

RESPECTFUL MATERNITY CARE

United Nations
Population Fund (UNFPA)
East and Southern Africa
Regional Office





**Synthesis of evidence
on respectful maternity
care relevant for the
East and Southern Africa
region, and identification
of country-specific
accelerators for two ESA
countries for improving
respectful maternity care**

CONTENTS

EXECUTIVE SUMMARY	5
ACKNOWLEDGEMENTS	7
ABBREVIATIONS AND ACRONYMS	8
1. BACKGROUND AND OBJECTIVES	9
2. METHODOLOGY	12
2.1. REVIEW OF THE PEER-REVIEWED LITERATURE	12
2.2. COUNTRY CASE STUDIES	16
3. LITERATURE REVIEW FINDINGS	17
3.1. POLICY FRAMEWORK AND IMPLEMENTATION	20
3.2. HEALTH WORKFORCE DEVELOPMENT	23
3.3. CLIENT EXPERIENCE	25
3.4. FINANCING	27
4. COUNTRY-SPECIFIC ACCELERATORS	28
4.1. RMC IN TANZANIA	28
4.2. RMC IN ETHIOPIA	29
4.3. SUCCESS FACTORS FOR RMC IN TANZANIA AND ETHIOPIA	29
4.4. POLICY FRAMEWORK AND IMPLEMENTATION	32
4.5. HEALTH WORKFORCE DEVELOPMENT	33
4.6. CLIENT EXPERIENCE	34
4.7. FINANCING	34
5. DISCUSSION	36
REFERENCES	40



EXECUTIVE SUMMARY

BACKGROUND: The prevalence of disrespect and abuse to women during labour and childbirth is well documented in low- and middle-income countries (LMICs). As well as violating women's rights, this presents a barrier to accessing intrapartum care services. Various different types of disrespect and abuse have been identified, with the most common being verbal abuse and neglect/abandonment. The World Health Organization (WHO) Intrapartum Care Guidelines highlight respectful care as a key recommendation, and respectful maternity care (RMC) is emerging as an essential concept for ensuring the rights and safety of women during labour. Evidence of interventions which aim to improve RMC is sparser within the literature. UNFPA East and Southern Africa Regional Office (ESARO) commissioned this evidence synthesis on RMC initiatives in LMICs to learn more about what has and has not worked. The study comprises a review of the peer-reviewed literature on RMC interventions in LMICs, and an exploration of accelerators of the roll-out of RMC interventions in two East and Southern African countries: Tanzania and Ethiopia.

METHODOLOGY: A structured literature review was conducted using two databases: PubMed and African Journals Online. The search retrieved 1,441 publications, of which 10 met the inclusion criteria. Data from these 10 papers were analysed using four themes pre-identified by UNFPA: policy framework and implementation, health workforce development, client experience and financing. Tanzania and Ethiopia were selected as case study countries, in consultation with UNFPA. In each of these two countries, four key informant interviews were conducted with key stakeholders experienced in RMC initiatives.

LITERATURE REVIEW FINDINGS: The 10 reviewed papers report findings from seven interventions spanning five countries (Kenya, Malawi, South Africa, Sudan and Tanzania), of which four are within East and Southern Africa. Evidence was found of RMC interventions reducing the incidence of disrespect and abuse, improving clients' awareness of their rights, and strengthening provider-patient relationships. Positive impacts were also found for health service providers related to efficiency, sense of empowerment at work, effectiveness of teamwork and communication between facility staff. Three factors particularly stand out as contributing to securing these outcomes: 1) building consensus on the importance of RMC through dissemination of evidence and advocacy, in advance of intervention design and implementation; 2) a participatory approach to RMC intervention design and implementation, involving all levels of the health system; 3) addressing structural and resource constraints in facilities, which otherwise moderate the impact of RMC interventions.

IMPLEMENTING RMC IN TANZANIA AND ETHIOPIA: Both countries are pioneering efforts to improve RMC and stand as insightful examples for other countries within East and Southern Africa. Tanzania and Ethiopia are at similar stages, currently disseminating and implementing national guidelines which enshrine the principles of respectful care within the health sector, with specific focus on maternal health services. However, quite different paths have been followed by each country to arrive at this point. Securing support for, and action on, RMC is extremely challenging and highly specific to the country context. Substantial efforts to generate demand for RMC (through advocacy, use of evidence and community sensitization), the existence of strong political will and extensive investment in building the capacity of the health workforce, have been fundamental to the RMC journey undertaken by both Tanzania and Ethiopia to date.

DISCUSSION: Several factors critical to fostering RMC in East and Southern Africa over the last decade have been identified through this evidence synthesis. The evidence suggests considered focus on each of these is essential to achieve RMC. However, the organizational and cultural shifts in understanding, attitudes and behaviours that are required to embed RMC within the health system, coupled with the participatory nature of the most successful design and implementation process, mean that there is no simple, technical 'quick fix' for RMC. It requires extensive change at all levels of the health system. The pace at which this can be achieved is dependent on the extent to which a readiness for change already exists.



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ACKNOWLEDGEMENTS

This report was co-authored by Antonia Dingle and Andrea Nove of Novametrics Ltd, UK, with support from Kirsty Hughes and Martin Boyce. The project was managed by Muna Abdullah of UNFPA East and Southern Africa Regional Office, with support from Nora Kasonga and Jyoti Tewari. Aster Berhe (UNFPA Ethiopia country office) and Felister Bwana (UNFPA Tanzania country office) provided support by seeking the relevant permissions from government, arranging and coordinating key informant interviews, and sharing relevant grey literature with the report authors. Mathias Gakwerere (UNFPA Rwanda country office) provided helpful advice regarding the selection of case study countries.

We are grateful to the following key informants for giving up their time to be interviewed and provide information on country activities relating to RMC:

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- Aster Berhe, Programme Analyst, Midwifery, UNFPA Ethiopia
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- Melaku Tamir, Senior Midwife Expert at Ethiopian Midwives Association and Programme Manager for the Transform Primary Health Care programme
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TANZANIA

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- Selemani Mbuyita, Public Health Consultant
- Mary Rwegasira, Technical Advisor for Gender and Youth, Jhpiego Tanzania

ABBREVIATIONS AND ACRONYMS

AJOL	African Journals Online	LMICs	Low- and middle-income countries
CBM	Catchment-based mentorship	MNH	Maternal and newborn health
CLEVER	Clinical care, Labour ward management, Eliminate barriers, Verify care, Emergency obstetric simulation training, and Respectful care	MoH	Ministry of Health
CPD	Continuing Professional Development	MOU	Midwife-led obstetric units
CRC	Compassionate and respectful care	NGO	Non-governmental organization
D&A	Disrespect and abuse	OBDs	Open Birth Days
DCST	District Clinical Specialist Teams	PMNCH	Partnership for Maternal, Newborn and Child Health
EmOC	Emergency Obstetric Care	QIT	Quality Improvement Team
EMwA	Ethiopian Midwives Association	RBF	Results-based financing
ESA	East and Southern Africa	RMC	Respectful maternity care
ESARO	East and Southern Africa Regional Office	RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
GRC	Gender and Respectful Care	SRH	Sexual and reproductive health
HSTP	Health Sector Transformation Plan	UNFPA	United Nations Population Fund
KI	Key informant	USAID	United States Agency for International Development
KII	Key informant interview	VCAT	Values, Qualification and Attitude Transformation
		WHO	World Health Organization
		WRA	White Ribbon Alliance

BACKGROUND AND OBJECTIVES

1

Ensuring high quality sexual and reproductive health (SRH) care is a major challenge in the East and Southern Africa (ESA) region. Lack of respectful maternity care (RMC) is an important contributor to poor quality of care. For this reason, the World Health Organization (WHO) Intrapartum Care Guidelines highlight RMC as a key recommendation, and RMC is emerging as an essential concept for ensuring the rights and safety of women during labour and childbirth.¹ WHO defines RMC during labour and childbirth as “*care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth*”.² A global movement for RMC is calling for respectful care and protection of all childbearing women, especially those in marginalized and vulnerable groups such as adolescents, ethnic minorities and those with disabilities.^{3,4,5,6} The East, Central and Southern Africa Health Community promotes and supports the RMC agenda through its Ministerial Committee,⁷ paving the way for development of this agenda throughout the region.

In many ESA countries, disrespectful and undignified care is prevalent.^{8,9,10,11,12,13} As well as violating women’s rights, this presents a major barrier to accessing intrapartum care services.¹⁴ In addition, the prevailing models of intrapartum care provision in the region, under which the care provider holds all or most of the power to control the birthing process, expose healthy pregnant women to the risk of unnecessary clinical interventions which interfere with the physiological process of childbirth.¹⁵ Therefore, improving RMC and quality of care around the time of birth has been identified as a key strategy in ESA and in most low- and middle-income countries (LMICs) for reducing the rates of fresh stillbirths and maternal and newborn mortality.



The White Ribbon Alliance (WRA) RMC charter¹⁶ defines RMC in terms of the rights of childbearing women to:

1 freedom from harm and ill treatment

5 equality, freedom from discrimination, equitable care

2 information, informed consent and refusal, and respect for choices and preferences

6 timely healthcare and the highest attainable level of health

3 confidentiality and privacy

7 liberty, autonomy, self-determination and freedom from coercion

4 dignity and respect

Various different types of disrespect and abuse have been identified, the most common being verbal abuse and neglect/abandonment.¹⁷



Many ESA countries have developed and are implementing quality of care guidelines to improve delivery care,¹⁸ but there is a tendency to focus on clinical guidelines to the extent that RMC can be overlooked. UNFPA wishes to support countries in the region to strengthen the RMC components of their quality of care improvement processes. Most of the studies relating to RMC have focused on documenting its prevalence.^{9 10 19 20 21} Validated tools exist to increase accountability for preventing disrespect and abuse (D&A),²² but there have been few studies documenting interventions to reduce or prevent it. Of the published studies which do exist on RMC interventions, most emanate from ESA.²³

UNFPA East and Southern Africa Office (ESARO) commissioned this synthesis of relevant evidence about RMC initiatives in LMICs to document what has worked and what has not worked in relation to: (1) client experience of RMC or disrespectful care, (2) policy framework and implementation, (3) health workforce development, and (4) financing. This report focuses on ESA countries, but also incorporates relevant evidence from other regions. In addition, for two countries, additional in-depth work was conducted with a view to identifying and describing key accelerators of the roll-out of RMC interventions. The study is in two parts:

1. A structured review of relevant peer-reviewed literature looking at the implementation of RMC initiatives, with the aim of synthesising the evidence about what works in the implementation of RMC initiatives in LMICs.
2. The identification and description of key accelerators of the roll-out of RMC interventions in two ESA countries.



2

METHODOLOGY

2.1. Review of the peer-reviewed literature

The first stage of this study consisted of a structured review of the peer-reviewed literature. An earlier systematic literature review, published in 2018 and conducted in 2017, looked at the effectiveness of RMC policies in health facilities.²³ It was slightly narrower in scope than the current study as its focus was solely on facility-level RMC policies. However, it is highly relevant, and our search strategy was adapted from the one used for that study. There has been a lack of consensus in the literature regarding the terminology used to document issues relating to RMC.¹⁵ For this reason, a broad set of search terms was used to maximize the chances of locating relevant literature.

The following databases were searched for relevant literature:

- PubMed,²⁴ and
- African Journals Online (AJOL).²⁵

2.1.1 PubMed

The PubMed search was conducted on 11 November 2019, using the following search terms and filters:

Search terms:

((maternity[All Fields] OR "labour, obstetric"[MeSH Terms] OR ("labour"[All Fields] AND "obstetric" {all fields} OR "obstetric labour"[All Fields]) OR intrapartum[All Fields] OR ("delivery, obstetric"[MeSH Terms] OR ("delivery"[All Fields] AND "obstetric"[All Fields]) OR "obstetric delivery"[All Fields]) OR intranatal[All Fields]) AND (respect\$[All Fields] OR disrespect\$[All Fields] OR dignity[All Fields] OR consent[All Fields] OR humanis\$[all fields] OR priva\$[All Fields] OR confidential\$[All fields] OR mistreat\$[All Fields] OR abus\$[All Fields] OR violen\$[All Fields] OR humiliat\$[All Fields])

Filters:

- Article types: Journal articles
- Publication dates: 20/09/10ⁱ to 10/11/19
- Species; Humans
- Languages: English or French.

ⁱ The mistreatment of women during facility-based childbirth was first brought to global attention in a report published on 20 September 2010,¹⁴ since when a large amount of qualitative and quantitative research has been published on the subject²² It is therefore likely that nearly all of the relevant literature will have been published since that date.

2.1.2 AJOL

The AJOL search was conducted on 11 November 2019, using the following search terms and filters:

Search terms:

(respect* OR disrespect* OR digni* OR consent OR priva* OR confidential* OR mistreat* OR abus* OR violen* or humiliat*) AND (matern* OR labour OR labor OR intrapartum OR obstetric OR childbirth)

Filters:

- Publication dates: 20/9/10 to 10/11/19

The PubMed search yielded 1,356 articles, and the AJOL search yielded 85: a combined total of 1,441 publications which went forward for title and abstract review. One researcher reviewed each title and abstract. Those definitely or possiblyⁱⁱ meeting the inclusion criteria specified in Table 1 progressed to full-text review.

TABLE 1: CRITERIA FOR INCLUSION IN THE REVIEW

CRITERION	REASONING
Study relates to intrapartum care provided in health facilities	RMC studies tend to focus on intrapartum care in health facilities as this is where disrespect and abuse is most likely to occur. Both qualitative and quantitative studies were eligible for inclusion.
Study took place in at least one low- or lower-middle-income country ⁱⁱⁱ	The majority of ESA countries are low- or lower-middle-income, so the literature reviewed was relevant to the objectives of this study.
Study assesses the success or otherwise of RMC initiatives relating to: <ul style="list-style-type: none"> • Client experience • Policy framework and implementation • Health workforce development • Financing 	These were the areas highlighted in the terms of reference. Commentary or opinion pieces were excluded.
Language of publication: English or French	These are the languages in which the research team could work.

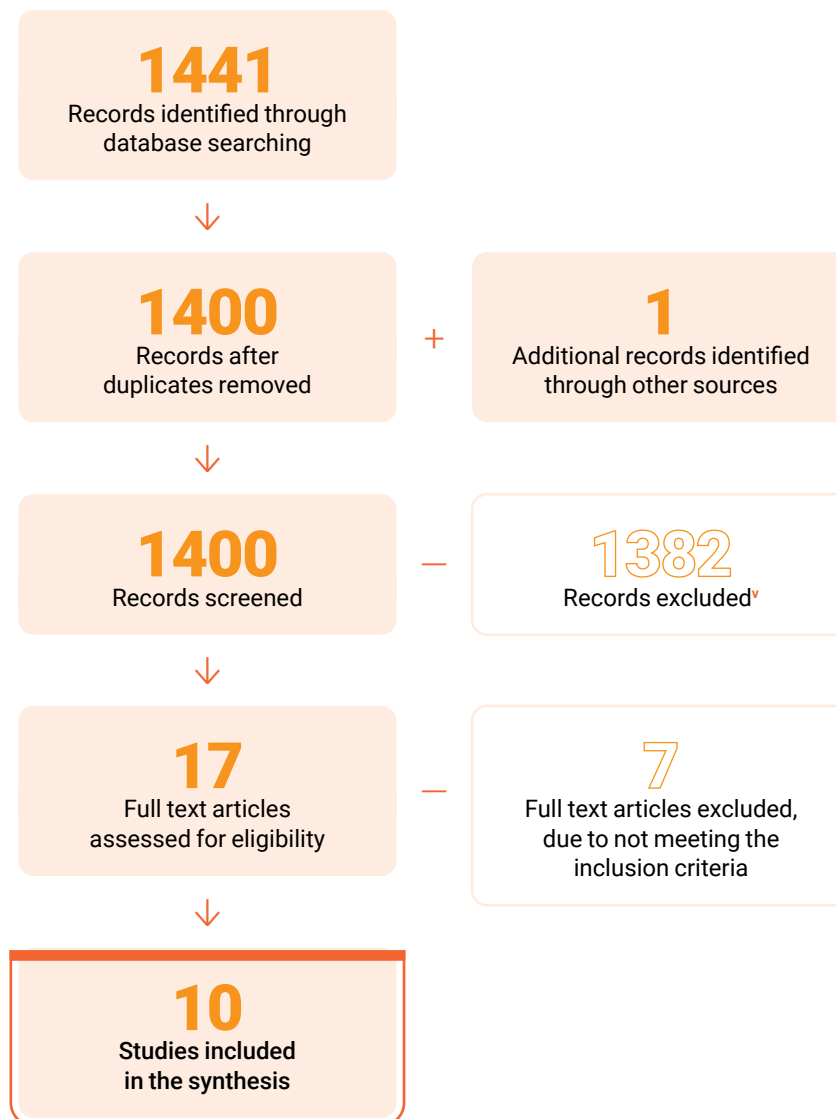
ⁱⁱ Sometimes the title and abstract did not contain sufficient information to determine whether a paper met all of the inclusion criteria. In such cases, the paper was put forward for full text review, and a decision taken at that stage.

ⁱⁱⁱ We did not restrict the search to ESA, because it was judged to be very likely that relevant literature would be found from other regions.

The reference lists of all papers which met the above inclusion criteria were examined to locate additional relevant articles, but no new articles were found via this route. Other literature reviews were excluded to avoid double-counting, but we also examined their reference lists manually and found one additional paper for full text review through this method. We also searched the 3ie systematic review repository,^{iv} to make sure we had captured the original articles included in those reviews. This returned no additional papers meeting the inclusion criteria.

Figure 1 illustrates the results of the above searches:

FIGURE 1: FLOW DIAGRAM ILLUSTRATING THE STUDY SELECTION PROCESS



^{iv} <https://www.3ieimpact.org/evidence-hub/systematic-review-repository>

^v Of these, 76 were excluded because they were written in a language other than English or French, and the rest were excluded because they did not meet all the inclusion criteria.

Subsequently, the research team noticed that the PubMed search terms did not include the word 'childbirth', as this term had not been part of the systematic review on which this methodology was based.²³ This was judged to be a potentially important omission, so we re-ran the original search with the same filters but added 'childbirth' to the first set of search terms.

This search yielded 1,551 returns. One researcher looked at the titles and abstracts of all the papers which were located via this second search but had not been located by the first PubMed search and found none which met the inclusion criteria. We therefore concluded that the omission of 'childbirth' as a search term had had no detrimental effect on the comprehensiveness of the PubMed search.

The following data items were extracted from the 10 papers which met the inclusion criteria for the review:

- Description of RMC intervention
- Objectives of RMC intervention
- Theoretical or conceptual framework on which the intervention was based
- Aspects of RMC which the intervention tried to affect
- Administrative levels at which the intervention was implemented
- Level of the health system at which the intervention was implemented
- Description of study design
- Study quality
- Study outcomes
- RMC themes examined in the paper (client experience, health workforce development, policy framework and implementation, financing)
- What worked well during implementation in relation to each of the above four themes
- Why these aspects worked well
- Potential accelerators identified in the study for further consideration
- What did not work well during implementation, or what unintended consequences occurred
- Why these aspects did not work well
- Barriers, challenges or bottlenecks identified
- Strategies that were identified to address these barriers, challenges or bottlenecks
- Are the findings generalizable to other contexts
- Implications for policy
- Implications for practice.

Once collated, data were analysed within the four themes previously identified by UNFPA: policy framework and implementation, health workforce development, client experience and financing.

2.2. Country case studies

Four ESA countries featured in the literature identified via the above search: Kenya, Malawi, South Africa and Tanzania. Tanzania was selected for the second phase of the study because the literature review found evidence of at least two RMC interventions, and because the UNFPA country office had the capacity to support the identification of suitable key informants (KIs). Additionally, UNFPA ESARO was aware that two other ESA countries (Ethiopia and Rwanda) were making good progress on RMC initiatives, even though they did not feature as much in the peer-reviewed literature. Both countries were approached, and Ethiopia was selected as a case study country due to being further advanced with implementation of RMC initiatives.

UNFPA country offices from Ethiopia and Tanzania assisted the research team to identify suitable KIs, with extensive experience of RMC initiatives within their country. An interview tool was prepared by the research team and interviews were conducted via Skype and WhatsApp. Four interviews were conducted in Ethiopia and five in Tanzania. KIs included representatives of the Ministry of Health, midwives' associations, UNFPA, non-governmental organizations (NGOs) and academic research institutes. In addition, the KIs were asked to supply the research team with relevant grey literature, including policy documents and health worker education curricula. The grey literature was used to provide additional detail to the information provided during the key informant interviews (KIIs).



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LITERATURE REVIEW FINDINGS

3

The 10 papers reviewed reported findings on a total of seven interventions either partly or solely focused on RMC, spanning five countries: Kenya, Malawi, South Africa, Sudan and Tanzania. Descriptive details of the papers and the interventions are presented in Table 2. It is noteworthy that four of the five countries are within ESA, even though the search was not restricted to this region. All eligible papers were produced in English and published in 2014 or later. Study designs varied across reviewed papers. Five of the 10 papers used mixed methods. Seven studies used a pre-post design; three of which included control data. Three of the papers included clinical observation data. One study design was based on the Consolidated Framework for Implementation Research²⁶ and drew on project documents, reports and interview data. Study quality varied quite substantially across the papers.

Five of the seven interventions included in the review covered all seven aspects of the WRA RMC charter. These were Kenya's Heshima Project, CLEVER (Clinical care, Labour ward management, Eliminate barriers, Verify care, Emergency obstetric simulation training, and Respectful care) in South Africa and the Staha Intervention, Open Birth Days and Health Workers for Change in Tanzania. The Results-Based Financing for Maternal and Newborn Health intervention in Malawi and the patient-provider communication training in Sudan each only covered two of the seven WRA RMC charter components: informed consent and confidentiality/privacy. The interventions were implemented across all levels of the health system: community, facility, district and national levels. Interventions involved a variety of types of facilities including referral hospitals, district hospitals, maternity homes, health centres, comprehensive emergency obstetric care facilities and basic emergency obstetric care facilities.



TABLE 2: DESCRIPTIVE DETAILS OF THE 10 PAPERS WHICH MET THE INCLUSION CRITERIA

AUTHORS	YEAR	COUNTRY	RMC INTERVENTION	INTERVENTION DESCRIPTION
Ndwiga, N, Warren, C, Ritter, J,	2017	Kenya	The Heshima Project	Policy-level: Baseline findings on drivers of disrespect and abuse discussed at national stakeholder forum, participatory intervention development, development of RMC resources and curricula, national policy dialogue and development and extensive advocacy. Facility-level: 1 and 3 day workshops with health providers using the Values, Clarification and Attitude Transformation (VCAT) curriculum. Workshops built provider capacities to recognise D&A, improved their knowledge and application of international and national laws, professional ethics, facility accountability and management. Workshops emphasised provider and clients rights and obligations during childbirth. Staff mentorship through facility champions. Facility quality improvement teams (QITs) strengthened on management of resources and staff allocation, and monitoring of RMC. Counselling for providers to discuss work challenges and pressures. Maternity Open Days for pregnant women and families to tour wards, learn about labour and delivery procedures, and discuss birth plans with partners and family. Installed mechanisms to report incidences of disrespect and abuse. Community-level: 1 day community workshop on rights. RMC sensitisation meetings with community members, including men.
Warren, C, Ndwiga, C, Sripad, P, Medich, M, Njeru, A, Maranga, A, Odhiambo, G, Abuya, T.	2017	Kenya	The Heshima Project	
Abuya, T, Ndwiga, C, Ritter, J, Kanya, L, Bellows, B, Binkin, N, Warren, C.	2015	Kenya	The Heshima Project	
Ratcliffe, H, Sando, D, Lyatuu, G, Emil, F, Mwanyika-Sando, M, Chalamilla, G, Lander, A, McDonald, K.	2016	Tanzania	Open Birth Days and Health Workers for Change	Dissemination of baseline findings on prevalence of disrespect and abuse amongst facility staff (including administrators), district officials and national representatives. A multi-stakeholder working group was established to select appropriate RMC interventions. Respectful Maternity Care Workshops for health providers + Open Birth Days (OBDs) for pregnant women and their families were chosen. All women attending ANC at the study hospital in 3rd trimester were eligible to attend the OBDs. OBDs designed to facilitate communication between women and providers, offer women a step-by-step guide of what to expect arriving at hospital for delivery, guidance on commodities to bring with them, raise awareness of their rights during childbirth, generate trust and mutual accountability between providers and patients by openly discussing expectations of/for both groups. OBD comprised participatory health education session and tour of hospital/maternity unit. RMC workshops were based on WHO's Health Workers for Change curriculum. Workshops were facilitated by medical school professors. At the end of the workshop, participants were tasked with developing an action plan to address the issues identified during the workshop - small structural changes e.g addition of privacy curtains for delivery beds.
Ratcliffe, H, Sando, D, Mwanyika-Sando, M, Chalamilla, G, Lander, A, McDonald, K.	2016	Tanzania	Open Birth Days and Health Workers for Change	
Kujawski, S, Freedman, L, Ramsey, K, Mbaruku, G, Mbuyita, S, Moyo, W, Kruk, M.	2017	Tanzania	The Staha Intervention	Baseline study to measure prevalence of disrespect and abuse. Disseminated findings of baseline to community and health system stakeholders, who analysed own experiences of disrespect and abuse in light of baseline study. Discussions with community, health workers and managers to design a multi-component intervention to reduce D&A. First, community and facility stakeholders adapted a client service charter, via a committee. Adapted charter reviewed by 70 local stakeholders for feedback. Focus of charter was to build consensus on norms and standards to foster RMC. Charter then disseminated to communities and posted in facilities (6 months). Second, maternity ward quality improvement process at 1 intervention facility. Staff presented with findings from baseline study, identified drivers of D&A, and proposed interventions for change. QIT made up of facility staff implemented interventions and tracked weekly progress. Interventions included using curtains for delivery and physical examinations, continuous anonymous customer satisfaction exit interviews, tea provided to ward staff, counseling for staff who continued to show D&A behaviour, best practice sharing with other wards and hospitals (11 months).

AUTHORS	YEAR	COUNTRY	RMC INTERVENTION	INTERVENTION DESCRIPTION
Webber, G, Chirangi, B, Magatti, N.	2018	Tanzania	Health Workers for Change	Health Workers for Change curriculum includes 6 workshops: Why am I a health worker?, How do our clients see us?, Women's status and society, Unmet needs, Overcoming obstacles at work, and Solutions. Workshops are highly participatory. Held over 3 days. One off training of a total of 60 nurses.
Oosthuizen, S, Bergh, A, Grimbeek, J, Pattinson, R.	2019	South Africa	CLEVER: Clinical care, Labour ward management, Eliminate barriers, Verify care, Emergency obstetric simulation training, Respectful care	Implemented by the District Clinical Specialist Team (DCST) of Tshwane district. 3 phases: 1) baseline assessment and feedback to raise awareness and solicit participation and simultaneous health systems strengthening activities tailored to individual midwife-led obstetric units (MOUs), 2) an intensive 3-month engagement period, the 'CLEVER' package was delivered, with follow-up support. RMC-specific activities included training on professional boundaries, golden rule of no shouting, improving communication and information sharing, obtaining permission for examination and procedures, confidential and prompt care, establishing coherent teamwork. Weekly sessions focusing on these aspects of care. CLEVER package was delivered during the early-morning change of shift rounds. RMC was embedded in all actions. 3) endline assessment.
Kambala, C, Lohmann, J, Mazalale, J, Brenner, S, Sarker, M, Muula, A, De Allegri, M.	2017	Malawi	Results Based Financing for Maternal and Newborn Health (RBF4MNH)	RBF4MNH aimed to improve the quality of MNH services. Financial incentives awarded to facilities, conditional on their performance, and to women for delivering in the health facility. Implemented through MOH Reproductive Health Unit in 4 out of 28 districts, accounting for 13% of the population. Intervention covers 28 Basic EmOC facilities and 4 Comprehensive EmOC facilities. Intervention comprises both supply and demand side components. PBF (supply side): financial incentives for facilities upon attainment of predefined set of indicators on clinical and organisational performance for labour delivery and newborn care. 30% of financial rewards (paid quarterly) must be invested into the health facility, and 70% can be spent on staff bonuses. CCT (demand side): payment to women who deliver in facility - a fixed lump sum plus a variable sum to cover transportation. Receipt of CCT is conditional on having registered at the facility for ANC.
Umbeli, T, Murwan, IO, Kunna, A, Salah, I, Sulman, M, Elmahgoub, A.	2014	Sudan	Training on patient-provider communication during labour	Training for registrars, house officers and midwives on communication skills, support during childbirth, providing information and empathy.

Literature review findings are reported below based on four themes: policy and framework implementation, health workforce development, client experience and financing. Within each theme, outcomes, success factors and challenges are discussed.



3.1. Policy framework and implementation

Eight of the 10 papers touched on the theme of policy framework and implementation to some degree. Whilst only one paper mentioned specific outcomes related to this theme, the rest included useful evidence regarding both success factors and challenges related to RMC policy framework and implementation.

3.1.1 Outcomes

Applying the Consolidated Framework for Implementation Research to the Heshima Project, Warren et al (2017) concluded that Heshima successfully influenced national RMC policy in Kenya.²⁷ The Nursing Council of Kenya incorporated RMC training into the national nurses' curriculum, and RMC language was incorporated into the Maternal, Newborn and Child Health Bill that arose from the continued involvement of Heshima members in the policymaking process.

3.1.2 Success factors

Four success factors for successful RMC policy and implementation were identified from the eight papers which touched on this theme. Firstly, successful interventions operate at all, or at least multiple, levels of the health system, understanding D&A in maternity care as a systemic problem. This was the approach taken in the Staha Intervention in Tanzania,²⁸ the RMC Workshops and Open Birth Days in Tanzania,^{29,30} and the Heshima Project in Kenya.^{11,27} These interventions included components that raised awareness of RMC and established ownership over the need to improve RMC and eliminate D&A at national, district, facility and community levels. The Heshima Project highlighted the role of national-level RMC champions – high profile individuals who helped establish the importance of RMC for Kenya.²⁷ Ratcliffe et al (2016) commented on the importance of fostering a cultural shift towards respectful care as an organizational norm.³⁰ Achieving such a shift necessitates cross-sectoral engagement to instigate change at multiple levels, and even wider societal change.

Secondly, building consensus around RMC in advance of intervention design and implementation has been a critical step for successful interventions. This has been achieved through multiple strategies including disseminating baseline findings on prevalence of D&A in maternity care within the district/region/country amongst key stakeholders,^{27,28,29,30,31} identifying RMC champions to raise awareness of the issue²⁷ and stimulating continuous discussion and advocacy on RMC policy at a national level.²⁷ This consensus-building stage of the process gives stakeholders the opportunity to reflect on their role in the D&A that has been identified and establishes ownership of the problem.

Thirdly, several of the interventions were either part of wider health system strengthening activities or involved specific facility-level health system strengthening components. This was important as the impact of RMC interventions is moderated by the extent to which critical structural and system improvements are made, particularly on staffing and resourcing issues. RMC cannot be addressed in isolation. Section 3.2 on Health Workforce Development gives specific examples related to this point.

Finally, a critical success factor for progressing towards RMC is adopting a participatory approach to intervention design and implementation. Most of the interventions included in this review involved a participatory component and those which reported significant improvements in RMC adopted a highly participatory approach.^{27 28 32} This involves activities such as: garnering consensus for the need to improve RMC at all levels of the health system; establishing multi-stakeholder working groups to steer RMC intervention design and implementation; identifying facility-level RMC champions to model appropriate behaviour for other staff; health workforce-owned action plans for making RMC-related improvements to facilities, management, and staff attitudes and behaviour; and engaging pregnant women and their families on the issue of RMC and their experiences of services, as well as the wider communities surrounding individual facilities. Warren et al (2017) stated in relation to the Heshima Project in Kenya, that *“the consultative process is at the heart of implementation success”*.²⁷



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3.1.3 Challenges

Projects associated with significant improvements in RMC tend to be complex, multi-component interventions, which are extremely challenging to implement. The challenges reported in the literature were many and varied. A common theme was that the external policy environment is intertwined with, and impacts upon, RMC interventions. This was seen most prominently in papers reporting on the Heshima Project in Kenya. During implementation of Heshima, health sector responsibility was devolved from national to county-level, the Kenya Free Maternity Mandate removed user fees for maternal health services, and there were also two national nursing strikes lasting a total of five out of the 20 months of implementation.^{27 32 33} These events are understood to have negatively impacted the implementation of Heshima, for example they are considered to have contributed to the decline in staff emotional health and job satisfaction found by Ndwiga et al (2017) over the course of the project. However, overall Heshima was able to weather these external policy changes and still produced substantial improvements in RMC.^{27 32 33}

Ratcliffe et al (2016) stressed the need for a cultural shift towards a norm of respectful care, as outlined above. However, they also suggest that this is necessary but not sufficient to achieve RMC, stating *"In the absence of significant investments in the health system, many structural contributors to disrespect and abuse remain unchanged"*.³⁰ The issue of RMC being contingent on, or moderated by, commensurate health system strengthening is a consistent theme within the literature and we return to this in the sections below.

3.2. Health Workforce Development

All 10 papers focused at least in part on health workforce development. Of these, four included health workforce-specific outcomes.

3.2.1 Outcomes

Many positive outcomes for health workforce development were found in the literature relating to RMC interventions. RMC workshops and Open Birth Days in Tanzania were found to improve providers' knowledge and attitudes regarding RMC.²⁹ Ratcliffe et al (2016) also reported improved relationships and communication between providers and clients following the intervention, particularly as a result of the Open Birth Days, as well as increased feelings of efficacy and empowerment at work, and improvement in stress management amongst providers, following the intervention.²⁹ Providers in the Heshima Project in Kenya attributed significantly higher scores to their perceived quality of facility supervision and management (using five-point Likert scales for five statements relating to job supervision and 14 statements relating to management) at endline, compared to baseline.³⁴ Similarly, the CLEVER intervention in South Africa was found to enhance supportive teamwork amongst midwife leaders and their teams, and shared decision-making communication practices between managers, midwives and birthing women.³⁵ Training on provider-patient communication in Sudan improved information given by providers to patients at the onset of labour, regarding the progress of labour and requests for examinations.³⁶

3.2.2 Success factors

The majority of the RMC interventions in this review included a baseline assessment of D&A in maternity care in the local context and disseminated this evidence to facilities in advance of the intervention design and implementation.^{27 28 29 30 31 32} This enabled providers to reflect on their own practices, and the role these might play in contributing to D&A, and subsequently garnered consensus on the need to address D&A through delivery of RMC. This was understood to be a critical precursor to introducing an RMC intervention – *“engaging stakeholders, nationally and locally, to agree that disrespect and abuse is an issue that needs to be addressed ensures the acceptance of an intervention”*.²⁷

Several RMC interventions utilized a participatory approach to design and implementation.^{27 28 29 30 32} This enabled providers to develop bespoke work plans and identify changes within their facilities that were required in order for them to implement RMC. Provider training on RMC tended to be complemented by structural and/or systemic improvements at facilities, sometimes overseen by Quality Improvement Teams (QITs).^{28 32} Provider training alone is not deemed sufficient to bring about lasting change in RMC.³⁰

For example, in the Staha project in Tanzania, once facility staff had been presented with baseline findings on D&A and worked together to identify the drivers of D&A within their facility, a QIT was tasked with implementing an action plan, developed in collaboration with facility staff to address these issues. Improvements included creating a private admissions area for women, installing curtains for use during deliveries and examinations, publicizing supply stock-outs in the maternity ward to ensure transparency and build trust with clients, providing tea for staff in their break room and offering counselling for staff who continued to behave in a disrespectful or abusive way.²⁸ The QIT also initiated ongoing patient surveys on quality of care, the findings of which were fed back to maternity staff and management.²⁸ The Heshima Project in Kenya included a peer mentoring component whereby designated staff members were identified as mentors to share their skills with fellow providers and foster knowledge sharing amongst peers about mistreatment and RMC.²⁷ In one hospital in Tanzania, a technical working group was formed following dissemination of findings on D&A, to develop RMC interventions which were deemed applicable and appropriate for the facility. The working group chose RMC Workshops for facility staff and Open Birth Days open to all women attending antenatal care at the hospital.³⁰ Regarding the applicability of findings on the Staha intervention to other contexts, Kujawski et al (2017) state *“future initiatives... should carefully adapt the intervention to local context [and] retain the active participation of key stakeholders”*.²⁸

Successful RMC interventions tended to involve regular or consistent training and monitoring of healthcare providers in order to effect sustained behavioural and

attitudinal change.^{27 30 36 37} RMC training involving facility managers and senior administrators, as well as ward staff, contributed to improvements in providers' and clients' experiences of RMC in Tanzania.²⁹ Weekly team meetings were used in the South African CLEVER intervention to embed training and monitor progress towards RMC and other intervention outcomes.³¹

Several interventions saw facilities establish non-monetary reward systems to recognize staff efforts and achievements regarding RMC, such as awarding trophies, or putting up photos of staff members.^{27 33} It is possible that these approaches helped to embed intrinsic motivation for staff towards adhering to RMC.

3.2.3 Challenges

Again, external policy changes had a negative impact on some RMC interventions. For example, Kenya's Free Maternity Policy was initiated part way through implementation of the Heshima Project. Ndwiga et al (2017) concluded that this contributed to the statistically significant decrease in provider emotional health observed over the course of the intervention.³³ The Free Maternity Policy removed user fees for maternity care, thereby increasing service use, without any specific increase in staffing or resourcing of services. The consequence was increased pressure on providers which challenged their ability to fully implement the RMC in which they had been trained. Ndwiga et al (2017) also report that providers' ability to deliver woman-centred care in Kenya was moderated by their work environment; one provider in their study commented *"if the provider does not have curtains or blankets, they can do nothing to ensure comfort and privacy"*.²⁷ Here we return to the common theme within the literature of the interconnectedness of RMC interventions and health system strengthening activities. Kujawski et al (2017) state *"there will never be a simple, single technical fix"* for RMC, rather *"eliminating disrespect and abuse requires individual behaviour change, organisational and systems change, and ultimately deeper societal transformation"*.²⁸

3.3. Client Experience

Five of the 10 papers included findings on client experience relating to RMC. Of these, four reported on specific client experience outcomes.

3.3.1 Outcomes

There is evidence that RMC interventions result in substantial improvements in outcomes for clients. The Heshima Project in Kenya was associated with a 7 per cent decrease in feelings of humiliation and disrespect amongst clients.³² Participants in the Staha Intervention in Tanzania saw a 66 per cent reduction in the likelihood of experiencing D&A following the intervention, as well as an increased likelihood of

rating quality of care as excellent or very good.²⁸ Both the Staha Intervention and the Heshima Project found that the greatest improvements in RMC were in declines in physical abuse of clients.^{28,32} The RMC Workshops and Open Birth Days intervention in Tanzania were found to increase patient knowledge about their rights during labour and delivery, and knowledge about the labour and delivery process; to increase clients' sense of empowerment regarding their childbirth experience; to significantly increase patient-reported satisfaction with services; to improve communication and relationships between patients and providers; and to reduce the incidence of D&A.^{29,30}

3.3.2 Success factors

Integral intervention components which helped to achieve the above outcomes are raising awareness amongst pregnant women of their rights during labour and delivery, and also educating women on birth preparedness, and the birthing process. This was typically achieved through facility open days for pregnant women where clients could come and meet facility staff and tour the maternity ward and wider facility. This gave women the opportunity to learn about what would happen when they arrived in labour at the facility and as their delivery progressed, to understand what they needed to bring to the facility for their labour, and also to receive training in their rights during labour and delivery.^{27,29} Facility Open Days are also acknowledged as a key mechanism through which to establish a genuine relationship between providers and clients, which helps to build trust and respect on both sides.²⁷ The Staha project in Tanzania spent six months engaging communities in revitalizing the Clients Services Charter, a legal document which details several aspects of respectful care, in doing so generating consensus on norms and standards to foster RMC.²⁸

The Heshima Project in Kenya included a substantial community-focused component. It offered a one-day workshop on community rights to sexual, reproductive and maternal healthcare and also RMC sensitization meetings for community members, with deliberate efforts made to include men in the workshops.^{27,32} Warren et al (2017) state that the facilities within their intervention that made the most progress on RMC were those that embraced building linkages with community members.²⁷

3.3.3 Challenges

Despite the achievements made by the Heshima Project in Kenya, there were some instances of women not wanting to report an incident of D&A following the intervention, or not being willing to act as a witness or to go through a mediation process, following the report of an incident of D&A. Many individuals felt they would be treated improperly if they needed the help of the health provider in the future. In light of this, Warren et al (2017) suggested that using a collective accountability strengthening approach may be a more effective strategy than case-by-case mediation.²⁷

3.4. Financing

None of the 10 papers reported on financial outcomes, but one of them was a finance-based intervention: Results Based Financing for Maternal and Newborn Health (RBF4MNH) in Malawi.³⁷ This was the only intervention in this review to report no impact on RMC. RBF4MNH tracked progress towards some elements of RMC in its evaluation, even though it did not contain specific intervention components focused on RMC. No significant effect of the intervention was found on RMC outcomes, and the authors note that results-based financing (RBF) interventions often struggle to set incentives that address the provider-patient interaction that is inherent to RMC.³⁸ It is possible that this is because RMC requires intrinsic rather than (or as well as) extrinsic motivation, and RBF is based on extrinsic motivators. Warren et al also commented on the challenge of achieving intrinsically motivated attitudinal and behavioural change, for example facility staff observing clients' rights and treating clients respectfully because this is the right thing to do, and reflects professional behaviour, rather than because of a financial reward linked to the behaviour. Strong mentoring was required to align staff with intrinsic motivations in relation to RMC, and this was eventually achieved.²⁷



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4

COUNTRY-SPECIFIC ACCELERATORS

The following section reports findings from KIIs conducted in Tanzania and Ethiopia. Sections 4.1 and 4.2 provide a brief overview of progress towards RMC in each country. Section 4.3 discusses two specific factors that have been critical in the paths to RMC in both Tanzania and Ethiopia – generating demand for RMC (through advocacy, use of evidence and community sensitization), and political will. Subsections 4.4 to 4.7 bring together data from the KIIs that relate to the four key areas also discussed in the report above: policy framework and implementation, health workforce development, client experience and financing.

4.1. RMC in Tanzania

Tanzania has been actively engaged in the RMC agenda for the last decade, as is well reflected in the peer-reviewed literature reviewed in Section 3. Initial seminal studies estimating prevalence of D&A during childbirth and evaluating RMC interventions were the result of a collaboration between Ifakara Health Institute in Tanzania and Columbia University in the United States.²⁸ The policy and practice landscapes in Tanzania were initially very resistant to the evidence regarding D&A. Despite the substantial positive impact found from the Staha Intervention on reducing D&A, learnings from the study were not taken on board by Government or scaled up. It took four to five years after the end of the Staha study for RMC to rise up the political agenda. During this time, evidence from other projects such as Uzazi Bora (implemented by Management and Development for Health), and Thamini Uhai (which focused on birth companionship to address RMC) contributed to the evidence base and advocacy efforts surrounding RMC in Tanzania.

Following this long period of learning, reflection, advocacy, growth and cultural change, Tanzania is now starting to make significant strides in RMC and is emerging as a leading example for other countries in the region. In June 2019, Tanzania launched its National Guidelines for Gender and Respectful Care Mainstreaming and Integration Across Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) Services (National GRC Guidelines), which it is now planning to disseminate and implement nationally.³⁹ The National GRC Guidelines focus on respectful care across the whole continuum of care of RMNCAH services, with special emphasis on RMC during labour and delivery. In addition, the forthcoming new National Health Policy, and the National Reproductive and Maternal Health Policy (One Plan 3), are both due to be published in the first half of 2020, detailing how RMC is to be implemented across the country.

4.2. RMC in Ethiopia

Ethiopia has had a considered focus on RMC, since the launch of the National Strategy on Compassionate and Respectful Care (CRC) in 2016. The National CRC Strategy was initiated without a pilot phase, as it was considered important to implement nationally from the outset, although it did build on earlier initiatives such as the Ethiopian Hospitals Alliance for Quality, which focused on patient satisfaction.⁴⁰ The CRC Strategy takes a system-wide approach. There is no specific focus on RMC, rather CRC is applied across the health sector as a whole, and the Ministry of Health (MoH) has identified a few hospitals as 'CRC incubation centres' with special focus for implementation. Initially, the CRC Strategy's theory of change focused almost exclusively on health workforce development, but the MoH came to realise that this was too narrow a focus. The health workforce can implement CRC fully only if their working environment enables them to do so, and it was recognized by some health professionals that putting the workforce under pressure to deliver CRC without addressing shortcomings in the health system could lead to 'compassion fatigue' and ultimately burnout. The 2019/20 update of the Strategy¹⁸ therefore includes a revised theory of change, which has 'strengthening health systems' as one of four key interventions and 'improved responsive health systems' as one of the intermediate outcomes.

In addition to the CRC Strategy, UNFPA has been working with the Ethiopian Midwives Association (EMWA) to strengthen RMC specifically in four regions across the country, for example through development of training materials for midwives, although these have not yet been fully endorsed by the MoH.



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4.3. Success factors for RMC in Tanzania and Ethiopia

Two key success factors stood out from the KIs as critical pieces of the puzzle that have enabled Tanzania and Ethiopia to get where they are today in terms of implementing respectful care nationally across the health sector, including with a focus on maternity care. The first is generating demand for, or building consensus on, RMC. Several approaches have been taken between the two countries to achieve this, specifically advocacy, use of evidence and community sensitization. These approaches are not mutually exclusive; there is considerable overlap between them. Secondly, both Tanzania and Ethiopia could not have reached this point without the existence of strong political will in support of RMC.

4.3.1 Generating demand for RMC through advocacy

In Tanzania, a long and challenging advocacy campaign preceded the recent significant policy developments on RMC. In 2016, the RMC Task Force was established to bring together all key stakeholders with an interest in RMC, in order to join forces and work together to lobby Government. The Task Force was one of the key advocacy vehicles at the time in Tanzania and played a pivotal role in laying the foundation for the development of the National GRC Guidelines. Key to the RMC advocacy approach was the existence of high-level policy champions – senior members of Government (including the Minister for Health) who were inspired by the evidence on D&A in Tanzania and supported a drive for RMC within the country. National RMC champions raised awareness among policymakers of the issue of RMC, helping to shift the resistance surrounding the agenda and garnering support for the need to improve RMC nationally. The prolonged period of advocacy was necessary in Tanzania to overcome the substantial barrier of resistance, denial and lack of acceptance of D&A as a problem, that was pervasive at the national level for a long time.

4.3.2 Generating demand for RMC through use of evidence

Work on RMC in Tanzania began with studies identifying and estimating the prevalence of D&A during labour and childbirth.²⁸ As mentioned above, there was initially much resistance to the dissemination of this evidence. Policymakers, government staff and health service providers did not want to accept that this was a problem within the health system, indeed one that was widespread. It took a year from presenting the baseline data on the extent of D&A to get approval for the Staha intervention study that explored a number of different interventions to improve RMC. However, the use of evidence has been critical in the RMC advocacy journey in Tanzania. The publication of the WHO Quality of Care Framework (which emphasized 'experience of care' in addition to clinical standards)⁴¹ and Tanzania's active membership of the Quality of Care Network⁴² were instrumental in shaping and maintaining the government's commitment to RMC. This, and research on the prevalence of D&A and interventions to improve RMC, are considered cornerstones in the development of the National GRC Guidelines.

Building from the intervention research of the Staha study, the Government of Tanzania is now considering the following interventions to implement nationally: revitalizing the client services charter, birth companions, community score cards and improvements to facility infrastructure (privacy and space on maternity wards). These have already been implemented successfully in several regions in the country. Whilst the use of evidence has been critical in Tanzania, there is an understanding that other countries looking to make improvements in RMC need not start right at the beginning of the 'evidence stage' as Tanzania has done. Rather, countries can galvanise learning from Tanzania and use this to accelerate progress towards RMC in their own context.

In Ethiopia, the KIs reported that evidence from an accountability mechanism (the complaints system) initially drew political attention to the issue of D&A in health care. A high volume of complaints was received on the issue, most of which related to obstetric services. In addition, some high-profile cases of D&A were featured in the media. The Ethiopia KIs reported that, initially, there was resistance to the criticism from some health workers, but that the evidence was so strong that most accepted that D&A was a problem which needed to be addressed. The KIs were of the view that public dissatisfaction was a key driver for the development and launch of the National CRC Strategy, but so far there has also been no national study to identify the impact of the strategy. A proposal for such a study has been developed but resource constraints are currently impeding implementation of the study. A team from Harvard University conducted a small-scale assessment, and WHO is planning to conduct a national implementation research study on the CRC strategy in Ethiopia. Universities are being encouraged to make CRC a key thematic research area and some are studying it.

4.3.3 Generating demand for RMC through community sensitization

Since the launch of Ethiopia's CRC strategy in 2016 there have been huge community mobilization efforts with events being held across the country. In some states there is a CRC focal person in every region/district. There has been extensive coverage of the strategy in print and social media, documentaries have been made and there is a CRC Strategy Facebook page to keep people informed. This serves to further strengthen demand for respectful care by raising communities' awareness of their rights relating to health care and keeping them up to date on the efforts being made by Government and health professional associations to ensure the health system recognizes and respects these rights. At the health facility level, CRC focal points are responsible for disseminating messages to service users about important elements and principles of CRC. They have found this to be most effective if the larger messages are broken down into the constituent parts, e.g. designating weeks to celebrate justice, privacy and calling service users by their name.



4.3.4 Political will

In both Tanzania and Ethiopia, political will in support of RMC has been fundamental in making progress towards this agenda. The willingness of the Government to engage in and support the RMC agenda in Tanzania was critical to the development of Tanzania's National GRC Guidelines. A change in the language being used, from discussion of 'disrespect and abuse' to 'respectful maternity care' fundamentally helped to shift the collective mindset surrounding the agenda from one of blame, defensiveness and lack of acceptance, to a sense of collective responsibility and a desire for change. This development in terminology was important in garnering sustained support for the issue at the national level amongst Government and key stakeholders. As mentioned above, RMC champions within Government were essential in fostering more wide-reaching support for the campaign. The RMC Task Force coordinated sustained multi-stakeholder lobbying of Government to move the agenda forward. The outcome of these efforts has been an organizational and cultural shift in the understanding and perceptions of client rights and client-provider interactions. It was not a quick process to achieve this, but respectful care is now widely held as a priority area for the Ministry of Health.

Similarly, in Ethiopia there has been high political will for the CRC strategy, with which senior parliamentarians and a wide range of stakeholders are engaged, such as high-level government ministers, religious leaders and professional associations. The CRC Strategy is led by a deputy minister who is reacting positively to the strong public demand for more respectful care. The policy environment is understood to be strongly supportive of CRC, which features heavily in the forthcoming update of the Health Sector Transformation Plan (HSTP-II). It is hoped that political will for CRC will continue to be strong under the new Ethiopian Prosperity Party, because there is alignment between the CRC agenda and the party's stated principle to 'respect the dignity of the community'.

4.4. Policy framework and implementation

It has taken Tanzania at least a decade to establish national guidelines enshrining the principles of RMC and to begin to contextualize these in national health policies. This has been the product of a hard-fought campaign to galvanize support at the national level. Tanzania is now perceived to be at a stage where there is no longer a need for further evidence regarding D&A and RMC; rather it is now felt to be the time for action, and the country is exploring how best to implement the new guidelines and policies. This brings its own challenges, but there now exists substantial national commitment to improve RMC across the country. One of the key factors aiding Tanzania's success so far in working towards RMC has been the strong collaboration between the various organizations in support of RMC – they came together through the RMC Task Force to lobby the Government together with a common goal, rather than working individually.

Ethiopia has taken a more accelerated approach to RMC, launching their National CRC Strategy in 2016 without a strong evidence base of data from within the country, as it was considered such an important issue. The speed with which Ethiopia has acted on the RMC agenda is possibly a response to widespread public demands and complaints regarding disrespectful maternity care. CRC is now incorporated into the health worker pre-service education curricula in Ethiopia and is listed as the first learning outcome for the midwifery curriculum.⁴³ External partners have supported efforts to build the capacity of the midwifery faculties in relation to RMC so that they are equipped to teach it properly. CRC has also been incorporated into the country's continuing professional development (CPD) curriculum. CPD is a condition of re-licensing which takes place every three years, and recently it has become a requirement for 5 per cent of the required CPD points to relate to CRC and professional ethics. CRC e-learning materials for CPD have been developed and are due for launch in early 2020.

4.5. Health workforce development

The experience from training health service providers in RMC so far in Tanzania mirrors the experience at the policy level. Initially there was passive resistance amongst facility staff (mainly to the introduction of birth companions, rather than to RMC more broadly) and advocacy was required to convince them that the aim was to improve MNH outcomes rather than to 'police' their work. However, once RMC training was provided, it was well received and staff did not want it to end. It is suggested that as training is developed and rolled out to facilities, initial advocacy work with providers should be conducted by those who have already received the training, to dispel myths and fears surrounding it. There are also calls for a more integrated approach to RMC training, which covers all aspects of RMC rather than just some components of it. In Ethiopia, the MoH works closely with the national professional association for midwives (EMwA) to deliver RMC training to midwives, followed by supportive supervision to monitor how well the training is put into practice. As part of this work, an RMC best practice guide was published by EMwA and UNFPA.⁴⁴

There is a very small knowledge gap surrounding D&A and RMC at the national level in Tanzania – the majority of stakeholders understand what the problem is and are supportive of the plans in place to improve the situation. However, in some regions a large knowledge gap remains at the district and facility levels. The latter may impede efforts to roll out the National GRC Guidelines. Focus needs to be placed on simplifying and translating the evidence on D&A and RMC for this specific audience, in order for them to understand the issues without experiencing blame or defensiveness, and to receive the new guidelines and policies in a positive and supportive manner. Jhpiego already has much experience successfully disseminating training and engaging district and facility staff and communities on the issue of RMC within its seven focal regions and is likely to support the Government with this process.

As a result of the CRC Strategy in Ethiopia, all health facilities have a CRC focal person to disseminate weekly messages on CRC to facility staff and service users. High-achieving CRC facilities are publicly celebrated. There has been some experience of resistance to the CRC Strategy implementation in Ethiopia among some health workers and their leaders. An initial lack of understanding and a belief that the initiative is to punish those not implementing CRC within their work created fear amongst some health providers. However, through supportive supervision the strategy is understood to be showing results, with improvements in health worker behaviours and client satisfaction. The supportive supervision approach is delivered under an MoH flagship programme of Catchment-Based Mentorship (CBM), under which professional associations provide support via the development of guidelines and training materials and the provision of mentors.⁴⁵ Although the main focus is on clinical skills, respectful care is included. For maximum impact, it is important to deliver mentorship in the workplace.

In the past, the selection criteria for acceptance to a health worker education programme focused solely on academic performance, but the Ministries of Health and Education are currently in discussion about changing the selection criteria so that there is an equal focus on the person's values and their passion for health work. Interestingly, CRC is also part of the life skills curriculum for primary and secondary school children, with the dual aim of educating the next generation about their rights when accessing healthcare and educating potential future health workers about its importance. The idea is to teach children that a career in the health service should be seen as a vocation which requires a passion for CRC, as well as academic strength.

4.6. Client experience

RMC interventions evaluated through the Staha study in Tanzania placed a strong focus on engaging communities and raising their awareness of RMC and their rights surrounding use of maternal health services, as well as building linkages between communities and health facilities. Jhpiego's work on RMC also emphasizes the involvement of communities and individual service users in strengthening RMC. A number of interventions already used in some regions are currently being considered by the Government as plans are being made to roll out the National GRC Guidelines. These include revitalizing the client services charter in coordination with communities and facilities; integrating birth companions into the health system; and improving facility infrastructure to provide more privacy for clients.

As mentioned above widespread public demand for improved services were an important precursor to the development of Ethiopia's National CRC Strategy. Service users continue to be engaged in implementation of the CRC Strategy in Ethiopia through the use of community scorecards, which are being conducted every quarter to assess facilities on CRC. The scorecard includes six indicators, of which CRC is the first.

4.7. Financing

Support from international donors such as Jhpiego and United States Agency for International Development (USAID) has been important for RMC in both Tanzania and Ethiopia. In Tanzania, Jhpiego funded the RMC Task Force and USAID funded the initial research on D&A and RMC. Jhpiego is currently funding a five-year initiative to strengthen RMC in seven regions of the country. Both donors have committed funds to support the implementation of the National GRC Guidelines. However further funding is required to implement the roll-out of the guidelines across all regions and this presents a potential bottleneck in improving RMC nationally. It has also been suggested that there is a need for donors to move beyond the system of supporting individual regions to take a more nationalized approach.

In Ethiopia, financial resources from the national health budget have been made available for CRC because of the high level of political will attached to the initiative. The CRC Strategy is mostly funded by the Ministry of Health so there is good national ownership of the issue. As noted above, development partners have also made financial contributions because of the alignment of the principles of CRC with the health-related Sustainable Development Goals. However not all regional governments have a budget to implement CRC. It is recognized that funding also needs to come from regional government and health facility budgets, in addition to national budget allocations, to increase ownership of and commitment to CRC. A few health facilities have been motivated to integrate CRC within their existing systems without the need for additional funding, but in others this motivation has not yet become evident.



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DISCUSSION

5

Evidence of the widespread prevalence of D&A in maternal healthcare in LMICs is well established. This not only violates birthing women's human rights, it is also a significant barrier inhibiting progress in increasing utilization of maternal health services.⁴⁶ The evidence is less well-established regarding the implementation and outcomes of interventions designed to improve RMC. A structured literature review was conducted which retrieved 10 papers with evidence of the effect of RMC interventions. The papers spanned seven interventions from five countries. Findings from these papers were analysed based on four themes: policy framework and implementation, health workforce development, client experience and financing. In addition, eight key informant interviews were conducted in Tanzania and Ethiopia, and grey literature from these two countries was reviewed, to gain a deeper understanding of progress towards improving RMC in these two countries, one of which (Tanzania) features prominently in the published literature, and the other (Ethiopia) is making progress in RMC despite not featuring as prominently in the peer-reviewed literature.

Evidence was found of RMC interventions significantly reducing incidence of D&A, improving clients' awareness and understanding of their rights and strengthening patient-provider relationships and communication. In addition, RMC interventions were found to positively impact on providers' awareness and knowledge of client rights, to increase provider efficacy, sense of empowerment at work and ability to manage stress, as well as strengthening teamwork, relationships and communication between providers, facility management and administrators. Multiple success factors were identified which contributed to securing these outcomes. Three in particular stand out as relevant for all themes:

- 1 Building consensus on the importance of RMC through dissemination of evidence and advocacy in advance of intervention design and implementation.
- 2 A participatory approach to RMC intervention design and implementation involving multiple and ideally all levels of the health system.
- 3 Addressing structural and resource constraints, typically at the facility-level, which otherwise limit the impact of RMC interventions.

In addition, the importance of building links with the community, raising awareness of clients' rights and educating on birth preparedness is noteworthy for achieving real progress in RMC. Numerous challenges were experienced in implementing RMC interventions, many of which are context specific. Most RMC interventions were complex, involving multiple components and several levels of the health system, which leaves them vulnerable to changes in the wider policy environment.



The majority of the studies reviewed were from ESA, even though the search was not restricted to this region. There is substantial evidence from other regions regarding the prevalence of D&A, however the published evidence on the impact of RMC interventions tends to come from ESA. This may mean that ESA is ahead of the curve in terms of implementing RMC interventions, or merely that they are more likely to publish papers on this issue. However, we also know that there are some countries in ESA, such as Ethiopia and Rwanda, which are making substantial progress in RMC and not publishing information on impact, learnings or their experiences. Ethiopia is aware of the need to evaluate the implementation of its CRC Strategy, but resource constraints are a barrier. The global RMC movement would be aided by learning from such countries which are currently making much effort to prioritize RMC, and perhaps more support could be offered to support the evaluation of these efforts and publish the results for a wider audience.

Tanzania and Ethiopia are two countries within ESA making good progress in RMC. They both have national guidelines focusing on respectful care within the health sector which are being disseminated nationally, and respectful care is being detailed in the latest iterations of national health policies within each country. The two countries have experienced different journeys to get to similar points in their progress towards RMC. Common to both contexts are a strong political will supportive of the RMC agenda and extensive efforts to build the capacity of the health workforce to deliver RMC. Ethiopia shows that a more accelerated path towards RMC is possible, if the intention and commitment is present within Government. This intention and commitment were derived as a result of public demand, which provided a significant incentive for action. Importantly however, Ethiopia's fast-tracked approach to RMC means there is no evidence to document the impact of their CRC Strategy on quality of care and client satisfaction; this is a critical next step.



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What we can learn from both countries is that initial demand for RMC must be generated in some way – either through extensive use of evidence and advocacy (as in the case of Tanzania), or through public demand and complaint (as in Ethiopia). Demand for RMC must also be coupled with high-level political engagement and support of the issue for progress to be made, and with efforts to institutionalize RMC via pre-service education and in-service training. Evidence from the peer-reviewed literature strongly indicates that creating strong demand for, or consensus on the importance of, RMC and the presence of a policy environment supportive of and sensitive to the RMC agenda are critical factors in making progress towards RMC.

Both Tanzania and Ethiopia are still at a relatively early stage in their RMC journeys, they have promising initiatives and there is much that can and should be learnt as they go further in implementing respectful care nationally. It was suggested in the KIIs that Tanzania's lengthy RMC journey needs to be examined and useful lessons can be adapted by other countries and need not be replicated as it is. Rather it is hoped that learning from countries such as Tanzania can be used to propel other countries more quickly to reach RMC goals, and that they need not start at the very beginning of the evidence stage. However, as highlighted above, the evidence reviewed here indicates that creating demand for RMC is a critical step in the process, typically executed through dissemination of evidence to and engagement of policymakers, other stakeholders, health service providers, facility administrators, communities and service users. Therefore, it may be important not to move too quickly through the evidence stage of the process, to ensure that demand for and political will towards RMC are firmly established. This raises the wider issue of whether indeed RMC is something that can be significantly accelerated.

To sustain fundamental change in provider and patient attitudes and behaviours regarding RMC, a cultural, and even societal, shift is required in the prioritization, internalization and respect given to the rights of birthing women. This is an organic process which must be owned by all stakeholders at all levels of the health system. It can be challenging to curate such a process; it must be crafted specific to the context and is more easily achieved if an underlying readiness for change already exists. In the case of Tanzania there was initial overt resistance to change and a challenging, lengthy advocacy period was required to achieve a common understanding of the importance of RMC and to establish a robust foundation of political will.⁴⁷ The evidence reviewed here indicates several factors that are critical to successfully implementing RMC interventions, but it is not clear that their presence will necessarily accelerate progress towards RMC. The pace of progress in achieving RMC is very much dependent on the country context, the extent to which demand, political will and an environment ripe for change already exist. In Ethiopia, on the other hand, the underlying public demand for change was already evident from the volume of complaints received about D&A in health care, and especially obstetric care.

Given the context-specific, organic and participatory nature of the most successful RMC interventions, there is also a question over the extent to which they can be scaled up in a generic way. Even interventions involving all levels of the health system were making changes at the individual facility level, or on a very small scale, working in a few facilities at a time. In Tanzania, Jhpiego is implementing training in RMC across 51 districts, covering more than 1,000 facilities. Likewise, in Ethiopia, EMwA is delivering training in four of the most populous regions. The experience in these two countries suggests that operating at scale is possible, especially if strategic partnerships are formed with national and/or international stakeholders. Both Tanzania and Ethiopia are now engaging in a national roll-out of guidelines on respectful care. Further study of the experience of both these countries will provide valuable insights into the process of scaling up highly participatory interventions that so far have largely been implemented on a small scale.

One of the four themes identified by UNFPA for analysis within this evidence synthesis was financing of RMC interventions. Unfortunately, very little evidence was found relating to this theme. Given the size and complexity of RMC interventions and their interconnectedness to health system strengthening, there are significant financing implications for their success. The RMC movement would benefit from future research including outcomes and commentary on financing of RMC interventions.

The key learnings from this review echo those of a systematic review by Partnership for Maternal, Newborn and Child Health (PMNCH) on professional accountability mechanisms for women's and children's health.⁴⁷ PMNCH found that success factors for such mechanisms included *"involvement of a broad range of stakeholders, a culture of learning, the voluntary nature of participation in the mechanism, integration into national processes, champions and local ownership within the system, independent and external assessors, data transparency, clear recommendations, and annual reviews and dialogue"*. The similarity of these success factors with those emerging from this review could indicate that the large body of knowledge on accountability and accountability mechanisms within the health system can be informative when working on RMC.

There is a small but insightful body of evidence regarding the implementation of interventions to improve RMC in LMICs, most of which comes from ESA. Several success factors are identifiable which are fundamental in achieving progress towards RMC. Firstly, the generation of demand for RMC across the health system from national to community level, through the use of evidence and advocacy, if this does not already exist. Secondly, strong political will in support of the RMC agenda, which will likely also be derived through demand generation initiatives. Thirdly, once demand for RMC and political will are established, a participatory, system-wide approach to the design and implementation of RMC interventions, to establish ownership over the process. Finally, investment in structural and resource constraints at health facility-level, which can otherwise impede progress in RMC.

The organizational and cultural shifts in understanding and awareness of the RMC agenda that must precede any widespread action, coupled with the participatory nature of the most successful design and implementation process, calls into question the possibility of significantly accelerating the attainment of RMC, at least in contexts where there is not already significant public demand for change. However, we can infer that the presence of these four factors is integral to the success of any RMC intervention. There is a clear need for further research documenting the process and outcomes of RMC initiatives from countries such as Tanzania, Ethiopia and Rwanda who are pioneering approaches to national implementation of RMC within ESA. Further evidence from these contexts may enable us to define with more certainty RMC accelerators, versus key success factors.



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