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Maternal and Child Health
Integrated Program

Respectful Maternity Care

Country experiences



Survey Report

November 2012

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This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00. The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

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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Abbreviations and Acronyms

ANC	Antenatal Care
IEC	Information, education, communication
IMBCI	International Mother Baby Childbirth Initiative
MCHIP	Maternal and Child Health Integrated Program
MMI	Model Maternities Initiative
MNH	Maternal and Newborn Health
NGO	Nongovernmental organization
RMC	Respectful Maternity Care
SBA	Skilled birth attendant
SBM-R	Standards Based Management and Recognition
TBA	Traditional Birth Attendant
TRAction	Translating Research into Action
USAID	United States Agency for International Development
WRA	White Ribbon Alliance

Executive Summary

This report describes the experiences gained during local and national efforts to prevent disrespect and abuse in maternity care. These efforts also promoted respectful maternity care (RMC), which recognizes that 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, such as having a companion wherever possible. Recognizing the importance of this subject, the United States Agency for International Development (USAID) has supported a three-pronged approach of advocacy, research, and support for implementation. With the White Ribbon Alliance working on advocacy for RMC and the Translating Research into Action (TRAction) project working on research, the Maternal and Child Health Integrated Program (MCHIP) has focused on support for field-level implementation. In this context, MCHIP conducted the RMC survey with the objective of collecting information from key stakeholders about their experience implementing interventions to promote RMC. A convenience sample of 48 individuals from 19 countries responded to a survey about disrespectful care and abuse in maternity care, approaches for prevention, and ways to promote RMC.

The RMC approach is centered on the individual and based on principles of ethics and respect for human rights. The Respectful Maternity Care Charter,¹ developed by the White Ribbon Alliance and RMC partners, is based on a framework of human rights and is a response to the growing body of evidence documenting disrespect and abuse of childbearing women.

USAID has long recognized the importance of prevention of disrespectful and abusive care and has long supported integration of respectful care in maternal health projects. Currently, USAID is supporting specific and coordinated efforts in advocacy and promotion through the White Ribbon Alliance, in research and the development of a strong evidence-based through University Research Co., LLC (URC), and in implementation through MCHIP, USAID Bureau for Global Health's flagship maternal, neonatal, and child health (MNCH) program. Therefore, MCHIP developed and conducted a survey with the objective of collecting information from key country stakeholders about their experiences implementing RMC interventions. Anecdotally, it was already known that disrespect and abuse is common in maternal health care, contributing to untold suffering, and discouraging women from seeking care in facilities. Further confirmation of these reports came from a landscape study by Bowser and Hill in 2010.²

This survey was based on a literature review of existing materials and documents related to promotion of RMC as well as humanization of birth, a similar movement that originated in Latin America. Potential respondents were identified through elaboration of contact lists of individuals and groups working in the RMC area. The initial list was drawn from the participant list for the III Conference on Humanization of Childbirth 2010 and expanded through networks of known participants involved with RMC. Surveys were sent electronically to this purposive sample of potential participants. Data collection was conducted March–May 2012.

This survey identified key areas of disrespect and abuse and associated factors related to: policy, infrastructure and resources, health care management; ethics and culture; knowledge, skills, attitudes and standards of practice in facilities and communities. This report summarizes

¹ Respectful Maternity Care Advisory Council, White Ribbon Alliance for Safe Motherhood (WRA). (2011). *Respectful maternity care: the universal rights of childbearing women*. Washington, DC. http://www.whiteribbonalliance.org/WRA/assets/File/Final_RMC_Charter.pdf.

² Bowser D and Hill K. 2010. *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*. USAID TRAction Project.

the experiences of selected countries, including programs, interventions, results, challenges, and recommendations.

A number of strategies and interventions to promote RMC were reported (Annex D). These are grouped into the categories of: 1) advocacy; 2) legal approaches; 3) interventions focused on the health facility (management, infrastructure, clinical practices, and interpersonal communications); 4) educational and training programs; 5) community; and 6) research and monitoring and evaluation.

Despite the challenge and the complexity of this subject, we found that there is interest in promoting RMC in many countries, that various interventions have been implemented to address this issue, that a variety of tools are available and that some consistent results have been produced. Finally, we describe the challenges, lessons learned, and recommendations provided by the key informants. We hope that this report will help inform actions to strengthen efforts to prevent disrespect and abuse and promote RMC around the world.

The survey information included here does not permit broad generalization for the represented countries. However, this report captures the perceptions and experiences of informants who have been working within the maternal health context. The information analyzed in this report can inform actions that can be applicable in similar contexts, and may enable readers to apply lessons learned in other settings with similar contexts.

Introduction

Significant progress has been made globally in maternal and neonatal health (MNH) care, and both maternal and neonatal mortality rates have dropped in recent decades.³ Strengthened legal frameworks and effective clinical and programmatic practices have improved the quality of services provided. Despite these improvements, access to quality services is not guaranteed for many, especially in developing countries.⁴ Even when services are available, care may be compromised by social, ethnic and cultural barriers, an unwelcoming reception at the health care facility, lack of privacy and information for the client, and disrespect and abuse. Bowser and Hill's landmark review of evidence for disrespect and abuse in facility-based childbirth (2010) identified numerous examples, including physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care, and detention in facilities⁵. They noted that women avoid seeking care in health facilities because of mistreatment, thus compromising the achievement of Millenium Development Goal 5—improve maternal health.

In recent years, a movement has been advancing to promote the implementation of more respectful maternity care, emphasizing the importance of underlying professional ethics and psycho-socio-cultural aspects of health care delivery as essential elements of care.⁶ As early as the 1970s in the United States and Canada, some recognition of the need for respectful care was made by doulas, midwives, women giving birth, and a few rare doctors and nurses, and so a movement developed for the humanization of childbirth. The Latin American and Caribbean Network for the Humanization of the Childbirth (RELACAHUPAN) was founded after the Childbirth & Birth Humanization Conference that took place in Ceará, Brazil, in November 2000. RELACAHUPAN is a set of national networks, groups and people that propose to improve the experience of childbirth and the way a baby is born. Also, by the late 2000s, there was a mention of obstetric violence in some laws addressing violence against women in South America.⁷ Overlapping with the humanization of childbirth movement, and with increasing momentum, is the respectful maternity care (RMC) movement.

RMC is an approach centered on the individual, based on principles of ethics and respect for human rights, and promotes practices that recognize women's preferences and women's and newborns' needs. The categories of disrespect and abuse and the corresponding rights are shown in the Table 1 below (Table 1).

³ World Health Organization (WHO). 2010. *Trends in Maternal Mortality 1990–2008*. Geneva. Lawn, et al. 2010. 3.6 Million Neonatal Deaths—What Is Progressing and What Is Not? *Seminars in Perinatology* 34:371–386.

⁴ Countdown Coverage Writing Group, Countdown to 2015 Core Group. Bryce J, Daelmans B, Dwivedi A et al. 2008. Countdown to 2015 for maternal, newborn, and child survival: the 2008 report on tracking coverage of interventions. *Lancet*; 371: 1247–58.

⁵ USAID TRAction Project. 2010. *Exploring Evidence and Action for Disrespect and Abuse in Facility-Based Childbirth*.

⁶ Lesley B, Davis-Floyd RE, Daviss B and Tritten J. (eds). 2009. *Birth Models That Work*. University of California Press. Davis-Floyd R., Cheyney M. 2009. Birth and the big bad wolf: An evolutionary perspective. In *Childbirth across Cultures: Ideas and Practices of Pregnancy, Childbirth, and the Postpartum*, edited by Helaine Selin and Pamela K. Stone, Springer, pp. 1-22

⁷ Personal correspondence Hélène Vadeboncoeur, Ph.D., independent childbirth researcher from Canada and member of the board of directors of the International MotherBaby Childbirth Organization.)

Table 1: Tackling Disrespect and Abuse: Seven Rights of Childbearing Women⁸

CATEGORY OF DISRESPECT AND ABUSE	CORRESPONDING RIGHT
1. Physical abuse	Freedom from harm and ill treatment
2. Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice wherever possible
3. Non-confidential care	Confidentiality, privacy
4. Non-dignified care (including verbal abuse)	Dignity, respect
5. Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
6. Abandonment or denial of care	Right to timely health care and to the highest attainable level of health
7. Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

The focus of the Maternal and Child Health Integrated Program (MCHIP) has been working collaboratively and in coordination with other partners active in this area, specifically supporting and complementing the advocacy work of White Ribbon Alliance (WRA) and the ongoing research efforts of the Translating Research into Action Project (TRAction) project. MCHIP’s focus has included summarizing program experience, developing program tools and templates, supporting countries interested in strengthening RMC programming, and supporting global advocacy efforts.

It is within this context that MCHIP conducted a survey with the objective of collecting information from key countries/project stakeholders about their experiences implementing interventions to prevent disrespect and abuse and to promote RMC. This report summarizes the findings and provides further information to strengthen efforts to promote RMC.

Methods

The survey was planned, developed, revised and conducted over a period of eight months.

1. Literature Review: A desk review of published and grey literature employed PubMed and Google search engines for a web-based search of relevant documents and articles, as well as a review of other materials from key informants. Search terms used included, “childbirth care,” “maternal and neonatal health,” “humanization,” and “disrespectful” and “respectful care.”
2. Sample: Identification of potential respondents was done through elaboration of contact lists of individuals and groups working in the RMC area. The initial list was started at the International Conference of Humanization of Childbirth Care, held in Brasilia, Brazil, in November 2010. Participants from this initial list were contacted and asked for their collaboration for completion/update of data and also to identify individuals and countries they considered successful in efforts to implement programs and projects to promote RMC.

⁸ White Ribbon Alliance. 2011. *Respectful Maternity Care Charter: The universal rights of childbearing women*. As seen in Bowser and Hill. 2010.

3. **Instrument:** A survey instrument was developed to collect information from country and project stakeholders about experiences, descriptions of interventions and activities, tools and resources used, main results, and challenges and lessons learned (Annex A). Iterations of the survey were reviewed by a group of experts in the field, and revisions made prior to conducting the survey. The survey was developed in English, Spanish, and Portuguese in order to reach a broad group of respondents.
4. **Data collection:** The survey tool was sent electronically to the identified sample of 80 individuals from 25 countries. There were 48 responders, a 60% return rate. Respondents were from 19 countries. (Annex B). The data collection was conducted from March to July 2012, and reminders were sent monthly for three months.
5. **Analysis:** Analysis began after data collection was completed. Descriptions of programs and experiences were categorized as were frequency of responses by categories. A summary of survey findings, interventions, and results, and countries with respondents can be found in Annexes C, D, and E. The report also describes several categories of promising interventions and describes resources used to implement programs, lessons learned, and recommendations on potential actions to promote respectful, non-abusive care at childbirth.

The quantity of data received from respondents was massive, with much of it relating to “evidence-based care” rather than to RMC as described in the WRA RMC Charter, found in the Table 1 above. Therefore, the analysis has been limited primarily to those responses that involved RMC as described in the RMC Charter.

Findings

PROFILE OF INFORMANTS

Of the 48 respondents for the survey, 40% were from Africa, 33% from Latin America, and the remaining 27% from Asia, Europe, and Oceania. The main areas of their work were training/teaching (37%), clinical practice (27%), technical advising/consulting (25%), program/management (23%), and 19% of them work in other areas, including research; information, education, and communication (IEC)/promotion; and advocacy (annex C). Seventy-three percent of the informants were female.

MISTREATMENT TO WOMEN IN LABOR WARD OR OTHER MATERNITY AREAS

Consistent with the literature, this survey revealed a spectrum of areas of abuse and disrespect, including physical abuse; non-consented, non-confidential, and non-dignified care; discrimination; abandonment; and detention in facilities.⁹

Examples of mistreatment in maternity care areas identified from the survey are listed in order of frequency.

⁹ Bowser and Hill, 2010; WRA. 2011. *Respectful Maternity Care: The universal rights of childbearing women*. Warren C. *Measuring disrespect and abuse during childbirth in Kenya: Heshima Mama Project*. A presentation at RMC Advisory Council Meeting, November 17, 2011)

Table 2: Examples of Disrespect and Abuse¹⁰

EXAMPLES	# (%) INFORMANTS
a. Lack of privacy	27 (56)
b. Performing harmful practices	25 (50)
c. Lack of information about the care provided	24 (50)
d. Lack of informed consent	24 (50)
e. Denying choice of position for birth	24 (50)
f. Verbal abuse (insult, intimidation, threats, coercion)	22 (46)
g. No choice of companion	20 (42)
h. Abandonment of care (leaving the woman alone or unattended)	20(42)
i. Lack of confidentiality	20 (42)
j. Denying drink and food during labor	20 (42)
k. Denying liberty of movement during labor	17 (35)
l. Discrimination based on ethnicity, race, or economic status, including denial of admission due to illegal immigration status	16 (33)
m. Unnecessary separation of mother and newborn after the birth	15 (31)
n. Physical abuse (slapping/hitting)	7 (15)
o. Detention of the woman in facility due to lack of payment of facility fees	7 (15)
p. Other	5 (13)

Other examples of mistreatment cited were:

- Poor or absent communication, failure to introduce oneself as a caregiver, address the woman by name, ask about her needs or questions, listen to the woman, or explain care.
- Long waits with little attention to the woman or her family.
- Overcharging in the health facility.

It was noted that even in developed countries like the United States, disrespectful maternity care may also occur. Often this occurs in subtle ways such as use of fear tactics and lack of balanced information to push a woman to have a cesarean section, dismissing birth plans as “ridiculous,” and limiting freedom of movement.

UNDERLYING FACTORS OF DISRESPECTFUL AND ABUSIVE MATERNITY CARE

While the underlying factors contributing to disrespectful and abusive maternity care, as stated by survey respondents, are similar to those found by Bowser and Hill, some areas received more mention in the survey. Bowser and Hill found that a weak health system and human resource shortages may contribute to provider demoralization and thus to disrespectful or abusive care, in the survey, greater mention was made about the contribution of health systems issues, such as facility infrastructure, resources, and commodities, to the lack of RMC.

¹⁰ Although evidence-based care is not directly referred to in the WRA RMC Charter, half of the respondents noted “performing harmful practices” and lack of evidence-based care as examples of non-RMC. The promotion of evidence-based care was, therefore, reflected in responses, but because these interventions and results are so broad in scope and not specific to RMC as defined in the charter, they are not included here.

Based on survey information, the following factors were associated with disrespect and abuse:

A. Policy

- National policy: lack of regulations and legal frameworks for health rights; failure to enforce existing laws or to apply policy or laws.
- Institutional policy: client rights and RMC not reflected in institutional policy; lack of, or failure to use, protocols, guidelines, and performance standards related to RMC; ignorance of the existing laws related to pregnancy, labor, and delivery care; norms that exclude fathers, family members, friends, traditional birth attendants (TBAs), and doulas from the labor and birth process.
- Cross-cutting issues(national/institutional/community): women and communities unaware of women’s rights in policy, or of laws that protect them; health care providers do not respect norms or rules and so work in an undisciplined way.

B. Facility infrastructure, physical resources, and commodities

- Lack of adequate infrastructure (physical space and environment).
- Lack of essential supplies and equipment.
- Poor facility conditions including extreme overcrowding with patient sharing beds, poor sanitation.
- Lack of resources for facilitating normal birth, e.g., birth stools, floor mats; lack of informational materials related to respectful maternity care.
- Few or no supplies for community midwives who work in rural/remote sites.

C. Human resources

- Inadequate staffing and resources, and little reward leading to high stress and frustration among skilled birth attendants (SBAs).
- Acute shortages of health workers.
- Staff underpaid or not paid.
- Few midwives participating in maternity care; and lack of credibility for midwives within the medical community.
- The thoughts and ideas of the medical hierarchy predominate over the thoughts of other care providers.
- Poor communication among medical professionals, with resistance to dialogue and change.
- Lack of support for the work of traditional midwives in remote areas; lack of motivation and interest in improving quality of services; health workers who have no love for the profession and no compassion for women; staff frustrated.

“Trainings on maternal health have a component of respectful maternity care but it hardly is translated into actions. The main difficulty is that, in India, the number of institutional deliveries has doubled in the last several years without corresponding increase in infrastructure, staff, and supplies; this results in crowded facilities that compromise several components of respectful maternal care.”
—Survey respondent

- Health worker attitudes: lack of “humanism” among professionals; lack of empathy and commitment of care providers.
- Few professionals with holistic vision that support RMC.

D. Knowledge and practice of health care providers

- Authoritarian culture in health services with socialization of health care providers into a hierarchical system of care; denigration of midwives by obstetricians.
- Lack of knowledge and skills of staff, including limited understanding of the normal, physiologic birth process and how to facilitate it.
- Lack of awareness of rights and gender issues; lack of harmonization of clinical care and treatment with respect for the woman as an individual.
- Attention focused on specific clinical issues without regard to a woman’s beliefs or culture or an understanding of the emotional and physical needs of women and babies.
- Outdated practices not supported by evidence.
- Professional resistance to changing practice routines based on evidence.
- Institutional/professional culture of performing unnecessary cesarean sections and/or overuse of unnecessary technology.
- Health team exercises power over people seeking care, with women being seen a “patient” with pathology rather than as an equal person who can participate in her own care.
- Abusive care as punishment for traditional practices.
- Institutionalized discrimination by ethnicity and socio-economic position.
- Pervasive levels of corruption in all areas of health services; institutional culture that assimilates and “normalizes” the practices of violence.

E. Knowledge and skill development

- Professional pre-service education: gaps in the education of professionals; out-dated curricula in pre-service institutions, which do not emphasize respectful care or evidence based approaches. Medicalized care, rather than woman-centered care, is taught in pre-service education; lack of RMC in undergraduate training of health teams; poor behavioral practices learned during trainings by senior professionals; lack of training sites that can serve as a model for provision of RMC.
- In-service education/training: lack of training and updating in best practices and respectful care.
- Lack of positive role models.

F. Management

- National level factors: poor distribution and management of human resources; managerial and political leadership with little knowledge about RMC issue; poor management of service delivery system; leaders and decision makers not chosen for technical ability but for political and economic reasons.

- Institutional/facility management: poor care and use of human resources; TBAs¹¹ are not allowed to work in facilities; lack of supportive supervision; lack of individual and institutional accountability and mechanisms that ensure RMC; lack of incentives for good and penalties for bad practices on health care; limited numbers of beds in facilities force health care providers to discharge women and their newborns earlier than is safe.

G. Ethnicity, gender, socio-economic, and culture

- Ethnicity/culture: belief that traditional but harmful practices should be preserved; lack of respect for minority cultures.
- “The project “Te Escucho” (I hear you) addresses the health team in maternity through a training process—reflection and action aimed at promoting respect for the rights of women and their babies and promoting gender equity... As part of the strategy we plan on incorporating online courses on multiculturalism and pregnancy, participation and empowerment in health services...”
—Survey respondent
- Society: lack of respect for basic human and civil rights prevalent in the society.
 - Gender: disempowerment and low status of women; influence of culture “to give birth with pain;” paradigm of care where the woman is the object and not the subject.
 - Socio-economic: institutionalized racism/classism by providers from high socio-economic background and different ethnicity/cultural background from clients.
 - Culture: generalized lack of respect and disregard for human life; lack of respect for the woman’s culture.

H. Communities

- Lack of awareness among pregnant women and families of their rights.
- Lack of understanding of healthy practices during pregnancy, labor and birth.
- Limited demands from mothers for quality care services.
- Lack of information through the media.
- Lack of availability of community-level service providers, such as community midwives.

I. Factors identified in developed countries

- Lack of effective and comprehensive education for health professionals, including physicians, about the process of normal labor and birth and the non-clinical aspects of care.
- Lack of understanding of the role of a labor-support person.
- Provider perception that birth is highly dangerous for women and for their babies.
- Unequal power relationships among professionals (physician, nurse).
- Birth is hospital territory: the woman is a “patient,” she belongs to the institution (the facility) and the baby, even more so, belongs also to the institution.
- Rigid protocols.
- Overuse of technology to support clinical practice with corresponding decrease of clinical skills.

¹¹ While TBAs are not considered skilled birth attendants, they may have a role during childbirth as a companion or support person.

- Lack of midwives as specialists in normal care.
- Widespread adoption of medicalized model of birth. Denigration, and sometimes overt humiliation, of women who desire a normal birth in the hospital.
- Fear of legal repercussions and policies/guidelines with excessive emphasis on avoiding risk frames maternity care.

WAYS IN WHICH THE ISSUE OF RESPECTFUL CARE HAS BEEN ADDRESSED

Just as the types of abuse are varied, and the underlying factors can be myriad, so the ways in which RMC has been addressed are diverse. While a number of reports and articles have attempted to describe the types and causes of abuse and disrespect in maternity care, less has been written about interventions that are being used to address this issue.

These following categories of interventions were mentioned by survey respondents as ways to prevent disrespect and abuse and promote RMC. They are listed in the order of frequency.

Table 3: Types of Interventions to Address Respectful Maternity Care

TYPE OF INTERVENTION	# INFORMANTS (%)
a. Strengthening training	29 (60)
b. Implementing quality improvement approaches	28 (58)
c. Developing clinical guidelines and protocols	28 (58)
d. Implementing community activities, including campaigns	22 (46)
e. Strengthening local laws and regulations	20 (42)
f. Advocacy, including initiatives and clients' rights charter	3 (6)
g. Other	12 (25)

Other types of interventions mentioned:

- Supporting women who want to give birth, sharing responsibility with their care provider.
- Professionalizing midwifery so that midwives have the autonomy to be primary care providers in partnership with women and their families in the community.

“New standards in the humanization of service and quality improvement. Also in Law 1438 of 2011; reform of the health system is included in Article 3—principles of the Social Security System in Health, contain equality, rights prevalence, differential focus, equity, quality, humane care.
—Survey respondent in Colombia

MAIN STRATEGIES OR INTERVENTIONS RELATED TO PREVENTION OF DISRESPECT AND ABUSE AND PROMOTION OF RMC

Several strategies or interventions related to the promotion of RMC have been implemented in countries represented (Annex D). These interventions are categorized as follows: 1) advocacy; 2) laws, policies, and protocols; 3) health facility interventions; 4) educational and training programs; 5) community interventions; 6) research, monitoring, and evaluation interventions. Of course, there will be some overlap between the subcategories. Listed below are the strategies and interventions by categories with the respective countries where they have been implemented in brackets. Though these strategies/interventions may also have been implemented in other countries, we have only recorded those countries that are mentioned in survey responses.

1. Advocacy (efforts to promote respectful care)

- Strengthening obstetric provincial networks (Argentina)
- National campaign for the promotion of the “humanization of childbirth” care (Brazil)
- Campaign for normal birth (England)
- Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN). This network was created in 2000 and includes Latin American and Caribbean countries (LAC), Spain and Spanish-speaking U.S. organizations. It promotes development of laws, standards, and regulations that favor evidence-based care and prevent the use of unnecessary interventions (LAC, Spain, and Spanish-speaking US).
- Development of IEC materials on RMC - posters, pamphlets, etc. (Mozambique)

2. Laws, Policies, and National Protocols

- Establishment of policies and guidelines to support RMC as well as rules and regulations that discourage disrespectful care that is brought to the notice of appropriate authorities (India)
- Investment in Social Security System in Health, including equality rights, equity, quality, humane care issues (Colombia)
- Law permitting presence of companion during labor and delivery in health facilities (Canada, Brazil)
- Legalization of professional midwifery (Canada)
- Legal protection of children and adolescents; and a basic rights law for the right of women to live free of violence (Venezuela);
- Establishment of laws, regulations, and decrees that favor RMC practices, implementation of evidence-based practices, and avoidance of unnecessary interventions (Uruguay, Venezuela, Canada)
- Updating of national manuals, protocols, and guidelines to include RMC (Guinea, Mozambique, Brazil, Mexico, Paraguay)
- Adoption of official standard for reproductive health care that includes RMC (Venezuela)
- Establishment of governance and policy in partnership with women, i.e., women as members of several organizations and as voting members influencing policy, education, regulation, and practice (New Zealand)
- Establishment of political strategies that give midwives autonomy to practice independently; establishment of partnership between community midwives and hospitals with midwife to provide feedback to help shape policies; establishment of continuity of care—same midwife throughout pregnancy, labor, postpartum (New Zealand)

3. Interventions Focused on the Health Facility

A. Campaigns and Initiatives to Affect Service Provision

- Implementation of the national Model Maternities Initiative (MMI) since 2009 to improve quality and humanization of care in MNH services; model sites also serve as clinical training sites; includes scale-up of high-impact interventions. (Mozambique)
- Large scale implementation of the Baby Friendly Hospital Initiative by UNICEF (Nigeria, Canada)

- Implementing the Mother-Friendly Childbirth Initiative (MFCI)—precursor to the International MotherBaby Childbirth Initiative (IMBCI) (USA)
- Implementation of the IMBCI developed in 2008 with international input from childbirth experts and consumers. The IMBCI has been implemented in many countries due to birth activist groups. It is currently being pilot-tested in eight hospitals (Austria, Canada, Mexico, Brazil, Philippines, India, South Africa, and Mozambique)
- Use of guidelines to facilitate lower cesarean rates (Canada)
- Implementing the “Te Escucho Project” (I hear you) that promotes a gender-focused approach in public maternity hospitals; implementation of the “Safe and Family-Focused Motherhood Initiative (Argentina)
- Implementation of a maternal mortality reduction program among mothers assisted by traditional midwives; this program was modeled on a pilot program in Rubel Tzul, an isolated community in Guatemala (Uruguay)
- Monitoring the Code of Consumer Rights for informed choice and consent, a maternity system that is centered on the women; women are allowed to choose their care provider (midwife or doctor) and are aware of their rights (New Zealand)
- Implementation of the Keeping Childbirth Natural and Dynamic Programme that aims to establish a national referral criteria and care pathway and promotes the midwife as the first point of professional contact in pregnancy and the lead maternity professional for normal birth regardless of birth setting (England)

B. Interventions Related to Infrastructure and Management

- Supportive supervision visits to health facilities (Guinea, Mozambique)
- Review of practices by quality assurance committees at district level (India)
- Commission on Respectful Care (Comision de Trato Digno, the commission is a subgroup under the National Committee for Quality and linked to the National Health Council (Peru)
- Investment for better salaries for health workers (Netherlands)
- Investment to improve health facility conditions, including provision for privacy (Guinea, Mozambique)

C. Interventions to strengthen clinical practices¹²

- Promoting birth in the position that women desire and skin-to-skin contact of the baby (Guinea, Mozambique, Brazil)
- Promotion of (through the MMI in Mozambique) respect for beliefs, traditions, and culture; the right to information and privacy; choice of a companion; liberty of movement and position; skin-to-skin contact and early breastfeeding; appropriate use of technology and effective lifesaving interventions; and prevention of violence and disrespectful care (Mozambique, Brazil)
- Implementing violence screening for pregnant women; health services that promote respect for culture and gender, and that are evidence-based (e.g., respect for preference for birth position) (Peru).
- Strong role of midwives in collaboration with other care providers (Netherlands, New Zealand)

¹² Although evidence-based care is not directly referred to in the WRA RMC Charter, a substantial number of respondents indicated that all evidence-based clinical MNH care is part of RMC. Interventions to promote evidence-based care in general was, therefore, reflected in responses, but because these interventions are so broad in scope and not specific to RMC as defined in the charter, they are not included here.

- Consumer feedback on midwifery-led maternity care; this feedback is part of the midwife's practice review done every two years; a review panel includes midwives and consumers (New Zealand)
- Encouragement of fathers/partners and families to stay during labor and birth, choice of place of birth; and state payment for all births, including home births (New Zealand)
- Implementation of the Jhpiego SBM-R (Standard Based Management and Recognition) quality approach in select areas of the country. Standards include evidence-based practices and woman-centered care (Guinea, Mozambique, Zimbabwe)
- Development of checklists for MNH care, including standards related to RMC (Guinea, Mozambique, Colombia, Peru)
- Development of tools to support supervision (Mozambique)
- In some facilities, instituting mandatory consents at hospital admission; improving communication and patient participation in care; strict regulations to ensure respect for privacy; permission to have a doula or other companion during childbirth (USA)
- Inclusion of attitude and communication tasks in performance standards and checklists (Nigeria, Guinea, Mozambique)

4. Education and Training¹³

A. *Pre-service*

- Revision of reproductive health modules for medical school to include evidence-based practices (Mozambique)
- Revision of curriculum of School of Nursing, introducing aspects of respectful care (Guinea, Mozambique)
- Investment in pre-service education and in postgraduate training of resident doctors (Nigeria)
- Development of learning resources for training professionals (Guinea, Mozambique)
- Improving performance with classroom assessment methods (Peru)
- Training health workers in interpersonal communication (Nigeria)

B. *In-service*

- Introduction of aspects related to RMC in the clinical in-service training course (Guinea, Mozambique, India)
- Investment in training health workers (Guinea, Mozambique, Mexico, Paraguay, Peru)
- Strengthening training through the identification of training needs and use of competence-based training methodology with a strong practical component (Mozambique)
- Classroom and online courses on multiculturalism and pregnancy, participation and empowerment in health services, maternal and neonatal health, and disability; and assessment on gender and rights (Argentina)
- National and regional seminars for professionals and managers to promote the humanization of childbirth care (Brazil)
- Qualification of emergency, MNH care through courses of ALSO—Advanced Life Support in Obstetrics (Brazil)
- Conducting specialized courses in midwifery (Brazil)

¹³ Although respondents did not clarify, it is assumed that each revision of training materials, improvement of training, or conducting of training included aspects of RMC

C. Community-based interventions

- Radio and TV programs to disseminate RMC content (Equatorial Guinea)
- Promotion of community mobilization through the implementation of activities involving community leaders and community health workers (Mozambique)
- Community mobilization through linkage of community with facility committees (Nigeria)
- Awareness campaigns in communities run through mass media such as print and electronic media, and organizing focus group discussions in community and health education areas for communities (India)
- Training of community volunteers (doulas) to support woman during labor and birth (Brazil)
- Advocacy groups to publicized the existence of violence in childbirth and to spread the model of humanized care through open campaigns targeting the public as well as the medical community (Mexico)
- Training of ethnic groups, vulnerable populations; promotion of a written birth plan developed during ANC to encourage women to plan for an institutional delivery; development of a poster on the right to quality care; development of best practice guidelines (Peru)

D. Research, monitoring and evaluation

- Systematic performance standards measurement in facilities (Guinea, Mozambique)
- Observational quality of care study carried out in 2011 (Mozambique)
- Dissemination and monitoring of maternal and neonatal indicators that include aspects of RMC (Brazil, Mozambique)

EXAMPLES OF ASPECTS OF RESPECTFUL MATERNITY CARE PROMOTED

The following table describes examples of aspects of RMC promoted in the countries of the respondents. Respondents were ask to rate each aspect of care on a graduated scale with “4” indicating more widespread application of an aspect, and “1” indicating less widespread application; and “0” indicating that this aspect of RMC has not been observed. The numbers in the columns below indicate the average ranking of respondents for each aspect of respectful care.

Table 4: Aspects of Respectful Care

ASPECTS OF RESPECTFUL CARE	RANK 1-4 ¹⁴
a. Provision of drug-free comfort and pain relief methods during labor	1.8
b. Provision of continuous support during labor (i.e., lack of abandonment)	2.1
c. Choice of position for birth	2.1
d. Choice of companion during delivery	2.2
e. Mutually respectful and collaborative relationship among all cadres of care providers	2.2
f. Provision of a continuum of collaborative care with all relevant health care providers, institutions, and organizations	2.2
g. Avoidance of the overuse of drugs and technology (such as oxytocin augmentation, episiotomy, cesarean section, newborn blood gases, incubation, sonograms)	2.3
h. Provision of drink and food during normal labor	2.3
i. Choice of companion during labor	2.4

¹⁴ Ranked on scale from 1-4, from least widely reported to most widely reported

ASPECTS OF RESPECTFUL CARE	RANK 1-4 ¹⁴
j. Prevention of institutional violence against women and babies, including disrespectful care	2.4
k. Respect for beliefs, traditions and culture	2.5
l. The right to information, confidentiality, and privacy	2.6
m. Early breastfeeding (within the first hour after birth)	2.6
n. Provision of care that seeks to avoid potentially harmful procedures and practices	2.6
o. Evidence based care that enhances and optimizes the normal processes of pregnancy, birth, and postpartum	2.6
p. Freedom of movement during labor (e.g., walking, moving around)	2.7
q. Skin-to-skin contact of the newborn with the mother immediately after the birth for at least the first hour	2.8
r. Avoidance of detention in facilities due to lack of payment	2.9
s. Keeping mother and baby together 24 hours a day	2.9
t. Appropriate use of technology and effective lifesaving interventions	3.0
u. Promoting breastfeeding on demand	3.1
v. Other	4.0

Other:

Provision of residence for mothers; active participation of parents in the care of hospitalized newborns; siblings and grandparents visits; training on gender rights and health equipment; information on rights of family; parent training in newborn care; hospital-based training in neonatal CPR; comprehensive preparation for parenthood rights-based and gender-monitoring networks for sick newborn care; prevention of excessive coercion—women being forced to undergo medical procedures.

SOURCES OF FUNDS USED TO SUPPORT IMPLEMENTATION OF STRATEGIES

The main sources of funds used to support the implementation of strategies or interventions related to RMC are indicated in the following table. They are listed in the order of frequency that they were mention with the total number and percentage of informants for each.

Table 5: Source of Funds

MAIN SOURCE OF FUNDS	NUMBER (%) OF INFORMANTS
a. National government	28 (58)
b. Non-governmental non-profit	25 (52)
c. Private Sector	7 (15)
d. Other	7 (15)

Other:

- Professional organizations and insurance
- Universities
- Partners for bilateral cooperation (USAID, Canadian International Cooperation, Ireland, Norway, UK Department for International Development), international cooperation

partners (UN agencies: UNFPA, WHO, UNICEF, World Bank, World Food Program, and others).

MAIN RESULTS ACHIEVED IN THE WORK IMPLEMENTED IN COUNTRIES

The main results mentioned by respondents are listed below with the indication of the respective countries (more details in Annex D):

- National strategic document to support the implementation of RMC developed (Mozambique, Brazil)
- MNH guidelines and protocols revised to include RMC aspects (Equatorial Guinea, Mozambique, Brazil)
- Government officials sensitized on the importance of mainstreaming health, rights, and respectful care (Argentina, Brazil, Mozambique)
- New focus of attention on the rights of women during pregnancy (Uruguay)
- Health workers trained in MNH evidence-based and respectful care (Equatorial Guinea, Mozambique, Argentina, Brazil)
- Increase in staff commitment and engagement (Argentina, Brazil and Mozambique)
- Health facilities infrastructure and materials improved (Equatorial Guinea, Mozambique)
- Residence for mothers built (Argentina)
- Midwifery schools opened (in several countries of LAC)¹⁵
- Education provided to many communities and rural traditional birth attendants (Uruguay)
- Approximately 15 related organizations created with support of RELACAHUPAN in Latin America and the Caribbean to promote RMC
- Some good maternity practices such as avoidance of episiotomy, early and on-demand breastfeeding have become a routine part of maternity care (Nigeria)
- Compared to 30 years ago, there are more birthing rooms, more women with their husband/partner with them in labor, and breastfeeding has increased (Canada)
- Several hospitals have been granted the “baby-friendly” designation (Canada)
- Midwifery has been legalized in several Canadian provinces (Canada)¹⁶
- Increased rates of maternity services utilization (Equatorial Guinea, Mozambique)
- Increased institutional delivery care (Equatorial Guinea, Mozambique)
- Malnutrition of infants associated with breastfeeding reduced due to milk campaign (Brazil)
- Rate of hospital acquired infections decreased (Argentina)
- Reduction of institutional maternal and neonatal mortality and morbidity¹⁷ (Equatorial Guinea, Mozambique, Argentina, Brazil)
- Client satisfaction with maternity services increased (Mozambique)

¹⁵ Respondent considered this result linked to RMC because the midwifery model is usually less medicalized and conducive to RMC; and the opening of additional schools means that more women will have access to midwives

¹⁶ Respondent considered this result linked to RMC because legalization of midwifery gives women more access to midwifery and less medicalized care

¹⁷ Respondent considered that this result was linked to RMC because RMC promotes evidence-based practices

- Improved indicators related to RMC in New Zealand according to 2008 data; Significant reduction in rate of overused technologies (New Zealand)

MAIN TOOLS AND RESOURCES USED TO IMPLEMENT STRATEGIES

The following are the tools and resources mentioned by respondents as being used to implement strategies/interventions/activities related to RMC, with their respective countries noted in parentheses:

- Law that allows companion during childbirth (Canada, Brazil)
- MNH guidelines, manuals, protocols, partogram, performance standards and practices checklists (Guinea, Mozambique, Nigeria, Brazil)
- Jhpiego SBM-R tools (Guinea, Mozambique)
- IEC materials on RMC (Mozambique, India, Brazil)
- Anatomical models and other equipment for training practice (Guine, Mozambique)
- Medical records and perinatal information system with record books (Guine, Mozambique, Argentina, Brazil)
- Tools for assessment and supervisions (Mozambique, Argentina)
- In-service training resources, such as Jhpiego's comprehensive and basic emergency obstetric and newborn care (EMONC) training resources available on Jhpiego's web site (Nigeria, India)
- Advanced Life Support for Obstetrics (ALSO) materials (Brazil)
- Reproductive and MNH materials from WHO (Guine, Mozambique)
- WHO manual about transforming health services focused on rights and gender (Argentina)
- Health training manual and child rights education for professionals (FLACSO-CRED PRO) (Argentina)
- Audiovisual aids (Zimbabwe)
- Material developed for community-based workers and trainers (India)
- The virtual course for TBAs and the course for maternal health educators (Uruguay).
- Policy and guideline documents accessible to Provincial Colleges of Midwives (Canada)
- Protocols are easily accessible online hospital employees (USA)
- Creating awareness through education, counseling, and support: www.patth.org (USA)
- Campaign for normal birth ¹⁸(England)
- Keeping Childbirth Natural and Dynamic Programme (England)¹⁹
- Birth summary with topics that midwives should follow, i.e., consent, birth position, type of analgesia (including water, homeopaths, massage), skin-to-skin contact; breastfeeding (New Zealand)

¹⁸ <http://www.rcmnormalbirth.org.uk>

¹⁹ <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nursing/naturalchildbirth>); and <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH073312>

- Feedback forms for midwives in all settings to be sent to the New Zealand College of Midwives for re-certification every 2 years (New Zealand)
- Information from IMBCI, in multiple languages, can be accessed on its website: www.imbci.org
- The Book of Images, the virtual course for TBAs, and other materials that can be downloaded on the RELACAHUPAN website: www.relacahupan.net

MAIN CHALLENGES FACED IN IMPLEMENTATION OF STRATEGIES

The informants identified a number of challenges faced during the implementation of strategies/interventions/activities to promote RMC. These are organized into the following categories: 1) legal framework and governance, 2) resources, 3) management, 4) knowledge/skills, 5) attitude, and 6) community. Each challenge is followed by country (in parenthesis) of the respondent providing the response:

1. Legal Framework and Governance

- Lack of laws to promote RMC (Brazil)
- Lack of national policy to address RMC (Nigeria, Peru)
- Lack of attention to rights, ethics, and gender issues (Argentina)
- Limited political will, institutional commitments, and plans to implement RMC (India, Brazil, Canada)
- RMC practices not incorporated in national standards and protocols (India, global)
- Health practices based on biomedical paradigms that do not take into account the social determinants of health (Argentina)
- Lack of an enabling environment for RMC (New Zealand)

2. Resources

- Poor infrastructure and limited space to ensure the implementation of all recommendations especially for the guarantee of privacy (Mozambique, India)
- Limited human resources (Mozambique, Equatorial Guinea)
- Heavy work load (India, Mozambique, Equatorial Guinea)
- Lack of financial and material resources (Mozambique, Nigeria, Peru, Global)
- Stock-outs of medicine (Mozambique)
- Geographic distance of the population from some health facilities (Mozambique)
- Lack of mothers' waiting homes in some districts (Mozambique)
- Nursing shortage (Canada)

3. Management

- Large staff turnover (Equatorial Guinea, Mozambique, Peru)
- Poor management of human resources (Equatorial Guinea)
- Limited health system capacity and organization (Mexico)
- The lack of accountability of doctors and their dominance over maternity care (Canada)

- Weak governmental support of midwifery (Canada)
- Lack of team work and the understanding that change benefits all (Netherlands)

4. Knowledge and Skills

- Unqualified health workers (Equatorial Guinea)
- Insufficient training for health worker (Zimbabwe, India, Paraguay)
- Lack of availability of health workers to attend training (Paraguay)
- Lack of training to improve providers' client awareness (Zimbabwe)
- Lack of knowledge related to RMC practices (Brazil)
- Pre-service training programs do not include aspects of cultural awareness and respect (Peru)
- Lack of specific training related to RMC for nurses. (Canada)
- Incorrect information given to caregivers, e.g., ob-gyns, anesthetists, pediatricians, nurses (Canada)

5. Attitude

- Resistance to change in practice and paradigm (Equatorial Guinea, Mozambique, Nigeria, India, Argentina, Mexico, US)
- Little cooperation from some colleagues (Equatorial Guinea)
- Human resources with little interest and motivation (Equatorial Guinea, Mozambique, Nigeria)
- Resistance to accept evidence-based guidance and standards (Mozambique)
- Changing institutional culture (Argentina)

6. Community

- Harmful practices and beliefs of some groups (Equatorial Guinea)
- Low level of women's education (Mozambique)
- Lack of community involvement (Argentina)
- Lack of women's and families' empowerment (Uruguay, New Zealand)
- "Social issues" (Chile)

Conclusions, Lessons Learned and Recommendations

Despite the challenges and complexity of this subject, we found, based on the information provided, that there is some interest in promoting RMC around the world, some interventions have been implemented to address this issue, tools are available, and some results are consistently evident. We will describe these findings as well as the lessons learned and recommendations provided by these key informants.

LESSONS LEARNED

Respondents contributed a number of lessons learned. These are synthesized and presented under the same categories used for challenges above; 1) legal framework and governance; 2) resources; 3) management; 4) knowledge/skills; 5) attitude; 6) community; and 7) advocacy/communication. During the process of promoting the implementation of RMC in these selected countries it was learned that:

1. Legal Framework and Governance

- Successful implementation of RMC at the service delivery level requires political commitment and influence from the national as well as the regional and local levels. Policy, guidelines, and standards, as well as regional health plans must promote RMC at all levels. And adequate budgetary investment is required for implementation and scale up. Regional and local authorities should work jointly with nongovernmental organizations (NGOs) and donors in the region, so that all interventions will effectively contribute to an integrated strategy, timely implementation, and the desired results.

2. Resources

- Adequate budgetary commitment is essential for implementation and scale up of RMC. Government investment needs to be sufficient to provide for basic infrastructure, supplies, equipment, and commodities.

3. Management

- While change can be difficult, RMC goals are more effectively reached through teamwork and the collaboration of stakeholders at all levels, from providers to institutions. Committed teams need to be valued and continually supported, including the provision of tools necessary to implement RMC. A baseline assessment of organizational culture is foundational to planning or implementing change. And then, the early demonstration of high-impact results provides initial motivation. Teams must be continuously supported and encouraged and should feel valued. But change will continue to require negotiation.
- Leadership has a key role in the process of quality improvement and the promotion of RMC. And training, supervision, and continued monitoring are essential to ensure continued progress.
- Even with these requirements in place, setbacks are inevitable, but should stimulate renewed efforts with more creative and powerful methods to achieve RMC. Some people will be more resistant to change, and so managers and colleagues will need to patiently help those who resist change to gradually understand the change proposed, so that they become partners and advocates. During the challenging times, as well as the times when progress is evident, management must be consistent, never arrogant or rude, but always calm.
- The medical community is often strongly hierarchical, with physicians expecting to be in control. But again, patience and respect are key to achieving change. Maternity care does not need to be centralized, but made more accessible through the promotion of a midwifery model of care. And respectful care should include respectful treatment of caregivers as well as respectful care for women.

4. Knowledge/Skills

- Investment in capacity building is essential. Health care staff may not understand the importance of respectful care, and/or may not have the skills to incorporate RMC into clinical care. And as scientific evidence changes, new practices need to be incorporated in the care provided. While individual care providers need to be involved in RMC capacity development, also institutions such as scientific societies, professional associations, university training centers and groups of local “champions” need to be involved.

5. Attitude

- An effective RMC model requires a gender and rights perspective that incorporates respect between clients/communities and providers. Improvement in the attitude of health care providers towards patients and their families contributes to an increase in demand and use of services. Health workers are motivated when they see tangible results. On the other hand, health care providers may justify violation of clients’ rights with the excuse that their own rights are violated, e.g., poor labor laws, workers’ rights not respected. Attitudes of respect require mutual trust and acknowledgement among all involved in RMC.

6. Community

- Ensuring respectful care may contribute to user satisfaction and the use of services, thereby improving maternal and neonatal health. Even one well-informed woman, who is listened to, respected, and well cared for will inform others in her community (multiplier effect) and improve the reputation of the health facility. It is always important to understand the expectation of the community about respectful care.

7. Advocacy/Communication

- Advocacy at all levels is important in creating networks and partnerships between different individuals and institutions. A wide range of stakeholders, including government, NGOs, and civil society must also be involved. It is recognized that information gaps exist on rights and gender, as well as in RMC in general. However, effective advocacy efforts, especially for scale up, may involve the collection and dissemination of local, national, and international experiences in similar settings. And at the center of RMC are women. Therefore women need to be educated about birth and respectful care at birth so that change can also come from them, as well as from educated men who can be actively involved in decision-making. Client demand is important.

RECOMMENDATIONS

Survey respondents were asked to provide “recommendations to countries or institutions wishing to implement strategies/interventions activities to promote humanized/respectful maternity care.” Participant responses are presented under the same categories used for challenges and lessons learned above: 1) legal framework and governance, 2) resources, 3) management, 4) knowledge/skills, 5) attitude, 6) community, and 7) advocacy/communication.

1. Legal Framework and Governance

- Incorporate key elements of RMC into appropriate laws, rules, protocols, and standards
- Develop legislation that supports client-friendly services and makes institutions accountable

- Develop a regulatory framework to guide implementation of laws and public policies
- Develop policies, strategies, and work plans that clearly define and address disrespect and abuse and promote RMC
- Ensure ownership of this process by the government
- Adopt initiatives that promote RMC such as IMBCI's 10 Steps to Optimal Maternity Care

2. Resources

- Ensure strong political commitment and sufficient funding from the government to achieve meaningful and sustainable results. Commitment should translate into:
 - Sufficient funding for piloting and subsequent roll out of implementation plan
 - Sufficient funding for health workers' wages and essential tools
 - Sufficient funding for physical and material improvement of health facility infrastructure
 - Sufficient funding to support general infrastructure, e.g., roads to access facilities
 - Sufficient funding to develop at least one model demonstration site
- Include resources for women who have experienced obstetrical violence
- Invest in an adequate referral system that includes linkages to the surveillance system (health management information system) and the community
- Invest in girl-child education in order to empower women
- Provide support to individuals and NGOs working for RMC

3. Management

- Develop and institute clearly defined standards, guidelines, protocols, job aids, and behavior change communication activities to support RMC and to put the childbearing woman at the center of the process
- Use a whole team approach to RMC training and staff development, which will promote teamwork and help prevent staff from feeling isolated
- Ensure regular monitoring and supervision of health care providers' performance
- Establish patient charters to guide monitoring of maternal care services
- When establishing a management system that promotes quality improvement of services:
 - Incorporate goals and standards in a phased manner, with simpler goals and early success to motivate continued efforts
 - Incorporate performance-based rewards for women-centered services
 - Invest in good relationships with an interdisciplinary team of stakeholders through consensus building, regular meetings, and careful coordination
 - Track MNH outcome and process indicators to document effectiveness of approach
- Exchange information and program successes with authorities and with other countries that are seeking a model for their own country

4. Knowledge/Skills

- Invest in the training of health workers in clinical, communication, and management skills
- Work with pre-service training institutes, in-service trainers, and professional organizations to include prevention of disrespect and abuse and promotion of RMC in all programs related to MNH and reproductive health
- Create a pool of trainers who also act as supportive supervisors
- Develop short training activities to improve access and reduce staff time away from posts
- Develop comprehensive assessment models and new approaches that will generate evidence
- Include ethical and interpersonal communication in programs to expand clinical capacity
- Promote the use of evidence in decision making, including rational use of technology
- “First do no harm”
- Identify knowledge gaps, and conduct appropriate research concerning:
 - Effective interventions
 - Successful practices and policies regarding abuse and disrespect in obstetrical care
 - Effective birth models
 - Grass-roots organizations that promote RMC
 - Cost-effectiveness of programs and interventions

5. Attitude

- Include content to strengthen ethical and moral values, and to address client-provider interaction and cultural adaptation and respect in pre-service and in-service training
- Use a participatory approach to behavior change, giving sufficient attention to those who are resistant to change
- Conduct perception surveys (baseline and periodic) to monitor the progress of strategies
- Remember that health workers may not promote RMC because they lack knowledge, have a heavy workload, and/or do not have sufficient resources to work efficiently and effectively; and not because they are inherently bad people who want to harm patients
- Work in any forum possible, and with women at every level, as well as with those who are resistant to change
- Have patience and creativity
- Begin as soon as possible and move one step at a time

6. Community

- Include childbearing-age women in every community as stakeholders
- Adapt strategies and standards to the country's reality
- Include in any program to promote RMC a quality assurance component with a system to incorporate feedback from communities/women/clients, including women and their stories
- Share results about RMC promotion with communities and staff

- Include a focus on understanding rural and isolated communities, including midwives and health promoters in these communities
- Promote awareness about client's rights through radio and other media (public service announcements)

7. Advocacy/Communication

- Advocate at all levels from the beginning, building working partnerships and collaboration among all stakeholders
- Address difficult situations in the early phases of planning and implementation
- Participate in meetings and international conferences related to RMC
- Give political visibility to RMC and its benefits
- Generate an effective communication strategy that reaches all stakeholders
- Use media campaigns to raise awareness
- Link RMC awareness to international events such as Women's Day, World Respected Childbirth Week, Day of Action for Women's Health on May 28, World Breastfeeding Week, Violence Against Women Awareness Month
- Engage the professional associations and academia as advocates
- Advocate with the private health care system to promote RMC and its economic benefits
- Identify champions at central and provincial levels
- Identify best practices and success stories, and adapt and apply them in the local situation as appropriate
- Support midwives who can work autonomously within a variety of settings
- Publicize the economic benefits of humanized birth

CONCLUSIONS

Survey respondents provided a broad array of insights from their experiences with RMC, and the lack thereof, in many cases. The field perspective is invaluable in showing us what is really happening on the ground, thus enabling programmers and technical advisors to provide more knowledgeable support and assistance to programs. Many of the lessons learned and recommendations from the respondents reflect an ambitious and aggressive approach to implementation of the RMC agenda. However, we can be inspired and encouraged by the energy and aspiration that our colleagues in the field are bringing to the promotion of RMC in their own countries and globally.

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Annex A: Data Collection Questionnaire (English)

INTRODUCTION

Important progress has been made around the world related to reproductive health (RH) and maternal neonatal health (MNH) improvement, particularly through strengthened legal frameworks and evidence for effective clinical and programmatic practices. Despite these improvements, access to quality RH and MNH services is not yet guaranteed for many, especially in developing countries. Some of the contributing factors compromising quality of care lies within the ethical-socio-cultural dimension, which includes issues such as an unwelcoming reception at the health care facility, lack of privacy and information to the client, use of non-evidence based practices, overuse of drugs and technology, disrespect and even abuse. A review of the evidence has identified examples of abuse during childbirth: physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment of care and detention in facilities. Many women avoid seeking care in health facilities because of this mistreatment which compromise the achievement of MDG5.

In recent years, a movement has been advancing slowly but progressively to promote the implementation of a more humanized / respectful maternity care, emphasizing the importance of the underlying professional ethics and psycho-socio-cultural aspects of health care delivery as essential elements of care. The “humanized/respectful maternity care” can be defined as an approach centered on the individual, based on principles of ethics and respect for human rights, promoting evidence-based practices that recognize women’s preferences and women’s and newborns’ needs. Approaches used to promote humanized / respectful maternity care include²⁰: adopting a human rights framework and stigma reduction approaches; quality and performance improvement process; improving accountability.

OBJECTIVE

We are conducting this survey to assess your views on this topic as well as your thoughts about your experience in implementing and supporting interventions to promote respectful maternity care. Your contribution will help inform actions that will strengthen efforts to promote respectful maternity care.

Many thanks for your collaboration!

1. What is your gender?

- Male
- Female

2. What is your main current work?

- Clinical practice
- Training/teaching
- Program/management
- Technical advisor
- Other (please specify) _____

²⁰ Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth; USAID TRAction Project 2010

3. In which region do you primarily work?

- Africa
- Asia
- Near/middle East
- Latin America/Caribbean
- North America
- Europe
- Globally

Please write the name of the main country (countries) and institutions where you work:

4. In the country (or countries) where you work has mistreatment to women in labor ward or other maternity care areas been identified? If so, select the more frequent examples in the following list:

- No examples been identified
 - Verbal abuse (insult)
 - Physical abuse (slapping/hitting)
 - Abandonment of care (leaving the woman alone or unattended)
 - 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
 - Denying drink and food during labor
 - Denying liberty of movement during labor
 - Denying choice of position for delivery
 - Unnecessary separation of mother and newborn after the delivery
 - Overuse of drugs and technology (like episiotomy, cesarean section, newborn incubation, sonograms, etc.)
 - Performing harmful practices (such as poor infection prevention practices, excess of vaginal examination)
 - Detention of the woman in facility due to lack of payment of facility fees
 - Other (specify) _____
-

5. What do you think are the underlying factors for disrespectful and abusive maternity care?

6. In your country (or in the countries where you work) has the issue of respectful care been addressed? IF SO, HOW?

YES NO

- Local laws and regulations
 - Clinical guidelines and protocols
 - Training
 - Quality improvement approaches
 - Community activities including campaigns
 - Other (specify) _____
-

7. Please describe the main strategies or interventions related to humanized/respectful maternity care that have been promoted in your country (or in the countries where you work). Please feel free to use the entire space you need or to attach additional information or documentation.

8. What examples of respectful care aspects have been promoted in your country (or in the countries where you work)? Please place “X” in the appropriate boxes to specify the intensity with which the action has been taken: 4 for greater intensity and 1 to lesser; and “0” for if it has not taken place.

RESPECTFUL CARE ASPECTS	4	3	2	1	0
a. Respectful care, including respect for beliefs, traditions and culture					
b. The right to information, confidentiality, and privacy					
c. Choice of companion during labor					
d. Choice of companion during delivery					
e. Evidence based care that enhances and optimizes the normal processes of pregnancy, birth and postpartum					
f. Liberty of movement during labor (e.g., walking, moving around)					
g. Provision of drink and food during normal labor					
h. Provision of drug-free comfort and pain relief methods during labor					
i. Provision of continuous support during labor (i.e., lack of abandonment)					
j. Choice of position for delivery					
k. Contact of the newborn skin-to-skin with the mother immediately after the delivery for at least the first hour					
l. Early breastfeeding (within the first hour after birth)					
m. Keeping mother and baby together 24 hours a day					
n. Promoting breastfeed on demand					
o. Appropriate use of technology and effective lifesaving interventions					
p. Provision of care that seeks to avoid potentially harmful procedures and practices					
q. Mutually respectful and collaborative relationship among all types of care providers					
r. Provision of a continuum collaborative care with all relevant health care providers, institutions, and organizations					
s. Avoidance of the overuse of drugs and technology(such as oxytocin augmentation, episiotomy, cesarean section, newborn blood gases, incubation, sonograms)					
t. Avoidance of detention in facilities due to lack of payment					
u. Prevention of institutional violence against women and newborns, including disrespectful care					

9. Please indicate the main sources of funds used to support the implementation of strategies/interventions/activities related to humanized/respectful maternity care in your country (or in the countries where you work)

- Government
- Non-governmental non-profit
- Private Sector
- Other (specify)

10. Please describe the main results achieved on the work developed in your country (or in the countries where you work).

11. Please list the main tools and resources used to implement these strategies/interventions/activities (if possible, please provide a copy of these tools).

12. Please describe the main challenges faced in the implementation of these strategies/interventions/activities.

13. Please describe the main lessons learned from this work.

14. What recommendations do you have to countries or institutions wishing to implement strategies/interventions/activities to promote humanized/respectful maternity care?

May we contact you for questions?

- Yes
- No

May we mention your name as a contributor to the document summary of this survey (we will send the document for your approval prior to the dissemination)?

- Yes
- No

Please indicate others people from your country (or countries where you work) that you consider key informants to respond this questionnaire (with their respective contact)

Annex B: List of Countries and Contributors

COUNTRY	RESPONDENTS, PROFESSION, ORGANIZATION, TITLE
AFRICA	
Equatorial Guinea	Almudena Gonzalez-Vigil—Nurse, Jhpiego, Country Director
	Amparo Efri—Matrona, directora de enfermería del Hospital Regional de Bata
	Pastora Ndong—Matrona, Coordinadora Regional de SR
	Judith Nsang—Matrona del H. Regional de Bata y profesora de SMN en la Escuela Enfermería y
	Aquilina Nfuru—Matrona del H. Bata y profesora de prácticas de enfermería
	Regina Edeguedegue—Matrona supervisora de Salud Materna del Hospital de Bata
Mozambique	Leonardo Chavane—MD, MOH/Central level
	Deolinda Sarmento—Nurse, MOH/Central level Carolien Albers [CALbers@pathfinder.org] Carolien Albers [CALbers@pathfinder.org]
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	Lilia Jamisse and Conceição—ObGyn, USAID
	Carolien Albers—Pathfinder
	Jim Ricca—MD, MCHIP, Chief of Party
	Maria da Luz Vaz—MD, MCHIP technical director
	Natercia Fernandes—MCHIP
	Ernestina David—ObGyn, MCHIP, MNH senior assessor
Nigeria	Bukola Fawole—ObGyn, University College Hospital, Ibadan, Department of OG
	Lydia Airede— Usmanu Danfodiyo University Teaching Hospital, Sokoto, Department of Obstetrics and Gynecology
	Emmanuel Otolorin—ObGyn , Jhpiego, Country Director,
Zimbabwe	Rose A. Kambarami—MD, MCHIP, Chief of Party
ASIA	
India	Chandrakant Ruparelia—Jhpiego
	Rashmi Asif—Jhpiego
	Kailash Saran—Jhpiego
LATIN AMERICA	
Argentina	Raul Mercer—Centre for Research in Population Health and FLASCO
	Flavia Cristina Raineri—Directora del Programa Materno Infantil de Buenos Aires, Argentina
	Susana Fernandez-Jacomet— FLACSO/UNICEF, Proyecto “Te Escucho” en maternidades de Argentina
	Marcela Miravet—Directora del Programa Materno Infantil de la Provincia de Córdoba
Brazil	Daphne Rattner —MD, UNB/REHUNA
	Marcos Ymayo —ObGyn, Santa Marcelina from Itaim Paulista Hospital and ALSO Brazil
	Kelly Nishikawa —JICA
Chile	Anne Davenport—Nurse-midwife, Jhpiego consultant
	Gloria Metcalfe—CNM, midwifery and training consultant
Colombia	Hernan Rodriguez—Consultor Nacional OPS

COUNTRY	RESPONDENTS, PROFESSION, ORGANIZATION, TITLE
México	Gil Araceli—Nueve Lunas
Paraguay	Vicente Bataglia—MD, Jhpiego
Peru	Marcia Viviana Rios Noriega—Médica, Ministerio de la Salud, Microred Lluylucucha. Red Moyobamba -DIRES San Martin
	Alfonso Villacorta—Médico Gineco Obstetra, Proyecto Calidad en Salud USAID
	Maria Luz Perez Goycochea—Comunicadora
Uruguay	Gilda Vera López—Coordinadora da RELACAHUPAN
Venezuela	Beltran Lares Diaz—Auroramadre y Centro clínico La Castellana en Caracas
NORTH AMERICA	
Canada	Hélène Vadeboncoeur—PhD, independent childbirth researcher, Board of Directors of IMBCO
	Rivka Cymbalist —Director of Montreal Birth Companions
USA	Alexandre Buckley de Meritens—ObGyn, Johns Hopkins Hospital
	Robbie Davis-Floyd—Anthropologist, international childbirth research
EUROPE	
England	Soo Downe—University of Central Lancashire Professor; Board of Directors of IMBCO
Netherland/ Holland	Mary C. Zwart—Private midwife working in Europe and in Brazil
OCEANIA	
New Zealand	Larissa Grandi—Midwife
	Karen Guilliland—Midwife, New Zealand College of Midwives

Annex C: Work Areas and Locations of Respondents

Number of respondents: 48

Male: 13

Female: 35

Main Work Area of the Respondents

WORK AREA	NUMBER OF INFORMANTS
a. Training/teaching	18
b. Clinical practice	13
c. Technical advisor/consultant	12
d. Program/management	11
e. Other (research, IEC/promotion, advocacy, medical anthropologist)	10

Primary Region of Work

REGION	NUMBER OF INFORMANTS
a. Africa	19
b. Latin America/Caribbean	16
c. North America	4
d. Asia	3
e. Europe	2
f. Oceania	2
g. Globally	2

Annex D: Interventions and Main Results Related to RMC

Implementation by country²¹ as reported by survey respondents

COUNTRY	INTERVENTIONS/ACTIVITIES IMPLEMENTED AND MAIN RESULTS
AFRICA	
Equatorial Guinea	<p>Interventions: Implementation of the Jhpiego SBM-R quality improvement approach since 2011 in one region of the country with focus on strengthening maternity quality and respectful care in health facilities.</p> <p>Results: Health workers trained in quality and humanized MNH care. Quality and humanization of maternity care improved in selected health facilities.</p>
Mozambique	<p>Interventions: Implementation of the National Humanization of Health Care Plan and the Model Maternity Initiative (MMI), using the Jhpiego SBM-R approach. Professionals from 34 major hospitals in the country and also professors from medical and nursing schools were trained in respectful maternity care practices and also in the methodology to implement the SBM-R process. These hospitals have been implementing the process for humanizing care and improving the quality of services.</p> <p>Results: Since 2009, MMI has been implemented in the 34 largest hospitals throughout the country (there are plans to expand to other facilities). Observed results included some improvement in quality and respectful care in MNH, especially related to the gradual increase in the implementation of evidence-based practices. Improvements were seen in:</p> <ul style="list-style-type: none"> • RMC indicators related to the presence of a companion during labor and birth and delivery in alternative positions; • Demand for maternity services; • Morbidity indicators; and • Obstetric complications. <p>Although there is no baseline data on the prevalence of harmful/disrespectful practices before the initiative, data collectors from an observational quality of care study carried out in 2011 had the perception that the level of respectful care had improved.</p>
Nigeria	<p>Interventions: The main strategy is training in interpersonal communication and postgraduate training of resident doctors; inclusion of attitude tasks in performance standards and checklists; and community mobilization, including linkage of communities with facility committees.</p> <p>There is also a large scale implementation of the Baby-Friendly Hospital Initiative by UNICEF and an investment in pre-service education and in postgraduate training of resident doctors. Although there is no coordinated national program, most donor-funded programs include interventions that address RMC issues.</p> <p>Results: Unknown</p>
Zimbabwe	<p>Interventions: RMC interventions related to information, education, and training were implemented through the SBM-R quality improvement approach.</p> <p>Results: MNH quality of care improved in selected health facilities.</p>

²¹ Although evidence-based care is not directly referred to in the WRA RMC Charter, half of the respondents noted “performing harmful practices” and lack of evidence-based care as examples of non-RMC. The promotion of evidence-based care was, therefore, reflected in responses, but because these interventions and results are so broad in scope and not specific to RMC, as defined in the charter, they are not included here.

COUNTRY	INTERVENTIONS/ACTIVITIES IMPLEMENTED AND MAIN RESULTS
ASIA	
India	<p>Interventions: India has policies and guidelines on providing respectful care to clients in health facilities. Trainings on maternal health have a component of RMC, but it is rarely translated into actions. The main difficulty is that the number of institutional deliveries has doubled in the last several years without a corresponding increase in infrastructure, staff, and supplies, resulting in crowded facilities that compromise components of RMC. The government is also promoting evidence-based innovations and practices. There is a provision for review of practices in quality-assurance committees at district level. Awareness campaigns in communities are run through mass media, such as print and electronic media, and through organized focus group discussions and health education camps in the community.</p> <p>Results: The focus on evidence-based practices and adoption of best practices has been well-received by administrators and clinicians. At government level, after intense evidence-based advocacy, officials were motivated to include these practices in their policies and to amend the policies where it was required.</p>
LATIN AMERICA	
Argentina	<p>Interventions: Strengthening the obstetric provincial networks. Promoting the Safe Motherhood Initiative and the family-centered model that proposes patient safety and compliance with the humanization of delivery, and antenatal and postnatal care. Development of a law on rights of women, children, and families during labor and delivery. This law is already being implemented in 74 maternities that are part of UNICEF's Safe Motherhood Initiative and the family-centered hospital initiative. Application of quality improvement methodology. Implementing "Te Escucho" (I hear you), a project for the promotion of children's rights and a gender-sensitive approach in public maternity hospitals (www.flacso.org.ar). The project addresses the maternity health team through a training process—reflection and action aimed at promoting respect for the rights of women and their babies and gender equity. A decision process is used to generate institutional transformation projects. The strategy includes incorporating four online courses: multiculturalism and pregnancy, participation and empowerment in health services, maternal and neonatal health and disability, and assessment with a gender and rights focus.</p> <p>Results: Te Escucho has been implemented in 100 maternity units with a census of over 1,000 births annually. Implementation of the UNICEF action plan in each maternity is done through cooperation agreements with the MOH. Government officials have been sensitized on the importance of mainstreaming health and rights, more than 200 health professionals have been trained, and institutional projects have been generated to implement the gender and rights focus. A complex evaluation model has been implemented in order to monitor changes associated with the incorporation of this perspective. Staff are committed and involved. Other results included maternity residences for mothers, neonatology patient safety, reductions in hospital acquired infections, and decreases in maternal and neonatal mortality rates at provincial level institutions.</p>

COUNTRY	INTERVENTIONS/ACTIVITIES IMPLEMENTED AND MAIN RESULTS
Brazil	<p>Interventions: Implementing the National Program for Humanization of Childbirth Campaign for the promotion of RMC. Seminars for professionals to promote the RMC model “Rede Cegonha” (Stork Network). Instituted the “Galba de Araujo” prize to recognize efforts to improve humanization and quality of maternity care. The prize is awarded periodically to the best hospital in each region.</p> <p>Results: Training about respectful maternity care has been conducted at the national level to involve representatives from teaching hospitals across the country. In 2006, training reached a total of 2,657 people from 550 hospitals. Most of these hospitals have begun the process of humanizing and improving the quality of services. The number of services and professionals who have a respectful attitude has increased, but the rates for cesarean sections remain high. However, society is becoming increasingly aware of the problem and the media keeps the subject in circulation, which contributes to awareness. Reduction of maternal death, but not as expected.</p>
Chile	<p>Interventions: Implementation of grassroots and internet campaigns focused on educated clients; with some (inconsistent) university education intervention.</p>
Colombia	<p>Interventions: New standards in the humanization of service and quality improvement. Article 3 of Law 1438 of 2011 (reform of the health system) covers principles of the Social Security System in Health, which includes equality, rights, differential focus, equity, quality, and humane care.</p>
México	<p>Interventions: The main strategies include dissemination of guidelines, training for health providers, and creation of guidelines for care in the MOH programs. Advocacy groups have been spreading the humanized care model through campaigns targeting the general population.</p>
Paraguay	<p>Interventions: Implementing the A.N.I. (Atención Neonatal Integral/Comprehensive Neonatal Care). Program of the MOH in the humanization of maternal and neonatal care in some hospitals. Implementing MCHIP Project. Main activities are: update midwifery standards, EmONC, training human resources, training of trainers, and development of centers of excellence.</p> <p>Results: Decreased rate of episiotomies, use of active management of third stage of labor in all births, relative decline in the cesarean rate, increased coverage of postpartum family planning.</p>
Peru	<p>Interventions: Improving performance with classroom assessment methods; involving labor standards with cultural adaptation; maternal care personalized, humanized. Good practices of intercultural and gender relevance in health services have been institutionalized in the Regional Health Directorate of Ucayali, allowing services to be provided closer to the population. The Birth Plan is regarded as a link between prenatal care and institutional delivery. The establishment of the Dignified Commission, National Committee for Quality, National Health Council.</p> <p>Results: Better performance of professionals; violence screening in prenatal care; childbirth with cultural adaptation; privacy; regard for the ideas and customs of all cultures; improved care by improving staff training; improved care with warmth; raise awareness among ethnic groups.</p>

COUNTRY	INTERVENTIONS/ACTIVITIES IMPLEMENTED AND MAIN RESULTS
Uruguay	<p>Interventions: Implementing laws, regulations, and decrees that favor RMC practices such as a companion during childbirth, implementation of evidence-based practices, and avoidance of unnecessary interventions.</p> <p>Implementation of a pilot program to reduce the maternal mortality among the mothers assisted by traditional midwives. This program was modeled on the experience of a pilot program implemented in Rubel Tzul, an isolated community in Guatemala.</p> <p>Results: New focus on the rights of women during pregnancy; creation of midwifery schools and the association of traditional birth attendants; provision of education to many communities and rural traditional birth attendants using the book of images that can be downloaded from the RELACAHUPAN website. Started remote education with an online course for pregnant women and their families.</p>
Venezuela	<p>Interventions: Implementing laws to protect the child and adolescent; basic law for the right of women to live free of violence, official standard for reproductive health care.</p> <p>Results: Provision of humanized birth care in private and public facilities (currently have a maternity ward where water births are conducted). Promotion in public media (TV TEVES) of breastfeeding and postnatal care.</p>
NORTH AMERICA	
Canada	<p>Interventions: Several hospitals in Montreal have been trying to initiate more RMC by following the WHO baby-friendly hospital initiative, and by following the MORE guidelines which are perceived to facilitate lower cesarean rates. There have been documents written like the one by Santé Canada in 1980 (re-edited) on family-centered maternity care.</p> <p>Perinatal official policies published by the Ministry of Health and Social Services in the province of Quebec.</p> <p>There has been one large inquiry in the 1990s about obstetric practices in Canadian hospitals that looked at family-centered care. Establishment of laws legalizing midwifery and accompanying rules in the provinces of Quebec, Ontario, British Columbia, Alberta, and Manitoba.</p> <p>Results: Results are patchy and are usually the result of individual efforts. Compared to 30 years ago, there are more birthing rooms, women in labor can have their husband/partner besides them, and breastfeeding has increased. Several hospitals have been granted the “baby-friendly” designation. Midwifery has been legalized in several Canadian provinces (it had almost totally disappeared due to the pressures of the medical profession in the 20th century). In Quebec, with regarding humanized maternity care, the 10 birth centers (all outside of hospitals and staffed only by midwives) are considered to be the best places to have a baby.</p>
USA	<p>Interventions: Mandatory consent on admission to the hospital is improving communication and patient participation. Strict regulations for respect of privacy. Allow companion during childbirth. Introduction of WHO recommendation for drink and food during labor. Implementation of the Mother-Friendly Childbirth Initiative—precursor to the IMBCI</p> <p>Results: Having doulas present at births may be preventing some disrespectful care, but sometimes the doulas are abusive and coercive (although subtle). Certified nurse midwives (CNMs) are doing their best in the hospitals where they work—it is rare to hear anyone complain that a CNM’s care is disrespectful or abusive. But they only attend around 9% of American births.</p> <p>Another positive recent development in the United States is that more hospitals seem to be implementing policies of no inductions or scheduled cesarean sections before 39 weeks, which is helping to empty the neonatal intensive care units of premature babies.</p>

COUNTRY	INTERVENTIONS/ACTIVITIES IMPLEMENTED AND MAIN RESULTS
EUROPE	
England	<p>Interventions: Implementing the Campaign for normal birth: www.rcmnormalbirth.org.uk/ Keeping Childbirth Natural and Dynamic Programme.</p> <p>Results: Revising Changing Childbirth and government policy documents that support normal childbirth, and individualized care for women, including choice and control; It is now normal for women to have their partners with them in labor, to be offered food and drink, to mobilize in labor, etc. Some of these activities are standard practice and some resulted from the seminal Changing Childbirth report.</p>
Netherlands/ Holland	<p>Interventions: The main strategy in the Netherlands is a strong organization of midwives in cooperation with other care providers;</p> <p>Result: Great investment in information and education. Respect for each other and midwives receive good salaries.</p>
OCEANIA	
New Zealand	<p>Interventions: interventions noted are related to strong investment in midwifery: establishment of political strategies that enable midwifery autonomy; the formation of the New Zealand College of Midwives and the development of a midwifery degree in 1992, separating it from nursing education; direct entry midwifery training; independent midwifery; partnership between community midwifery and hospital policies; continuity of care—same midwife throughout pregnancy, labor, post-partum. Consumer feedback on their lead maternity care midwife is part of the midwife’s practice review completed every two years. Review panel contains both midwives and consumers.</p> <p>Promoting informed choice in all maternity care:</p> <ul style="list-style-type: none"> • The Health and Disabilities Commissioner Act monitors the Code of Consumer Rights to informed choice and consent, a maternity system that is centered on the women—they choose their midwife or doctor and they know what they are entitled to. • Development of cultural competencies, particularly for indigenous Maori, into legislation and practice standards. • Encouragement of fathers/partners and families at births, family rooms to stay during labor and birth, choice of place of birth, and all choices free-provided by the state(including home birth). <p>Results: Around 85% of women choose a midwife as their lead maternity care (the one responsible for providing and co-ordination all that women’s care from first booking to six weeks postpartum).</p> <p>All the above respectful aspects of care are seen as rights and are mostly achieved.</p>

COUNTRY	INTERVENTIONS/ACTIVITIES IMPLEMENTED AND MAIN RESULTS
GLOBAL PERSPECTIVE	
<p>RELACAHUPAN (Latin American and Caribbean Network for the Humanization of Childbirth)</p> <p>IMBCO the International MotherBaby Childbirth Organization</p>	<p>Interventions: RELACAHUPAN (Latin American and Caribbean Network for the Humanization of Childbirth) is a network created 12 years ago, which reaches all South American countries, almost all of Central America and the Caribbean Islands, and also Spain and Spanish-speaking United States. RELACAHUPAN is working in many countries to promote the development of laws, standards, and regulations to support delivery that favor the scientific evidence, to avoid unnecessary interventions.</p> <p>The IMBCI was developed in 2008 with input from over 100 childbirth experts and consumers from all over the world. The IMBCI has been translated into 20 languages and has been put into place in many countries by birth activist groups. It is currently being pilot-tested in eight hospitals around the world (Austria, Canada, Mexico, Brazil, Philippines, India, South Africa, and Mozambique). IMBCO holds monthly webinars with its pilot/demonstration sites to monitor their progress (statistically documented) and to encourage them to fully implement the IMBCI 10 Steps to Optimal Maternity Care.²²</p> <p>Results: The IMBCI pilot sites are showing progress such as lowering their cesarean rates, hiring midwives (or empowering the midwives already employed), and improving care in respect to RMC.</p> <p>The main achievements observed in countries where RELACAHUPAN is being implemented are related to better communication with the woman and her companion/family, greeting women, treat her by name, and let women drink fluids and walk during labor. Most countries on the continent are implementing accompanying laws, and new rules focus attention on the rights of pregnant women. It has encouraged the creation of midwifery schools in several countries in the region, forming an association of traditional midwives.</p> <p>It has provided education to many communities of traditional and rural midwives, even if they do not read and write, using a book pictures (Guatemala, Ecuador, Brazil, Peru). In several countries, it has started a distance education program, with an online course for pregnant women and their family.</p>

²² Goodburn, 2000.