



RWANDA RESPECTFUL MATERNITY CARE SITUATIONAL ANALYSIS

MOMENTUM Country and Global Leadership



MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches and strengthen the resiliency of health systems.

This situational analysis is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) under the terms of the Cooperative Agreement #7200AA20CA00002, led by Jhpiego and partners. The contents are the responsibility of MOMENTUM Country and Global Leadership and do not necessarily reflect the views of USAID or the United States Government.

Cover photo: Kate Holt/MCSP

Suggested Citation

MOMENTUM. *Rwanda Respectful Maternity Care Situational Analysis*. 2023. Washington, DC: USAID MOMENTUM.

TABLE OF CONTENTS

Acknowledgments	3
Abbreviations	4
Section 1: Purpose, Background, and Approach	5
Purpose.....	5
Background.....	5
Rwanda Background.....	6
Policy Dialogue.....	6
Methods.....	7
Section 2: Situational Analysis and Findings	9
Disrespect and Abuse/Mistreatment	9
Impacts of Disrespect and Abuse	12
Drivers of Disrespect and Abuse.....	13
Newborn Experience of Care	15
Promising Approaches to Addressing Mistreatment.....	16
Policy for RMC Promotion and Country Examples	19
Measurement	22
COVID-19’s Impact on Respectful Maternity Care.....	24
Section 3: Pulling It All Together: Evidence-Based Recommendations and Policy Dialogue Process	26
Lessons Learned from the Policy Dialogue Process.....	27
References	29
Appendix A: Interview Guides	33
Tool 1: FGD Guide for Policymakers	33
Tool 2: FGD Guide for Implementers, Technical Working Group Members.....	35
Tool 3: FGD Guide for Service Providers/Clinical Representatives.....	37
Tool 4: Interview Guide for MOH Representatives	39

ACKNOWLEDGMENTS

MOMENTUM Country and Global Leadership is part of a suite of innovative awards funded by the U.S. Agency for International Development (USAID) to holistically improve voluntary family planning (FP) and maternal and child health (MCH) in partner countries around the world. The project focuses on technical and capacity development assistance to ministries of health and other country partners to improve outcomes.

The MOMENTUM Country and Global Leadership Maternal and Newborn Health team gratefully acknowledge the contributions of many individuals in the preparation of this document. Key MOMENTUM contributors include Shanon McNab, Christine Mutaganzwa, Susan Moffson, Sean Dryer, Suzanne Stalls, Victor Mivumbi Ndicunguye, Angeline Ngina Mutunga, and Isabella Atieno Ochieng. And special thanks go to the following organizations for their contributions: the Rwandan Ministry of Health, Rwanda Biomedical Center, and members of the RMNCH Technical Working Group.

ABBREVIATIONS

ANC	antenatal care
D&A	disrespect and abuse
FGD	focus group discussion
GoR	government of Rwanda
HR	human resources
IDI	in-depth interview
KII	key informant interview
MCSP	Maternal and Child Survival Program
MNCH	maternal, newborn, and child health
MNH	maternal and newborn health
MOH	ministry of health
NHSR	non-human subject research
PCC	person-centered care
PCMC	person-centered maternity care
PD	policy dialogue
PEPFAR	President’s Emergency Plan for AIDS Relief
PNC	postnatal care
QI	quality improvement
QoC	quality of care
RBC	Rwanda Biomedical Centre
RH	reproductive health
RMC	respectful maternity care
RMNCAH	reproductive, maternal, newborn, child and adolescent health
SA	situational analysis
USAID	U.S. Agency for International Development
WHO	World Health Organization
WISN	Workload Indicator of Staffing Needs
WRA	White Ribbon Alliance

SECTION 1: 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) to support the development of an RMC policy to be included in the country's Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategy. The MOMENTUM Country and Global Leadership project (MOMENTUM), through funding from the U.S. Agency for International Development (USAID), partnered with the GoR to provide technical assistance in designing and writing this SA. The SA includes a review of global and Rwandan-specific literature, as well as findings from focus group discussions (FGDs) and in-depth interviews (IDIs) with key stakeholders in Rwanda.

The GoR's MOH currently has an RMNCAH Policy. Although the policy mentions person-centered care (PCC), it does not include any specific language about RMC. With growing evidence and global prioritization of RMC, the GoR is committed to optimizing global and local evidence to inform the inclusion of an RMC-specific addendum to the existing RMNCAH Policy.

Globally, much has been documented on the benefits of RMC. Numerous interventions have proven to positively impact women's and newborns' experience of care at the various levels of the health system. At the national level, they include policy development and concerted implementation, national-level guidelines and trainings. At the facility level, raising health worker awareness, instilling teambuilding, and hosting open maternity ward days have been effective. At the community level, interventions have included education campaigns, community-facility dialogues, and accountability mechanisms that give voice to mothers and families. Although Rwanda has continued to learn and act on some of these initiatives, there has not been policy guidance for systematic application of best practices, guided by the local context, to ensure that RMC interventions are part of routine service delivery with financial investments and accountability measures in place to track progress and measure impact.

The political and technical leadership in Rwanda is known to embrace change and spearhead reforms. To this end, we intend for this SA is to be an evidence synthesis tool to support evidence-based dialogue between the government and partners to draft and include RMC-specific language to ensure that the health system delivers quality care to all pregnant mothers and newborns during childbirth.

This SA is organized into multiple sections to provide an overview of the current global RMC context and that specific to the Rwanda context. The sections are: Background; RMC Overview (including definitions of disrespect and abuse [D&A] both globally and within Rwanda), Impacts of D&A, Drivers of D&A, Newborns and RMC, Interventions, Measurement, Impact of COVID-19, Policy and Discussion and Recommendations.

BACKGROUND

In the last decade, RMC has garnered much-deserved attention. From the global to country level, there has been increased recognition of the need to improve the quality of care (QoC) women and newborns receive as well as many documented changes in the treatment and care provided. Given that the World Health Organization (WHO) has included women's experience of care in its QoC framework, country governments and diverse sets of partners have been working to operationalize these recommendations within their particular contexts. However, despite overall advances in maternal and newborn health (MNH) outcomes, ensuring that women, newborns, and families receive this much-needed respectful care during childbirth remains a challenge worldwide.¹ In many countries, women experience mistreatment during childbirth and are unable to make choices that put them in control of their own experience (Bowser and Hill 2010; Bohren et al. 2015).^{2,3}

In addition to other health systems and human resource (HR) constraints, staff may not receive guidance or support to ensure an enabling environment for the provision of RMC.⁴ Women still fear the implications of coming forward to share their experiences, especially when they are delivering in the only health facility accessible to them in the future.

These realities have been studied and interventions tested for the last decade. Since 2010, the global MNH community has witnessed a rapid expansion of evidence-based advocacy, research, and program implementation focused on improving women's and newborns' experience of care during facility-based childbirth and health care providers' experience of providing care.¹ There are numerous learnings from research approaches, policy creation, and implementation strategies that can be used to inform countries as they continue to make RMC a core aspect of their provision of care. It is how those lessons are then translated into real action by countries that remains a challenge.

RWANDA BACKGROUND

Rwanda has been working to improve the clinical and experiential QoC for women during the pregnancy, childbirth, and postpartum periods for the past two decades, while considering RMC as a serious issue. In 2015, Rwanda held its first national stakeholder consultation on RMC. This meeting was then followed by a global push and a bold statement from the WHO calling for greater action, dialogue, research, and advocacy on RMC—an important public health and human rights issue.⁵ Participants at the stakeholder consultation reviewed the thinking at the time on RMC, described the local context for D&A in maternity care in Rwanda, and outlined drivers of disrespectful and abusive care and systems factors that affected the provision of RMC.⁶ The consultation resulted in a set of guidance and proposed solutions to address existing forms of D&A in maternity care in Rwanda. Although implementation of interventions began, a section was missing that explicitly mentioned RMC within the RMNCAH policy, a section and language that some would argue would give weight to their RMC interventions.

POLICY DIALOGUE

Recognizing this gap, the Rwandan MOH and USAID's MOMENTUM partnered to conduct this SA of the current policy and implementation environment in the country and make 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 itself through policy and program interventions with matching advocacy and accountability mechanisms to ensure implementation follow-through to impact. This SA will inform a larger and progressive policy dialogue (PD) led by the Rwandan MOH with initial technical assistance from the MOMENTUM team. The PD process is designed to involve a diverse set of country stakeholders to ensure long-term implementation of the resultant RMC component. The targeted diverse stakeholders must include other aligned ministries as part of the SA process and the PD consensus meetings. They include ministries of finance and planning, gender, and others.

WHY IS IT STRATEGIC TO BEGIN INSTITUTIONALIZING CHANGE AT THE NATIONAL POLICY LEVEL?

Policy is a system lever for improvement of health programming and is a foundation for ongoing changes in health system interventions that include respectful care. Addressing the current gap between national-level goals and ambitions through a national policy will ensure that much of the work being done at the level of the health facility is done well and is sustained over time. Recognizing that policy can be beautifully written but may ultimately “sit on a shelf,” resulting in little change, this process strives to make the policy as action oriented and evidence based as possible. This process will adapt the project's newly developed *Guide to*

Policy Dialogue Process that includes lessons from diverse PD approaches and experiences. This guide is currently being applied for the first time in several countries including Rwanda. User experiences will further enrich the guide for final publication to ensure that it optimizes the most current learnings from countries as a practical guide to rigorous PD processes so that all key players and partners are appropriately included in shaping policy discussions and decisions.

WHAT IS THE PD PROCESS ABLE TO DELIVER?

Any policy drafted or adapted will not succeed or fail by itself, rather the success of a policy depends on the process taken to develop the policy and implement it. A co-designed process ensuring active participation of all users has been shown to improve overall support and acceptance for the policy. The PD process is a timely, deliberately constructed, well-resourced, and iterative discussion among a wide variety of stakeholders to reach consensus. The highly adaptable process engages all stakeholders at all levels of policy formulation, implementation, and tracking to ensure that evidence-based policies are made and implemented effectively for the good of the intended communities or individuals. MOMENTUM and the Rwandan MOH have adopted this process and prioritized the importance of a rich co-design process to include explicit RMC language in existing policy that will have the support of stakeholders. The ultimate intent is to build a deep understanding of why the RMC policy addendum is needed now and generate needed ownership and secure commitment to power its immediate implementation. This SA will be a basis for informing the participants of the current global and Rwandan-specific context of RMC from which to begin discussing language and interventions to promote.

METHODS

MOMENTUM conducted several literature reviews and collected qualitative data through FGDs and key informant interviews (KIIs) for the SA. Details of each method used are provided below.

LITERATURE REVIEWS

GLOBAL

A desk review of current RMC literature was conducted to provide a broad understanding of global best practices for RMC interventions, current charters/standards/policies that promote RMC or include RMC in their language, drivers of disrespectful treatment, and inclusion of newborns and measurement. Much of this literature review was conducted in 2020 as part of a larger landscape analysis on RMC conducted by MOMENTUM. This SA provided an opportunity to further expand the searches. The search strategy included a combination of the following search terms: respectful maternity care and one of the following: policy, newborns, bereavement, accountability, measurement, intervention, and COVID-19. Dates were from 2020 to the present and articles were excluded when they were already noted in the previous landscape analysis, did not include RMC in a low- or medium-income country, or were not in English.

RWANDA

A literature review was conducted to understand what has been written on RMC and/or mistreatment in Rwanda since the last review in 2015. The review included peer-reviewed articles and grey literature articles obtained through multiple database searches conducted between March–May 2022. The search strategy used a combination of the search terms respectful maternity care and Rwanda and was limited to articles published between 2015 and 2022. Articles were excluded if they did not provide information on RMC or mistreatment *and* did not provide information within the context of Rwanda. Data were extracted from included articles using an Excel spreadsheet for information regarding definition of use for RMC and mistreatment, mistreatment outcomes and prevalence, drivers of mistreatment, impact of mistreatment, facilitators of RMC, policy-related findings, intervention-related findings, and important country context.

QUALITATIVE DATA COLLECTION

DATA COLLECTION:

MOMENTUM conducted qualitative research with policymakers and selected implementing partners, including civil society to gain a deeper understanding of the challenges, barriers, and successes related to implementing RMC interventions in Rwanda. MOMENTUM country and regional staff conducted three semi-structured KIIs and two FGDs remotely (via Teams) with key national stakeholders in Rwanda, including policymakers, civil society/implementers, donors, and health care providers/provider representatives. Each FGD had four participants. In total, 11 interviewees were selected based on their official program portfolios to achieve diverse perspectives of policy users. **See Annex A for the survey tool.** Engaging local and regional staff with lived experience with the national policymaking ecosystem clarified the SA's purpose and enhanced country-level buy-in with an understanding of the call to action from the beginning. This engagement is critical in facilitating sustained action, progressive PD, and advocacy for RMC policies.

One key objective of these KIIs was to gain the perspective of key stakeholders throughout the levels of the health system and understand from their view what has helped or hindered the implementation of RMC (if any), programs, and best practices. The three questions for this component of the activity were:

1. What are existing programmatic efforts related to RMC?
2. What is the status of implementation of current RMC policies and programs/interventions, if any, including at the health facility level?
3. What is the impact of COVID-19 on RMC?

DATA ANALYSIS

Recordings of all FGDs and KIIs were transcribed. Transcripts were reviewed in full, then coded to a set of *a priori* structural thematic codes designed to group information relevant to each research question and align with the literature review to facilitate triangulation among data sources. Three researchers reviewed the excerpts coded to each structural code and extracted key themes, and then met to compare the results of their discrete analyses and agree on descriptive codes to capture the themes within each domain. The material within each structural code was coded in a second round to the corresponding descriptive codes, and material under each descriptive code was reviewed, with summaries and illustrative quotes extracted for this report.

INSTITUTIONAL REVIEW BOARDS

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.

SECTION 2: SITUATIONAL ANALYSIS AND FINDINGS

Below are findings from the literature reviews and qualitative data collection. The findings are presented by themes and then separated by the global level and then the Rwandan-specific findings. The topics cover D&A/mistreatment definitions and manifestations, impact, drivers, interventions, policy, COVID-19, measurement, and recommendations.

DISRESPECT AND ABUSE/MISTREATMENT

GLOBAL

As discussed, there has been a tremendous upsurge of publications on the topic of RMC from around the world. The majority of these studies have assessed manifestations, prevalence and, to a lesser extent, drivers of D&A or mistreatment in facility childbirth.⁷ In 2011, the White Ribbon Alliance (WRA) launched a global campaign to promote RMC as a universal human right, culminating in a WRA-led charter for the rights of childbearing women, which was updated in 2019 (WRA 2019).^{8,9} In 2015, the WHO published a mixed-methods systematic review of the literature on mistreatment in childbirth that identified seven core mistreatment themes: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and health care providers, and health system conditions and constraints.³ Mistreatment during childbirth is one of the biggest disincentives for utilizing institutional care and receiving quality maternity care in the public and private health care system. Prevalence ranges from setting to setting, but the global community agrees that mistreatment is a global problem and one that needs to be addressed urgently.

RWANDA

Mistreatment is comprised of the presence of negative interactions or the absence of positive interactions between providers and clients (i.e., women, husband/family).¹⁰ Mistreatment, as described in the experiences of women in Rwanda, is similar to what has been found globally and includes: neglect, verbal and/or physical abuse, insufficient information and time with provider, denial of husband as birth companion, unconsented procedures, lack of privacy, not receiving necessary relief for pain, lack of skin-to-skin contact, delay in treatment, unavailability of required health services, birth attendance preference, and unclean health facilities.¹¹⁻²⁰

“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)

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 very prevalent within facilities (all FGDs and KIIs). Respondents frequently noted that, although there may be an understanding of what constitutes D&A among high-level stakeholders, this is not clear to many direct providers of maternity services. Below are examples of what women have experienced in Rwanda, based on both the literature and the qualitative data.

Neglect

Neglect by health care providers includes not paying attention to a woman's needs, such as not being with her or not being her enough, not reacting or only responding after repeated calls from a woman or her companion, and ignoring or refusing to listen seriously to a woman's history, situation, or wishes. Neglect constitutes lack of empathy, indifference, and disinterest.¹¹

An example of neglect as reported by a birthing woman in Rwanda:

“When I was still alone, I happened to scream out to the nurse behind the curtain and she did not come. I yelled again saying that the baby’s head has come because I was alone and thought it had. The nurse came and said, ‘the cervix is yet to open,’ and left again ... I went on pushing, while alone, until the baby’s body came out. I called the nurse again and she picked up the body from the delivery table.”¹¹

Verbal and/or physical abuse

One mixed method study, using both self-administered surveys and FGDs of providers of reproductive, maternal, and newborn health services at public health facilities and district/referral hospitals, found that 30% of providers believed that yelling or shouting at a woman during labor was sometimes necessary to get the woman to push.¹² An observational study conducted in a Rwandan hospital noted an anesthesiologist yelling at a woman in labor who required surgery, which was delayed due to waiting on appropriate staff and supplies. The same study also found doctors hit a woman and pressured her to give birth in the conventional position on the bed when she wanted to deliver in the squatting position.¹³

Our qualitative findings confirmed what has been published. One of our key respondents noted: “everyone knows that there are some rude and very harsh midwives and nurses as well as doctors.” (Fourth IDI) Another respondent noted that it may be even worse for specific groups such as adolescents, saying:

“About adolescents, it is really bad, because when they have like those teenage pregnancies, and when you find them at the health facility, and if they meet that provider who doesn’t value respectful maternity care, that child or that adolescent will not come back to the health facility ...” (Second IDI)

Communication: Insufficient information, limited time with provider, and unconsented procedures

Rwandan women experience disrespectful communication, which includes insufficient information, little time with providers, unconsented procedures, and rude overall interactions. In one study, women reported not being given information and explanations about their condition and procedures that they would need to undergo, such as suturing and episiotomy.¹¹ Multiparous women also reported being more likely to receive less information with the assumption that they were experienced and knowledgeable, despite wanting further information about their current condition.¹⁴ Additionally, another study conducted in health centers in the Northern Province of Rwanda and Kigali City found that 25.3% of antenatal care(ANC) providers reported spending ≤15 min consulting with a pregnant woman.¹⁵ And another study reported that 30% of women were left with questions or felt confused after an ANC visit.¹⁶ One new mother explained the impact the lack of information had on her birthing experience in Rwanda:

“I was feeling like a cow they were taking to slaughter, when people are looking at things without explaining to you and you don’t see anything. When a person doesn’t tell you that you have a certain problem, you wonder if you will die or live. You think that there is something that they are hiding from you.”¹¹

A respondent from the FGDs explained the ongoing challenge with communication:

“So, I can say that the problem we have until now it is still, for example, lack of communication or proper communication during childbirth or even after ... some of the providers are not [communicative]. I can say they don’t have compassion and empathy and they are not speaking with good respect to those mothers.” (First FGD, A)

Inability to have a birth companion

Due to cultural gender norms and limited facility space, husbands are often not allowed to enter the delivery room and provide support as a birthing companion, leaving women feeling unprotected.¹¹ In one study conducted in health centers, and district and referral hospitals, only one woman (0.2%) was accompanied by her husband during birth.¹⁷ The issue of having a companion of choice came up several times in the qualitative research. Respondents felt that women were often not allowed to have birth companions but that it was mostly due to infrastructure and limited ability to provide privacy for the other women (First FGD).

Lack of privacy

Many studies emphasize the importance of privacy as an element of respectful care. Several women explained how they felt embarrassed throughout their birthing process and that their private parts had been exposed to strangers while in the facility.¹⁴ One birthing woman in a Mibilizi district hospital explained:

“They hurriedly moved me on a stretcher from the labor ward to [the operating] theater through corridors with many patients and I think caregivers, [with] my breasts exposed.... I felt uncomfortable but it was an emergency” (mother 14 primiparous).¹⁴

The key informants also noted that privacy was a challenge for many of the providers in their attempts to provide RMC to women due to a lack of curtains, limited space, attempting to allow birth companions, and the very nature of the facility. However, one key informant in a focus group noted that he felt that privacy was an area where Rwanda has really improved from the RMC perspective despite these challenges, noting “something that improved a lot also in maternity is privacy” (First FGD, Interviewee A).

Lack of necessary pain relief:

One study in 18 health facilities (health centers, district hospitals, referral hospitals) in Kigali City and Northern Province found that very few women received pain relief. Only 1.8% of participants who gave birth in the health facilities received pharmacological pain relief and 1.4% non-pharmacological pain relief.¹¹ Another household study in the Northern Province and Kigali City reported a nurse who denied the provision of pain relief.¹¹

Not receiving skin-to-skin contact

The ability of women to be with their babies following delivery and provide skin-to-skin contact is an important aspect of RMC in which Rwanda has shown great progress with 80% of live births in health facilities receiving skin-to-skin contact.²¹ However, these appear to be recent improvements. Studies conducted in 2017 and 2019 found that though it is a predictor of positive childbirth experience and maternal satisfaction, it is not universally done.^{17,22} One study in health centers and district and referral hospitals found that only 12.5% of the women had early skin-to-skin contact with their babies within one hour after birth.¹⁷ The issue of skin-to-skin contact will also be discussed in the section below on COVID-19—the denial of skin-to-skin contact was a near immediate response to the COVID-19 pandemic, which only further exacerbated stress and mistreatment during already anxious times.

Health system constraints

It is nearly impossible to deliver high-quality RMC without adequate and appropriate resources such as staffing, infrastructure, electricity, supplies for delivery, and ambulances.¹³ However, the Rwandan health system regularly experiences staff shortages and lacks essential services, such as ambulances.^{13,14,16,18,19} A qualitative study of postpartum women in Kigali City and Northern Province reported women perceiving inadequate provision of health care services, such as ambulances, as the reason for their health problems.²⁰

The respondents in our qualitative research also noted the importance of well-equipped facilities, but focused on the impact of overworked and overburdened health care providers. When talking about mistreatment, one respondent—herself a midwife—explained:

“If I am overwhelmed, I am tired, I have issues of not having a rest, I can at the end have a burnout and from burnout, it can compromise my empathy, my compassion to the client, that can happen to providers, I am talking to those who are not having that character of personality of rudeness or being harsh.” (Second IDI)

Rwanda has faced a chronic shortage of health care workers and was reported to have approximately only one physician, seven nurses and midwives, and three other health care workers per a population density of 10,000, which was far below WHO’s 2016 recommendation of 44.5 doctors, nurses, and midwives per 10,000.²³ Even more alarming, according to WHO’s *Global Health Observatory*, there has been a declining trend of doctors from 1.38 doctors per 10,000 in 2017 to 1.18 doctors per 10,000 in 2019.²⁴ An analysis using the Workload Indicator of Staffing Needs (WISN) conducted in 42 district hospitals and 460 health centers in 2014 found that the number of midwives available was only 14% of the number required. Since then, from 2018–2019, another WISN study found that the available workforce had improved to 70% of the required number of midwives, which still reflects significant shortages.²⁵

Outlook:

Despite the findings above, in both the literature and in our qualitative findings, it appears though mistreatment still exists, there has been much improvement over the last few years. One woman attending reproductive, maternal, and newborn health services at a public health facility noted: “You don’t see many people like that. Now many are really trying ... It is now rare to see a health provider who insults someone.”¹² And a participant in our FGDs confirmed that he felt the care had improved: “If you compare it with like 10 years before, I can say we have made some improvement” (FGD respondent [First FGD, Interviewee A]).

IMPACTS OF DISRESPECT AND ABUSE

GLOBAL

D&A, or mistreatment, not only violate an individual’s right to respectful care but it also affects care-seeking practices and health outcomes.²⁶ Mistreatment experienced by women during maternal care can deter women from returning to health care providers and can 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.²⁷ This negatively impacts ANC and postnatal care (PNC) service utilization and coverage, potentially causing delay in treatment that results in poor maternal and child health outcomes.²⁸ One study in India found that women who experienced mistreatment (e.g., discrimination) by providers during childbirth had significantly higher odds of obstetric complications at delivery and postpartum (e.g., obstructed labor, excessive bleeding).²⁹ Meanwhile, respecting a woman’s right to choose birth positions can improve a woman’s comfort level during labor and speed up the birthing process, reducing the need for unnecessary maternal interventions and reducing abnormal fetal heart rate.^{30,31}

RWANDA

Studies conducted in Rwanda have shown that mistreatment and poor childbirth experiences impact the perceptions of women and the community in relation to when to seek care and what to expect when they do reach a facility. Exposure to disrespectful care led women to feel powerless, unknowledgeable, sad, shamed, and fearful for themselves and their newborns, deterring women from seeking care, asking questions, or aspiring to have children in the future.^{11,19,20} Mistreatment also led to distrust in health care providers and facilities, influencing the choice of facilities for future pregnancies.¹⁷

A birthing woman in Rwanda reported that the mistreatment she experienced led her to deliver alone on the floor:

“When I arrived, I met a health professional, he examined me, asking me when the contractions had started, and shouting at me. I felt offended and wondered if this person who shouts like this to me would manage to help me give birth. ... I felt desperate and told my mother not to call the nurses anymore and prayed, ‘Oh Lord, you will do what you want to do.’ My mother and the other companion supported me until I gave birth on the floor.”¹¹

In one study conducted with both men and women, men also shared the stories of mistreatment their wives had experienced and the effect on their perception of childbirth:

“... some tell of sad stories about their deliveries, and they even think that they should not give birth anymore because of the abuse and mistreatment that they receive. (Men FGDs 1)”¹⁹

One woman shared how she was mistreated during delivery:

“I remember way back when I had gone to deliver my baby instead of being assisted, the nurses kept insulting me (you enjoyed doing it, why are you screaming now), don’t try and scream here. Nurses are just there not helping; you wonder if it’s a health facility you were brought to?” (Elderly women FGDs 2)”¹⁹

DRIVERS OF DISRESPECT AND ABUSE

GLOBAL

There is global consensus on the need to better understand the local forms and drivers of both RMC and mistreatment. This understanding will guide the design and implementation of interventions to improve RMC and reduce mistreatment. Mistreatment during childbirth is a complex, multi-component problem that may require solutions at various levels of the health system (national, regional, district, primary, and referral levels, as well as community), depending on local drivers of mistreatment and facilitators of RMC.⁷ The 2015 systematic review about mistreatment of women in health facilities by Bohren and colleagues demonstrated that mistreatment can occur at the level of interaction between the woman and provider, as well as through systemic failures at the health facility and health system levels.³ Taking into account the nature of interpersonal and system levels of RMC and the wide array of drivers of mistreatment, it is recommended to implement both bottom-up (e.g., individual level, including women, communities, service providers) and top-down (e.g., mostly national policies and guidelines) health system strengthening to promote RMC.³² It is essential to identify local drivers of mistreatment reported by women, providers, and families—through an SA—to ensure that RMC approaches are responsive to and more likely to be effective in the program context. The table below provides a brief snapshot of types of mistreatment discussed globally and their drivers.

TYPES OF MISTREATMENT AND SELECTED DRIVERS

Type of Mistreatment	Driver(s)
Physical abuse	Power asymmetries; control of women to force compliance
Sexual abuse	Power and control
Verbal abuse	Power asymmetries; “othering” or negating someone’s humanity Inadequate staffing/long hours worked; moral distress/burnout Gender inequality and structural GBV Mistreatment of health workers
Stigma and discrimination	Social stigma against marginalized populations (e.g., adolescent mothers, unmarried women, mothers who are HIV-positive, women with disabilities); maintenance of hierarchies
Failure to meet professional and ethical standards of care	Lack of professional ethics and explicit standards of care Power and control; punishment for women’s non-compliance Inadequate health system; provider moral distress/burnout Medical culture/socialization of students
Poor rapport between women and providers	Medical culture/socialization of students Fear of losing face (being embarrassed), liability, blame for a bad outcome Societal gender inequality/disempowerment of women Provider burnout/moral distress Poor communication skills/lack of training
Health system conditions and constraints	Non-supportive work environment; lack of professional development opportunities Medical culture/socialization of students Inadequate staffing

Adapted from the Maternal and Child Survival Program (MCSP) (2020), Appendix 2.⁷

RWANDA

In the 2015 consultation, the drivers of mistreatment identified were in line with what is found in the 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 around HIV status, and single mothers and teens.⁶ The stakeholders participating in the FGDs and KIIs corroborated these drivers. They discussed the impact of the pressure providers are under including excessive workloads, poor compensation, and lack of recognition. Health workers may still not be aware that certain behaviors are unacceptable. One FGD participant felt it was a combination—while some providers may not be aware, others very much are:

“They don’t know that [it] is even disrespectful to the rights of mothers and, of course, there are others that do it as a malpractice, and they know that they’re doing wrong things, but there are other aspects that are not yet fully well understood.” (Third FGD, F)

The culture of the health facilities was often discussed as a driver of the mistreatment. Hospitals and health centers can have a hierarchical nature, and the relationship in that hierarchy between the health care provider and maternity client may not be conducive to respectful care, or to creating a space where women feel comfortable voicing their complaints. Stakeholders also discussed infrastructure issues that contribute to mistreatment such as limited space and lack of curtains at times hampering privacy and the ability of birth companions to be allowed into a facility to support laboring women.

NEWBORN EXPERIENCE OF CARE

GLOBAL

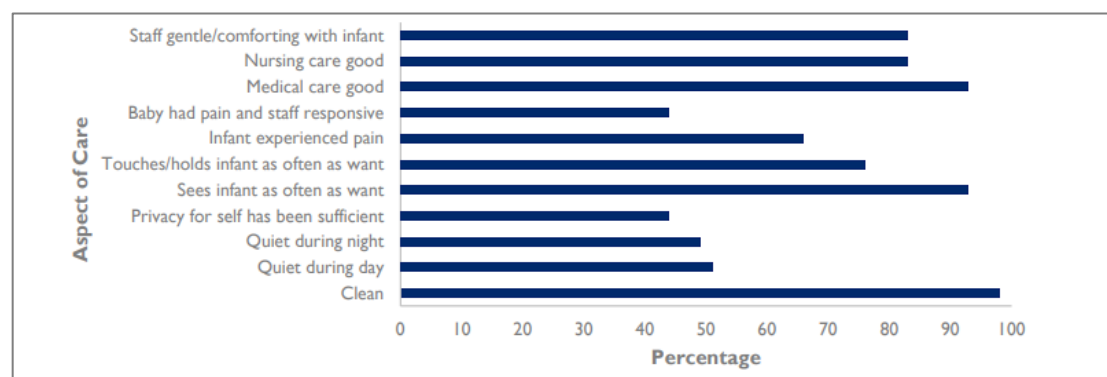
Until recently, the experience of newborns has largely been left out of the conversation of RMC.³³ In 2017, Defining disrespect and abuse of newborns: a review of the evidence and an expanded typology of respectful maternity care sought to address the gap in evidence on QoC and respectful care for newborns (and families of stillborn infants) around the time of birth. As part of a four-country study of MIST, WHO collected data on 15 newborn care practices across nine facilities in Ghana, Guinea, and Nigeria. It was the [first multi-country research describing the experience of care received by newborns in the first two hours after birth](#).³⁴ The study found that many newborns are not receiving the full complement of recommended practices after birth; some are even receiving care that might constitute mistreatment. Since 2019, there have been further studies that explored the experience of the newborn, as well as the mother-baby dyad and found high rates of mistreatment.^{33,35} Researchers have identified the need to better understand women’s and families’ expectations and preferences around facility-based neonatal care practices, as well as what practices might constitute mistreatment.³⁴

Stillbirth can be a devastating life event for women and their families. How women and their partners are treated following a stillbirth, what is explained to them, how they are spoken to and the opportunities they are given to decide how to connect (or not) with the baby have long-term implications on women’s mental health. Research has found that “empathic behavior in all encounters between bereaved parents and care providers can minimize additional emotional and psychological costs, both immediately after the stillbirth of a baby and in the longer term.”^{36,37} Respectful bereavement care should be provided immediately following a stillbirth and should be part of routine care practices for any health cadres working with women. This care may include supporting women in seeing and holding their babies to create memories with them, which have been shown to be helpful in maximizing parents’ well-being.³⁸ Providers should also have access to support for themselves after any maternal or neonatal death.³⁷

RWANDA

Though not much has been written about the experience of newborns in Rwanda, there are some studies and situational analyses, including the qualitative findings that suggest that newborns should be explicitly included in any work done on RMC in the future. An SA conducted by MCSP in 2019 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.”³⁹ The survey results shown below provide an insight into how caregivers perceived the care of their newborns.³⁹

FIGURE 1: CAREGIVERS’ PERCEPTION OF RESPECTFUL CARE (N=41)



From MCSP report noted above.

PROMISING APPROACHES TO ADDRESSING MISTREATMENT

GLOBAL

RMC is promoted through the delivery of care that is respectful and responsive to the needs, preferences, and values of women (person-centered maternity care [PCMC]).⁴⁰ Identifying humiliating actions and mistreatment in local context, and creating policy, guidelines, and protocols in RMC can lay the foundation for RMC and provide a link between the community and facility.^{16,19} Approaches to promote RMC and reduce mistreatment should be implemented according to the appropriate levels of engagement. At the national and subnational levels, the roles of advocacy and accountability and development of policies and guidelines are critical in setting the standards for RMC. At the facility and service delivery levels, the focus is on the awareness and capacity of health care providers and organizations to provide and improve RMC. At the community level, community channels can be utilized to promote RMC and break down barriers between facilities/providers and clients. Much has been written about interventions globally, and a detailed table of interventions can be found in MCSP's RMC operational guidance in "Appendix 3. Various Approaches for Promoting RMC and Reducing Mistreatment Described in Studies Across Different Contexts," found [here](#). Below, we summarize the current types of interventions that have been proven to have an impact at each level of the health system.

National/subnational level:

- **Policies and advocacy:** Advocating for national-level policies to overcome structural barriers to RMC (e.g., basic infrastructure, commodities) and favorable client-centered and human-rights-based policies that prevent and eliminate mistreatment in maternal care. Advocacy and policy development can and should be conducted at the national and subnational levels with appropriate stakeholder engagement.
- **Guidelines and training:** Guidelines are created to set professional standards, including incorporating professional ethics training into the curriculums of pre-service education and in-service training for maternity care providers. Additional supervision and mentoring can enforce professional ethics into practice.
- **Budgets and financing:** RMNCAH operational plans are funded nationally to address critical system weaknesses.

Facility level:

- **Linkages with quality improvement (QI) processes:** Ensure that the work done to support/promote RMC is linked (and measured) with the QI processes so that the RMC standards that are reported/measured are used by the facility-based QI teams to inform what is and isn't working.
- **Caring for carers:** Creating support for health care providers so that they can communicate, process, and receive support for their work-related stress.
- **Team building and on-site workshops for providers:** Workshops for health workers include RMC workshops that give health care providers an opportunity to reflect on their values and aspirations, client needs and priorities, and the reality in their local health facility (values clarification and attitude transformation). Additionally, workshops to help develop health workers' communication and interpersonal skills can increase and improve patient-provider and provider-administrator communication and improve women's experience.
- **Maternal and perinatal death surveillance and response:** A tool used to report every maternal and perinatal death followed by a detailed review of the death. This helps decision-makers, communities, and health workers to continuously dialogue and inform progressive course correction and prevent deaths in the future.

- **Open maternity days/open birth days:** Birth preparedness and ANC education program that provides an opportunity for pregnant women to discuss birth planning with male partners and for pregnant women and their families to interact with health care providers, visit maternity units, understand what to expect during labor and delivery, and overcome any fears they may have about giving birth in a facility. Open maternity/birth days are a chance for health care providers and community members to interact and learn how to tackle challenges that prevent RMC.
- **Patient satisfaction survey:** Questionnaires that focus on RMC and not mistreatment provide motivation for providers to serve with respect.
- **Community-facility linkages:** Community-facility dialogues provide an opportunity to address community-reported cases of mistreatment, mediate or resolve disputes, and break down barriers between providers and clients.⁷ This allows for a two-way process in which the community can put forward to the facility what they view as mistreatment and what RMC interventions they think will be important, and then linking this feedback to the QI processes.

Community level:

- **Social accountability:** Social accountability is an approach to building accountability through civic engagement in which citizens directly or indirectly demand accountability from providers and public officials. Examples of social accountability tools and mechanisms include participatory budgeting, public expenditure tracking, citizen report cards, community scorecards, social audits, citizen charters, right-to-information acts, and health committees.^{7,41} To address mistreatment, it may be important to consider engaging women's groups, groups on violence against women, health rights, etc.
- **Education campaigns:** Utilizing local community channels for community sensitization and participatory action planning workshops to promote RMC among community leaders and members.
- **Community-facility linkages:** Community-facility dialogues to address community-reported cases of mistreatment, mediate or resolve disputes, and break down barriers between providers and clients.⁷

More details about the specific interventions and studies can be found in the MCSP RMC Operational Guidance, 2020 (Appendix B).

RWANDA

In a response to the 2015 discussions, Rwanda has moved forward with a number of interventions to address RMC. Rather than having multiple pilots or small disconnected programs, Rwanda has introduced RMC components into nationwide programs or strategies. The following are elements of RMC programs or interventions that have taken place in Rwanda since 2015:

- Supported by USAID's MCSP, Rwanda's MOH conducted the First National Stakeholders' Consultation meeting on RMC on November 2015 during which stakeholders (professional associations, civil societies, health facility managers, and health care providers) from the 10 MCSP-supported districts met to discuss the D&A experienced in maternal care, their drivers, suggested solutions, and potential roles that health care providers, professional organizations, and civil societies have in addressing and promoting RMC.^{42,43}
- Integration of key principles of RMC into basic emergency obstetric and newborn care training tools.⁴²
- Addition of RMC indicator for birth companion of choice into the national health management information system indicators.⁴⁴
- Infrastructure improvements: new maternity wards and those being renovated, partitioning with curtains between beds in maternity wards to provide privacy to laboring women.
- Integration of key principles of RMC into obstetrics care protocol.⁴⁵
- Mentorship programs /mentorship tools.

Focus group participants described challenges in making RMC a priority in Rwanda, where the focus has historically been placed on access and survival. RMC was reported to have been included in the discussion and draft versions of the Maternal and Child Health policy, but was apparently cut from the final version. Although RMC may be acknowledged as important in theory, practical steps to address root causes, such as understaffing, fail to receive resources amid limited budgets.

“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.” (Third FGD)

“And, also, financing is quite a difficult issue to address. Because most of the time, they will tell you know, we don't have enough staff, we don't have enough resources to look for additional staff.” (Third IDI)

Focus group respondents stressed the importance of frequent reinforcement and the use of experiential learning to ensure that health workers empathize with what women experience when they are exposed to D&A.

“I think mentorship is a great way, but also the low-dose, high-frequency training within the hospital where you train on each other, I think is a really good way to understand how the patients feel when they are the ones laying on the bed or they are the ones getting treated. And that has been a really good way to change the way that health care workers see their patients because they experience what it is like to be the patient themselves on a frequent basis just because of the training.” (Third FGD)

Key informants stressed the particular importance in Rwanda of addressing the root cause of provider shortages.

“They know the workload for each hospital, so, they have to reduce the burden on the medical personnel and let them have time to relax and socialize with their patients without having the burden of their workload, being stressed every time.” (Fourth IDI)

Many publications reported that inadequate resources (i.e., staffing, ambulance, hospital beds, supplies) are major drivers of mistreatment. Support in ensuring availability of essential services and staffing can prevent insufficient information or time, unconsented procedures, delay in treatment, and overall patient satisfaction.¹⁵ Focus group respondents shared their perception that RMC in Rwanda has been enhanced and that programs empower women to advocate for their own interests. For example, ensuring that women are allowed their companion of choice was praised as a way for a woman to have someone available to advocate on her behalf according to her wishes when she is at her most vulnerable. Other initiatives operate on a larger scale, such as the Patient Voice Program, which empowers women to provide feedback according to their needs to make changes at a systemic level, while another respondent noted a hospital displaying a charter of patient rights at the entrance to ensure that women know what they have the right to expect.

“It helps, it empowers the laboring mom or the woman who is really vulnerable at that stage to have a voice when there is someone beside her and also someone who is able to follow up on what is happening.” (Third FGD)

“The patients aren't used to being able to have a voice and explain how they feel and have their rights met and so as well as the health care workers aren't, they are not used to that either.” (Third FGD)

The GoR has also begun to integrate social accountability structures and practices throughout its health system.⁴⁶ According to an assessment using the National SA System in Health Assessment Tool, Rwanda has an exceptional example of a national social accountability system. It has maintained and incorporated existing practices and mechanisms for community participation and cooperation toward claiming agency and ownership of the health system as part of a national framework and procedures. The development of an RMC

policy addendum to the RMNCAH policy provides an opportunity to strengthen existing social accountability mechanisms and to further integrate social accountability structures and practices throughout the health system to ensure that it is more responsive and inclusive.

POLICY FOR RMC PROMOTION AND COUNTRY EXAMPLES

Policy development is one of the key interventions to promote RMC. The section below focuses on the specific importance of policy development and implementation as well as examples from other low- and medium-income countries to illustrate the many ways in which RMC can be incorporated into national-level policy.

“Many states have failed to put in place a protective legal and policy framework to ensure that women receive care that is respectful of their needs and desires and that prevents and addresses mistreatment during childbirth. This has slowly begun to change. For example, in recent years, some countries have passed laws or issued policies that expressly allow a woman to be accompanied by a companion of her choice during childbirth and have developed broader legislation encouraging the ‘humanization’ of childbirth.⁵² However, other laws contribute to an environment of violence and mistreatment. These laws include spousal or third-party consent laws, and laws that deprive women with disabilities of their legal capacity, replacing women’s decision-making with that of a family member or other institutional authority. They also encompass laws that recognize fetal personhood, prioritizing the fetus over the life and health of the pregnant woman.”⁴⁷

The need to translate global standards and frameworks into policies at the national level is clear; however, who will lead this effort and with what resources by and large remain challenges. National laws and policies and their enforcement and accountability structures are critical components of strategies for improving RMC and for citizens to hold governments accountable for such care.² Studies have found that facility-level policies that include multiple RMC components do reduce overall D&A and improve women’s experience of RMC.⁴⁸ And others have stressed the importance of ensuring an enabling legal and policy environment so that RMC is integrated across many relevant policies and programs.⁴⁷ Exactly what these policies and laws look like remains up to countries to contextualize and as Downe et al.’s systematic review found—there remains a “need for rigorous research to refine the optimum approach to deliver and achieve RMC in all settings.”⁴⁸ Where mother policies exist, such as Rwanda’s RMNCAH policy, addendums articulating various issues have been considered. However, no one country has provided a blueprint on how to best incorporate RMC into their policies; thus, this SA and upcoming PD will help to formalize a structure with concrete steps to systematize and contextualize this policy creation. The examples below are not necessarily best practices, but rather illustrative examples to reflect upon. These examples include national-level reproductive health (RH) strategies and midwifery-focused guidelines. A few examples are below.

A. Ethiopia’s National Reproductive Health Strategy (2016–2020) includes RMC throughout its strategy.⁴⁹

Section	Page(s)	Language
Guiding principles	30	<i>Compassionate, respectful and competent human resource: The strategy outlines that the MOH shall focus on compassionate, respectful and competent health care by ensuring adequate skill mix of human resources at all levels of the health system. The relationship of RH clients with health care providers and the health system should be characterized by caring, empathy, trust, and an enabling environment for informed decision-making. This will also contribute to guaranteeing quality in RH services.</i>

Section	Page(s)	Language
Strategic objectives and interventions	44	<p><i>Strategy 19: Improve availability, motivation and retention of compassionate, respectful and competent RH care providers across all regions and all levels of health facilities.</i></p> <p>Strategic interventions: <i>Avail platforms to improve the availability of compassionate, respectful and competent HR for RH.</i></p>
Indicative work plan	65	<p>Strategic priorities <i>Strengthen respectful maternity care initiative in all facilities contribute to quality improvement in pre-service and in-service MNH care training</i></p> <p>Activity <i>Strengthening of mother-baby-friendly facilities such as allowing birth companion, preferential laboring and birthing position, and allowing for cultural ceremonies in facilities.</i> <i>Provide training on the concept of “respectful maternity care” to maternity care providers.</i> <i>Introduce facility-specific citizens charter in all health facilities.</i> <i>Conduct quarterly maternal satisfaction survey in facilities.</i></p>
	67–68	<p>Strategic priorities <i>Contribute to quality improvement in pre-service and in-service MNH care training</i></p> <p>Activity <i>Ensure competencies on attitude and professional ethics (Respectful Maternity Care) are incorporated and implemented in pre-service education (with MOE)</i></p>
Monitoring and evaluation (M&E) matrix	99	<p>(Indicator) <i>% of health facilities instituted protocol on respectful maternity care (mother baby friendly delivery service guidelines)</i></p>

B. Another approach is the creation of practical tools, such as **guidelines for midwives and nurses**, to support the implementation of policy can also be found in the region. A few examples are from **Tanzania**, where 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)*.^{50,51} Unlike the specific language of policies, these documents are entirely RMC focused and provide practical implementation strategies and suggested M&E frameworks that can be used at all levels of the health system. Examples of the purposes of each policy are below:

- **Purpose of National Guidelines on Respectful and Compassionate Nursing and Midwifery Care:** “The presence of the Respectful and Compassionate Care guidelines that focus on core values of nurses and midwives will ensure that the promise to deliver high-quality care with strong elements of respect and compassion is fulfilled, which lines with the major role of the Division to oversee provision of quality Nursing and Midwifery services in the country. This document will be operationalized by the Division of Nursing and Midwifery Services at all levels of health care delivery through effective implementation, monitoring, and evaluation mechanisms.”

- **Purpose of The National Guidelines for Gender and Respectful Care Mainstreaming and Integration Across RMNCAH services in Tanzania (2019):** “The goal of these guidelines for gender and respectful care mainstreaming and integration into the National RMNCAH interventions is to accelerate access to and utilization of high-quality, comprehensive, and integrated health services that are client centered. The core intent is to ensure that mothers’ and children’s lives are saved through services that are respectful and gender responsive. The main focus is on improving RMNCAH outcomes, by reducing barriers related to gender inequity and inequalities at all levels of the health system; from household to community, to health facility, and across governing bodies. Furthermore, the main emphasis is to improve availability of quality, respectful, client-centered, and gender-sensitive integrated services for children, adolescents, and adults of reproductive age regardless of their social-economic status.”

In Ethiopia, RMC was also incorporated into the *National Road Map for Midwifery Education and Service Provision (2016–2025)*.⁵²

A. Another approach is to **endorse the WRA RMC Charter**, as was done in several countries. A few examples are provided below:

- In 2013, **Nigeria’s** Federal MOH adopted the RMC Charter as a federal policy. “The Nigerian RMC charter further **highlights key words and messages to communicate RMC concepts in simple language to the provider and community**. The key message of the revised charter is as follows: “We value and respect the dignity and freedom of our pregnant women and mothers. The key words and phrases aimed at the community and providers include ‘safety and comfort,’ ‘informed decisions,’ ‘privacy and confidentiality,’ ‘dignity,’ ‘standard,’ ‘quality,’ and ‘rights/privilege for all women.’”⁵³
- In October 2018, the government of Nepal adopted the Safe Motherhood and Reproductive Health Rights Act of **Nepal** (the Act). “The legislation marks the **first time that respectful maternity care has been included in national legislation** and paves the way for the provision of high-quality, respectful care for mothers and babies in public and private health facilities in the country. The **Act articulates legal protections related to family planning, pregnancy, childbirth, and the postpartum period, which include paid maternity leave, privacy and confidentiality, information and informed consent, and prohibition against discrimination**. In addition, the Act ensures that the services provided are adolescent and disability friendly.”⁵⁴

Role of Advocacy and Accountability

Advocacy, policies, and financing accountability tracking are critical in establishing RMC. According to the Health Policy Project’s Guide for Advocating for Respectful Maternity Care, RMC advocacy includes increasing awareness of RMC and generating civil demand for RMC rights, mobilizing communities to hold local leaders and service providers accountable for RMC rights, and securing commitment at the national level to institutionalize RMC as a standard of care.⁵⁵ A compelling approach is connecting those who have been directly affected by mistreatment in maternal care and asking communities to share evidence of mistreatment, such as testimonies or numerical data, with local leaders and service providers. Evidence may even be in the form of the collective voice of the community demanding change from policymakers to improve RMC. To secure a national commitment for RMC, advocates and social accountability experts must set priorities or a specific area of focus, assess the political environment, and create a strategy to achieve the specified RMC advocacy and accountability goals. Maintaining good relationships with the government and working together with politicians and policymakers are key to successful advocacy and accountability approaches. As in clinical settings, capacity development of local advocacy and accountability partners is among the best investments. What, whom, when, how to ask, and backed by what evidence are capacity areas that must not be ignored. Misusing language and the wrong framing of asks can compromise objectives. Involving these actors from the start of policymaking deepens their understanding and increases the chance of forward-looking interventions grounded in data and local realities. Instead of spending enormous time conducting a parallel situation analysis, investments can also be channeled into programs to address felt needs and barriers. Rich and sustained inclusion builds rapport with decision-makers, promoting partnerships with non-state actors and the community.⁵⁵

RWANDA

In 2020 MCSP put forward guidance on the importance of having an existing RMC policy but also having stakeholders believing that the policy is necessary.

“Development of national policies that communicate an unequivocal expectation for and favorable environment for RMC, including zero-tolerance for mistreatment, is essential for fostering short- and long-term change. For effective identification and implementation of solutions at the policy and national level, stakeholders must see mistreatment as a significant problem and must value respectful care as an essential component of health service delivery.”⁷

The qualitative research confirmed a both recognition among our stakeholders that women during childbirth are not being treated with the respect that they have a right to, and a desire to address it at a national level. The question that remains is what to include in a policy. In 2019 the WHO’s expert meeting made a clear call to create a policy that will *“explicitly guarantee women’s rights to respectful maternity care and a birth companion of choice.”*^{47,56} Without this language explicitly stated in the existing RMNCAH policy, the stakeholders felt it was an omission with consequences – and one that needed to be addressed through inclusion of RMC specific language in existing policy rather than a new standalone policy for RMC only.

Focus groups and key informants further stressed the importance of a robust monitoring and evaluation system to ensure that the changes outlined in any new policy are actually being made and to establish

“But when you have a nice policy [and] when you want to implement your policy, you have to make sure that at least for the first two years that you are doing a very close follow-up of what is happening with a monitoring and evaluation framework that helps you to actually measure what you are doing. Even if it is just something like respectful maternity care. This will help you see if actually, you are changing behaviors, you are improving the health services.” (Third IDI)

MEASUREMENT

GLOBAL

No single measure can capture respectful or “person-centered” care in its entirety. Rather, PCC encompasses many elements. The experience of care—whether a person felt respected—is at the heart of measuring person-centered care, but important normative standards, such as whether a woman was offered the option to have a labor and birth companion of her choice, should also be captured.⁵⁷

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.⁵⁷ RMC and mistreatment in childbirth occupy two extremes of a continuum and studies demonstrate that women and newborns may experience a mix of both positive RMC and negative mistreatment along this continuum.⁵⁸ It is important that measures are able to capture both this continuum as well as positive and negative attributes of care. The absence of mistreatment does not equate with person-centered care. For example, the absence of a negative behavior such as verbal abuse does not assure positive caring behaviors such as asking a client for her consent before conducting a vaginal examination.⁵⁹ In the table below are examples of various global tools and guidelines for measuring PCMC, RMC, and establishing frameworks.

<p>PCMC Scale</p>	<p>Validated tools to measure person-centered care in developing settings: A promising resource for regularly monitoring RMC indicators in a large MNH program is the PCMC scale developed and validated in three countries by Afulani and colleagues. This scale, which measures positive and negative attributes of childbirth care, can be applied to calculate an overall PCMC score or to measure individual indicators of RMC and mistreatment. The PCMC scale could be applied, for example, in a large MNH program to monitor trends in individual indicators and/or a cumulative PCMC score:⁷</p> <ul style="list-style-type: none"> • a full (30 question) person-centered maternity scale *Refer to Table 5 in the article linked above for items from the 30-item PCMC scale. • a shorter (13 question) person-centered scale may be downloaded directly from the website.
<p>Mistreatment in Childbirth Index, Mother’s Autonomy in Decision-Making Scale, Mothers on Respect Index</p>	<p>The Birth Place Lab team developed and validated additional quality measures: the Mistreatment in Childbirth index, Mother’s Autonomy in Decision-Making scale, the Mothers on Respect index, which are being applied across 23 countries to evaluate quality of maternity care at the institutional, system, and country levels. Links to these resources may be found here: Tools to Measure Respectful Maternity Care - Birth Place Lab.</p>
<p>RMC Operational Guidance</p>	<p>The RMC Operational Guidance guides MNH program managers and local stakeholder counterparts through a flexible process of designing, implementing, and monitoring respectful care efforts based on a deep understanding of the local context. This document includes a section (pages 3–7) on understanding and measuring RMC and D&A in childbirth and includes three appendices (5,6,7) that summarize qualitative and quantitative data collection methods for measuring RMC and mistreatment, including references to many tools in the published literature. It is available in English, French, and Spanish.</p>
<p>QoC MNCH Network Monitoring Framework</p>	<p>The WHO QoC Network has developed a monitoring framework (and country implementation guidance), which builds on the WHO maternal and newborn quality standards and measures, and includes illustrative indicators for each WHO quality statement. The QoC MNCH Network Monitoring Framework outlines QoC indicators that can be used by national/subnational managers, facility managers, and health workers to monitor and guide improvements in care including management of subnational MNH QI programs. It includes an appendix of recommended common MNH QoC indicators in Annex 1 and a catalogue of flexible MNH QoC indicators categorized by quality statements for use by QI teams working to improve care in specific technical areas.</p>
<p>Measuring and Monitoring Quality of Health Care Services to Improve Care for Women, Newborns, and Children: A Practical Guide for Program Managers</p>	<p>Coming soon: A forthcoming guide being developed by WHO and the MOMENTUM Program titled <i>Measuring and Monitoring Quality of Health Care Services to Improve Care for Women, Newborns, and Children: A Practical Guide for Program Managers</i> reviews common approaches and practical considerations for measuring and monitoring person-centered care (anticipated November 2023).</p>

MEASUREMENT IN RWANDA

Rwanda does not currently have indicators, given the lack of formal RMC policy language. This will be something to address in the future though.

How to measure the mistreatment of newborns?

There have been several attempts to explicitly define and measure mistreatment of newborns over the last five years that have yielded strong tools for global- and national-level use. In a study in Nepal, the authors selected indicators to assess mistreatment of newborns based on the [WHO's 2016 "Standards for improving quality of maternal and newborn care in health facilities"](#) QoC statements and process of care.⁶⁰ Following this, Sacks developed a typology of mistreatment of newborns that builds on the seven first-order themes identified by Bohren's typology of mistreatment of women during childbirth to include bereavement at posthumous care and legal accountability.³ Notably, Abuya and colleagues expanded this typology to include an additional category on inappropriate feeding practices due to findings from a study on mistreatment of newborns and sick young infants in Kenya.³³ This study found that there were multiple examples of parents forcefully feeding their infants for fear of being threatened and verbally abused by providers if the infant did not gain enough weight. This was not an issue that was discussed in the interviews or FGDs or found in the literature from Rwanda.

COVID-19'S IMPACT ON RESPECTFUL MATERNITY CARE

GLOBAL

The COVID-19 pandemic has been and continues to adversely affect maternal health services in various ways. There has been continued interruption of the availability of ANC 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.³²

Despite growing global consensus about the importance of respectful care, there are multiple reports of hard-won gains in respectful, evidence-based maternity care vanishing due to the COVID-19 pandemic. COVID-19 has presented women, newborns, and health workers with unprecedented challenges, including violations of their rights. Some of these violations, in the name of preventing infection and spread, included harmful medical interventions when not medically necessary—such as cesarean sections, instrumental deliveries, and induction and augmentation of labor;^{61–63} newborns being separated from their mothers, skin-to-skin contact discouraged, and limited breastfeeding;^{61,63} and women being forced to give birth alone, or without a companion of their choice by their side.⁶² The pandemic further exacerbated a range of disrespectful and harmful practices that women contend with routinely: denial of care, restriction of transport, lack of access to staff, limited supplies and pain relief, as well as various ANC and PNC services.^{62,64} While some of these changes to policies and practices during antenatal, intrapartum, and postnatal care may be necessary to manage the spread of COVID-19, they should be “strictly necessary, proportionate, reasonable, and the least restrictive” measures available.^{62,64} Providers expressed the dramatic changes that have taken place in their daily interactions with women due to the context of COVID-19.

“With patients; we no longer spend time physically. We limit the face-to-face contact. That emotional comfort is not there anymore. Physical examination is no longer practiced as before.” (Obstetrician/gynecologist, referral hospital, Nigeria)⁶⁵

“All patients with confirmed COVID-19 are being discriminated [against], no one wants to help them in fear of getting the disease since we have no proper PPE [personal protective equipment].” (Midwife, district hospital, Malawi)⁶⁵

RWANDA

Rwanda was not immune to the impacts of COVID-19 on the health system, providers, and women themselves. Several impacts have been documented of both the government response to the COVID-19 pandemic and the new reality in the health centers. In the beginning of the pandemic, the GoR closed private and public transportation to all those except frontline-related services as a preventive measure.⁶⁶ During that time, the travel restrictions had an impact on women's ability to show up for their ANC visits to be as prepared for birth as possible and, when transportation options were reduced, many providers were delayed or prevented from getting to their health facilities for work.⁶⁶ At the beginning of the pandemic, there was a sense of fear across the country. Pregnant women were scared of hospitals, they did not want to go to the hospitals for fear of contracting COVID-19 and health care workers were scared to receive patients who could potentially infect them. That fear resulted in a lack of trust between providers and pregnant women, leading in turn to negative birth experiences reported by women. Staff shortages became worse as well. COVID-19 isolation units were set up and borrowed staff from surrounding facilities; this resulted in overburdened midwives who then experienced burnout and anxiety—for those most needed to be ready to help in this crisis.⁶⁶ There is much to be learned from the GoR's response to COVID-19 and both the resilience of the system and the areas that need support for future shocks to the system.

SECTION 3: PULLING 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 over the last seven years providing learning both in the country and at the regional and global levels with clear insights on what changes must occur at the policymaking and implementation levels for Rwanda to reap the full benefits of RMC QoC. The findings of this SA clearly underscore the strong RMC interventions currently being implemented that need to be systematized with policy backing to power potential implementation to scale. What does not get measured does not get reported. This calls for RMC-specific language or a relevant section to be included in the existing RMNCAH policy with specific strategic objectives and an M&E component. And lastly, COVID-19 tested the current system and exposed how easily RMC can fall in the face of infection prevention concerns and will happen again in the future without these policies and M&E systems in place.

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 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.

REFERENCES

1. Jhpiego. *Respectful Maternity Care*; 2018.
2. Bowser D, Hill K. *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*; 2010.
3. Bohren MA, Vogel JP, Hunter EC, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. Jewkes R, ed. *PLOS Med*. 2015; 12(6):e1001847. doi:10.1371/journal.pmed.1001847.
4. Filby A, McConville F, Portela A. What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective. Kumar S, ed. *PLoS One*. 2016; 11(5):e0153391. doi:10.1371/journal.pone.0153391.
5. WHO. *The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth: WHO Statement*; 2014.
6. MCSP Rwanda. *First National Stakeholders' Consultation on Respectful Maternity Care in Rwanda*; 2015.
7. Hill K, Stalls S, Sethi R, Bazant E, Moffson S. *Moving Respectful Maternity Care into Practice in Comprehensive MCSP Maternal and Newborn Programs: Operational Guidance*; 2020.
8. WRA. *Respectful Maternity Care: The Universal Rights of Childbearing Women*; 2011.
9. WRA. *Respectful Maternity Care Charter*; 2019. <https://www.whiteribbonalliance.org/respectful-maternity-care-charter/>.
10. Afulani PA, Moyer CA. Accountability for respectful maternity care. *Lancet*. 2019; 394(10210):1692-1693. doi:10.1016/S0140-6736(19)32258-5.
11. Mukamurigo J, Dencker A, Ntaganira J, Berg M. The meaning of a poor childbirth experience – A qualitative phenomenological study with women in Rwanda. Spracklen CN, ed. *PLoS One*. 2017; 12(12):e0189371. doi:10.1371/journal.pone.0189371.
12. Doyle K, Kazimbaya S, Levtov R, et al. The relationship between inequitable gender norms and provider attitudes and quality of care in maternal health services in Rwanda: a mixed methods study. *BMC Pregnancy Childbirth*. 2021; 21(1):156. doi:10.1186/s12884-021-03592-0.
13. Rosen HE, Lynam PF, Carr C, et al. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy Childbirth*. 2015; 15(1):306. doi:10.1186/s12884-015-0728-4.
14. Ndirima Z, Neuhann F, Beiersmann C. Listening to their voices: understanding rural women's perceptions of good delivery care at the Mibilizi District Hospital in Rwanda. *BMC Women's Health*. 2018; 18(1):38. doi:10.1186/s12905-018-0530-3.
15. Rurangirwa AA, Mogren I, Ntaganira J, Govender K, Krantz G. Quality of antenatal care services in Rwanda: assessing practices of health care providers. *BMC Health Serv Res*. 2018; 18(1):865. doi:10.1186/s12913-018-3694-5.
16. Miller P, Afulani PA, Musange S, Sayingoza F, Walker D. Person-centered antenatal care and associated factors in Rwanda: a secondary analysis of program data. *BMC Pregnancy Childbirth*. 2021; 21(1):290. doi:10.1186/s12884-021-03747-z.
17. Mukamurigo J. Quality of intrapartum care in Rwanda: management and women's experiences. Published online 2019.

18. Adair-Rohani H, Zukor K, Bonjour S, et al. Limited electricity access in health facilities of sub-Saharan Africa: a systematic review of data on electricity access, sources, and reliability. *Glob Health Sci Pract*. 2013; 1(2):249-261. doi:10.9745/GHSP-D-13-00037.
19. Kalisa R, Smeele P, van Elteren M, van den Akker T, van Roosmalen J. Facilitators and barriers to birth preparedness and complication readiness in rural Rwanda among community health workers and community members: a qualitative study. *Matern Health Neonatol Perinatol*. 2018; 4(1):11. doi:10.1186/s40748-018-0080-6.
20. Semasaka JPS, Krantz G, Nzayirambaho M, Munyanshongore C, Edvardsson K, Mogren I. "Not taken seriously"—A qualitative interview study of postpartum Rwandan women who have experienced pregnancy-related complications. Santos HP, ed. *PLoS One*. 2019; 14(2):e0212001. doi:10.1371/journal.pone.0212001.
21. National Institute of Statistics of Rwanda. *Rwanda Demographic and Health Survey 2019-20; 2021*.
22. Mukamurigo JU, Berg M, Ntaganira J, Nyirazinyoye L, Dencker A. Associations between perceptions of care and women's childbirth experience: a population-based cross-sectional study in Rwanda. *BMC Pregnancy Childbirth*. 2017; 17(1):181. doi:10.1186/s12884-017-1363-z.
23. National Academy of Sciences Engineering and Medicine, Committee on the Evaluation of Strengthening Human Resources for Health Capacity in the Republic of Rwanda Under the President's Emergency Plan for AIDS Relief (PEPFAR). Health Worker Production. In: *Evaluation of PEPFAR's Contribution (2012-2017) to Rwanda's Human Resources for Health Program*. National Academies Press (US); 2020.
24. WHO. SDG Target 3.c, Health workforce: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States. The Global Health Observatory.
25. Management Sciences for Health. *Workload Indicators of Staffing Needs (WISN) Application in Rwanda*; 2019.
26. Larson E, Sharma J, Nasiri K, Bohren MA, Tunçalp Ö. Measuring experiences of facility-based care for pregnant women and newborns: a scoping review. *BMJ Glob Health*. 2020; 5(11):e003368. doi:10.1136/bmjgh-2020-003368.
27. Currie S. *Alternative Birth Positions*; 2016.
28. Odiase O, Akinyi B, Kinyua J, Afulani P. Community Perceptions of Person-Centered Maternity Care in Migori County, Kenya. *Front Glob Women's Health*. 2021; 2. doi:10.3389/fgwh.2021.668405
29. Raj A, Dey A, Boyce S, et al. Associations Between Mistreatment by a Provider during Childbirth and Maternal Health Complications in Uttar Pradesh, India. *Matern Child Health J*. 2017; 21(9):1821-1833. doi:10.1007/s10995-017-2298-8.
30. Gizzo S, Di Gangi S, Noventa M, Bacile V, Zambon A, Nardelli GB. Women's Choice of Positions during Labour: Return to the Past or a Modern Way to Give Birth? A Cohort Study in Italy. *Biomed Res Int*. 2014; 2014:1-7. doi:10.1155/2014/638093.
31. Gupta JK, Sood A, Hofmeyr GJ, Vogel JP. Position in the second stage of labour for women without epidural anaesthesia. *Cochrane Database Syst Rev*. 2017; 2017(5). doi:10.1002/14651858.CD002006.pub4.
32. Asefa A. Unveiling respectful maternity care as a way to address global inequities in maternal health. *BMJ Glob Health*. 2021; 6(1):e003559. doi:10.1136/bmjgh-2020-003559.
33. Abuya T, Warren CE, Ndwiga C, Okondo C, Sacks E, Sripad P. Manifestations, responses, and consequences of mistreatment of sick newborns and young infants and their parents in health facilities in Kenya. Doherty T, ed. *PLoS One*. 2022; 17(2):e0262637. doi:10.1371/journal.pone.0262637.

34. Sacks E, Mehrtash H, Bohren M, et al. The first 2 h after birth: prevalence and factors associated with neonatal care practices from a multicountry, facility-based, observational study. *Lancet Glob Health*. 2021; 9(1):e72-e80. doi:10.1016/S2214-109X(20)30422-8.
35. Ashish KC, Moinuddin M, Kinney M, et al. Mistreatment of newborns after childbirth in health facilities in Nepal: Results from a prospective cohort observational study. Desseauve D, ed. *PLoS One*. 2021; 16(2):e0246352. doi:10.1371/journal.pone.0246352.
36. Burden C, Bradley S, Storey C, et al. From grief, guilt pain and stigma to hope and pride – a systematic review and meta-analysis of mixed-method research of the psychosocial impact of stillbirth. *BMC Pregnancy Childbirth*. 2016; 16(1):9. doi:10.1186/s12884-016-0800-8.
37. Frøen JF, Lawn JE, Heazel AEP, et al. Ending preventable stillbirths: An Executive Summary for The Lancet's Series. *Lancet*. Published online 2016.
38. Heazell AEP, Siassakos D, Blencowe H, et al. Stillbirths: economic and psychosocial consequences. *Lancet*. 2016; 387(10018):604-616. doi:10.1016/S0140-6736(15)00836-3.
39. Faustine A, Kalimba E, Khadka N, Mwali K, Shelus V, Wisner L. *Situation Analysis of Inpatient Care of Newborns and Young Infants*; 2019.
40. Mutaganzwa C, Wibecan L, Iyer HS, et al. Advancing the health of women and newborns: predictors of patient satisfaction among women attending antenatal and maternity care in rural Rwanda. *Int J Qual Heal Care*. 2018; 30(10):793-801. doi:10.1093/intqhc/mzy103.
41. Hurd S, Folse M, Fox S. *In Brief: Evidence on the Role of Social Accountability in Advancing Women's, Children's, and Adolescents' Health*; 2022.
42. MCSP. *MCSP Rwanda Technical Brief: Maternal Health*; 2017.
43. Baldwin C, Moffson S. Respect During Childbirth is a Right, Not a Luxury. Maternal and Child Survival Program. Published 2016. <https://www.mcsprogram.org/respect-childbirth-right-not-luxury/>.
44. MCSP. *MCSP Rwanda End of Project Report*; 2019.
45. Republic of Rwanda Ministry of Health, Rwanda Society of Obstetricians and Gynaecologists. *Obstetric Care Protocol 2020*; 2020.
46. Foster AA, Msiska TW, Havugimana C, Hilber AM. *Assessment Report: Assessing the National System for Social Accountability in Health: Applying an Assessment Tool to Measure Maturity and Performance of National Social Accountability Systems in Health: Results of a Pilot Study in Rwanda and Malawi*.
47. Zampas C, Amin A, O'Hanlon L, et al. Operationalizing a Human Rights-Based Approach to Address Mistreatment against Women during Chldbirth. *Health Hum Rights*. 2020; 22(1):251-264. <http://www.ncbi.nlm.nih.gov/pubmed/32669805>.
48. Downe S, Finlayson K, Oladapo O, Bonet M, Gülmezoglu AM. What matters to women during childbirth: A systematic qualitative review. Norhayati MN, ed. *PLoS One*. 2018; 13(4):e0194906. doi:10.1371/journal.pone.0194906.
49. Federal Democratic Republic of Ethiopia Ministry of Health. *National Reproductive Health Strategy for Ethiopia (2016-2020)*; 2016.
50. Ministry of Health Community Development Gender Elderly and Children. *National Guidelines for Gender and Respectful Care Mainstreaming and Integration Across RMNCAH Services in Tanzania*; 2019.
51. Ministry of Health Community Development Gender Elderly and Children. *National Guidelines on Respectful and Compassionate Nursing and Midwifery Care (2017), Tanzania*; 2017.

52. Federal Democratic Republic of Ethiopia Ministry of Health, UNFPA. *National Road Map for Midwifery Education and Service Provision 2016-2025: Midwifery Initiative Program*; 2015.
53. WRA. *Respectful Maternity Care: A Nigeria-Focused Health Workers' Training Guide*; 2015.
54. Elena Ateva. Nepal Passes Breakthrough Legislation Enshrining Respectful Maternity Care into National Law. Health Policy Plus. Published 2019. <http://www.healthpolicyplus.com/NepalMaternity.cfm>.
55. Windau-Melmer T. *A Guide for Advocating for Respectful Maternity Care*; 2013.
56. Council of Europe Parliamentary Assembly. *Resolution 2306 Obstetrical and Gynaecological Violence.*; 2019.
57. AlignMNH. Quality of Care, Experience of Care, and Respectful Care. Published 2022. Accessed May 16, 2022. <https://www.alignmnh.org/issue/quality-of-care/>.
58. Afulani PA, Diamond-Smith N, Phillips B, Singhal S, Sudhinaraset M. Validation of the person-centered maternity care scale in India. *Reprod Health*. 2018; 15(1):147. doi:10.1186/s12978-018-0591-7.
59. MCSP. *Achieving Respectful Maternity Care for Women, Newborns and Families*; 2020.
60. WHO. *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities*; 2016.
61. Hovhannisyan A, Karijo A. How has COVID-19 affected women's rights during childbirth? Help us track this globally. 50.50: Investigation. Published 2020. Accessed July 27, 2020. <https://www.opendemocracy.net/en/5050/womens-rights-during-childbirth-help-us-track-globally/>.
62. Jolivet RR, Warren CE, Sripad P, et al. Upholding Rights Under COVID-19: The Respectful Maternity Care Charter. *Health Hum Rights*. 2020; 22(1):391-394. <http://www.ncbi.nlm.nih.gov/pubmed/32669827>.
63. WRA. *Childbirth in Times of COVID-19: Respectful Maternity Care: Call to Action.*; 2020.
64. Reingold RB, Barbosa I, Mishori R. Respectful maternity care in the context of COVID-19: A human rights perspective. *Int J Gynecol Obstet*. 2020; 151(3):319-321. doi:10.1002/ijgo.13376.
65. Asefa A et al. The impact of COVID-19 on the provision of respectful maternity care: Findings from a global survey of health workers. *Women Birth*. 2022; 35(4): 378–386.
66. Tengera O, Ndayisenga JP, Mukamana D, et al. The Impact of COVID-19 Pandemic on Maternal and Child Health Services in Rwanda. *Res J Health Sci*. 2020; 8(3):221-222. doi:10.4314/rejhs.v8i3.9.
67. Ross J, Karlage A, Etheridge J, et al. *Adaptive Learning Guide: A Pathway to Strong Collaboration, Learning, and Adapting*; 2021.

APPENDIX A: INTERVIEW GUIDES

TOOL 1: FGD GUIDE FOR POLICYMAKERS

Introduce yourself to the participants. Describe the purpose of the focus group and how information will be used.

OVERVIEW/CONSENT SCRIPT/BACKGROUND:

Hello, my name is (insert the name of the interviewer here). Thank you for agreeing to share your perceptions on Rwanda's RMC efforts. The MOH Rwanda/RBC Division of Maternal and Child Health, with technical support from MOMENTUM project partner Jhpiego, are conducting mainly FGDs and a few interviews to better understand:

Existing efforts related to RMC and PCC:

1. Status of implementation of current RMC/PCC programs/interventions, if any, including at the health facility level.
2. The impact of COVID-19 on RMC.

Goal: The Rwandan Government's ultimate goal in this process is to mobilize decision-makers and partners to address barriers to the implementation of quality, respectful care policies and draft an RMC-specific policy that can be included in the larger RMNCAH policy. MOMENTUM will play a technical advisory role in this effort. We intend on learning from the experiences you all had with the creation and implementation of the current RMNCAH policy.

This FGD will last about 60 minutes. I will be recording this discussion for documentation and analysis purposes. We will summarize transcripts in a final report and share with all interview participants.

Can you please confirm your consent to participate in this qualitative study?

SECTION 1: BACKGROUND AND ROLE OF THE RESPONDENT:

1. Can you please describe your position, your role in the organization/Ministry and your connection to the creation of either the RMNCAH policy or RMC discussions?

SECTION 2: POLICY LEVEL EFFORTS:

1. In 2015, the First National Stakeholders' Consultation on Respectful Maternity Care in Rwanda took place here in Kigali. Were any of you a part of this meeting?
 - a. If yes, can you tell us what the discussion was around the need for policy and national-level support?
 - b. If no, are you aware of the consultation and the discussion of RMC in Rwanda?
 - i. **PROBE:** What is your understanding of what happened in the meeting?
2. To my understanding, no RMC-specific language exists in the current RMNCAH policy in Rwanda – if I am correct, can you tell me why you think it was not included?
 - a. **PROBE:** What are your perceptions about whether or not mistreatment happens here in Rwanda?

3. What is the feeling at the health system level of what the challenges are with promoting RMC for all women at every birth?
4. What language do you think should be included in the current RMNCAH policy to explicitly include RMC as part of the policy?
 - a. **PROBE:** What would it say? What issues to describe/note? What to promote? How would the language be sure to include those most marginalized (adolescent moms, mothers with HIV, poor mothers, etc.)?
5. From your experience, what does it take to make a policy turn into actual change in a health facility?
 - a. **PROBE:** What examples do you have of a policy that was adapted at the health facility level?
 - b. **PROBE:** What type, if any, of the advocacy, education (of population, providers), policy sensitization and awareness, clinical updates, accountability systems were useful?
 - c. **PROBE:** Financing from either government or partners (financial commitment, long-term sustainability, institutionalized)?

SECTION 3: PROGRAM ACTIVITIES:

1. Can you tell me what RMC activities are being implemented in the country that you know of?
2. From your understanding, how would a policy that explicitly include RMC in the language, impact the RMC program activities?

SECTION 4: THE IMPACT OF COVID-19 ON RESPECTFUL CARE:

1. In your opinion, how has COVID-19 impacted the availability and utilization of childbirth services?
2. From your perspective, what best practices during childbirth, specifically those associated with respectful care, are not being carried out because of COVID-19 concerns?
 - a. **PROBE:** for the following best practices: companion during labor and childbirth, mobility during labor, choice of position during second stage; skin-to-skin contact between the baby and mother; early and exclusive breastfeeding; keeping the mother and baby together at all times).
3. What are the policy considerations and shifts you recommend based on your observations to build better resilience to help support the health system now as well as for future pandemics?

SECTION 5: RECOMMENDATIONS:

1. Who has been left out that must be included in the policy formulation, implementation, and impact measurement/tracking. (**PROBE:** communities, women's voice and feedback, youth.)
2. Do you have any other comments or recommendations for what needs to be done at the policy level to promote and support implementation of RMC for all childbearing women in Rwanda at the health facility level?

TOOL 2: FGD GUIDE FOR IMPLEMENTERS, TECHNICAL WORKING GROUP MEMBERS

Introduce yourself to the participants. Describe the purpose of the focus group and how information will be used.

OVERVIEW/CONSENT SCRIPT/BACKGROUND:

Hello, my name is Christine Mutaganzwa and I am with my colleague Isabella Atieno. Thank you for agreeing to share your perceptions on Rwanda's RMC efforts. The MOH Rwanda/RBC Division of Maternal and Child Health, with technical support from MOMENTUM project partner Jhpiego, are conducting FGDs and a few interviews to better understand:

1. Existing efforts related to RMC and PCC.
2. Status of implementation of current RMC/PCC programs/interventions, if any, including at the health facility level.
3. The impact of COVID-19 on RMC.

Goal: The Rwandan Government's ultimate goal in this process is to mobilize decision-makers and partners to address barriers to the implementation of quality, respectful care policies and draft an RMC-specific policy that can be included in the larger RMNCAH policy. MOMENTUM will play a technical advisory role in this effort. We intend to learn from the experiences you have had implementing MCH programs linked to labor and delivery projects or clinical services.

This FGD will last about 60 minutes. I will be recording this discussion for documentation and analysis purposes. We will summarize transcripts in a final report and share with all interview participants.

Do I have your consent to participate in this qualitative study? I think we all know each other except Isabella. Maybe we can quickly introduce ourselves to each other. Name, your organization and your role or position in your organization, and briefly tell us what kind of work your organization does related to RMC or women's health or women's rights?

Can you please confirm your consent to participate in this qualitative study?

SECTION 1: BACKGROUND AND ROLE OF THE RESPONDENT – Skip in FGD:

1. Can you briefly describe your position, your role in your organization, and what kind of work your organization does related to human rights, women's health, or women's rights?
 - a. **PROBE:** for whether the organization's work is focused on policy, advocacy, and/or implementation and at what system levels the organization works (community, health center, hospitals, regional/district management, national-level, etc.).

SECTION 2: PROGRAM ACTIVITIES:

1. In your opinion, is mistreatment of women during childbirth an issue in our health facilities, if yes, what does mistreatment look like in our health facilities?
2. Would you know any programs, activities or efforts being undertaken to promote respectful care and/or address mistreatment during facility-based childbirth?
3. How do the programs take into consideration the needs of more vulnerable groups: adolescent mothers, mothers with HIV, poor women, etc.?
4. Would you know any kind of activities or interventions that are working and can potentially be built upon/scaled up to promote quality, respectful care and address mistreatment?

SECTION 3: POLICY-LEVEL EFFORTS:

Now we are going to shift a bit to speak about policy for RMC.

1. To my understanding, no RMC-specific language exists in the current RMNCAH policy in Rwanda – if I am correct, can you tell me why you think it was not included?
 - a. **PROBE:** Do those at the policy level believe mistreatment happens in our health facilities?
 - b. **PROBE:** What is the feeling at the health system level of what the challenges are with promoting RMC for all women at every birth?
2. What is the feeling at the health system level of what the challenges are with promoting RMC for all women at every birth?
3. Thinking about the challenges you face in implementing or supporting these programs, how would an RMC-specific policy help with implementation or support of RMC in labor and delivery programs?
4. What language do you think should be included in the current RMNCAH policy to explicitly include RMC as part of the policy?
 - a. **PROBE:** What would it say? What issues to describe/note? What to promote? How would the language be sure to include those most marginalized (adolescent moms, mothers with HIV, poor mothers, etc.)?
5. From your experience, what does it take to make a policy turn into actual change in a health facility?
 - a. **PROBE:** What examples do you have of a policy that was adapted at the health facility level?
 - b. **PROBE:** What type, if any, of the advocacy, education (of population, providers), policy sensitization and awareness, clinical updates, accountability systems were useful?
 - c. **PROBE:** Financing from either government or partners (financial commitment, long-term sustainability, institutionalized)?

SECTION 4: THE IMPACT OF COVID-19 ON RESPECTFUL CARE

1. In your opinion, how has COVID-19 impacted the availability and utilization of childbirth services?
2. From your perspective, what best practices during childbirth, specifically those associated with respectful care, are not being carried out because of COVID-19 concerns?

- a. **PROBE:** for the following best practices: companion during labor and childbirth, mobility during labor, choice of position during second stage; skin-to-skin contact between the baby and mother; early and exclusive breastfeeding; keeping the mother and baby together at all times).
3. What are the reasons for the disruption in best practices provided during childbirth services? (Probe for reasons, including insufficient staff, unavailability/stock-out of essential medicines or other health products.)
4. What are the policy considerations and shifts you recommend based on your observations to build better resilience to help support the health system now as well as for future pandemics?

SECTION 5: RECOMMENDATIONS

1. Who has been left out that must be included in the policy formulation, implementation and impact measurement/tracking. (Probe: communities, women's voice and feedback, youth)
2. Do you have any other comments or recommendations for what needs to be done at the policy level to promote and support implementation of RMC for all childbearing women in Rwanda?

TOOL 3: FGD GUIDE FOR SERVICE PROVIDERS/CLINICAL REPRESENTATIVES

Introduce yourself to the participants. Describe the purpose of the focus group and how information will be used.

OVERVIEW/CONSENT SCRIPT/BACKGROUND:

Hello, my name is Christine Mutaganzwa and I am with my colleague Isabella Atieno. Thank you for agreeing to share your perceptions on Rwanda's RMC efforts. The MOH Rwanda/RBC Division of Maternal and Child Health, with technical support from MOMENTUM project partner Jhpiego, are conducting FGDs to better understand:

1. Existing efforts related to RMC and PCC in Rwanda.
2. Status of implementation of current RMC/PCC programs/interventions, if any, including at the health facility level.
3. The impact of COVID-19 on RMC.

Goal: The Rwandan Government's ultimate goal in this process is to mobilize decision-makers and partners to address barriers to the implementation of quality, respectful care policies and draft an RMC-specific policy that can be included in the larger RMNCAH policy. MOMENTUM will play a technical advisory role in this effort. We intend to learn from the experiences you have had implementing MCH programs linked to labor and delivery projects or clinical services.

This FGD will last about 60 minutes. I will be recording this discussion for documentation and analysis purposes. We will summarize transcripts in a final report and share with all interview participants.

Do I have your consent to participate in this qualitative study? I think we all know each other except Isabella. Maybe we can quickly introduce ourselves to each other. Name, your organization and your role or position in your organization, and briefly tell us what kind of work your organization does related to RMC or women's health or women's rights?

Can you please confirm your consent to participate in this qualitative study?

SECTION 1: BACKGROUND AND ROLE OF THE RESPONDENT:

1. Can you briefly describe your position, and how it relates to the clinical provision of services to women during pregnancy and childbirth?

SECTION 2: PROGRAM ACTIVITIES

1. In your opinion, is mistreatment of women during childbirth an issue in our health facilities?
 - a. If yes, what does mistreatment look like in health facilities?
 - b. What prevents providers from being able to provide person-centered compassionate care?
2. What do you think needs to happen at a facility level to change provider behaviors?
3. Would you know any kind of activities or interventions that are working and can potentially be built upon/scaled up to promote quality, respectful care and address mistreatment?

SECTION 3: POLICY-LEVEL EFFORTS:

Now we are going to shift a bit to speak about policy for RMC.

1. To my understanding, no RMC-specific language exists in the current RMNCAH policy in Rwanda – if I am correct, can you tell me why you think it was not included?
 - a. **PROBE:** Do midwives and nurses believe mistreatment happens in health facilities?
 - b. **PROBE:** What is the feeling at the health system level of what the challenges are with promoting RMC with all women at every birth?
2. What language do you think should be included in the current RMNCAH policy to explicitly include RMC as part of the policy?
 - a. **PROBE:** What would it say? What issues to describe/note? What to promote? How would the language be sure to include those most marginalized (adolescent moms, mothers with HIV, poor mothers, etc.)?
3. From your experience, what does it take to make a policy turn into actual change in a health facility?
 - a. **PROBE:** What examples do you have of a policy that was adapted at the health facility level?
 - b. **PROBE:** What type, if any, of the advocacy, education (of population, providers), policy sensitization and awareness, clinical updates, accountability systems were useful?
 - c. **PROBE:** Financing either from government or partners? (financial commitment, long-term sustainability, institutionalized)

SECTION 4: THE IMPACT OF COVID-19 ON RESPECTFUL CARE:

1. In your opinion, how has COVID-19 impacted the availability and utilization of childbirth services?
2. From your perspective, what best practices during childbirth, specifically those associated with respectful care, are not being carried out because of COVID-19 concerns?
 - a. **PROBE:** for the following best practices: companion during labor and childbirth, mobility during labor, choice of position during second stage; skin-to-skin contact between the baby and mother; early and exclusive breastfeeding; keeping the mother and baby together at all times).
3. What are the reasons for the disruption in best practices provided during childbirth services? (Probe for reasons, including insufficient staff, unavailability/stock-out of essential medicines or other health products.)
4. What are the policy considerations and shifts you recommend based on your observations to build better resilience to help support the health system now as well as for future pandemics?

SECTION 5: RECOMMENDATIONS:

1. Who has been left out that must be included in the policy formulation, implementation and impact measurement/tracking. (Probe: communities, women’s voice and feedback, youth.)
2. Do you have any other comments or recommendations for what needs to be done at the policy level to promote and support implementation of RMC for all childbearing women in Rwanda at the health facility level?

TOOL 4: INTERVIEW GUIDE FOR MOH REPRESENTATIVES

Introduce yourself to the interviewee. Describe the purpose of the interview and how information will be used.

OVERVIEW/CONSENT SCRIPT/BACKGROUND:

Hello, my name is (insert the name of the interviewer here). Thank you for agreeing to share your perceptions on Rwanda’s RMC efforts. The MOH Rwanda/RBC Division of Maternal and Child Health, with technical support from MOMENTUM project partner Jhpiego, are conducting mainly FGDs and a few interviews to better understand:

1. Existing efforts related to RMC and PCC.
2. Status of implementation of current RMC/PCC programs/interventions, if any, including at the health facility level.
3. The impact of COVID-19 on RMC.

Goal: The Rwandan Government’s ultimate goal in this process is to mobilize decision-makers and partners to address barriers to the implementation of quality, respectful care policies and draft an RMC-specific policy that can be included in the larger RMNCAH policy. MOMENTUM will play a technical advisory role in this effort. We intend to learn from the experiences you have had with MCH program in general and RMC efforts implementation if any.

This interview should last about one hour. I will be recording this discussion for documentation and analysis purposes. We will summarize transcripts in a final report and share with all interview participants.

Can you please confirm your consent to participate in this qualitative study?

I, [interviewee name], agree to voluntarily participate in this qualitative study about Rwanda's RMC policy development.

SECTION 1: BACKGROUND AND ROLE OF THE RESPONDENT:

1. Can you please describe your position, your role in the organization/Ministry and your connection to either the creation of the RMNCAH policy or RMC discussions?

SECTION 2: POLICY-LEVEL EFFORTS:

1. In 2015, the First National Stakeholders' Consultation on Respectful Maternity Care in Rwanda took place here in Kigali. Were you a part of this meeting?
 - a. If yes, can you tell us what the discussion was around the need for policy and national level support?
 - b. If no, are you aware of the consultation and the discussion of RMC in Rwanda?
 - i. **PROBE:** What is your understanding of what happened in the meeting?
2. To my understanding, no RMC-specific language exists in the current RMNCAH policy in Rwanda – if I am correct, can you tell me why you think it was not included?
 - a. **PROBE:** Do midwives and nurses believe mistreatment happens here in Rwanda?
3. What is the feeling at the health system level of what the challenges are with promoting RMC with all women at every birth?
4. What language do you think should be included in the current RMNCAH policy to explicitly include RMC as part of the policy?
 - a. **PROBE:** What would it say? What issues to describe/note? What to promote? How would the language be sure to include those most marginalized (adolescent moms, mothers with HIV, poor mothers, etc.)?
5. From your experience, what does it take to make a policy turn into actual change in a health facility?
 - a. **PROBE:** What examples do you have of a policy that was adapted at the health facility level?
 - b. **PROBE:** What type, if any, of the advocacy, education (of population, providers), policy sensitization and awareness, clinical updates, accountability systems were useful?
 - c. **PROBE:** Financing either from government or partners (financial commitment, long-term sustainability, institutionalized)?

SECTION 3: PROGRAM ACTIVITIES:

1. Would you know what RMC activities are being implemented in the country?
2. From your understanding, how would a policy that explicitly includes RMC in the language impact the RMC program activities?

SECTION 4: THE IMPACT OF COVID-19 ON RESPECTFUL CARE:

1. In your opinion, how has COVID-19 impacted the availability and utilization of childbirth services?
2. From your perspective, what best practices during childbirth, specifically those associated with respectful care, are not being carried out because of COVID-19 concerns?
 - a. PROBE: for the following best practices: companion during labor and childbirth, mobility during labor, choice of position during second stage; skin-to-skin contact between the baby and mother; early and exclusive breastfeeding; keeping the mother and baby together at all times).
3. What are the policy considerations and shifts you recommend based on your observations to build better resilience to help support the health system now as well as for future pandemics?

SECTION 5: RECOMMENDATIONS:

1. Who has been left out that must be better included on the policy formulation, implementation, and impact measurement/tracking?
 - a. PROBE: Probe communities, women's voice and feedback, youth?
2. Do you have any other comments or recommendations for what needs to be done at the policy level to promote and support implementation of RMC for all childbearing women in Rwanda at the health facility level?



USAID
FROM THE AMERICAN PEOPLE



www.usaidmomentum.org

X @USAID_MOMENTUM

f @USAIDMOMENTUM

in @USAID MOMENTUM

