreatment in Childbirth

Awareness of the magnitude and common manifestations of mistreatment in childbirth has increased substantially in the decade since the publication of the Bowser and Hill Landscape Analysis of Disrespect and Abuse in Facility-based Childbirth (Bowser and Hill 2010). As the Millennium Development Goals drew to a close in 2015 and goals 4 and 5 related to maternal and newborn mortality were noted to be lagging seriously behind, governments and organizations started to examine the barriers to utilization of institutional childbirth services and the quality of these services. Evidence demonstrated that poor quality of childbirth care, including outright mistreatment of women, newborns and families, was a significant deterrent to seeking care along with other more well-documented barriers to accessing care, including geographic and economic barriers (Bohren et al. 2015; Kruk et al. 2014, Abuya et al. 2015a). Emerging evidence also suggested an association between mistreatment during childbirth and poor maternal health outcomes (Raj et al. 2017). This awareness helped fuel efforts by maternal and newborn stakeholders to better understand key manifestations and drivers of mistreatment, as well as promising local approaches to improve RMC, reduce mistreatment and increase utilization of childbirth services.

One challenge with defining and measuring mistreatment of women and newborns in childbirth is that the definition of mistreatment varies according to whose perspective and/or which normative standards are applied. Freedman and coauthors (2014) propose a definition of mistreatment that includes both normative standards and experiential building blocks, as visualized in Figure 2 below.

Figure 2. Defining disrespect and abuse of women in childbirth
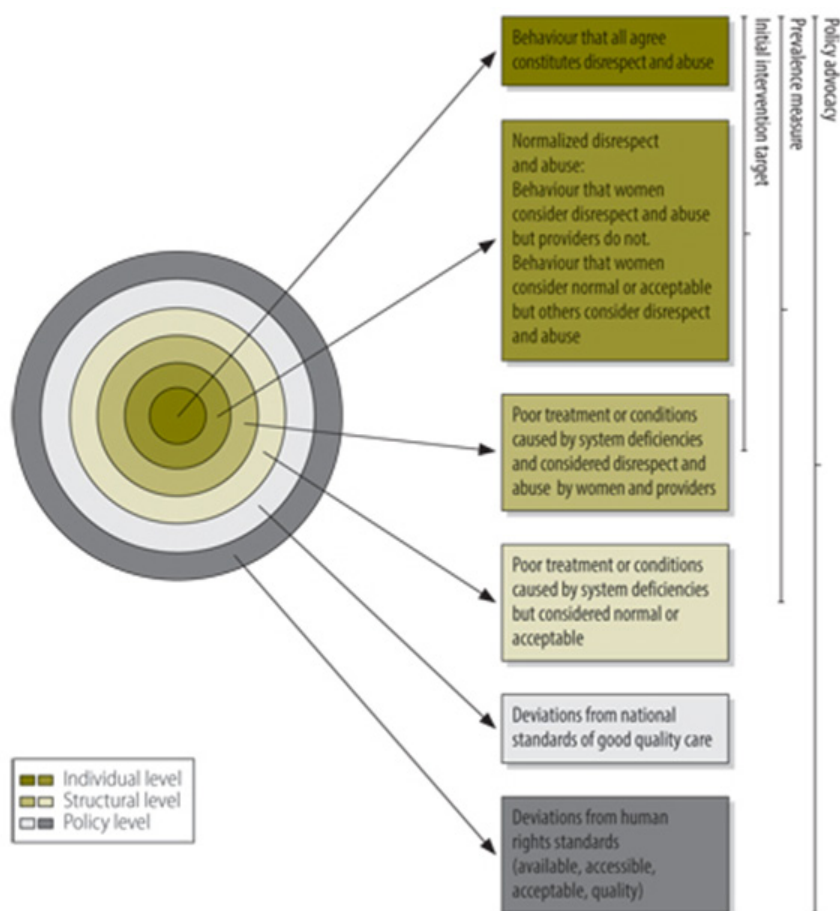
Source: Freedman et al. 2014.

In their 2010 landscape analysis of disrespect and abuse in facility-based childbirth, Bowser and Hill described seven categories of mistreatment during childbirth commonly reported in the literature: physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment and detention in health facilities (Bowser et al. 2010). At the time there was sparse public health evidence on the prevalence of mistreatment of women in facility-based childbirth. There was, however, an increasing number of reports describing mistreatment of women in childbirth particularly in the human rights literature. In 2015, following a rapid increase in public health research and publications on the topic, Bohren and coauthors published a systematic review of mistreatment in childbirth based on a review of quantitative and qualitative literature (two thirds of which was published after the 2010 Bowser and Hill landscape analysis.) Their systematic review identified seven third order themes of mistreatment in childbirth including:

- 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

Multiple studies have documented the widespread occurrence of mistreatment of women during labor and childbirth in every region of the world. Evidence on the experience of newborns is more limited, but is slowly increasing (Sacks E. 2017). In addition to mistreatment of women, newborns and families, there is increasing evidence that providers themselves are often mistreated in the workplace (WHO 2016a; Ogunlaja et al. 2017). In a study in Addis Ababa, over half of surveyed providers reported mistreatment (Asefa et al. 2018) and in recent situational analyses conducted by MCSP in the Western Highlands of Guatemala and in Kogi and Ebonyi states in Nigeria, approximately one third to one half of health care workers reported verbal or physical abuse at the hands of clients, family members of clients or colleagues.

Quantitative studies have reported prevalence rates of mistreatment of women in facility childbirth ranging from 15% to 98% (Bohren et al. 2018; Afulani et al. 2018; Abuya et al. 2015a; Sando et al. 2016; Okafor et al. 2015; Raj et al. 2017). Verbal abuse is the most commonly described form of mistreatment in studies from countries around the world to date. However, comparisons of mistreatment types and prevalence across studies are limited by differences in the definitions and methods used to measure mistreatment. Measurement challenges include inconsistent definitions of mistreatment and the use of varying tools and study designs in studies (Sando et al. 2017). The recent review by Sando et al. of methods used in the first five prevalence studies of disrespect and abuse in facility-based childbirth highlights a lack of standardized "definitions, instruments, and study methods used to date [affecting] generalizability and comparability of disrespect and abuse prevalence estimates across studies." For example, rates of client-reported mistreatment may vary with the timing and place of questionnaires. In a study in Tanzania, the proportion of women reporting mistreatment during facility childbirth increased from 19% during maternity exit questionnaires to 28% during home-based questionnaire conducted six weeks after birth (Kruk et al. 2014).

In 2019, Bohren and colleagues published a cross-sectional four-country study of how women are treated in childbirth, with a focus on mistreatment, using common measurement methods across countries (Bohren et al. 2019). In their study, 41.6% of 2016 observed women and 35.4% of 945 women surveyed postpartum in the community experienced physical or verbal abuse, or stigma or discrimination across countries (Burma, Ghana, Guinea, and Nigeria). Their study was implemented in two phases. A first phase consisted 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. A second phase measured the prevalence of mistreatment using direct observation and a community postnatal survey based on the formative phase findings (Bohren et al. 2016, Bohren et al. 2017, Balde et al. 2017a, Balde et al. 2017b). The study generated an important measure of mistreatment prevalence in four countries using common methods and instruments across countries. However, labor observations and postnatal community surveys require significant resources which is likely to limit their usefulness for assessing and monitoring mistreatment in large MNH programs outside of research studies.

Until recently, there were few validated instruments to measure women's experience (both positive and negative) of facility childbirth in low-resource settings. A 2017 systematic review by Nilver and colleagues of validated instruments to measure women's experience of childbirth care was an important contribution to the literature (Nilver et al. 2017). However, most instruments in their review, including a scale validated by Vedam and colleagues in North America (Vedam et al. 2017), were validated in high-resource settings where the health care context differs from that in low-resource settings. Two recent studies validating quantitative scales of women's experience of childbirth care may be more applicable in low-resource settings. One study validated a quantitative scale in Ethiopia (Sheferaw et al. 2016) and the other validated a 30-item scale of PCMC in India, Ghana and Kenya (Afulani et al. 2019, 2017). These scales can be incorporated into brief client questionnaires and used by MNH program managers to monitor interventions to improve RMC and reduce mistreatment. However, the tension between reliable, generalizable measurement methods (e.g., RMC/PCMC scales) and validity in an individual local context will continue to be a challenge for assessing and monitoring RMC in individual MNH programs.

Due to the range of constructs included in conceptual frameworks of mistreatment and RMC, no single indicator can measure the entirety of RMC or mistreatment in facility-based childbirth. Rather, individual indicators can measure specific elements of RMC and mistreatment constructs with respect to both normative standards (e.g., presence of a companion of choice during birth) and clients' self-reported experience of care (e.g., being treated with respect.) A combination of indicators and quantitative and qualitative methods will be necessary in most programs to assess and monitor RMC and mistreatment. Work is ongoing to prioritize and test various RMC and mistreatment indicators and measurement methods as part of quality improvement efforts in countries participating in the WHO Quality of Care Network and to distill and disseminate learning for MNH program managers.

There are many efforts underway to prioritize and refine RMC and experience of care indicators including as part of the WHO QoC network; however, there is no global consensus on a small set of priority RMC indicators that can be used for routine monitoring of RMC interventions and the effects of these interventions in comprehensive MNH programs. The Ending Premature Maternal Mortality

> *"[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

working group identified the development of RMC indicators as a priority area for future research (Moran et al. 2016). An anticipated forthcoming publication on routine indicators for monitoring RMC proposes a set of RMC indicators that can be measured using quantitative methods such as a periodic brief client questionnaire.

Routine assessment and monitoring of mistreatment and RMC to monitor and guide implementation efforts in comprehensive MNH programs is a challenging but important area that is addressed in several sections of this guidance (situational analysis, p. 13; designing a program monitoring and evaluation framework, page 21; Quantitative and Qualitative Data collection methods and resources, Appendices 5 and 6). Appendices 5 and 6 summarize qualitative and quantitative methods for assessing RMC and mistreatment using a range of data sources (e.g., clients, providers, managers, policy-makers) and highlight the strengths and limitations of individual methods. These appendices include references and links to tools that can be adapted by program managers for a situational analysis and for routine monitoring to inform the design and implementation of RMC and mistreatment reduction efforts in a comprehensive MNH program. Further research is needed to develop, refine and validate (as appropriate) qualitative and quantitative RMC and mistreatment assessment and measurement methods that are feasible and sustainable in comprehensive MNH programs operating at scale in low-resource settings.

Approaches for reducing mistreatment and promoting RMC

Despite limited evidence on effective program approaches and interventions to promote RMC and reduce mistreatment of women, newborns and families in comprehensive MNH programs, several recent studies have documented encouraging improvements in RMC and reductions in mistreatment after implementation of locally designed interventions (Abuya et al. 2015b; Ratcliffe et al. 2016a; Kujawaski et al. 2017). To date, studies have been implemented as stand-alone RMC studies focused on a set of prioritized RMC approaches in a few sites rather than on the design and incorporation of RMC interventions into a comprehensive MNH program operating at scale. Such studies have generated essential learning and are

> *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: *Maternal Health Task Force Blog.* Respect during Childbirth Is a Right, Not a Luxury

important resources to guide the design and implementation of RMC interventions. An important next frontier is to build experience and learning about how RMC and mistreatment reduction efforts can be incorporated into comprehensive MNH programs operating at scale.

Experience demonstrates that there is no single magic bullet to reduce mistreatment or improve RMC. Rather, the published and gray literature illustrates the importance of a multi-stakeholder process that engages local actors in a participatory process to develop and test interventions to reduce mistreatment and improve RMC based on key facilitators of RMC and drivers of mistreatment in the local context. In order to support an effective multi-stakeholder process, it is important for program managers to engage key stakeholders early in the process and for all stakeholders to understand facilitators of RMC and common forms and drivers of mistreatment in the local program setting. Appendix 2 summarizes common types of mistreatment in childbirth and selected drivers described in the published literature, using the Bohren classification scheme (Bohren et al. 2015.) This appendix can help MNH program managers and stakeholders think about the drivers of common forms of mistreatment in their context to guide the local design of interventions. Appendix 3 reviews various approaches for strengthening RMC and reducing mistreatment that have been tested in studies across different contexts and outlines potential facilitators and barriers to applying specific approaches in an individual program context.

> Because the absence or lessening of disrespect does not assure RMC, it is important to actively promote RMC while working to reduce mistreatment

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

- 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 that support health care providers (Caring for the Carer)
- Gender-focused approaches
- Participatory accountability/social accountability mechanisms (e.g., community score cards that include measures of families' reported experience of care)
- Incorporation of a strong focus on professional ethics and communication and interpersonal skills into pre-service and in-service education, training and supportive supervision
- Strengthening local health systems to overcome structural barriers (lack of commodities, lack of basic infrastructure)

Despite an expanding body of research on how women are treated in childbirth from around the world, evidence on the design, implementation and monitoring of local interventions to improve and monitor RMC in large MNH programs in low-resource settings remains limited. Building this evidence represents the next frontier for improving women, newborns and families' experience of care in facility-based childbirth and is the primary focus of this operational guidance.

Design and Implement RMC Approaches in a Comprehensive MNH Program

Drawing on the global literature, this section outlines a flexible process for program implementers and allied stakeholders to design and implement locally developed approaches to improve RMC and reduce mistreatment of women and newborns in facility childbirth services. As shown in figure 3, the guidance recommends a sequence of flexible steps in an initial design phase to engage key stakeholders, understand the local context and design approaches to improve RMC and reduce mistreatment based on the local context. In a second implementation phase, as shown in figure 3, the guidance recommends a sequence of steps to implement and monitor prioritized approaches, maintain stakeholder engagement and regularly distill and disseminate key learning.

Figure 3. Process to design approaches to promote RMC and reduce mistreatment in a Comprehensive MNH Program
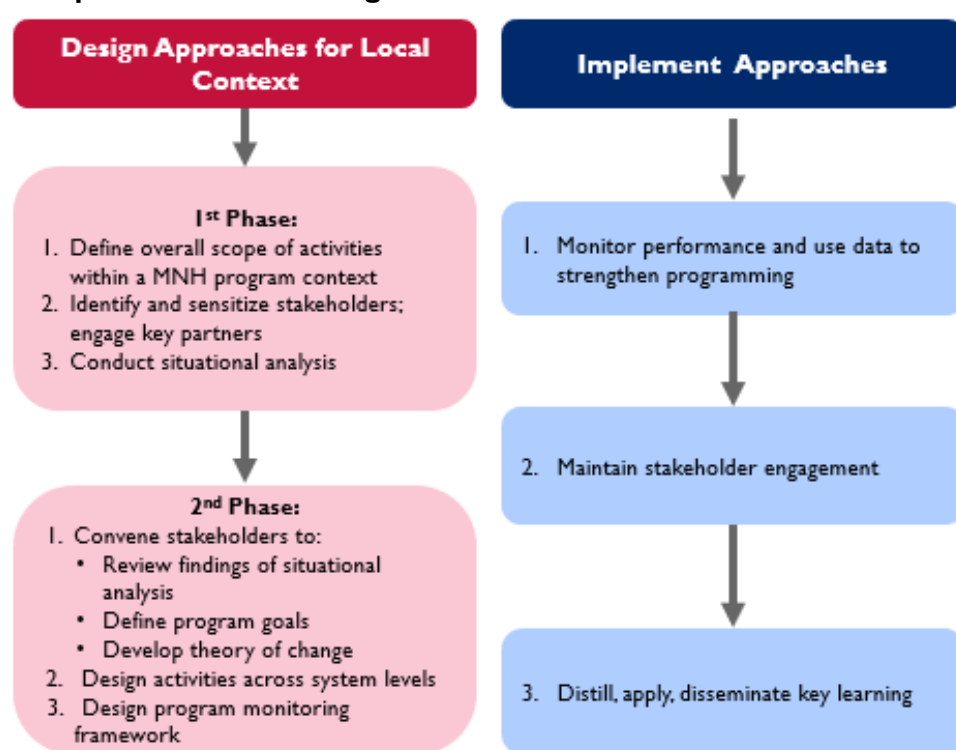
Introduction

Designing RMC approaches within a comprehensive MNH program can be a daunting task given the complexity of MNH programs, the multiple RMC and mistreatment constructs and the many deep-seated issues related to mistreatment that reflect some of the most sensitive aspects of any culture. This section provides

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

flexible guidance for a step-wise process to determine which aspects of RMC and/or mistreatment a program will address and how program activities will be woven into a comprehensive MNH program. Appendix 4 provides an illustrative MCSP concept note and work plan for incorporating RMC approaches into a comprehensive MNH program, based on the design and implementation stages described below. MNH program managers are encouraged to adapt the concept note based on their MNH program scope and goals,

country context and resources. It will be helpful for program managers to keep in mind that RMC efforts will usually need to address multiple RMC and mistreatment constructs, target various system levels and include both supply and demand-side approaches (e.g., community participatory approaches such as community score cards; national/subnational legislation, policy and advocacy; subnational management, facility quality improvement [QI] initiatives). Ultimately, the design of RMC approaches will need to be responsive to the needs and desires of women and health workers, ensuring that their voices are heard on an ongoing basis. The first phase of understanding what women and health workers want and need is addressed in an initial situational analysis and provides the foundation for the design of people-centered RMC approaches.

Despite the importance of multifaceted approaches, it is important to recognize that a single program working within a specific time frame is unlikely to be able to address or resolve the many factors that contribute to mistreatment and to a positive experience of care for women and newborns in childbirth. In addition to the complexity of the issues involved, programmatic constraints related to funding, timelines and overall scope will influence what can

> 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 Blog:* Respect during Childbirth Is a Right, Not a Luxury

be accomplished during a specific program phase. It is important that efforts to reduce mistreatment and improve RMC are locally led and designed for the long-term with the close engagement of local/national government, civil society and other key stakeholders. Programs should expect to design, implement and monitor promising local RMC approaches and to continuously learn and adapt interventions as part of an iterative process of achieving and sustaining RMC and eliminating mistreatment, understanding that most societal norms and values only change after long periods of effort and attention.

Design RMC approaches for local context: First phase
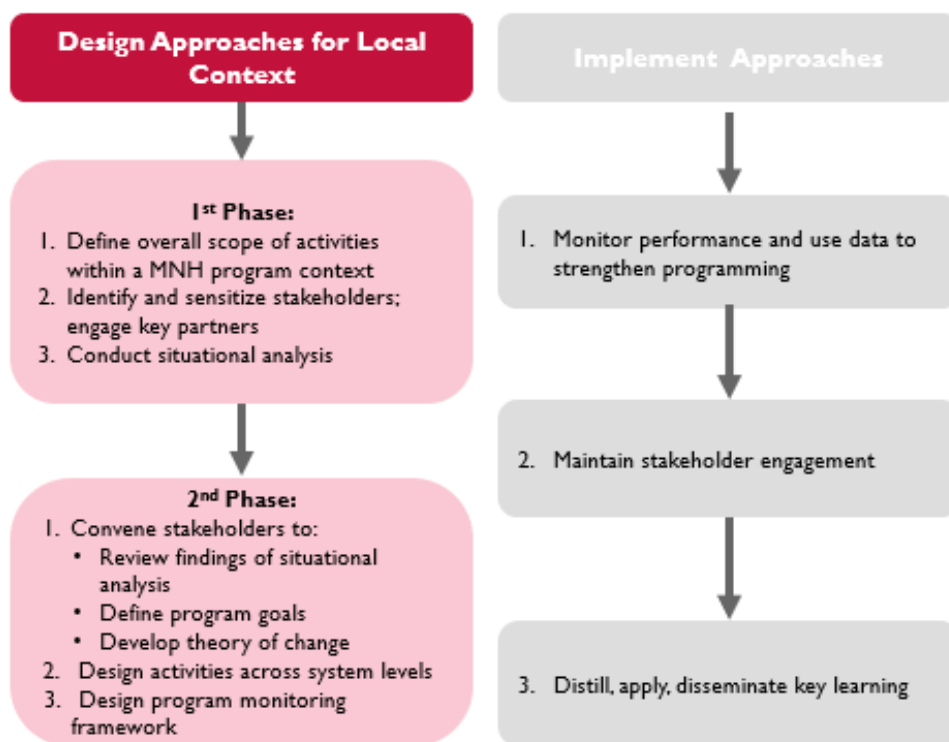
1. Define overall scope of activities within an MNH program context

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

- Local stakeholder priorities for RMC and mistreatment reduction
- Parameters of RMC activities based on the MNH program's mandate, objectives and overall scope (e.g., relative focus on RMC promotion and/or mistreatment reduction)
- Available program resources (e.g., for a situational analysis, local design process, implementation, monitoring, shared learning)
- Status of RMC awareness in the program and country context, including prior or ongoing RMC advocacy, research, implementation, and achievements (national, local) on which a program can build (e.g., a national RMC charter)
- Feasibility of implementing RMC approaches at distinct system levels based on the reach and resources of the MNH program (e.g., activities at community, primary and referral-level; district, regional, and national levels)
- The scale of the RMC effort based on the coverage and scale up plans (if any) for the comprehensive MNH program

2. Identify and sensitize stakeholders; engage key partners

An important first step in designing RMC interventions in a comprehensive MNH program is to identify and raise awareness among key stakeholders in the country and program local context. These stakeholders will be essential partners throughout the design and implementation of RMC approaches and will contribute to program sustainability. Key stakeholders may include:

- Representatives of relevant Ministries (e.g., Ministry of Gender, Youth, Family Welfare, Education, Justice)
- Representatives of relevant departments in the Ministry of Health (MOH) (e.g., maternal, newborn/child; quality; reproductive health; community health; service delivery; human resources; commodities/infrastructure; health information systems)
- Relevant MOH officials at national, regional, district level (e.g., district nursing officers, safe motherhood coordinators, quality of care focal points)
- 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 childbirth 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 RMC advocacy, implementation, research (e.g., White Ribbon Alliance)
- Representatives of women's groups, community leaders, traditional healers and birth attendants, adolescent groups, concerned community members
- Human rights organizations, women lawyers collectives
- UN agencies, especially WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and UN Women

- Donors supporting MNH, RMC, quality of care, reproductive and human rights, and other relevant policy, program, advocacy, research in the country context

- Professional associations, including associations of midwives, obstetricians, pediatricians, and nurses (if nurses have a significant role in providing obstetric care)

- Organizations, government agencies, institutions or individuals with expertise in assessing, measuring and analyzing quality of care including person-centeredness of care and clients' experience of care. These may include local universities or NGOs in which staff have the quantitative and qualitative skills to support data collection and analysis and build skills of program staff. In some countries, there may be government-sponsored research agencies or institutes that can provide technical support to program staff.

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. Utilize tech-based platforms that are easily accessible and commonly used in the program setting.

- Identify and support champions, influencers, and early adopters within the stakeholder group.

- Identify and engage actors who have the influence or authority to promote RMC.

- Identify and leverage established national/subnational policies and strategies favorable for RMC; leverage program activities and enabling structures and processes already in place.

- 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 1 for WHO's Quality of Care MNH framework). Linking to rights-based approaches endorsed in the Sustainable Development Goals can help 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 platforms (e.g., regular community meetings) that can be leveraged to support RMC.

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 RMC, mistreatment and experience of childbirth care in the local context. Consultations with key stakeholders are an important first step to raise awareness and deepen stakeholders' understanding of RMC and mistreatment issues in the local context.

3. Conduct a Situational Analysis:

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 of and drivers of both RMC and mistreatment in the local context. Even in MNH programs with limited resources, programs should undertake at least a modest situational analysis 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 situational analysis is essential for the design of RMC approaches that are responsive to, and hence more likely to be effective, in the program context.

Ideally a situational analysis will employ a mix of qualitative and quantitative methods to assess key manifestations and drivers of RMC and mistreatment at multiple system levels in the local context. Involving the community in planning and implementing a situational analysis and follow-on interventions can build

trust and increase collaboration between members of the community (e.g., women, families) and health worker staff to enhance the usefulness and success of RMC interventions as they are implemented.

Appendix 7 outlines and links to a set of qualitative and quantitative situational analysis tools developed by MCSP based on a scoping review of tools from studies in low and high-resource settings (summarized in Appendices 5 and 6). The MCSP situational analysis tools include a combination of qualitative and quantitative methods targeting women, families, community members, health care workers and managers. These tools were applied by MCSP in Nigeria and Guatemala in 2018 and subsequently updated. Based on their program's scope, resources and context, program managers can select and adapt a subset or all of the tools in Appendix 7 to implement a situational analysis. Appendices 5 and 6 summarize qualitative and quantitative methods and include references to additional tools that can be adapted and used by program managers in a situational analysis.

What it may be useful to find out during a situational analysis:

- 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 and a negative 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 and underlying drivers; health workers attitudes about providing maternity care, including their view of professional standards and the rights of women to specific standards of care
- Health workers' views of their work environment and their personal experience of providing care in the local health system (e.g., level of support, enabling work environment) including whether or not health workers are themselves experience mistreatment (e.g., verbal or physical abuse by women, families or colleagues)
- Common experiences of mistreatment reported by women and families 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

Qualitative Approaches

Qualitative approaches that can be used in a situational analysis are summarized in appendix 5 with a brief description of strengths and limitations of individual methods.

Qualitative methods may include:

- In-depth or semi-structured individual interviews with open-ended questions for key stakeholders (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 individual preferences and experiences and according to contextual factors such as cultural norms and local expectations and behaviors. Qualitative methods can be used 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.

The qualitative tools in Appendix 5 were adapted by MCSP from the qualitative tools in the four-country study of how women are treated (Bohren et al. 2019) (see MCSP Situational Analysis and Monitoring tools in appendix 7). 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 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 situational analysis may, in some cases, be modified for periodic monitoring during program implementation (see section on designing a program monitoring framework, page 21). 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. If possible, program implementers are encouraged to identify local sources of qualitative expertise enhance the situational analysis. Please see appendix 6 for a further discussion of qualitative methods.

Quantitative Approaches

Quantitative approaches can be used for many purposes, including as part of a situational analysis, as part of a situational analysis, 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 6. Although routine health management information systems (e.g., service registers and client forms) will not typically 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. These surveys may be exit surveys (at facilities) or community-based surveys, based on program resources and implementation considerations.
- Structured surveys with health care workers and managers/administrators
- Direct clinical observations with a focus on RMC and/or mistreatment

Client exit interviews are usually more affordable and sustainable for regular monitoring in comprehensive MNH programs; however, community-based surveys generate rich information that is less subject to social bias and may be useful to incorporate into a situational analysis. There is evidence that women are more likely to report mistreatment when interviewed at home several weeks after giving birth (Kruk et al. 2014).

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 a situational analysis when resources permit. For example, health worker surveys and facility readiness 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; however, observations may not be feasible in many settings due to resource constraints Each of the quantitative methods has strengths and limitations (see appendix 6), particularly in settings where mistreatment is normalized.

Planning for Data Collection in a Situational Analysis

As data collection plans are being made, it is important to consider local capacity to support the proposed activities. Ideally, someone who has skills and experience in measurement and assessment methods should be identified to support the situational analysis. Sometimes, hiring a local research firm or university students or faculty can help collect and analyze the data in a timely way; however, this is unlikely to be feasible in most large MNH programs outside a research setting. If the program has the resources to implement a baseline and endline survey to support a formal 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 planning for a situational analysis. For example, increasingly data are being collected on tablets, phones, or computers. With some planning, the use of such information technologies may help make a situational analysis more efficient.

Ethical Considerations

RMC and mistreatment are sensitive topics, and all information collected during a situational analysis and routine monitoring should 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 that may be helpful to program implementers planning a situational analysis (WHO 2016a).

Data collected for program purposes only and not as part of "human subjects' research" does not necessarily need be submitted to ethical review boards. It is important, however, to review and respect the local data collection regulations in the country and region where the program is being implemented.

Design approaches for local context: Second phase

1. Convene stakeholders

Situational analysis findings

After involving stakeholders and partners in the initial sensitization and other aspects of the program's situational analysis, the program can now begin designing activities and interventions to promote RMC and reduce mistreatment. The program should convene key stakeholders to review the situational analysis findings, prioritize issues to be addressed, define specific program goals and develop a theory of change to guide selection of RMC interventions and activities.

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 situational analysis 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 situational analysis, 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.

Develop 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.

> **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

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 situational analysis results. The theory of change should define RMC approaches that address contextual drivers of mistreatment elicited in the situational analysis 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 8, 8A and 8B for guidance on how to develop a theory of change and for 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, Warren 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 3 summarizes promising RMC approaches from various studies, 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 1). Several of the standards are particularly relevant to respectful care, including standards 1, 4, 5, 6, and 7 (see appendix 1).

2. Design activities across system levels

The prioritization of RMC goals and activities should ideally be guided by the program's theory of change based on the situational analysis findings as well as the overall scope of the broader MNH program. Given that the situational analysis is likely to identify facilitators of RMC and drivers of mistreatment operating at multiple system levels, it will make sense in most programs to target multiple system levels as feasible. Programs may choose to address broad systemic factors and/or more focused local factors, depending on the 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 with stakeholders at multiple system 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 or program phase and should be carefully considered when prioritizing RMC interventions based on the local theory of change and overall program resources.

This following section explores considerations for designing RMC activities for various system levels in a comprehensive MNH program. These considerations and associated examples are illustrative only and are not intended to be exhaustive.

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 situational analysis 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.

> **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 overburdened 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

If the program chooses to address a broad systemic issue, an important consideration is to decide *which* stakeholders to engage at *which* level. While specific RMC interventions may often be targeted at the community and/or facility level, program designers reviewing the results of the situational analysis may conclude that national advocacy for respectful care is imperative for bringing about desired changes. In this case, greater impact will 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 situational analysis 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 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. 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. Curriculums 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 promote RMC in 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.

Local health systems (regional, district, facility)

The sociocultural and health system characteristics of each country will vary (including often by sub-region) and will influence the optimal design of RMC interventions at various levels of the local health system. 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 of RMC interventions in the context of the overall MNH program.

Ideally, RMC approaches should be embedded in and leverage local health system assets and structures. RMC approaches are more likely to be sustainable when they are embedded in health systems and communities' systems and are designed by key actors in these systems. For example, established human capacity development activities in the local health system (e.g., training, supervision, and 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 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 health care workers. "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 designing and implementing RMC interventions. 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 3 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).

> **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

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 that include both community members and facility health workers (Ndwiga et al. 2014). (Please see appendix 3 for

a description of promising RMC approaches described in studies at community and local health system level and the potential pros and cons of individual approaches.)

3. Design a program monitoring framework

Once the program has defined its RMC program goals, RMC interventions and program activities based on the situational analysis and theory of change, the program must consider how it will define and monitor routine indicators of RMC and mistreatment to assess progress and continuously strengthen program RMC activities.

Quantitative and qualitative methods used in the situational analysis can be selectively adapted to support routine monitoring during implementation of program RMC activities. For example, a short quantitative questionnaire for women, families and providers used in a situational analysis can be periodically administered during program implementation to assess and accelerate progress, including for woman-reported person-centered 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, multi-country 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 according to the program's RMC goals, 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. The multi-country QoC network monitoring framework includes a flexible catalogue (menu) of experience of care indicators that may be a useful resource for MNH policy-makers and program implementers (please refer to WHO Monitoring Framework Network Countries.) 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 may include women's self-reported experience of care and future intention to use facility childbirth services and health workers' experience of providing maternity services (Wassihun et al. 2018). A promising resource for regularly monitoring RMC indicators in a large MNH program is the PCMC scale developed and validated in three countries by Afulani and colleagues. This scale, which measures positive and negative attributes of childbirth care, can be applied to calculate an overall PCMC score or to measure individual indicators of RMC and mistreatment. The PCMC scale could be applied, for example, in a large MNH program to monitor trends in individual indicators and/or a cumulative PCMC score.

Since mistreatment and RMC are multifaceted, and often context specific, a combination of indicators and data collection methods will be needed in most programs to monitor the effects of RMC interventions. 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 and Analysis

As with the situational analysis, a combination of qualitative and quantitative data (see appendix 5 and 6) can be adapted and used for ongoing monitoring. The appropriate data collection methods will vary based on the

program's RMC goals and prioritized interventions. The program can adapt tools and methods used in the situational analysis for ongoing monitoring.

Quantitative data collection methods can be used at all stages to monitor trends in RMC and mistreatment indicators (e.g., structured client questionnaires). Indicators should be clearly defined with a numerator and denominator and the data source and frequency of data collection should be specified. The program should map available data sources to determine what data do and do not exist with respect to prioritized indicators. If resources permit, periodic structured observations of clinical care or simulated client–provider interactions may be conducted to complement other data collection methods such as periodic client questionnaires. Each quantitative method has advantages and disadvantages (see appendix 6). The most appropriate method depends 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 are increasingly available (Bohren et al. 2019; Afulani et al. 2018).

Qualitative data (e.g., information from semi-structured or open interviews and focus group discussions) 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 situational analysis such as focus groups and structured in-depth interviews can be modified for periodic use during program implementation.

The program monitoring plan should specify who will collect and analyze data and how results and learning will be shared with stakeholders. Many program managers and health workers have not been trained to calculate and analyze RMC or mistreatment indicators or to conduct or analyze the results of focus group discussions and interviews. It will be important to plan for how these skills will be developed among program staff to support monitoring and the regular use of data to strengthen program implementation and adaptive management. In some settings, there may be a local organization or institution (e.g., university) that can be engaged to build needed skills among program staff.

It is also important to consider the ethical implications for collecting certain types of data. Appendix 7 outlines the ethical considerations that must be addressed collection as part of data collection and use during a situational analysis and program implementation and monitoring phase.

Implement RMC Approaches in an MNH Program
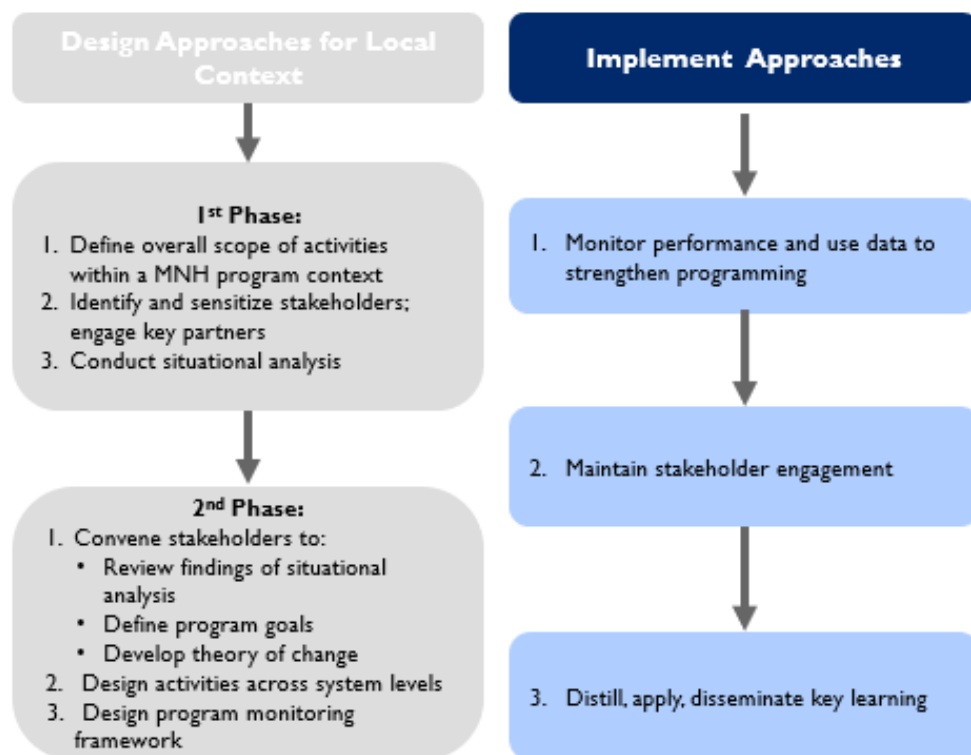
Monitor performance and use data to strengthen RMC programming

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.

Maintain 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 RMC.

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.

Distill, apply, and disseminate 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 design, implementation and monitoring of program RMC approaches?
- How should program RMC learning be structured and regularly disseminated?
- What are the achievements and successes of the RMC program approaches?
- What can be learned about RMC and mistreatment indicators and the regular measurement and use of these indicators to inform program implementation, including course corrections when needed? What can be learned about incorporating qualitative methods into program monitoring to support real-time program adaptations based on the experience, priorities and needs of local stakeholders (women, families, health workers.)

Due to the limited evidence base for implementing and monitoring RMC interventions as part of comprehensive MNH programs operating at scale, a concrete plan for program monitoring and documentation should be developed to facilitate real-time course-correction and to support regular dissemination of learning to local and global stakeholders. Several resources may help program managers to develop a robust program documentation plan to support regular analysis and adaptation of program interventions, learning and dissemination among local and global stakeholders.

One resource is the WHO Programme Reporting Standards for Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (WHO, 2017.) The WHO program reporting standards provide guidance for complete and accurate reporting on the design, implementation, and monitoring and evaluation processes of Sexual, Reproductive, Maternal, Newborn, Child and Adolescent health programs. The program reporting standards can be used by program

> **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).

implementers or researchers prospectively to guide the reporting of a program throughout its life cycle, or retrospectively to describe what was done, when, where, how and by whom.

Another resource developed under MCSP that may be useful for program managers provides a systematic approach to documenting and understanding how interventions are designed, implemented, and operated in a specific context. The Quick User's Guide Documenting Program Processes (DPP) *Quick User's Guide* is part of a larger toolkit and 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 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 implemented as planned based on the program's theory of change, or were there significant changes in planned activities? Any deviation from what was planned, as well as reasons for the changes, are important to document to help generate and disseminate learning among local and global stakeholders about what worked and did not work and why.

> **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

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 the priority information needs of key stakeholders and develop a program documentation and dissemination plan that addresses these information needs (e.g., policy-makers, program managers.) The program should identify and intentionally use communication formats that will resonate with key 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. Leaning and dissemination activities should be clearly defined and budgeted for.

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 RMC have blossomed from a small community of concern with a handful of

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

stakeholders to a universal movement with multiple organizations working on this issue across six continents. In focusing attention on women's and families' experience of care 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 and respectful childbirth care as a fundamental human right. Hopefully, this operational guidance can help MNH program implementers and allied stakeholders to build essential learning to realize this commitment to women and newborns.

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Other Resources

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Appendix 1. WHO Maternal and Newborn Experience of Care Quality Standards and Corresponding Quality Statements

Experience of Care Standard	Quality Statements
Standard 4: Communication with women and their families is effective and responds to their needs and preferences.	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.
Standard 5: Women and newborns receive care with respect and preservation of their dignity.	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.
Standard 6: Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens the woman's capability.	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.

Appendix 2. Types of Mistreatment and Selected Drivers

(These are based on Bohren et al. classification, 2015)

Type of Mistreatment	Selected drivers of mistreatment and illustrative examples
Physical abuse • Use of force • Physical restraint	**Power Asymmetries (health workers, clients); control of women to force compliance** • Provider belief that physical force is a "necessity" to ensure compliance and good birth outcomes; believing they were "forced by circumstance" (Bohren et al. 2015). • 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).
Sexual abuse • Sexual abuse	**Power and control** • "Rape" and "sexually abused by health worker," self-report from woman at exit interview and self-report from woman at follow-up (Kruk et al. 2014) • "Sexually abused by health worker" self-report from woman at 6wk postpartum immunization visit (Okafor et al. 2015)
Verbal abuse • Harsh language • Threats and blaming	**Power asymmetries; "othering"** • "Hierarchical authority in health system" legitimizes health workers' control over women (Bohren et al. 2015). • Provider belief that such behavior as a necessary practice to have a safe outcome for the baby (Bohren et al. 2016).
	Inadequate staffing/Long hours worked; moral distress/burnout • Workers "overstretched," "tired," or "overworked" (Bohren et al. 2015).
	Gender inequality and structural gender-based violence • Some clients are perceived to be "aggressive and arrive primed for confrontation." • 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).
	Mistreatment of health workers (by clients, other health workers) • Over half of surveyed health workers in a study in Ethiopia reported being disrespected or abused in the workplace (Asefe, 2017).

Type of Mistreatment	Selected drivers of mistreatment and illustrative examples
Stigma and discrimination • Discrimination based on sociodemographic characteristics • Discrimination based on medical condition	**Social stigma against marginalized populations (e.g., adolescents; ethnic/racial minorities; women with disabilities); maintenance of hierarchies (social, economic, other)** • 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). • 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). • 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).
Failure to meet professional standards of care • Lack of informed consent and confidentiality • Physical examinations and procedures • Neglect and abandonment	**Lack of professional ethics and explicit standards - policies/training/enforcement** • 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 toward producing respectful health care providers (D'Oliveira et al. 2002).
	Power and control; punishment for women's non-compliance • Providers do not feel obligated to provide care when women are "noncompliant" *(global reviews)*. • 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). • Providers commonly blamed a woman's "disobedience" and "uncooperativeness" during labor and delivery for her experience of mistreatment (Bohren et al. 2016).
	Inadequate health system (staffing, supplies, etc.); provider moral distress/burnout • Providers overworked (women's perspectives, McMahon et al. 2014). • 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 (Arnold et al. 2014).
	Medical culture/socialization of students • In pre-service training, students often witness care that meets to professional standards and, in turn, copy that behavior.
Poor rapport between women and providers • Ineffective communication • Lack of supportive care • Loss of autonomy	**Fear of losing face; fear of liability/being blamed for a bad outcome** • Providers may fear being humiliated in public or being blamed for a professional error or losing their job and consequences for themselves and their family. In a culture of fear and blaming, "surviving might mean blame someone else before you are blamed" (Arnold et al. 2014).
	Gender inequality/disempowerment of women • 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).

Type of Mistreatment	Selected drivers of mistreatment and illustrative examples
	Provider burnout/moral distress • "When the burden of difficulty becomes too great" [associated with social, professional and economic pressures] midwifery personnel feel abandoned, reach burnout and are in a state of "moral distress" (World Health Organization. 2016b. Midwives' voices, midwives' realities.).
	Poor communication skills/lack of training • Providers' lack of training on communication skills may be contribute to poor communication with women (Ishola et al. 2017).
Health system conditions and constraints • Lack of resources • Lack of policies • Facility culture	**Non-supportive work environment; lack of professional development opportunities** • 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).
	Medical culture/socialization of students • In settings where abusive care has been normalized (e.g., as part of midwifery pre-service education) it becomes routine, accepted, and expected (Kruk et al. 2014; Moyer et al. 2016).
	Inadequate staffing • 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).

Appendix 3. Various Approaches for Promoting RMC and Reducing Mistreatment Described in Studies Across Different Contexts

Approach for Promoting RMC and Reducing Mistreatment from selected studies	Potential facilitators based on anecdotal experience	Potential barriers based on anecdotal experience
National Policy/Advocacy		
1. **Strategic advocacy and policy efforts** 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 (e.g., laws and policies enshrining the right to RMC at national level).	Existing advocates for inclusion of RMC principles and standards in national policy and relevant guidelines, training materials, quality standards, job aids, etc. (national, regional, and facility). Civil society organizations are engaged and their role is maximized in implementation and the learning side of RMC approaches.	Frequent turnover of decision-makers; Absence of visible champions; poor policy development processes in place Lack of voice and influence of midwives in hierarchical systems
2. **Strengthening local health systems** to overcome structural barriers (e.g., lack of commodities, lack of basic infrastructure). Preventing and eliminating mistreatment in childbirth requires a "systems approach" to address structural barriers to provision of RMC.	• Women are empowered through participatory accountability mechanisms that promote the status of women as both providers and receivers of health care. • Barriers to provision of quality care are taken seriously and addressed by managers	More evidence needed on the most common system drivers of mistreatment across different contexts (e.g., skilled and supported health workers with necessary communication and interpersonal skills; lack of basic infrastructure and commodities.) Lack of political will Centralized, hierarchical systems in which do not have authority to make changes at subnational level
3. **Continuous Quality Improvement (QI)** to overcome critical gaps in person-centered maternity care by improving care processes to achieve RMC for every woman and newborn;	• RMC is valued as a central element of QoC by women, families, managers and health workers • Quality improvement efforts target RMC and mistreatment reduction improvement aims in addition to aims related to clinical effectiveness and patient safety • QI teams include both facility health workers and community members • Regular measurement of women's and families' experience of care	QI is not valued and prioritized by health system and maternity leaders and managers QI teams are weak or non-functional Lack of QI skills among key actors Lack of regular monitoring of women's and families' experience of care

Approach for Promoting RMC and Reducing Mistreatment from selected studies	Potential facilitators based on anecdotal experience	Potential barriers based on anecdotal experience
	• Regular measurement of health workers wellbeing in the workplace	
4. Strengthening of **professional ethics** for maternity care providers and	• Professional associations and training institutions champion clear robust professional ethics for maternity health worker cadres • Professional ethics are strongly incorporated into pre-service education, in-service training, and supervision and mentoring of maternity health workers • Managers model and enforce professional ethics in the maternity • Licensure and regulatory frameworks that enforce professional ethics and standards	• Lack of established professional ethics for maternity health worker cadres • Absence of strong professional associations • Absence of health worker regulation (e.g., licensure) linked to observation of professional ethics • Absence of redress mechanisms to manage health workers who violate professional ethics
Local System and Service Delivery		
1. **Development of health worker communication and interpersonal skills**	• Pre-service and in-service educators/trainers prioritize and build health worker communication and interpersonal skills • Resources, competency-based curriculums and skilled educators in place to support health worker acquisition of communication skills	• Lack of valuing of importance of health worker communication skills for provision of RMC • Lack of resources, curriculums and skilled educators to build health worker communication skills • Communication skills-building is not incorporated into pre- and in-service education/training
2. **Engagement of health workers in values clarification and attitude transformation** Help providers and managers conduct a self-evaluation of their behaviors and attitudes in relation to RMC and mistreatment. Values clarification and attitude transformation training is included in a comprehensive package called **The Respectful Maternity Care Resource Package.** This package, includes a set of manuals, tools, and resources to promote high-quality, respectful maternal and newborn health care services. These resources can help program managers to plan and run workshops for facility-based providers and community health workers.	• Individuals recognize that behavior and attitude change is self-driven; and individuals are willing and able to challenge their own behaviors and attitudes in a non-judgmental setting.	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.

Approach for Promoting RMC and Reducing Mistreatment from selected studies	Potential facilitators based on anecdotal experience	Potential barriers based on anecdotal experience
3. **Caring for the Carer** (supporting health workers). Provide opportunities for health workers to communicate work-related pressures and receive support for addressing critical challenges facing health workers; address health system factors that negatively affect health care workers in the workplace, support health care workers 4. (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).	• 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. • 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). • 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. • 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. • Community representatives are in the facility, giving the community a voice, so that they understand issues and lobby for providers' needs. • Counselor is committed and is well accepted by the staff.	• Counselor is either too familiar or in a management position. Providers perceive management as a stressor. • Confidentiality is a concern.
5. **Open Birth Days**[1], also referred to as **Maternity Open Days**[2] 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.	There are effective community–facility linkages and community willingness to engage and participate in Maternity Open Days.	• Facility management or health workers are not willing to let the community in the facility or are not trusted by the community • There is poor community mobilization and/or cultural barriers prevent full engagement, such as presence of males during child birth.

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[1] Used in the Uzazi Bora Project in Tanzania.
[2] Used in the Heshima project in Kenya. Some of the content in this table on barriers and facilitators (pros and cons) of promising approaches is pulled from the Heshima Lessons Brief.

Approach for Promoting RMC and Reducing Mistreatment from selected studies	Potential facilitators based on anecdotal experience	Potential barriers based on anecdotal experience
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 for community members and health workers to interact informally, better understand how they can respect one another and tackle challenges that prevent the provision of RMC. 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: • Promote mutual understanding, accountability, and respect among community members and service providers. • Improve knowledge and demystify procedures during labor, childbirth, and the immediate postnatal period.		
6. **A Respectful Maternity Care (RMC) workshop** 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.	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: Uzazi Bora Project Article).	No follow-up mechanism to sustain action and communication toward the implementation of action plans. High facility staff turnover or rotation may limit the lasting impact of the workshop if conducted at the facility level.

Approach for Promoting RMC and Reducing Mistreatment from selected studies	Potential facilitators based on anecdotal experience	Potential barriers based on anecdotal experience
	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.	
7. **Development or adaptation of a client charter,** (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.	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. 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. 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. Will work well if the charter has items that are measurable/achievable in that context, as well as accountability mechanisms that will support patients/families if the rights are not respected.	If mistreatment is normalized and/or there are ineffective structures for redress.
8. **Patient satisfaction surveys**: They are easy to do; the hospital analyzes the data. Questions focus on RMC, not MISTREATMENT, (because positive reinforcement to elicit respectful behaviors may be more effective than "naming and shaming"). 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.	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. • Literacy in context will determine use of paper surveys and putting them in a locked box. • Every woman fills out the questionnaire. • Suggestion boxes – not effective • Issue – determine whether to have exit survey done in community or facility.	

Approach for Promoting RMC and Reducing Mistreatment from selected studies	Potential facilitators based on anecdotal experience	Potential barriers based on anecdotal experience
	In surveys, look at most common concerns of women: • Do clients feel that they have a choice of facilities? • Do clients feel that they can talk about facilities' care and not feel retribution? • Follow up with specifics. Ask about overall satisfaction as a starting point (e.g., overall childbirth experience, care received at the facility, interactions with providers, facility infrastructure) • Ask about respectful care received, and whether they were treated well. • <5 questions? • Hospital management may suggest an exit survey to monitor QI process – ratings of QoC elements. • May use yes/no responses; easier to analyze. Add "I don't know," as an answer choice. (Note: Likert scale may be more useful for satisfaction questions because it provides greater range/more accuracy in responses, and is not too complex to analyze.)	
9. **Promoting mutual accountability**: rights and responsibilities of health care providers and clients.	Behavior change is addressed as part of MCSP programming because behavior change among service providers is key to addressing disrespect and abuse (D&A) at the facility level.	
10. **Local participatory approaches** are focused on iterative refinement of locally defined priorities and program approaches.	National, regional, and district ownership is prioritized for setting strategies for participatory approaches from the beginning of the project.	Further research is needed on local participatory implementation design and processes that can be adapted and sustained locally to reduce D&A and sustain RMC—with a focus on iterative learning and adaptation.
11. **Community sensitization and participatory action planning workshops** 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.	Utilizing existing community channels for meetings (e.g., chief/tribal leaders meeting, women's groups, religious gatherings).	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.
12. *Alternative dispute resolution* for mistreatment establishes joint facility and community mechanism to resolve and seek redress for mistreatment	If community is willing to report cases (and facilities are willing to listen to cases) and there are effective Community–	If mistreatment is normalized and/or there are ineffective structures for redress.

Approach for Promoting RMC and Reducing Mistreatment from selected studies	Potential facilitators based on anecdotal experience	Potential barriers based on anecdotal experience
incidents, including continuous Quality Improvement Teams (cQITs), community score cards, or community "rights watch groups."	facility linkages. Must be managed well to ensure mutual respect between communities and facilities.	
13. **Approaches that break down barriers between providers and clients** (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).		
14. **Social accountability approaches:** Social accountability is an approach to 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.	Works well if: community groups already exist and engage. For mistreatment, could consider women's groups, groups on violence against women, health rights, etc.	May not work well if: there aren't many/any community action groups in the setting.

Appendix 4. Illustrative MCSP Concept Note and Workplan for Incorporating RMC Approaches into a Comprehensive MNH Program

Background and Objective

As part of MCSP's ongoing 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 Support by MCSP as Part of Maternal, Newborn and Child Health (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 situational analysis (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 situational analysis and follow-on interventions and routine measurement of RMC as applicable based on the results from the situational analysis.

The situational analysis is expected to build on and complement ongoing 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 1**, MCSP *COUNTRY* will undertake a modest mixed methods (qualitative and quantitative) situational analysis 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 situational analysis 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 7 in the MCSP RMC operational guidance for a set of situational analysis 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 1 will be implemented in ## selected MCSP-supported facilities. The criteria for selecting these facilities will include: XX

It may involve:

1. Key informant interviews with the Health Facility Managers using the situational analysis in-depth interview guide/tool

2. Key informant interviews with X selected health care workers from targeted facilities using the situational analysis 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 situational analysis 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:

- Civil society groups? (e.g., WRA)

- Professional associations

- Government policy-makers and actors at different levels of the health system

- Selected community committees

In **Phase 2** (end of YR X or early Q Y)**,** results from the mixed methods situational analysis, 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 situational analysis 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 situational analysis 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.

Situational Analysis 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 and key facilitators and barriers to achieving RMC for every woman, newborn and family.

- Investigate the experience of health facility users and providers/managers (clients, providers, and administrators) with childbirth services in the facilities; explore what women characterize as a positive facility childbirth experience (i.e., their priorities and expectations).

- Assess health care workers' experience in the workplace, including the specific stresses that they may experience in the workplace and their priority needs to be successful as maternal and newborn health care 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 RMC 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 situational analysis 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 COUINTRIES 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
PHASE I: Situational analysis (April–July, 2017)			
1.	Development of RMC situational analysis Objectives and protocol and Program Monitoring Document	April	
2.	Tool Development and Adaptation	April/May	
3.	Share tools with key stakeholders for review	Mid–June	
4.	Translate tools and consent forms	June–July	
5.	Solicit IRB approval and local approval per protocol	June–July	
6.	Stakeholders advocacy meeting to raise awareness of the situational analysis and to solicit feedback	July	
7.	Recruitment and training of Data Collectors	August	
8.	Data collection and analysis of results	September–October	
PHASE 2: Development of a theory of change and plan for implementation and monitoring			
1.	Preparation for in–country stakeholder meeting	September–November	
2.	Stakeholder meeting to review findings from situational assessment and to design theory of change to prioritize local interventions to improve RMC and reduce mistreatment	Oct–Nov	
3.	Development of detailed implementation and monitoring plan based on theory of change that includes targeted facilities/catchment areas	Oct–Nov	
PHASE 3: Implementation and routine program monitoring			
1.	Implementation and routine monitoring per plan developed in phase 2	February	
2.	Regular activities to share learning across sites (e.g., periodic face to face meetings; WhatsApp groups)	March–Sept	
3.	Regular sharing of results, challenges and gains with key stakeholders (community representatives, civil society organizations, facility managers and health workers, MOH policy–makers, etc.)		

Appendix 5. 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 carefully thought out groups of participants on a predetermined topic. With a skilled facilitator, groups of roughly 5-10 individuals (women or men, community members or others who are comfortable gathering as a group) can share opinions in a short period of time. The "unit of analysis" is the group—and the common themes that emerge. No one person should be identified or singled out during the analysis phase.	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.	Cindoglu and Unal, 2016 https://www.ncbi.nlm.nih.gov/pubmed/20390649	Turkey	FGDs with clients and separately midwives, physicians
			Ganle et al. 2014 https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-014-0425-8	Ghana	FGDs with women
			Magoma et al. 2010 https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-13	Tanzania	FGDs with women
			Moyer et al. 2014 http://www.sciencedirect.com/science/article/pii/S0266613813001514	Ghana	3 FGDs with grandmothers, 2 FGDs with compound heads, and 2 FGDs with household heads
			Maya et al. 2018 https://www.tandfonline.com/doi/full/10.1080/09688080.2018.1502020	Ghana	10 FGDs involving 110 women.
			Bohren et al. 2016 https://www.sciencedirect.com/science/article/pii/S2352827316300453?via%3Dihub Bohren et al. 2017 https://reproductive-health-journal.biomedcentral.com	Nigeria	FGDs with women

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Description
			/articles/10.1186/s12978-016-0265-2		
			Balde et al. 2017 https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-016-0262-5 Balde et al. 2017 https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-016-0266-1	Guinea	FGDs with women.
2. In-depth interview or key informant interview	These one-on-one discussions between facilitator and participant 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. Non-clinician moderator is preferred to build rapport and reduce social desirability bias Can be semi-structured or in-depth interviews.	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.	Heshima		
			http://www.popcouncil.org/research/Measuring-disrespect-and-abuse-to-promote-respectful-maternity-care	Kenya	
			Staha https://www.mailman.columbia.edu/research/averting-maternal-death-and-disability-amdd/respectful-maternity-care	Tanzania	
			Maya et al. 2018 https://www.tandfonline.com/doi/full/10.1080/09688080.2018.1502020	Ghana	39 indepth interviews
			Vogel et al. 2015 https://bmcmedresmethodol.biomedcentral.com/artic	Nigeria, Ghana, Guinea, Myanmar	Development and validation of tools to measure how women are treated in facility childbirth in 4 countries.

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Description
			les/10.1186/s12874-018-0603-x		
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. Selection of observer is important to reduce bias (e.g., clinician may not be the ideal observer due to social desirability bias) Observer needs to commit to objectivity. Open-ended comments added to structured surveys may yield brief responses.	Beebe J. 2001. Rapid Assessment Process: An Introduction. Walnut Creek, CA: Altamira Press. Volume 3, No. 4, Art. 33 Rapid Assessment Process in Qualitative Inquiry http://www.qualitative-research.net/index.php/fqs/article/view/773/1678#g1	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 policy-makers.
			Magoma et al. 2010 https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-10-13	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
			Arnold et al. 2014 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4489341/	Afghanistan	For regular RMC assessment. 6 weeks of daily observations of staff with field notes taken and discussed with interpreter.
			Rosen et al. 2015 https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4	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, and mapping) and later on in policy or service delivery	Few examples to date; requires certain expertise to organize and analyze data from participatory methods. An example of a participatory method is "Rich Picture."	Community-based participatory research (US); participatory rural appraisal (low-resource settings); participatory action research Salgado et al. 2017a	Nigeria and Uganda	

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.		https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.12381 Salgado et al. 2017b https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.12382		
			Stakeholder Analysis Guidelines by Kammi Schmeer. http://www.who.int/workforcealliance/knowledge/toolkit/33.pdf	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.
			Influence and importance matrix http://www.mspguide.org/tool/stakeholder-analysis-importanceinfluence-matrix	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.
			Rich Picture http://www.managingforimpact.org/tool/rich-picture-0	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.
			Bardach E. 2012. A Practical Guide for Policy Analysis: *The Eightfold Path to More Effective Problem Solving* Fourth Edition.	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

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Description
			Sage/ CQ Press, Thousand Oaks, CA, USA.		confronting the trade-offs. The steps culminate with "Decide!" and telling your story.
			Net-Map (social networking mapping tool)	NA	Quality of care (structure, process, community-reported outcomes related to L&D services and RMC)
			Community Score Card http://www.care.org/sites/default/files/documents/FP-2013-CARE_CommunityScoreCardToolkit.pdf		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 of those solutions in an ongoing process of quality improvement.

Appendix 6. Quantitative RMC/Mistreatment Data Collection Methods

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
1. Client exit interview	• May be done routinely for each client if self-administered • Text message or phone follow-up may be feasible in some settings • Clients can directly report on their own experiences • May be administered to a sample of clients • Captive audience and logistically easier to engage women while still at the facility	• Household surveys may be more accurate but are not feasible as part of routine program implementation. • Exit interviews probably tend to underestimate mistreatment in childbirth • Text message or mailed written surveys or questions require a minimum level of literacy. • Text message or phone follow-up excludes poorer women without access to a phone. • Possible loss-to-follow-up if not administered while the client is still in the facility. • Self-administered questionnaires are challenging in low-	Sando et al. (2014): n=1,954 client interviews (single large referral hospital). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4251905/	Tanzania	N	Mixed methods study that included interviews with postpartum women	Assesses satisfaction and quality with specific focus on experience of disrespect and abuse (D&A) in childbirth, including physical abuse, non-consented care, and non-confidential care, lack of privacy, non-dignified care, and abandonment during or after labor and delivery, and detention in facilities.
			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) https://academic.oup.com/heapol/advance-article/doi/10.1093/heapol/czu079/2907853	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.
			Abuya et al. (2015a): Exit survey with n= 641 women http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0123606	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.

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
		literacy populations. • Possible response bias (e.g., courtesy bias) depending on who administers survey. • May not be able to measure negative experiences that have been normalized.	Asefa (2015): Exit interviews prior to discharge with n=173 women https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4403719/	Ethiopia	N	Cross-sectional interviews with women immediately prior to discharge	Levels of D&A during childbirth were measured using seven performance standards (categories of D&A) and their respective verification criteria developed by the Maternal and Child Health Integrated Program (MCHIP) as part of their RMC tool kit.
			Scheferaw et al. (2016): n=509 postnatal clients interviewed to develop a scale https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0848-5	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.
			Women's Views of Birth Labour Satisfaction Questionnaire https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743424/pdf/v010p00017.pdf	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.
			Staha Study Facility Exit Questionnaire	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	Perceived quality and satisfaction; experience ofD&A.

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
						section on women's reported experience of D&A; the length of this questionnaire may make it prohibitive for routine use of the entire questionnaire but it could be used to collect baseline/endline data.	
			Maternity Ward Survey for Magunga Hospital (Staha project in Tanzania)	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.
			Pregnancy and maternity care patients' experiences questionnaire (Sjetne et al. 2015). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4546178/pdf/12884_2015_Article_611.pdf	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 sub-scales: personal relationships in delivery ward, resources and organization of ward; attention to partner in ward.
			Survey of Bangladeshi women's experience of maternity services (Duff et al. 2001).	Bangladesh	Y	72 items (3 sub-scales: 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	Vali-dated? (Y/N)	Description	Dimensions covered
			https://www.ncbi.nlm.nih.gov/pubmed/11476146				
			Questionnaire for Assessing Childbirth Experience (QACE). Carquillat et al., BMC Pregnancy and Childbirth 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5577741/pdf/12884_2017_Article_1462.pdf	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.
			Citizens Report Cards http://siteresources.worldbank.org/INTPCENG/1143380-1116506267488/20511066/reportcardnote.pdf	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.
			Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; http://www.hcahpsonline.org/home.aspx	No published results from use of this tool for RMC/D&A	Y—in multiple countries	For RMC assessment related to patients. The Hospital Consumer Assessment of Healthcare Providers and Systems) 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	Vali-dated? (Y/N)	Description	Dimensions covered
			The Mothers on Respect (MOR) Index Measuring Quality, Safety, and Human Rights in Childbirth (Note: the tool referenced does not explain the scoring/weighting). http://www.sciencedirect.com/science/article/pii/S2352827317300174	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.
			Afulani et al. 2017, *Reproductive Health*. Development of tool to measure person-centered maternity care in developing settings: validation in rural and urban Kenya https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0381-7	Kenya	Y	30 item scale with 3 sub-scales to measure *positive and negative aspects* 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)
			Montesinos-Segura, R et al. 2017. Disrespect and abuse during childbirth in 14 hospitals in 9 cities of Peru http://onlinelibrary.wiley.com/doi/10.1002/ijgo.12353/abstract	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	Vali-dated? (Y/N)	Description	Dimensions covered
			Paridhi Jha et al. 2017. *Global Health Action*. Satisfaction with childbirth services provided in public health facilities: results from a cross-sectional survey among postnatal women in Chatisgarh, India http://www.tandfonline.com/doi/full/10.1080/16549716.2017.1386932	India	N		
				India	Y	30 item scale with 3 sub-scales to measure positive and negative aspects of person-centered maternity care (PCMC). Authors present the results of the psychometric analysis of the PCMC tool that was previously validated in Kenya using data from India. They aimed to assess the validity and reliability of the PCMC scale in India, and to compare the results to those found in the Kenya validation. They performed psychometric analyses, including iterative exploratory and confirmatory factor analysis, to assess construct and criterion validity and reliability.	
			Alufani et al. 2018 https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0591-7				
				Kenya, Ghana, India	Y		

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
			Afulani et al. 2019 https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(18)30403-0.pdf			Reports on findings from 3 countries (Ghana, India, Kenya) applying the PCMC scale to assess women's experience of care.	
2.Structured questionnaire with birth companion	• May be done periodically or routinely for each client's companion or a sample of clients' companions in a facility setting • Text message or phone follow-up *may* 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.	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	• Possible response bias (e.g., social desirability bias). • Mistreatment may have become normalized for many staff.	Ndwiga et al. 2017 https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0364-8	Kenya	N		
			Hospital Survey on patient safety culture https://psnet.ahrq.gov/resources/resource/5333/surveys-on-	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	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	Vali-dated? (Y/N)	Description	Dimensions covered
	organizational culture. • Because staff are always present, can observe patterns of RMC and mistreatment • Can measure health workers' experience of providing care		patient-safety-culture			was developed in 2004 to help hospitals assess their culture of safety. This link includes survey tools and a user's guide.	
			Human Resources Management Assessment Approach https://www.capacityplus.org/files/resources/hrm-assessment-approach.pdf	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
			Safety https://med.uth.edu/chqs/surveys/safety-attitudes-and-safety-	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	This tool can assess teamwork climate, safety climate, perceptions of management, job satisfaction, working

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
			climate-questionnaire/			domains: teamwork climate, safety climate, perceptions of management, job satisfaction, working conditions, and stress recognition. This link includes the survey tool, permission letter to use the short form of the questionnaire, and a scoring key.	conditions, and stress recognition.
			Health Workforce Productivity Analysis and Improvement Toolkit https://www.capacityplus.org/productivity-analysis-improvement-toolkit/	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.
			Employee Satisfaction Survey	NA	N	For RMC assessment related to organizational culture, work environment, and employee satisfaction.	This tool assesses fair treatment of employees; employees' understanding of expectations; employee's

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
			https://www.k4health.org/sites/default/files/Employee_Satisfaction_Tool.pdf			Developed by the Management and Leadership Program, 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.	feelings about performance feedback, their value to the organization, and opportunities for career development.
5 Direct or one-to-one 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)	Resource intensive so not feasible as part of routine programming but could be done as part of quality assurance (e.g., periodic supervision visits) More subjective tasks may require more interpretation; does not measure women's perception of mistreatment or experience of care.	MCHIP Quality of Care Surveys. Rosen et al. (2015): n=2,164 L&D observations. https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0728-4	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 Bohren et al. (2015) Physical abuse, sexual abuse, verbal abuse, failure to establish professional standards of care, discrimination, health system
			Abuya et al. 2017 http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0123606	Kenya	N	For RMC and D&A related to patients. This observation tool was used at endline in the Heshima study. The tool was developed by Population Council, incorporating	

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
						modifications of tools used in several studies	
			Sethi et al. (2017): n=2,109 L&D observations. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0370-x	Malawi	N	Adaptation of the MCHIP Quality of Care labor and delivery observation tool.	
			Bohren et al. 2019 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31992-0/fulltext	India, Nigeria, Myanmar	Y	Structured observation (and community survey)	
6.Simulation of care and provider–client interactions	• Could provide objective measures for tasks that are easier to observe. • Does not require availability of L&D case, so could potentially be used in low caseload settings. • Permits assessment of simulated provider communication skills (not performance) • May help simultaneously	• Could be conducted as part of quality assurance process: • More subjective tasks may require more interpretation. • Some aspects of care are difficult to observe during simulation (e.g., discrimination/bias) • Possibility of Hawthorne effect • Does not measure provider actual performance (only skills)	-No published studies on RMC/mistreatment using this method identified in low- and middle-income countries.	NA	NA	NA	NA

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
	build provider skills.						
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 offered or not requested); were birth companions not offered, 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. • May not measure "density" of the intervention, e.g., companionship present only at the time the baby came out, vs. companion present throughout the duration of labor and childbirth.	• No published studies/reports currently available related to data use. • 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.	NA	NA	NA	NA
8. Questionnaire with family member			Questionnaire on family experiences of intensive care	Denmark, The Netherlands	Y	For RMC and D&A related to families of patients. Developed by Jensen et al. (2015), the euroQ2 was	Quality of care including interpersonal care (structure, process, family-

Method	Strengths of method	Weaknesses of method	Reference/tools (with links if available)	Country	Vali-dated? (Y/N)	Description	Dimensions covered
			unit quality of care. Jensen et al. 2015.			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.	reported outcomes related to L&D services and RMC)

Appendix 7. MCSP RMC Situational Analysis Tools, Monitoring and Evaluation Tools, and Guidance on Ethical Review

For adaptation by country programs

The MCSP RMC situational analysis 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 during home-based 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 civil society organization representatives (Table 2); and 2) quantitative tools including client, manager and provider surveys (Table 1). The tools listed below are available at: RMC Metrics Tools Appendix 7.

The qualitative situational analysis 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 an observation and 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 situational analysis 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

Baseline and endline data collection tools to inform design and evaluation of RMC interventions (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 1: Provider Survey	Collects information from facility-based **health care providers** as key informants about how women in general are treated during labor and delivery in facilities and how their colleagues are treated.
Tool 2: Client Exit Survey	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: Situational Analysis Qualitative Tools

| **Situational analysis tools: to understand local context and inform design of local RMC interventions** (adapted from WHO multi-country study and other tools.)	
Tool 3: In--depth interview guide for women of reproductive age (WRA)	Collects information from **women in the community** 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: In--depth interview guide for women receiving antenatal care (ANC)	Collects information from pregnant **women in the community** 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: In-depth interview guide for administrators	Collects information from **health facility administrators** 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: In-depth interview guide for providers	Collects information from facility-based **health care providers** 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: In-depth interview guide for policymakers and CSOs	Collects information about how **civil society organizations (CSOs), professional associations and policy-makers** are promoting RMC in communities and health facilities. *Note: May also be used for human subjects research.
Tool 8: In-depth interview guide for TBAs	Collects information from **traditional birth attendants (TBAs)** 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: FGD Guide for women in the community	This FGD guide collects information about **women in the community** about how they think women should be treated during labor and delivery, as well as their own facility-based maternity care experiences.
Tool 10: RMC Facility Readiness Assessment Tool	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).

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 assement 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 Johns Hopkins School of Public Health 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 Johns Hopkins School of Public Health IRB determined that the activity did not qualify as human subjects research defined by Department of Health and Human Services regulations 45 CFR 46.102. Some situational analysis tools collect key informant information on perceptions of general experiences and community norms, and should qualify for non-human subjects research (NHSR). However, you should work with your measurement, monitoring, evaluation, and learning 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 measurement, monitoring, evaluation, and learning 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 NHSR 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 NHSR data to avoid potential issues later on. Consult IRBHelp@Jhpiego.org with any questions or for a consultation.

Appendix 8: 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
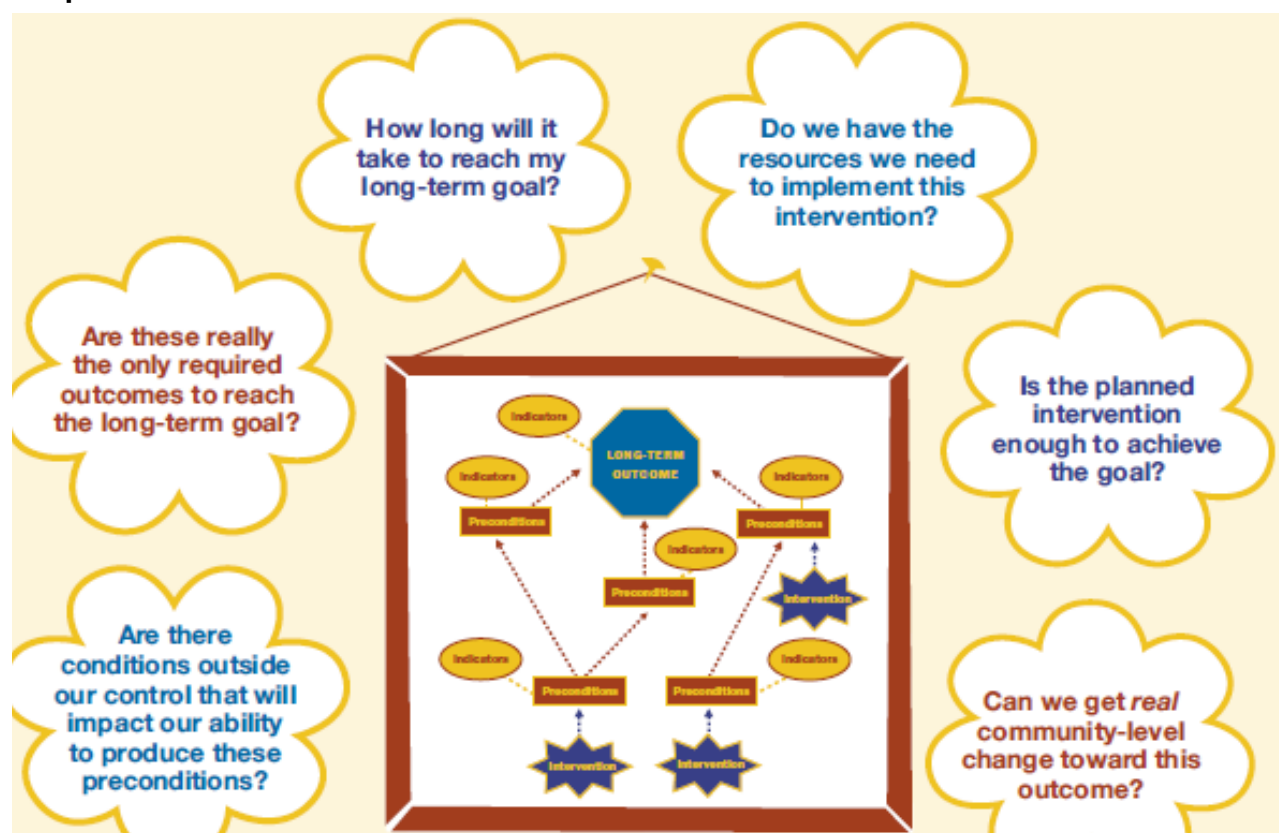
Illustrative example of tasks involved in creating and refining a theory of change

1. Identifying long-term goals

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

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, theory of change 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:

Theory of Change: A Practical Tool for Action, Results and Learning
(Annie E. Casey Foundation, 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 8A: Template/Worksheet for Creating a Theory of Change

(Also called a conceptual model)

To access the electronic Theory of Change (logical model) Excel template below; please click here: Theory of Change Excel Template

Program:	(name)	Logic Model
Situation:		

Inputs	Outputs		Outcomes		
	Activities	Participation	Short	Medium	Long

Assumptions

External Factors

Appendix 8B: Examples of a Theory of Change from RMC Programs in Tanzania and Kenya

Examples of theories of change from two unique programs in Tanzania (Staha project; Ratcliff et al. publication) and one program in Kenya (Heshima project) are illustrated below in Figures 1, 2, and 3 with hyperlinks just below.

Sample theory of change from project in Tanzania
Sample theory of change from Staha Project
Sample theory of change from Heshima Project

Figure 1. Theory of Change from project in Tanzania

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[1,2*], David Sando[1,3], Goodluck Willey Lyatuu[3], Faida Emil[3], Mary Mwanyika-Sando[4], Guerino Chalamilla[3,4*], Ana Langer[1] and Kathleen P. McDonald[1,5]
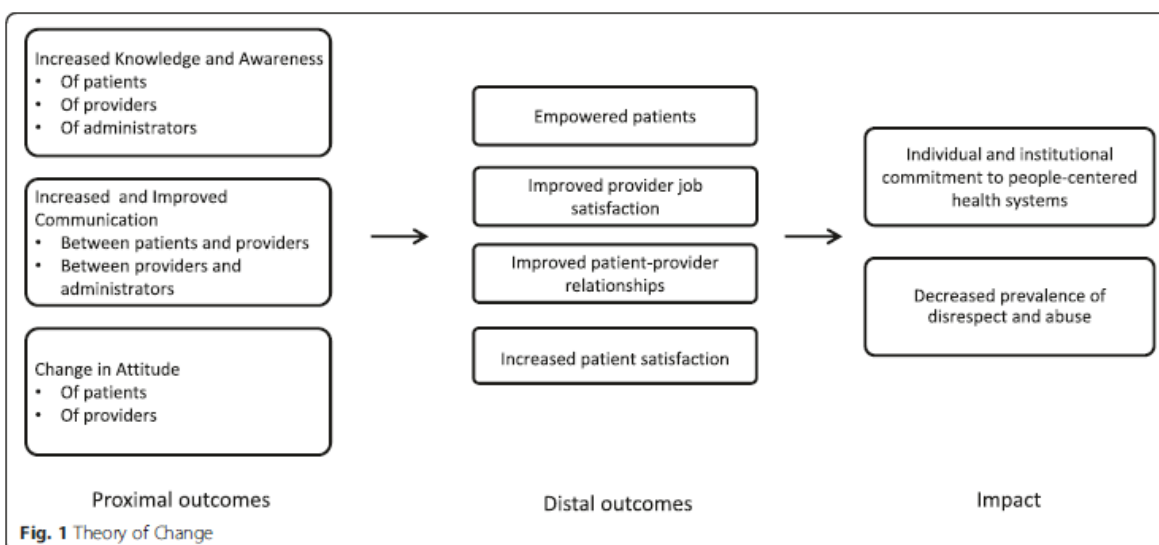

Fig. 1 Theory of Change
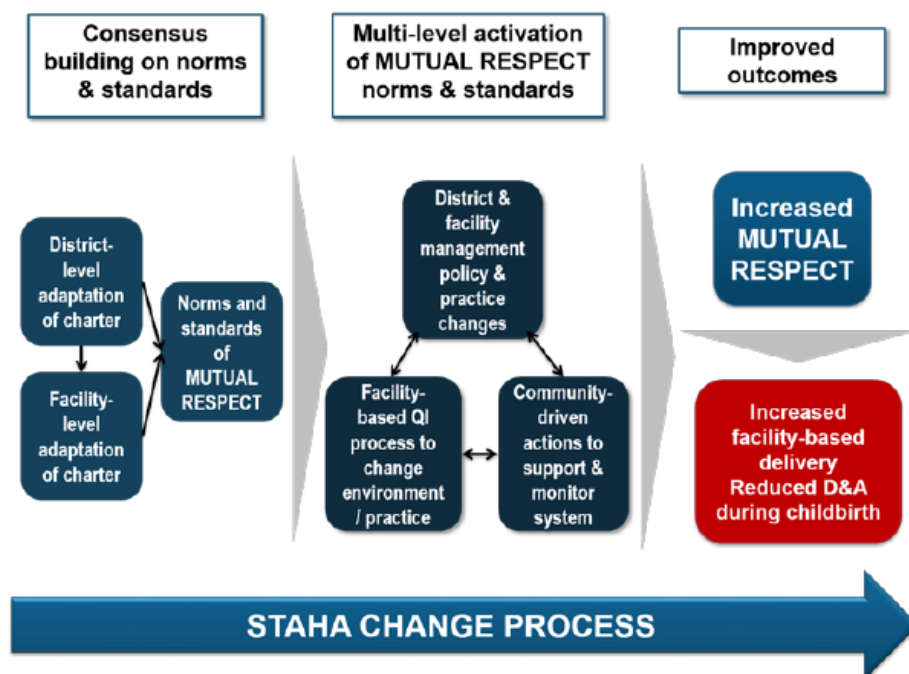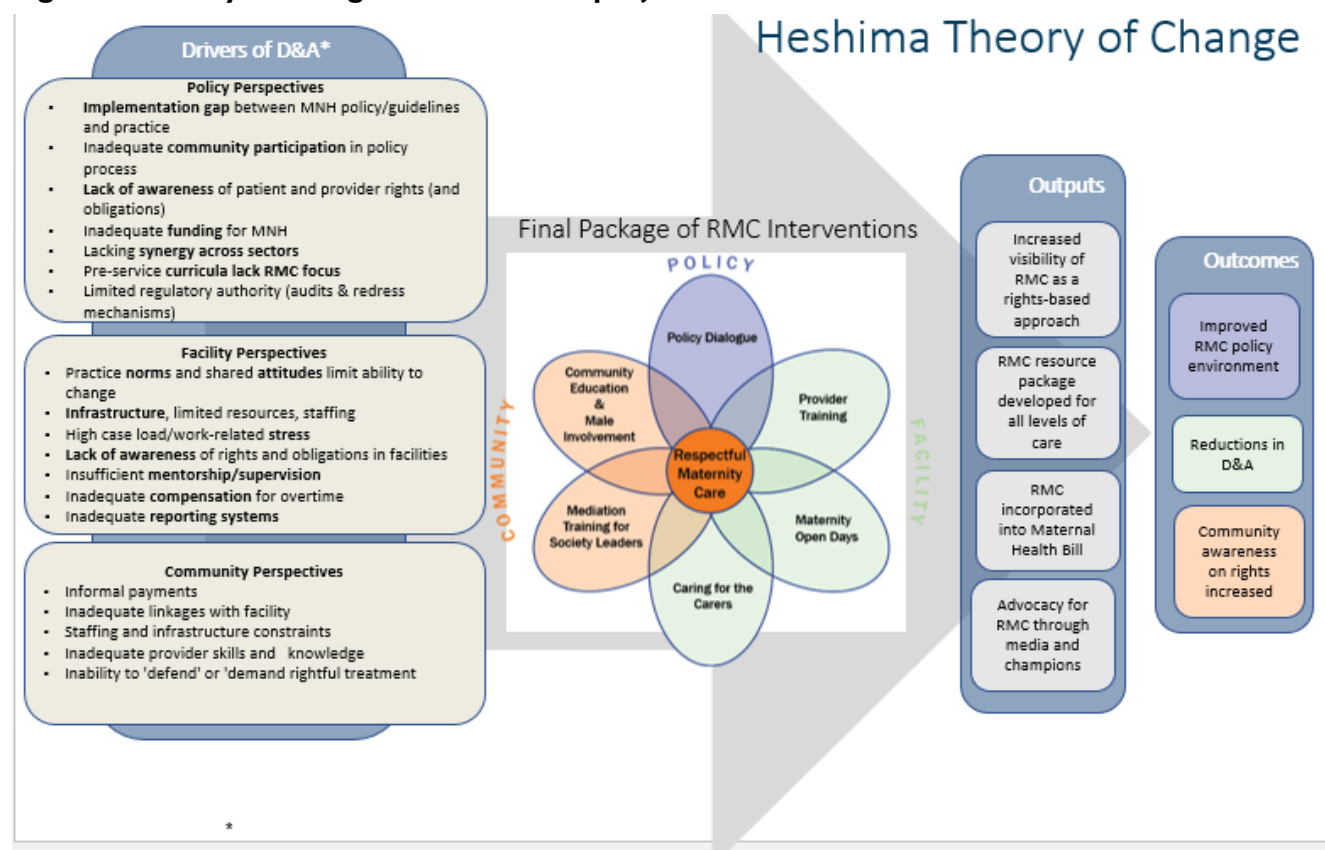
Figure 2. Staha process theory of change diagram

Figure 3. Theory of change from Heshima project

Warren et al. 2017

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