Respectful Maternity Care Program Review Instrument

INTRODUCTION

Some of the contributing factors compromising the quality of maternal and newborn health (MNH) care are related to interpersonal, ethical, and socio-cultural issues. These issues include physical abuse; non-consented care; non-confidential care; non-dignified care, including verbal abuse; discrimination based on specific attributes; abandonment or denial of care; and detention in facilities.[1] Many women avoid seeking care in health facilities because of such mistreatment, which then hinders a country's achievement of Millennium Development Goal 5—improve maternal health.

In recent years, a movement has been advancing to promote the implementation of respectful maternity care (RMC), an approach centered on the individual, and based on respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences. RMC touches upon many aspects of care, including respect for beliefs, traditions and culture; the right to information and privacy; confidentiality; consent and preferences in care; choice of companion during labor and birth; continuous care during labor and birth; freedom of movement during labor; non-separation of mother and newborn; and prevention of institutional violence against women and newborns, including abusive and disrespectful care. RMC is not a separate activity or intervention, but is an attitude that permeates all care.

In this context, the Maternal and Child Health Integrated Program (MCHIP) conducted a survey of maternal health programs with the objective of collecting information from key countries/project stakeholders about their experience implementing interventions to promote RMC. Based on the information collected and recognizing this subject's importance, this instrument was developed for use by country programs to assess their program efforts in the prevention of disrespectful and abusive care and the promotion of RMC. The result of this assessment will help inform actions to strengthen RMC within their programs.

The instrument has been designed to identify typical examples of mistreatment, disrespect or abuse in MNH care. However, you may be aware of other types of abuse that you also want to include in this self-assessment.

[1] Bowser and Hill. 2010. *Exploring Evidence and Action for Respectful Care at Birth*. USAID, TRAction Project.

PROGRAM REVIEW INSTRUMENT

Country: _____

Date (dd/mm/yr): _____/_____/_____

Respondent: _____Job title: _____

Institution: _____

Location (District, Region): _____

Level of in the facility: (circle): tertiary, teaching hospital, referral facility, regional hospital, district hospital, health center

Brief information about the program/institution:

_____

_____

_____

_____

_____

Total number of births/deliveries per month in the program or institution: _____

COUNTRY INFORMATION

Has any of the following kind of mistreatment, disrespect or abuse in MNH care been identified in your country and/or program?

Table 1.

KIND OF MISTREATMENT, DISRESPECT OR ABUSE	YES	NO	COMMENT
Physical abuse (slapping/hitting)			
Verbal abuse (insult)			
Lack of information about the care provided/lack of informed consent			
Lack of privacy			
Lack of confidentiality			
Discrimination based on ethnicity, race, or economic status			
Birth companion not allowed to be present			
Denying freedom of movement during labor			
Denying choice of position for birth			
Unnecessary separation of mother and newborn after the birth			
Abandonment of care (leaving the woman alone or unattended)			

KIND OF MISTREATMENT, DISRESPECT OR ABUSE	YES	NO	COMMENT
Detaining the woman at the facility because of lack of payment of facility fees			
Other (specify)			

PROGRAM EFFORT

Has your program/institution supported the promotion of RMC? If so, which types of interventions did your program use? Please add additional information in Comment section.

Table 2.

TYPE OF INTERVENTION SUPPORTED	YES	NO	COMMENT
Policy and Guidelines			
Advocacy to promote RMC			
Dedicated budget/resource mobilization			
Inclusion of this subject in local laws and regulations			
Related clinical guidelines and protocols			
Development of training and promotional materials (job aids) related to RMC			
Training and Quality Improvement			
Inclusion of this subject in training			
Inclusion of this subject in pre-service curricula			
Inclusion in quality improvement approaches (i.e., implementation of specific standards related to RMC)			
Infrastructure, materials, supplies			
Adequacy of infrastructure (i.e., to ensure privacy, accommodation of companion during labor and birth, freedom of movement during labor)			
Acquiring necessary 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)			
Community involvement			
Community activities, including campaigns			
Feedback/anonymous reporting unprofessional behaviors			
Other (specify)			

What aspects of RMC has your program/institution been promoting?

Table 3.

RMC ASPECTS	YES	NO	COMMENT
Respect for beliefs, traditions, and culture			
Protection of dignity, including avoidance of verbal abuse			
The right to information, confidentiality, and privacy			
Ensuring informed consent and respect for choices and preferences, including the right to companionship of choice wherever possible			
Freedom of movement during labor (i.e., walking around)			
Provision of continuous support during labor (i.e., provider not abandoning the woman)			
Choice of position for birth			
Keeping the newborn with the mother immediately after the birth			
Keeping mother and baby together 24 hours a day			
Avoid detaining of women in facilities because of lack of payment			
Prevention of institutional violence against women and newborns			
Other (specify)			

Has your program/institution used an operational definition of RMC, or another similar topic? Or has the program/institution used guiding principles for RMC? If so, please describe.

Table 4.

DEFINITION/GUIDING PRINCIPLE	YES	NO	COMMENT
Has the program/institution used an operational **definition of** RMC, or another similar topic?			
Has the program/institution used **guiding principles** for RMC? If so, please describe?			

Has your program/institution been monitoring RMC indicators related to policy, service readiness, or practice?

Table 5.

RMC INDICATORS	YES	NO	COMMENT
Readiness: Infrastructure or materials and resources (i.e., condition to ensure privacy, accommodation for birth companion, place for women to walk around during labor, resting place for health workers)			
Policy (admission of family members, person of choice to accompany during labor/birth, requirement of informed consent for procedures, mother and baby kept together throughout time in facility, prohibit detention in facility for lack of payment			
Practice (percentage of births with a companion, percentage of births in alternate position, mother and baby kept together, etc.)			
Other (specify)			

Has your program/institution been monitoring RMC indicators in the following domains?[2]

Table 6.

DOMAIN	YES	NO	COMMENT
Abandonment (or alternatively, continuity of care)			
Birth position/freedom of movement (or alternatively, denying of any choice)			
Cleanliness			
Companion (for labor and/or birth)			
Confidentiality of client information			
Allowing culturally appropriate practices, such as allowing woman/family to take placenta home if desired			
Delay in provision of needed care or available medications/supplies			
Discrimination and/or different treatment of HIV-positive clients			
Food and drink			
Maintaining mother–baby connection (not separating unnecessarily)			
Pain relief (during repair procedure, during birth)			

[2] For examples of items measured in surveys and facility assessments in these domains, please refer to MCHIP's RMC Measurement Workshop Report, April 2013

DOMAIN	YES	NO	COMMENT
Payment is affordable, costs are equitable (also attention to bribes, detention for lack of payment)			
Staffing adequate and gender-appropriate			
Physical abuse/force			
Privacy (also overcrowding and sharing beds)			
Sexual harassment			
Assault and rape			
Redress and accountability mechanisms for any of the above			
Greeting of client and support person			
Information exchange and understanding (provider-client), explanations, asking questions			
Emotional support			
Verbal abuse/scolding/shouting/insults			
Threat or coercive statements			
Consent/respect for autonomy or non-consented care, forced procedure			

From what data sources, does the institution collect data on RMC?

Table7.

DATA SOURCES	YES	NO	COMMENT
Routine or regular facility-based assessment, such as for ongoing quality improvement?			
In-depth facility-based study of RMC?			
Provider self-assessment?			
Supportive supervision?			
Policy and health system assessment?			
Community or population-based assessment of RMC?			
Service statistics for antenatal care (number of visits)			
Service statistics for labor and birth			
Service statistics for post-natal care			
Other?			