MOMENTUM

Country and Global Leadership

Technical Brief

RWANDA RESPECTFUL MATERNITY CARE SITUATIONAL ANALYSIS: BRIEFER

PURPOSE, BACKGROUND, AND APPROACH

PURPOSE

This situational analysis (SA) on respectful maternity care (RMC) has been compiled in response to a request from the Government of Rwanda (GoR)'s Ministry of Health (MOH) and was done in partnership with MOMENTUM Country and Global Leadership (MOMENTUM), with funding from the U.S. Agency for International Development. The GoR MOH's Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Policy mentions person-centered care, but does not include any specific language on RMC. With growing evidence and global prioritization of RMC, the GoR is committed to include an evidence-based RMC-specific addendum to the existing RMNCAH strategy.

Republic of Rwanda
Ministry of Health

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BACKGROUND

In the past decade, RMC has garnered much deserved attention. From the global to country level, there is increased acknowledgment of the need to improve the quality of care (QoC) women and newborns receive and document changes in care provided. Given that the World Health Organization (WHO) included experience of care, along with provision of care, in its QoC framework, country governments and their partners have been working to operationalize these recommendations within their contexts. However, despite overall advances in maternal and newborn health (MNH) outcomes, ensuring that women, newborns, and families receive respectful care during childbirth remains a challenge worldwide.[1] Rwanda has been working to improve the clinical and experiential QoC for women during pregnancy, childbirth, and the postpartum period for the past two decades, but acknowledged in 2015 that there was a gap between its intentions and the reality of the care women are receiving.

POLICY DIALOGUE

Recognizing the GoR's desire to improve the quality and experience of care for maternity services, the Rwandan MOH and MOMENTUM partnered to conduct this SA of the current policy and implementation environment and made recommendations for an addendum with explicit RMC language to be included in the existing RMNCAH policy. The intention is to identify ways to better serve the women, newborns, and health system through policy and program interventions with matched advocacy and accountability mechanisms to ensure implementation to impact.

METHODS

MOMENTUM conducted global and national literature reviews on RMC and conducted three semi-structured key informant interviews (KIIs) and two focus group discussions (FGDs) with policymakers, civil society organizations/implementers, donors, and health care providers/provider representatives in Rwanda. In total, 11 interviewees were selected to achieve diverse policy-user perspectives. The Johns Hopkins University's institutional review board approved the protocol as "non-human subject research" (NHSR) and the Rwanda National Ethics Committee provided an NHSR waiver.

SITUATIONAL ANALYSIS AND FINDINGS

DISRESPECT AND ABUSE/MISTREATMENT

There has been a tremendous upsurge of publications on the topic of RMC. Many of these studies have assessed manifestations, prevalence, and drivers of disrespect and abuse (D&A) or mistreatment in facility childbirth.[2] In 2011, the White Ribbon Alliance (WRA) launched a global campaign to promote RMC as a universal human right, culminating in a charter for the rights of childbearing women, which was updated in 2019.[3,4] In 2015, WHO published a mixed-methods systematic review on mistreatment in childbirth that identified seven core themes: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and

> ***"Disrespect of our pregnant or delivering, laboring women in our settings is an issue*** *and it is not only in our setting, I can't say it is worldwide but it is in many areas of the world because when you read literature, articles published, you find it is everywhere. It is an issue because it is disturbing our women to seek care from [a] health facility, any care during pregnancy, during labor and delivery, even postpartum …"* (Second IDI)

health care providers, and health system conditions and constraints.[5] Women in Rwanda describe similar experiences to those found globally. Our qualitative findings confirmed that although many of the respondents believed that the overall QoC women receive during pregnancy and childbirth has improved, mistreatment is still taking place within the facilities (all FGDs and KIIs).

IMPACTS OF DISRESPECT AND ABUSE

D&A, or mistreatment, both violate an individual's rights and affects care-seeking practices and health outcomes.[6] Mistreatment experienced by women during maternal care can deter women from returning to health care providers and even discourage other women in the community from using facility maternity services. For example, denial of the freedom to choose a preferred birth position is recognized as a barrier to accessing care.[7] This reduces antenatal and postnatal care service utilization and coverage, potentially causing delay in treatment and poor maternal and child health outcomes.[8] Studies in Rwanda have shown that mistreatment and poor childbirth experience affect the perceptions of women and the community on when to seek care and what to expect when reaching a facility. Exposure to disrespectful care led women to feel powerless, unknowledgeable, sad, shamed, and fearful for themselves and their newborns, deterring women to seek care, ask questions, or aspire to have children.[9–11] Mistreatment also led to distrust in health care providers, influencing facility choice for future pregnancies.[12]

DRIVERS OF DISRESPECT AND ABUSE

Mistreatment during childbirth is a complex, multi-factorial problem that may require solutions at multiple health system levels, depending on local drivers of mistreatment and facilitators of RMC.[2] Drivers of mistreatment identified in the 2015 consultation mirrored global literature—ranging from health system issues (poor infrastructure, staff shortages, lack of training on respectful care) to a culture of discrimination based on social class, age, occupation (sex workers), stigma about HIV status, and single mothers, and teens.[13] The FGDs and KIIs corroborated these findings, discussing the pressure providers experience, excessive workloads, poor compensation, and lack of recognition.

NEWBORNS

Until recently, the experience of newborns has been largely absent from the conversation on RMC.[14] However, there has been a recent attempt to address the gap in evidence showing that many newborns are not receiving the full complement of recommended practices after birth, with some receiving care that may constitute mistreatment. In 2019, an SA conducted by the Maternal and Child Survival Program (MCSP) found that "Though mothers reported positive experiences of care by doctors and nurses, they also reported that communication was inadequate, privacy was lacking, and staff did not respond sufficiently when infants were in pain, suggesting that the experience of care was not as positive as reported."[15]

INTERVENTIONS

Below we summarize interventions shown to have an impact at each health system level.

NATIONAL/SUBNATIONAL LEVEL: Policy and advocacy development conducted at the national and subnational levels with level-appropriate stakeholder engagement; guidelines, curricula, and trainings include professional ethics, RMC principles, and standards of care in pre- and in-service education; and budget and financing for RMNCAH operational plans.

FACILITY LEVEL: Link interventions with facility-based quality improvement processes; create support for health workers/"caring for carers;" team building and on-site workshops for providers; maternal and

perinatal death surveillance and response at both the facility and community levels to continuously engage stakeholders to prevent future deaths; open maternity days/open birth days; patient satisfaction surveys focusing on RMC (not mistreatment) as motivation for staff; and community-facility dialogue to break down barriers between providers and women and their families to co-create solutions to address mistreatment and promote respectful care.

COMMUNITY LEVEL: Social accountability approaches such as participatory budgeting, public expenditure tracking, citizen report cards, community scorecards, social audits, citizen charters, right-to-information acts, and health committees;[2,16] and education campaigns and community-facility linkages.

Interventions specific to Rwanda include the integration of key RMC principles into basic emergency obstetric and newborn care training tools;[17] the addition of RMC indicator for birth companion of choice into the national health management information system;[18] and infrastructure improvements including new or renovated maternity wards, partitioning with curtains between beds to provide privacy to laboring women; integration of key principles of RMC into Obstetrics Care Protocol; and mentorship programs and tools.

"Yes, I think the challenge is that traditionally we have been appreciating the quality of maternity care in terms of the outcome from the pregnancy, like the mother is alive, the baby is alive. We clap for ourselves that everything is fine. But the experience of care and the respect in the respectful maternity care has not been given due attention, and I think it is an issue of behavior change." (FGD 3)

POLICY

Although global standards and frameworks must be translated into policies at the national level, who should lead this effort and with what resources remain challenges. National laws and policies with enforcement and accountability structures are critical components for improving RMC and for citizens to hold governments accountable.[19] Studies have found that facility-level policies with multiple RMC components reduce overall D&A and improve women's experience of RMC.[20] Others have stressed the importance of an enabling legal and policy environment so that RMC is integrated across policies and programs.[21] Countries must contextualize what these policies and laws look like, and there remains a "need for rigorous research to refine the optimum approach to deliver and achieve RMC in all settings."[20] Despite this gap in national- and facility-level policy understanding, there are examples from the region that can be drawn from:

A. Ethiopia's *National Reproductive Health Strategy (2016–2020),* in which the country includes RMC throughout its health strategy.[22]

B. Creation of practical tools, such as guidelines for midwives and nurses, to support the implementation of policy. In Tanzania, standalone national guidelines supported policy on RMC through the *National Guidelines on Respectful and Compassionate Nursing and Midwifery Care (2017) and The National Guidelines for Gender and Respectful Care Mainstreaming and Integration Across RMNCAH services in Tanzania (2019)*.[23,24] Unlike language placed in policies, these are entirely RMC focused and provide practical implementation strategies and suggested monitoring and evaluation (M&E) frameworks that can be used at all levels of the health system.

C. Endorsement of the WRA RMC Charter, as was done in several countries such as Nigeria and Nepal.

MEASUREMENT

No single measure can capture RMC. The WHO vision and framework for quality of maternal, newborn, and child health (MNCH) care includes eight aspirational standards (domains of quality care), of which three are categorized as "experience of care" standards (refer to WHO QoC standards): effective communication, respect and dignity, and emotional support.[25] RMC and mistreatment in childbirth occupy two extremes of a continuum, and women and newborns may experience a mix of both positive RMC and negative mistreatment along this continuum.[26] Measures should capture both this continuum as well as positive and negative attributes of care. The following are tools to review when selecting indicators and M&E strategies: Person-Centered Maternity Care (PCMC) Scale; Mistreatment in Childbirth (MIST) Index and Mother's Autonomy in Decision Making (MADM) Scale & Mothers on Respect (MOR) Index; tools derived from the Maternal Child Survival Program's RMC Operational Guidance; QoC MNCH Network Monitoring Framework; and *Measuring and Monitoring Quality of Health Care Services to Improve Care for Women, Newborns, and Children: A Practical Guide for Program Managers* (expected publication in November 2023).

There have been several attempts to explicitly define and measure mistreatment of newborns, yielding strong tools for global and national use. One tool selected indicators to assess mistreatment of newborns based on WHO's 2016 "Standards for improving quality of maternal and newborn care in health facilities" QoC statements and process of care. Following this, Sacks developed a typology of mistreatment of newborns that adds bereavement at posthumous care and legal accountability to the seven first-order themes identified by Bohren's typology of mistreatment of women during childbirth. Abuya and colleagues expanded to include inappropriate feeding practices.[5,14]

COVID-19'S IMPACT ON RESPECTFUL MATERNITY CARE

The COVID-19 pandemic continues to adversely affect maternal health services. There has been continued interruption of the availability of antenatal care and childbirth services, disruption of essential supplies and logistics, diversion of attention away from maternal health, reduction of women seeking maternal health care services out of fear of infection, inappropriate separation of mothers and newborns, and reduced interpersonal care to minimize contact between clients and service providers.[27] Several impacts have been documented in Rwanda of both the government response to the COVID-19 pandemic and the new reality in health centers. Travel restrictions prevented women and providers from getting to facilities; the fear of women and providers of contracting COVID-19 affected the way women experienced care; and staff shortages led to burnout and anxiety across midwifery cadres.

PUTTING IT ALL TOGETHER: EVIDENCE-BASED RECOMMENDATIONS AND POLICY DIALOGUE PROCESS

Multiple messages were clear from the qualitative data—stakeholders believe much progress has been made during the past seven years, providing clear insights on what changes must occur at the policy and implementation levels for Rwanda to reap the full benefits of RMC. This SA underscores strong existing RMC interventions that need to be systematized with policy to power implementation to scale. For the PD workshop held August 1 and 2, 2022, we proposed strategies to consider when building RMC policy language to guide sustained decision-making and program design for impactful implementation. We divided the recommendations into what is working well and should be continued, what should be done now, what should be done in the next 18-24 months, and what are the long-term plans for the next three to five years, and shared with PD participants.

POLICY DIALOGUE WORKSHOP AND OUTCOMES

MOMENTUM hosted the PD workshop, which included a diverse set of stakeholders representing the MOH/Rwanda Biomedical Centre (RBC), UN agencies, international nongovernmental organizations, community-based organizations, academia, and providers. Prior to the workshop, MOMENTUM hosted a series of joint planning sessions with RBC where they shared the findings of the SA that provided rich contextual evidence with priorities for consideration. The actual meeting was scheduled to take place over one and a half days with an additional day for advance preparation with an already-established RMC Policy Development Core Team constituted by the MOH.

Initially, the objectives were to provide an overview of the findings of the SA to provide partners and MOH/RBC colleagues a deeper understanding of Rwanda's RMC-specific situation, draft a policy addendum, and map concrete steps to finalize and launch the policy. Over time, these objectives were adjusted (discussed below), but they were what originally structured the workshop.

Participants were put into groups to discuss the seven themes that emerged in the SA: health workforce, health service delivery and resilience (particularly when confronted with "shocks" to the system), medical infrastructure, equipment and supplies, measurement and data use, financing, and partnerships and community engagement. The participants worked together to make suggestions for what should be included under each of the seven themes in any policy. They were not able to complete their worksheets during the set time for the workshop. Many competing priorities took over and the team was not able to participate on the second day. Ultimately, the following suggestions were made:

Companion of choice for improved maternal health

Evidence demonstrates the need for mothers who want one to have a companion of choice for her safety, satisfaction, and comfort.

- The right to a companion of choice should be part of the continuum of care between the community and health facility.
- Health infrastructure should be renovated, rehabilitated, or constructed to enable every mother to have a companion of her choice.
- Health facility staff should encourage women to have a companion of choice.

Human resources for health

The shortage of human resources for maternal health care is a barrier to implementation of best practices in RMC.

- The ministries in charge of the workforce should develop a particular strategy for health workforce retention.
- Existing opportunities—decentralized health system, private health facilities, health development partners—should be leveraged to help address this challenge.

The existing health workforce lacks the knowledge, skills, and attitudes to deliver RMC. However, it is recognized that this is also a product of not having adequate infrastructure, supplies and equipment, policies, and supportive supervision. The following were suggested:

- Inclusive RMC guidelines and protocols should be developed.
- RMC should be strengthened in all facilities.
- Capacity-building should target community health workers and health care providers.
- Awareness and knowledge should be built regarding any type of violence (physical, sexual, emotional, and verbal abuse) with an emphasis on inclusive services (no stigmatization of vulnerable populations).
- Health facilities (infrastructure, supplies, equipment) should be improved to create an enabling environment for the staff.

Engaging mothers and families

Mothers and their families lack the information they need to advocate for their right to RMC.

- Mothers and their families should be better involved in decision-making during the continuum of care.
- Awareness and knowledge should be built regarding any type of violence (physical, sexual, emotional, and verbal abuse), harmful social norms in the community, and available RMNCAH services.

LESSONS LEARNED FROM THE POLICY DIALOGUE PROCESS

This was the first use of the MOMENTUM Country and Global Leadership Policy Dialogue Process Guide in Rwanda. The process allowed for a country-owned and -led multi-stakeholder engagement built on a systematic process backed by a deep understanding of Rwanda's RMC situation. The multi-stakeholder engagement provided an opportunity to build from evidence of other partners' most current data sets resulting in a shared opportunity to enrich the country's RMC SA findings. The Rwandan PD process mapped and engaged diverse subject matter experts (beyond clinical) to include those familiar with health care financing and M&E for wholistic policy priority setting. MOMENTUM guided these experts to establish thematic task force teams specific to policy interventions, leading to the development of practical considerations and language to be included in the policy, as presented in this document.

MOMENTUM supported the process with technical assistance and tools specifically designed to suit the local context, including a policy articulation worksheet for use by each thematic task force. The initial set of policy articulation timelines, starting with a two-day workshop, was insufficient to allow teams to deploy the technical rigor and consensus building needed. Led by the government, workshop participants planned for an additional three-day workshop to complete the policy inputs needed. Due to competing priorities faced by the country experts, the second workshop was not able to achieve all objectives, leading to a change of plans to allow each

thematic team to coordinate their inputs individually. These local dynamics led to a series of adaptations to ensure the PD principles designed to facilitate local experts' policy development process were implemented from start to finish. Plans to include an RMC policy addendum into the existing national RMNCAH policy changed due to the MOH hiring of an expert consultant to update the RMNCAH policy and a government directive to hold off on writing an addendum. Rather, the MOH requested that we develop a concise, document of two to four pages suggesting specific language for inclusion in the updated RMNCAH policy and Maternal Child Health (MCH) Strategic Plan. The resultant synthesized product with recommended policy language may be found here: Rwanda RMC Policy Document.

Based on the current Rwandan context, the following steps and categories are envisioned for action in phased segments. The action categories recommended are: what is currently working well and should be continued, what should be done in the 18 months following the policy language approval and long-term plans for the next three to five years.

WHAT TO CONTINUE:

- Respondents from FGDs and key informants suggested the **scale-up of existing successful programs** such as the promotion of companions of choice, the Patient Voice Program, and activities to educate women about their rights.
- Rwandan stakeholders identified the need to strengthen the **health workforce** through an expansion and more efficient management of the existing health workforce, and to invest in a sustainable and purposeful system of training, mentorship, and supportive supervision with set performance standards to reinforce behavior change. Capacity-building should target community health workers and health care providers.
- Sustained investment to ensure that facilities are adequately equipped to address root causes of D&A.

WHAT SHOULD BE DONE IN THE 18–24 MONTHS AFTER THE POLICY LANGUAGE IS ADOPTED:

- Draft guidance for how to implement policy in order to move policy into actionable change.
- Secure funding to support the action items of the new RMC specific language in the policy and strategic plan.
- Implement policy priorities in order to evaluate and make time for course corrections.
- Track and document progress and use learnings and data to inform priorities over the next three to five years, with adaptive management approaches suggested as one aspect of data collection and analysis.
- Hold quarterly learning and adaptation sessions to foster continued PD and ensure timely course correction:
  - This might need additional stakeholders depending on the sectors and ministries charged with some policy support roles as needed.

PROJECTIONS FOR THE FUTURE (THREE TO FIVE YEARS)

- To be able to invest optimally to propel this policy addendum into impact, sufficient financing, human resources and functional accountability systems should be clearly put in place by the third year, informed by the first two years of lessons. A costed plan should therefore be considered at the end of the second year.

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