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Respectful Maternity Care Measurement Workshop Report

April 2013

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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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This report was prepared by Kate Brickson, Eva Bazant, Barbara Deller, Caitlin Warthin, and Nicole Lunardi of MCHIP.

Abbreviations and Acronyms

AMDD	Averting Maternal Death and Disability
ASSIST	Applying Science to Strengthen and Improve System Project
ANC	Antenatal Care
D&A	Disrespect & Abuse
GMHC	The Global Maternal Health Conference
IOM	Institute of Medicine
MCHIP	Maternal and Child Health Integrated Program
MHTF	Maternal Health Task Force
MOH	Ministry of Health
PMP	Performance Monitoring Plan
PNC	Postnatal Care
PPFP	Postpartum Family Planning
Q	Quality Improvement
RMC	Respectful Maternity Care
TRAction Project	Translating Research into Action Project
USAID	United States Agency for International Development
URC	University Research Co.
WRA	White Ribbon Alliance

Introduction

The Maternal and Child Health Integrated Program (MCHIP) convened a group of organizations active in respectful maternity care (RMC) programming, research, and advocacy for a half-day workshop to inform routine measurement of RMC. Representatives from MCHIP, United States Agency for International Development (USAID), Averting Maternal Death and Disability (AMDD), Maternal Health Task Force (MHTF), Population Council, University Research Co. (URC)/Translating Research into Action (TRAction) and Applying Science to Strengthen and Improve System (ASSIST) projects, and the White Ribbon Alliance (WRA) attended the workshop in Washington DC. Attendees gathered to share experiences and lessons learned in measuring RMC, and to discussion how the global community can more effectively measure needs and progress in this area. (See Appendices 1 and 2: RMC Measurement Workshop Agenda and Attendee List).

This short report covers the workshop objectives, the pre-workshop questionnaire, and summaries of discussions on key topics. These topics covered definition/guiding principles of RMC, data collection methods, and indicators, questions to inform RMC measurement, and next steps.

Workshop Objectives

- Arrive at a common definition of RMC for routine measurement
- Review indicators used for measurement of RMC
- Propose a list of recommended methods and indicators for routine measurement
- Plan for testing of indicators

Pre-Workshop Questionnaire

Prior to the workshop, the MCHIP team surveyed a number of groups who are either implementing RMC programming or who have conducted special studies on RMC (see Appendix 3: Questionnaire on Tools for Measuring RMC). Our objective was to scan the landscape and determine which RMC definitions and indicators had previously been used by organizations in studies or routine measurement in order to inform a set of draft indicators for routine measurement.

At the Global Maternal Health Conference (GMHC) in Arusha, Tanzania, in January 2013, many presentations, panels, and a plenary session focused on RMC (see Appendix 4: List of RMC Presentations at GMHC). From the presentations made and others that were cited in the conference program, approximately 30 individuals were found to have spoken about RMC or a related topic. This included USAID funded entitles as well as other program implementers and evaluators in the field. This group formed the beginning of a list of potential questionnaire participants. Additional names of people having an interest or experience in RMC were shared with us and were contacted. In total, approximately 25 organizations were contacted. Because email addresses were not found for all the speakers at GMHC, the questionnaire was sent to approximately 30 individuals from 16 organizations.

The MCHIP team gathered information from responses to the questionnaire and from published, RMC-relevant tools and reports from a total of 10 organizations. From the tools and reports, the team was able to glean the components, items, and indicators of RMC or disrespect and abuse (D&A) that have been studied. In addition, information was also received from researchers and program implementation staff.

Definition of RMC/Guiding Principles

The questionnaire asked programs to share their operational definition of RMC. The team reviewed the variety of definitions of RMC and D&A and compiled a summary document that included frameworks and definitions referenced by questionnaire respondents. The team drafted a composite definition, which drew from those operational definitions and the frameworks that informed them. However, during discussions at the workshop it was agreed that "guiding principles" would be preferable to a definition.

Development of these guiding principles should coordinate with and draw upon:

- WRA's efforts to establish criteria for Mother Friendly Birthing Facility (and monitoring process)
- AMDD's and Population Council's current work on defining RMC/D&A
- Institute of Medicine principles of patient-centered care
- Ipas' tool on values clarification
- Judith Bruce's quality of care framework that presents the fundamental elements of quality in family planning. Adaptations of the framework for quality antenatal care (ANC), including client-provider interactions, have been published in the literature.

Considerations to be included in guiding principles:

- Must address policies, systems, and facility level
- Must refrain from blaming providers
- Must be detailed enough to be descriptive, but allow flexibility for regional and cultural variation
- Must center around individual client's experience of care
- Recognition that not all D&A can be observed; also the intent to inflict distress is important to determine
- Should include forms of redress
- Requires buy-in from ministries of health for policy principles

Data Collection Methods and Indicators

All of the indicators and/or items/elements the team received in response to the questionnaire were put into one file (see Appendix 6: Indicator Compendium). The resulting document contained approximately 20 components of RMC and D&A, and over 100 items that can inform routine indicators. Similar items from multiple organizations' instruments were retained in order to show the variety of wording and nuances. For the purpose of stimulating small group discussion, similar items were grouped together by level and area, as follows:

1. Program and policy
2. Labor and delivery RMC/D&A
3. Client-provider communications and consent
4. Antenatal and postnatal care RMC/D&A

Indicators were further grouped by domain (e.g., abandonment, birth position, confidentiality).

Responses to the questionnaire included methods and data sources used by respondents. These methods and data sources were included in the indicator compendium and shared for reference at the workshop. Potential methods and data sources for measurement of RMC were identified and discussed in general discussions and small-group sessions. Preliminary data sources that were discussed for routine data collection included:

- Health facility assessments:
  - Readiness assessments
- Health facility registers recording data on services provided
- Exit interviews with clients:
  - Both within the facility and immediately adjacent to the facility upon discharge. Considerations included:
    - Who is best suited to do this data collection (e.g., community representatives, facility staff)
    - Literacy level of data collectors should be addressed in tools
- Household surveys:
  - Potentially useful to query non-users of facilities and to interview users away from the facility
  - In some locations, household surveys are carried out annually
- Supportive supervision visits to facilities:
  - Standards-Based Management and Recognition standards and verification criteria or other quality improvement (QI) approaches
- Provider self-assessments
- Community scorecards, community discussion groups or interviews

Having multiple forms of data (i.e., triangulation) was considered necessary. Client-provider interactions were considered a topic to be assessed routinely with clients or community-involved methods.

Several indicators for measuring critical elements of RMC at the point of care were highlighted during small group discussion sessions. The following illustrative indicators were presented:

- Abandonment:
  - Did the woman deliver alone or was a provider present at birth? (To be measured via exit interview or possibly registers)
- Birth position: (to be measured via exit interview or registers)
  - Was the woman informed that she had the *option* to deliver vertically?
  - Did she have an opportunity to indicate her preference?
  - At admission, was she informed that she has the right to act on her preference?

One small group was tasked to discuss indicators regarding client-provider communication and consent. The group felt the need to consult the client-centered care literature. They agreed that asking clients and non-users of services whether they would use or return to a health facility, i.e., satisfaction items, was important as indicator of a threshold of poor quality of care.

Questions to Inform RMC Measurement

Workshop attendees identified a number of questions whose answers will help to guide the global community in implementation of programs and measurement of program results. These priority questions should be incorporated into the agenda of the global RMC community, including funding agencies, researchers, implementing agencies, and advocacy groups.

1. How do we know what interventions, policies, and practices are most effective in improving RMC?
   a. What lessons should be taken from countries with positive respectful maternity care practices (e.g., Norway)? It is important to understand what works at the program level in order to inform policy development.
   b. A landscape analysis of supportive policies and practices should inform decisions on the strongest interventions and strategies to improve RMC. Indicators can then be proposed to measure progress on those strategies and interventions. (Note: MCHIP has conducted a survey of country policies and implementation strategies. The draft report on this survey is under USAID review.)
2. How do we determine that policies, definitions, or guiding principles for RMC are in alignment with women's preferences and priorities? (E.g., how do we know that presence of a companion at birth is a priority for women? Do we know which companions women prefer?)
3. Do registers already contain proxy indicators that could prove useful in measurement of RMC? (Note: Any or all of the services could be carried out in the midst of disrespectful and abusive care. Below, a, c, and d indicate that counseling is occurring. It is possible to counsel and not show respect to the woman. Indicators of quality of care may not indicate respectful care.)
   a. Complication readiness/birth preparedness plans in antenatal period
   b. Delivery with skilled birth attendant
   c. Danger signs counseling in postnatal care
   d. Postpartum family planning counseling and informed choice

4. Are redress mechanisms and accountability measures in place, and are these working?

Next Steps

- Convene working groups with participation of representatives from low-resource settings for several purposes:
  - To develop guiding principles/definition for RMC
  - To examine data collection methods and arrive at recommendations and guidance for routine programmatic use
  - To further examine indicators for RMC in service delivery, including client-provider communication, aligned with the data sources
  - To identify priority research and advocacy agendas that will help foster RMC, including culturally competent care and the systemic factors that undergird D&A measurement of RMC in antenatal and postnatal care,
- Develop a "capacity map" to identify organizations working in RMC and their respective strengths, areas of focus and operation, and agendas for future work in RMC
- WRA will share materials, including criteria and indicators for the newly developed Mother Friendly Birthing Center designation
- Initiate dialogue with WRA/International Federation of Gynecology and Obstetrics/WHO on measurement to inform indicators for policy/program level readiness for RMC
- MCHIP will ensure that MCHIP RMC materials are shared and posted to the MHTF RMC clearinghouse page

APPENDICES

1. RMC Measurement Workshop Agenda
2. Attendee List
3. Questionnaire on Tools for Measuring RMC
4. List of RMC presentations at GMHC
5. Handout – What Makes a Good Indicator?
6. Indicator Compendium

Appendix 1: RMC Measurement Workshop Agenda

AGENDA

Measurement of Respectful Maternity Care
MCHIP Main Office, 1776 Massachusetts Avenue, NW Suite 300, Washington, DC

April 9, 2013
9:00 AM – 12:30 PM
(Breakfast at 8:45, Lunch afterwards)

Objectives:

- Arrive at a common definition of respectful maternity care (RMC) for routine measurement
- Review indicators used for measurement of RMC
- Propose a list of recommended methods and indicators for routine measurement
- Plan for testing of indicators

Agenda

	TOPIC	PRESENTER
9:00	Gather, Welcome, Introductions	Barb Deller
9:05	Overview of workshop objectives, schedule	Barb Deller
9:10	Presentations of existing knowledge from 1. TRAction baseline assessment studies a. Kenya b. Tanzania 2. URC in Central Europe 3. Jhpiego – Mozambique 4. MCHIP Quality of Care	1. a. Charlotte Warren, Kenya b. Stephanie Kujawski/ Kate Ramsey, Tanzania 2. Kathleen Hill 3. Jim Ricca 4. Heather Rosen
10:00	Findings and feedback from survey questionnaire	Eva Bazant
10:15	Discussion • Definition of RMC for routine measurement purposes	Kate Brickson, Eva Bazant, Barb Deller
10:35	**Break**	
10:50	Discussion • Methods that can be used for routine measurement • Characteristics of good indicators	Eva Bazant
11:10	Small Group Break Out • Develop shortlists of proposed indicators	Groups
11:50	Report Back	Groups
12:10	Planning next steps • Review of the shortlisted indicators • Plan for testing of proposed indicators • Need for follow-up meetings • Scope and invitees for follow up	
12:30	**Close**	

Appendix 2: Attendee List

NAME	AFFILIATION	PARTICIPATION BY VIDEO
Debbie Armbruster	USAID	
Anne Austin	MHTF	
Eva Bazant	MCHIP	
Kate Brickson	MCHIP	
Barb Deller	MCHIP	
Frances Ganges	WRA	
Patricia Gomez	MCHIP	Yes
Deborah Gordis	WRA	
Kathleen Hill	URC/TRAction/ASSIST	
Stephanie Kujawski	AMDD	
Mande Limbu	WRA	
Jennifer Luna	MCHIP	
Esther Lwanga	USAID	Yes
Susan Moffson	MCHIP	
Emily Peca	URC	
Kate Ramsey	AMDD	
Barbara Rawlins	MCHIP	
Veronica Reis	MCHIP	Yes
Jim Ricca	MCHIP	
Heather Rosen	MCHIP	
Sarah Smith	URC/TRAction/ASSIST	
Nancy Termini	Pop Council	
Vandana Tripathi	MCHIP/JHU	Yes
Charlotte Warren	Pop Council	
Caitlin Warthin	MCHIP	

Appendix 3: Questionnaire on Tools for Measuring RMC

RESPECTFUL MATERNITY CARE: QUESTIONNAIRE ON MEASUREMENT & INDICATORS

This short questionnaire aims to inventory the tools used to assess and measure Respectful Maternity Care (RMC) and Disrespect and Abuse (D&A).

A. Respondent Information

Name: _____

Position: _____

Agency/Organization: _____

Country/ies included: _____

Date: _____

B. Definition of RMC

What operational **definition** does your organization use for RMC, or another similar topic?

_____

_____

The following questions ask first about tools for assessing and measuring RMC during labor and delivery (L&D), next antenatal care (ANC) and post-natal care (PNC), and lastly overall data sources.

C. Respectful L&D

1. Has your organization and its partners developed *qualitative* tools to assess RMC during L&D? ☐ Yes ☐ No (then skip to C2)
   a. What are the names of the qualitative tools? _____
   b. Are there web links to the tools or reports/articles? _____
   c. Please describe the purpose/objectives and sample/population. _____
2. Has your organization and its partners developed *quantitative* tools to assess RMC during L&D? ☐ Yes ☐ No (then skip to D1)
   a. What are the names of the quantitative tools? _____
   b. Are there web links to the tools or reports/articles? _____
   c. Please describe the purpose/objectives and respondents/population. _____

d. Please list the specific components/elements of RMC measured. _____

e. Have the quantitative tools been assessed for validity and reliability? _____

3. Do the tools cover:

a. The 1st and 2nd stage of labor? ☐ Yes ☐ No

b. The 3rd stage of labor? ☐ Yes ☐ No

c. Immediate essential newborn care? ☐ Yes ☐ No

d. PMTCT? ☐ Yes ☐ No

e. Other? _____

D. Respectful ANC and PNC

1. Has your organization and its partners developed *qualitative* tools to assess RMC during ANC and/or PNC? ☐ Yes ☐ No (then skip to D2)

a. What are the names of the qualitative tools? _____

b. Are there web links to the tools or reports/articles? _____

c. Please describe the purpose/objectives and sample/population. _____

2. Has your organization and its partners developed *quantitative* tools to assess RMC during ANC and/or PNC? ☐ Yes ☐ No (then skip to E)

a. What are the names of the quantitative tools? _____

b. Are there weblinks to the tools or reports/articles? _____

c. Please describe the purpose/objectives and respondents/population. _____

d. Please list the specific components/elements of RMC measured. _____

e. Have the quantitative tools been assessed for validity and reliability? _____

3. Do the tools cover:

a. The 1st ANC visit? ☐ Yes ☐ No

b. Follow-up ANC visits? ☐ Yes ☐ No

c. PMTCT? ☐ Yes ☐ No

d. 1st PNC? ☐ Yes ☐ No

e. Follow-up PNC? ☐ Yes ☐ No

f. Other? _____

E. Data Sources

Which of the above named tools use the following data sources:

1. *Routine or regular* facility-based assessment, such as for ongoing quality improvement? _____

2. In-depth facility-based study of RMC? _____

3. Provider self-assessment? _____

4. Supportive supervision? _____

5. Policy and health system assessment? _____
6. Client assessment? _____
7. Community or population-based assessment of RMC? _____
8. Other? _____

Please attach a copy of any quantitative or qualitative forms used that are not accessible online.

THANK YOU!

Appendix 4: List of RMC Presentations at GMHC[1]

FIRST NAME	LAST NAME	ORGANIZATION	WHERE PERSON IS LOCATED	NAME OF TALK
Emmanuel	Kenyi	Africa Medical and Research Foundation	South Sudan	Community participation for improved quality for maternal, newborn and child health care *[Not available online]*
Brenda	D'mello	CCBRT-TZ	Tanzania	(Gave a plenary talk on RMC - Improving municipal hospital L&D in Dar es Salaam) *[Moderator-No presentation]*
Aparajita	Gogoi	CEDPA India	India	Incorporating community voices [in QI for MNH] *[Not available online]*
Loveday	Penn-Kekana	Center for Health Policy	South Africa	Is there a relationship between women's reporting of abuse and disrespectful care and quality of care recorded in clinical records: Measurement & interpretation challenges
Lynn	Freedman	Columbia University	USA	Defining disrespect and abuse: Trouble at the intersection of law, policy, program, and research
Elysia	Larson	Columbia University	USA	Linking quality of care and patient satisfaction
Stephanie	Kujawski	Columbia University	USA	The association between disrespectful and abusive treatment during childbirth and health care satisfaction and future facility utilization in the Tanga Region, Tanzania *[Summary only]*
				How do you measure disrespectful and abusive treatment during childbirth? The application of 3 measurement methods in Tanzania
Amelia	Chamberlain	Concern Worldwide	USA	Approches to quality improvement in provider/client relations as an entry point for improved MNCH care and services *[Summary only]*
Kate	Teela	Gates Foundation	USA	Moderator of panel: Respectful, humanized birth; and moderator of panel: Making women-centered care a reality *[Moderator-No presentation]*
Angela	Kimweri	Ifakara Health Institute	Tanzania	Service quality informs delivery decisions
Ernestina	David	Jhpiego	Mozambique	Institutionalization of quality improvement and humanization of maternal and neonatal care in Mozambique's National Model Maternities Initiative
Eva	Bazant	Jhpiego	USA	Women's ratings of the experience of delivery care: Household survey findings from Nairobi's informal settlements

[1] http://www.gmhc2013.com/

FIRST NAME	LAST NAME	ORGANIZATION	WHERE PERSON IS LOCATED	NAME OF TALK
Bilal	Avan	London School of Hygiene & Tropical Medicine	UK	How to capture maternal voices in a systematic manner in order to influence quality of health services *[Not available online]*
Sabitri	Sapkota	Midwifery Society of Nepal	Nepal	The husband's companion to his wife during childbirth in Nepal: An approach to improve the emotional wellbeing of a new mother during the postnatal period *[Not available online]*
Heather	Rosen	MCHIP/JHU	USA	Measuring the quality of respectful maternity care: Evidence from a multi-country assessment of facility-based care *[Summary only]*
Matilda	Aberese Ako	Navrongo Health Research Center	Ghana	"Tell them to sue us!": Challenges, frustrations and their influence on frontline health workers' motivation in the provision of quality maternal health care in Ghana
				"Whatever he tells you is a lie!" Trust and health worker attitudes in the provision of maternal health care in Ghana
Matthias Sachse	Aguilera	Oaxaca State Safe Motherhood Committee	Mexico	Quality of care during pregnancy, childbirth and postpartum from the perspective of rights and multiculturalism in primary health centers in the State of Oaxaca, Mexico *[Summary only]*
				Evaluation of the quality of maternal health care in primary health centers in the state of Oaxaca *[Not available online]*
Pamela	Putney	PATH	USA	Putting women at the center of care *[Not available online]*
				The most significant change: "Learning how to care"
Charlotte	Warren	Population Council	Kenya	Manifestations and drivers of disrespectful maternity care: Providers' experiences in Kenya
Rebecca	Njuki	Population Council	Kenya	Community perceptions on dehumanization of childbirth: Manifestations and contributors in Kenya
Timothy	Abuya	Population Council	Kenya	Manifestations, type and prevalence of disrespect and abuse during child birth in Kenya
Sanghita	Bhattacharyya	Public Health Foundation of India	India	Trading off cleanliness: Women's priorities at delivery in Jharkhand, India *[Not available online]*
				Closing the cycle: Evidence to action [in QI for MNH] *[Not available online]*
				Beyond cash incentive: Making public health facilities more attractive places for childbirth *[Not available online]*
Aradhana	Srivastava	Public Health Foundation of India	India	Assessing what women want: Systematic review of maternal satisfaction with delivery care in developing countries
				Incorporating maternal satisfaction in assessments of maternal health services: Evidence from developing countries *[Summary only]*
Jashodhara	Dasgupta	SAHAYOG	India	Participation of informed users in monitoring quality of care

FIRST NAME	LAST NAME	ORGANIZATION	WHERE PERSON IS LOCATED	NAME OF TALK
Emem	Bassey Inyang	University of Uyo	Nigeria	Evaluation of the maternal health friendly status of traditional health care system in Akwa Ibom state, Nigeria
Nomafrench	Mbombo	University of Western Cape	South Africa	Empowering communities and individuals to demand accountability for the right to maternal health in developing countries: South African case study
Kathleen	Hill	URC	USA	Gave plenary talk on RMC *[Not available online]*; Measuring quality of maternal care: For what purpose? Needs in a post-MDG world
Jorge	Hermida	URC	Ecuador	Aligning two health systems to improve access and quality of maternal/newborn care for the most vulnerable: Linking formal care and traditional birth attendants in Ecuador
				Introducing and tracking maternal quality measures to drive country-level improvement: Lessons learned in Ecuador and ways forward
				Why health systems must align with community systems to deliver for vulnerable women: Innovative local solutions for improving equitable access to and demand for quality maternal care across 3 regions
Mande	Limbu	While Ribbon Alliance	USA	Gave plenary talk on RMC *[Not available online]*

Appendix 5: Handout—What Makes a Good Indicator?

WHAT MAKES A GOOD INDICATOR?

RMC Measurement Meeting

April 9th, 2013

RECOMMENDATIONS FOR RMC INDICATORS

1. Indicators should map the program's theory of change/logic model.
2. Indicators include both outputs and outcomes related to program's objectives and activities.
3. Each indicator should be practical, useful for decision-making, and attributable (related to program efforts). A program monitoring plan (PMP) should have only as many indicators as is necessary.
4. Systems are needed for timely data collection with clear data flow pathways.
5. Systems are needed to improve data quality, such as on-going training and mentoring of providers or data collectors, and guidelines to make data collection consistent.
6. Indicators are reviewed for importance and feasibility by M&E, program, and technical staff together, and used at the facility, program, or policy level.
7. Indicators should be assessed for validity (discussion below).

BEST PRACTICES

MAMA (Mobile Alliance for Maternal Action) M&E Framework

Selection of indicators is based on the following criteria:

- Maximization of existing data, to the extent possible
- Minimization of burden on country programs
- Monitoring over the life of the program
- Contribution to the global learning agenda

MEASURE Evaluation (2013): "Performance Management Plans, A checklist for Quality Assessment"

Do the indicators seem closely aligned with project activities and objectives?
The best indicators reflect outcomes that are central to a project's work, rather than being incidental. Some contextual factors may be included (e.g., maternal mortality); but for all but the largest and most ambitious projects, the majority of indicators should be activity-specific. A highly successful project should produce striking results. Indicators that are relatively impervious to the changes a project is trying to effect should usually be avoided in favor of more sensitive ones.

Do the indicators reliably measure what is intended, and is their use feasible?
The feasibility of valid, reliable data collection is a critical component of indicator quality. Most projects will not have to develop all new indicators; for nearly every type of activity there are established indicators in common use. These can be readily found on indicator compendia (e.g., the Family Planning and Reproductive Health Indicators Database developed by MEASURE Evaluation PRH[2]) and in published survey reports. Collecting and using established indicators for performance management can mean that less time and effort must be invested in developing definitions and calculation procedures. In addition, projects using the same established indicator can compare experiences in order to advance institutional learning.

Teams preparing a PMP must answer two basic questions about the indicator set:

- What should be measured?
- And how?

USAID's Automated Directives System recommends seven criteria for answering the first question, which can be abbreviated to **OPUDATA**:

- **O**bjective (clearly defined, uni-dimensional)
- **P**ractical (data can be obtained in reasonable time at reasonable cost)
- **U**seful (for management decision-making)
- **D**irect (used in lieu of proxy measures)
- **A**ttributable (to USAID/U.S. government efforts)
- **T**imely (available when needed)
- **A**dequate (as many indicators as necessary for effective performance assessment)

To confidently base decisions on measurements, we must also have reason to believe that the quality of the measurements is high. This requires an understanding of *measurement error*, or the various ways that the process of producing an indicator value has the potential to yield a result that differs from the *true* value. A second set of ADS criteria is principally concerned with this issue, the components of data quality: **validity (data represent the intended result)**.

- Integrity (data are not intentionally manipulated)
- Precision (reflects specific population of interest, margin of error is small)
- Reliability (data are collected and analyzed using consistent methods)
- Timeliness (current data are available with adequate frequency)

Steps taken to maximize data quality might include eliminating indicators that seem invalid or unreliable, choosing strategically from among all possible data sources for an indicator, changing survey questions, or improving training for those who conduct data collection. A good PMP will have an indicator list free from obvious sources of measurement error, and include acknowledgement of any measurement issues that may be unavoidable or justified.

[2] This database is available online at: http://www.cpc.unc.edu/measure/prh/rh_indicators.

Validity

Some types of validity, often a term used to mean accuracy, are related to the larger program or theoretical framework. Data analysis can be informative.[3]

- **Statistical conclusion validity** relates to the strength of relationship of two variables and the ability to infer that the two variables are related. Statistical conclusion validity can be assessed from the analysis when using appropriate statistical tests.
- **Internal validity** relates to whether the relationship between two variables is causal. Internal (causal) validity requires thinking of the underlying program theory or conceptual framework, and seeking alternative explanations that make explain why variables were found to be related. When controlling for known confounders in a study, the internal validity is strengthened.
- Construct validity refers to higher-order constructs or domains. Can we make inferences about high-order constructs based on what was studied? Construct validity also requires thinking outside of the specific items measured to consider higher-order constructs in the theoretical framework.
- **External validity** relates to factors outside of the study environment. Would the findings and relationships that we found hold in other settings and contexts?

Jhpiego Monitoring and Evaluation (M&E) Standards (2012)

M&E Standard 1. M&E is integrated into programs
Verification Criteria 1.3 Routine meetings between M&E and program staff are regularly held (*at least* quarterly) to share most recent data on key indicators, compare with expenditures, and inform ongoing programming.

M&E Standard 3. Each program has a logic model, PMP, and M&E work plan
Verification Criteria 3.1 A logic model exists for the program linking program activities with desired outputs, outcomes and health impact.

Verification Criteria 3.2 A PMP with both output and outcome level indicators exists for the program, includes indicator definition (numerator and denominator), source, frequency of collection, person responsible for data collection, and life-of-project targets, and is updated annually.

[3] http://www.southalabama.edu/coe/bset/johnson/oh_master/Ch8/Sumof4.pdf

Appendix 6: Indicator Compendium

[GROUP 1] Developing Process, Program and Policy Level Indicators for RMC			
Larger Domain	**Indicator**	**Possible Data Source**	**Study/Program/Country, Year**
Policy/Advocacy re policies to promote RMC	i.e. admission of family members, person of choice to accompany during labor/birth, requirement of informed consent for procedures, mother-baby kept together throughout time in facility, prohibit detention in facility for lack of payment		MCHIP Program Review Instrument 2013
Budget dedication/resource mobilization			MCHIP Program Review Instrument 2013
Local laws and regulations			MCHIP Program Review Instrument 2013
Clinical guidelines and protocols	i.e. percentage of births with a companion, percentage of births in alternate position, mother and baby kept together, etc		MCHIP Program Review Instrument 2013
Training and promotional materials related to RMC			MCHIP Program Review Instrument 2013
In-service training			MCHIP Program Review Instrument 2013
Pre-service curriculae			MCHIP Program Review Instrument 2013
Quality improvement approaches: Facility Readiness	(i.e. re specific standards related to RMC)		MCHIP Program Review Instrument 2013
Infrastructure	i.e., condition to ensure privacy, accommodation for birth companion, place for women to walk around during labor, resting place for health workers, etc		MCHIP Program Review Instrument 2013
Materials or supplies	(curtains, screens to ensure privacy; chairs for the birth companion; accessories to support drug-free comfort and pain relief methods during labor and freedom to birth in vertical position)		MCHIP Program Review Instrument 2013
Community activities including campaigns			MCHIP Program Review Instrument 2013

[GROUP 2] Point-of-care Part I: All Domains Except Client-provider Communication and Consent

Larger Domain (alphabetical)	Indicator	RMC/ D&A	Study/Program/Country, Year	Data Source	Routinely Collected?
Abandonment	"Health providers ignore/abandon patient when in need or when she called for help."	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Abandonment	Delivered alone/without any assistance	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Abandonment	Leaving woman alone or unattended	D&A	MCHIP 2013	MCHIP Program Review Instrument	
Abandonment/Refusal to help	"Was there anyone who refused to help you? If so, [which cadre]"	D&A	SAHAYOG, India	Household survey & Qualitative	
Abandonment	"The providers left you alone for long periods of time."	D&A	Maternal Health Survey, Nairobi informal settlements	Household survey	
Abandonment/neglect	Neglect post delivery	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Abandonment (or opposite, Attention)	Comes quickly when woman calls	RMC	MCHIP 2013	Performance Standards, Verification Critieria	
Abandonment (or opposite, Attention)	Never leaves woman alone or unattended	RMC	MCHIP 2013	Performance Standards, Verification Critieria	
Abandonment (or opposite, Attention)	Encourages woman to call if needed	RMC	MCHIP 2013	Performance Standards, Verification Critieria	
Birth Position	Birth in vertical/semi-vertical position	RMC	MCHIP Model Maternities Initiative (Mozambique); ALSO Mchip QoC survey	Health information System (HIS) and facility registers (35 to 125 facilities)	Yes
Birth Position/Movement	Encourages/assists woman to ambulate and assume different positions in labor (2 items), at least once	RMC	MCHIP QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)	
Birth Position/Movement	Allows woman to assume position of choice during birth (or Choice of Birth position)	RMC	MCHIP 2013; URC/HCI, Assessment of MNC in Albania, Armenia, Georgia and Russia, 2012	Performance Standards, Verification Criteria	
Birth Position/Movement	Allows the woman to move about during labor	RMC	MCHIP 2013	Performance Standards, Verification Criteria	
Birth Position/Movement (Denying Freedom, no choice)	Denying freedom of movement during labor	D&A	MCHIP 2013	MCHIP Program Review Instrument	
Birth Position/Movement (Denying Freedom, no choice)	Denying choice of position for delivery	D&A	MCHIP 2013	MCHIP Program Review Instrument	
Cleanliness	Clean place of delivery; someone cleans the place of delivery afterwards	RMC	Pulic Health Foundation of India	Community Survey with women, following Qualitative Research	
Cleanliness/Dirty conditions/no cleaning	Unhygienic conditions/No change of linen/Mothers being asked to clean delivery couches/Dirty bathroom/toilets	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Companion	Encourages woman to have support person in L&D	RMC	MCHIP QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)	
Companion	Encourages companion to remain with woman whenever possible	RMC	MCHIP 2013	Performance Standards, Verification Criteria	
Companion	Presence of a labor companion	RMC	MCHIP Model Maternities Initiative (Mozambique); AND MCHIP QoC Survey	Health information System (HIS) and facility registers (35 to 125 facilities)	Yes
Companion	Presence of birth companion	RMC	Multiple: MCHIP Model Maternities Initiative (Mozambique); MCHIP QoC Survey; AND Public Health Foundation of India	Health information System (HIS) and facility registers (35 to 125 facilities); Observations of L&D; community survey	Yes
Companion	Choice of companion during labor and delivery	RMC	URC/HCI, Assessment of MNC in Albania, Armenia, Georgia and Russia, 2012	Facility readiness, client exit interviews, provider interviews	

[GROUP 2 Cont.] Point-of-care Part I: All Domains Except Client-provider Communication and Consent

Larger Domain (alphabetical)	Indicator	RMC/ D&A	Study/Program/Country, Year	Data Source	Routinely Collected?
Confidentiality	Patient files are stored in locked cabinets with limited access.	RMC	MCHIP 2013	Performance Standards, Verification Criteria	
Confidentiality	"Staff do not discuss or disclose client information to non-health care staff"	RMC	Population Council, Kenya	Various data sources	
Confidentiality	"Health providers discussed patient's private health information in a way that others could hear". Client: 1. Experienced. 2. Witnessed. 3. Heard About. 4. None	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Confidentiality	"Health providers shared patient's private health information with others without patient's consent." Client: 1. Experienced. 2. Witnessed. 3. Heard About. 4. None	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Culturally appropriate contact and practices	Touch or demonstrate caring in a culturally appropriate way	RMC	MCHIP 2013	Performance Standards, Verification Criteria	
Culturally appropriate contact and practices	Allows woman and her companion to observe cultural practices as much as possible	RMC	MCHIP 2013	Performance Standards, Verification Criteria	
Delay to provide care or supplies	Delay in receiving care after a decision has been made e.g. to perform C/S	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Delay to provide care or supplies	Failure to provide supplies even if the supplies are available	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Delay to provide care or supplies	Failure to offer service even when the staffs are adequate on duty	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Discrimination	"Patients treated poorly because of age, marital status, health status"	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Discrimination	"Patients treated poorly because of ethnicity, religion, tribe"	D&A	Columbia Univ/AMDD/Ifakara; and MCHIP 2013	Facility Exit interview; Program Review instrument	
Discrimination	"Patients treated poorly because of social class, poverty"	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Discrimination	Denial of services due to lack of money, poverty	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Discrimination	Does not show disrespect to women based on any specific attributes	D&A	MCHIP 2013	Performance Standards, Verification Criteria	
Discrimination/no confidentiality	Mothers' record is clearly marked HIV positive	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Discrimination/no care	Failure to provide medical procedures to HIV clients (e.g. limit VE exam done)	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Food and Drink	Encourages woman to consume fluids/food throughout labor at least once (1st stage)	RMC	MCHIP QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)	
Food and Drink	Does not deny food or fluid to women in labor unless medically necessary	RMC	MCHIP	Performance Standards. Verificaiton Criteria	
Food and Drink	Denying drink or food during labor	D&A	MCHIP 2013	MCHIP Program Review Instrument	
Mother-baby connection	Delivery with immediate skin to skin after birth	RMC	MCHIP Model Maternities Initiative (Mozambique)	Health information System (HIS) and facility registers (35 to 125 facilities)	Yes
Mother-baby connection	Delivery with immediate breastfeeding (during first hour)	RMC	MCHIP Model Maternities Initiative (Mozambique)	Health information System (HIS) and facility registers (35 to 125 facilities)	Yes
Mother-baby connection	Immediate post-partum skin-to-skin contact between mother and newborn	RMC	URC/HCI, Assessment of MNC in Albania, Armenia, Georgia and Russia, 2012	Facility readiness, client exit interviews, provider interviews	
Mother-baby connection	Rooming-in of mother and newborn	RMC	URC/HCI, Assessment of MNC in Albania, Armenia, Georgia and Russia, 2012	Facility readiness, client exit interviews, provider interviews	
Mother-baby connection (Separation)	Never separate woman from baby unless medically necessary	D&A	MCHIP 2013	Performance Standards, Verification Critieria	

[GROUP 2 Cont.] Point-of-care Part I: All Domains Except Client-provider Communication and Consent

Larger Domain (alphabetical)	Indicator	RMC/ D&A	Study/Program/Country, Year	Data Source	Routinely Collected?
Pain (No pain relief), esp. for repair or episiotomy	Not providing anesthesia for the stitching of episiotomy (cutting to widen birth canal)	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Pain (No pain relief), esp. for repair or episiotomy	Stitching episiotomy without anesthesia	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Pain (No pain relief), esp. for repair or episiotomy	Provides comfort/pain relief as necessary	D&A	MCHIP 2013	Performance Standards, Verification Criteria	
Paln relief, Drugs, Supplies and Equipment	Availability of drugs for complications and pain management	RMC	Pulic Health Foundation of India	Community Survey with women, following Qualitative Research	
Paln relief, Drugs, Supplies and Equipment	"How would you rate the availability of drugs, supplies, and medical equipment at this facility for this delivery?" (client exit question)	RMC	Columbia Univ/AMDD/Ifakara Institute	Facility Exit Survey	
Paln relief, Drugs, Supplies and Equipment	Facility Readiness Indexes	RMC	MCHIP QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	Facility- Observation	
Payment/equity/cost	Cost of services (affordable)	RMC	Pulic Health Foundation of India	Community Survey with women, following Qualitative Research	
Payment/equity/cost	Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.	RMC	Population Council, Kenya	Various data sources	
Payment and Bribes	"Health providers suggesting or asking for a bribe or informal payment for better care."	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Payment and Bribes	Payments for provider fees - for which no receipt was given	D&A	SAHAYOG, India	Household survey & Qualitative	
Payment and Detention	"Woman or baby not allowed to leave the hospital due to failure to pay"	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Payment and Detention	Detaining woman at faciility because of lack or payment of facility fees	D&A	MCHIP 2013	MCHIP Program Review Instrument	
Payment and Detention	[The facility does not have a policy to detain women who do not pay.]	D&A	MCHIP 2013	Performance Standards, Verification Criteria	
Payment and Detention	When a woman is unable to pay if the baby is sick, welfare of the mother in the facility	D&A	Population Council, Kenya	Facilty exit interview and other data sources	
Personnel	Availability of qualified medical personnel	RMC	Pulic Health Foundation of India	Community Survey with women, following Qualitative Research	
Personnel- Gender (No respect for choice of provider gender)	No choice of gender of provider	D&A	Population Council, Kenya; ALSO Public Health Foundation of India	Facility exit interview and other data sources; qualitative	
Physical abuse/force	Hitting, slapping, pushing, pinching, or otherwise beating the patient	D&A	Columbia Univ/AMDD/Ifakara; ALSO Maternal Health Survey, Nairobi informal settlements	Facility Exit interview	
Physical abuse/force	Never uses physical force or abrasive behavior with the woman, including slapping or hitting	D&A	MCHIP 2013	Performance Standards, Verification Criteria	
Physical abuse/force	Never physically restrains woman	D&A	MCHIP 2013	Performance Standards, Verification Criteria	
Physical abuse/force	Pinching /Slapping/Pushing/Beating	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Physical abuse/force	FGM during labor/Re-stitching FGM scar	D&A	Population Council, Kenya	Facility exit interview and other data sources	

[GROUP 2 Cont.] Point-of-care Part I: All Domains Except Client-provider Communication and Consent

Larger Domain (alphabetical)	Indicator	RMC/ D&A	Study/Program/Country, Year	Data Source	Routinely Collected?
Privacy	Drapes woman (1st stage of Labor)	RMC	MCHIP QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa); also MCHIP 2013	HF study (observation of L&D); Performance Standards	
Privacy	Delivery room had audio and visual privacy (1st stage of Labor)	RMC	MCHIP QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (readiness)	
Privacy	You were given adequate privacy during the examinations by the nurse or doctor	RMC	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey	
Privacy	Uses curtains or other visual barrier to protect woman during exams, birth, procedures	RMC	MCHIP 2013	Performance Standards, Verification Criteria	
Privacy	"Every woman is examined or attended to behind screens"	RMC	Population Council, Kenya	Various data sources	
Privacy & Confidentiality	"History taking and examination is done in as much privacy as possible"	RMC	Population Council, Kenya	Various data sources	
Privacy & Confidentiality	Privacy and confidentiality (physical and confidential information)	RMC	URC/HCI, Assessment of MNC in Albania, Armenia, Georgia and Russia, 2012	Facility readiness, client exit interviews, provider interviews	
Privacy/ (Lack of it)/ Exposure	Body seen by others	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Privacy/ (Lack of it)/ Exposure	Not exposed unnecessarily	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Privacy & Facility Overcrowding	Bed sharing, several babies sharing incubators	D&A	Population Council, Kenya	Facility exit interview and other data sources	
Sexual Harassment, Assault, and Rape	"Health providers sexually harassing patients or making sexual advances (for example, inappropriate touching or sexual comments that make you feel uncomfortable)"	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Sexual Harassment, Assault, and Rape	"Rape, being forced to have intercourse or perform any other sexual acts against your will by someone other than your husband."	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview	
Sexual Harassment, Assault, and Rape	Rape/ Inappropriate touching during exam- genital/thighs	D&A	Population Council, Kenya	Facility exit interview and other data sources	

[GROUP 3] Point-of-care Part II: Client-provider Communication and Consent				
Larger Domain (alphabetical)	**Indicator**	**RMC/ D&A**	**Study/Program/Country, Year**	**Data Source**
Greeting	Respectfully greets pregnant woman (Initial Assessment of Pregnant Woman at Facility)	RMC	Mchip QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)
Greeting/Politeness	Introduces self to woman (and companion)	RMC	MCHIP 2013	Performance Standards, Verification Criteria
Greeting/Politeness	Speaks politely to woman and companion	RMC	MCHIP 2013	Performance Standards, Verification Criteria
Information Exchange	Explains procedures to woman (support person) before proceeding (Assessment of Pregnant Woman at Facility)	RMC	Mchip QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)
Information Exchange	Explains what is being done and what to expect throughout labor and birth	RMC	MCHIP 2013	Performance Standards, Verification Criteria
Information Exchange	Informs pregnant woman of findings (Assessment of Pregnant Woman at Facility)	RMC	Mchip QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)
Information Exchange	Gives periodic updates on status and progress of labor	RMC	MCHIP 2013	Performance Standards, Verification Criteria
Information Exchange	Explains to woman what will happen in labor, at least once (also support person) (1st stage of Labor)	RMC	Mchip QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)
Information Exchange	The providers explained your health status with terms that were understandable (asking woman after delivery)	RMC	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
Information Exchange	Speaks to the woman in a language and at a language-level that she understands	RMC	MCHIP 2013	Performance Standards, Verification Criteria
Information Exchange	Staff take time to explain: procedures, diagnosis, progress, results, options	RMC	Population Council, Kenya	Client exit interview
Information Exchange	Information is given in an open and friendly manner	RMC	Population Council, Kenya	Client exit interview
Information Exchange	Clients are encouraged to ask questions	RMC	Population Council, Kenya	Client exit interview
Information Exchange	Ask woman if she has questions (and support person if present) (Assessment of Pregnant Woman at Facility)	RMC	Mchip QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)
Information Exchange	Encourages woman and her companion to ask questions	RMC	MCHIP 2013	Performance Standards, Verification Criteria
Information Exchange	The providers listened to your questions or concerns (asking woman after delivery)	RMC	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
Information Exchange	Responds to questions with promptness, politeness, and truthfulness	RMC	Columbia Univ/AMDD/Ifakara Institute	Facility Exit Survey
Information Exchange	Staff are polite and use appropriate language	RMC	Population Council, Kenya	Client exit interview
Information Exchange	How would you rate the communication skills of the providers at this facility? By this, I mean, how well did they explain things to you during your labor and delivery	RMC	Columbia Univ/AMDD/Ifakara Institute	Facility Exit Survey
Information Exchange	Clear explanation during labor and delivery by provider	RMC	URC/HCI, Assessment of MNC in Albania, Armenia, Georgia and Russia, 2012	Facility readiness, client exit interviews, provider interviews
Information Exchange	No explanation of the scope of services offered	D&A	Population Council, Kenya	Facility exit interview and other data sources

[GROUP 3 Cont.] Point-of-care Part II: Client-provider Communication and Consent

Larger Domain (alphabetical)	Indicator	RMC/ D&A	Study/Program/Country, Year	Data Source
Emotional support	Supports the woman during labor in a friendly way (1st stage of Labor)	RMC	Mchip QoC survey, 2010-2012 (7 co. in Sub-Saharan Africa)	HF study (observation of L&D)
Emotional support	Overall, the providers offered compassionate care." (asking woman after delivery)	RMC	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
Emotional support	The providers showed a genuine interest in your well-being." (asking woman after delivery)	RMC	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
Verbal abuse: scolding/shouting/insults	The providers scolded or shouted at you.	D&A	Maternal Health survey, Nairobi informal settlements; ALSO Columbia Univ/AMDD/Ifakara	Household survey
Verbal abuse: scolding/shouting/insults	"Health providers making negative or disparaging comments about the patient."	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview
Verbal abuse: scolding/shouting/insults	verbal abuse/insults	D&A	MCHIP 2013	MCHIP Program Review Instrument
Verbal Threat/Coercion	"Health providers threatening to withhold treatment because patient could not pay or did not have supplies (including delivery kit)"	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview
Verbal Threat/Coercion	"Health providers threatening patient for any other reason."	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview
Verbal Threat/Coercion	Never makes insults, intimidation, threats, or coerces_woman or her companion	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview
Verbal Threat/Coercion	Threats (e.g. if you do not cooperate I take you to operating theater)	D&A	Population Council, Kenya	Facility exit interview and other data sources
Consent/Respect for Autonomy	The providers asked for your agreement before doing clinical procedures." (asking woman after delivery)	RMC	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
Consent/Respect for Autonomy	Routine patient consent procedures;	RMC	URC/HCI, Assessment of MNC in Albania, Armenia, Georgia and Russia, 2012	Facility readiness, client exit interviews, provider interviews
Consent (Non-consented care/forced procedure)	Non-consent for tubal ligation ("Tubal ligation (tying of the fallopian tubes) without her permission"	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview
Consent (Non-consented care/forced procedure)	Non-consent for hysterectomy ("Hysterectomy (getting your uterus removed) without patient or her relatives' permission")	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview
Consent (Non-consented care/forced procedure)	Non-consent for Cesarean section ("Caesarean section without patient or her relatives' permission"	D&A	Columbia Univ/AMDD/Ifakara	Facility Exit interview
Consent (Non-consented care/forced procedure)	lack of informed consent	D&A	MCHIP 2013	MCHIP Program Review Instrument

[GROUP 4] Antenatal and Postnatal Care Indicators		
Indicator	**Study/Program/Country, Year**	**Data Source**
The providers explained your health condition with terms that were understandable.	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
The providers explained what to expect during labor and delivery.	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
The providers listened to your questions or concerns.	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
The providers were respectful of you.	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
The providers scolded or shouted at you.	Maternal Health Survey, Nairobi informal settlements, 2008	Household survey
Provision of humanized Pre-natal attention at the ANC (interpersonal communication, provision of information/education, respect for woman and families values and preferences)	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Physical conditions of the ANC service	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Availability of material and equipment	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
How the women are attended by the health professional in the ANC service, etc	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
How the women are attended by the health professional in the ANC service, etc	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
If the delivery plan was done during the ANC visit	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
If the emergency plan was done during ANC visit	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
If the essential procedures are done at the ANC according to the guidelines (immunization, TIP malaria, HIV screening, nutritional support)	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
HIV positive client is managed according to guidelines (AVASS)	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Most common pathologies in pregnant woman are managed according to guidelines	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Number of clients in humanized post-natal care	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Physical conditions of the PNC service	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Drugs, supplies, and equipment are available	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
How woman re attended by the health provider in the PNC ward (respectful and humanized care, interpersonal communication, provision of information/education, respect for women and families, values and preferences)	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Assessment and essential PNC is carried out according to guidelines	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
family planning methods and provision is offered at the PNC visit	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization
Assessment and essntial care for newborn is carried out in PNC	Jhpiego MCHIP Mozambique, 2013	Standards of the Model Maternities Initiative/Humanization

[GROUP 4 Cont.] Antenatal and Postnatal Care Indicators		
Indicator	**Study/Program/Country, Year**	**Data Source**
Never uses physical force or abrasive behavior with the woman, including slapping or hitting	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Touches or demonstrates caring in a culturally appropriate way	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Introduces self to woman and her companion	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Encourages companion to remain with woman whenever possible	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Encourages woman and her companion to ask questions	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Responds to questions with promptness, politeness, and truthfulness	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Explains what is being done and what to expect during the examination	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Gives information on status and findings of examination	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Obtains consent or permission prior to any procedure	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Does not share client information with others without permission	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Does not leave client records in area where they can be read by others not involved in care	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Uses curtains or other visual barrier to protect woman during exams, procedures	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Uses drapes or covering appropriate to protect woman's privacy	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Speaks politely to woman and companion	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Never insults, intimidation, threats, or coerces woman or her companion	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Speaks to the woman in a language and at a language-level that she understands	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Does not show disrespect to women based on any specific attributes	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Provides essential care to the woman	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC
Never detains a woman against her will	MCHIP 2013	Performance Standards, Verificaiton Criteria for ANC and PNC