Respectful Maternity Care: What to measure and how to measure it

Eva Bazant, DrPH, MPH, Sr. MER Advisor, MCHIP/Jhpiego
Jennifer Huang, Jhpiego

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Outline

- Background
  - 7 Domains of RMC
  - FIGO Code of Ethics
  - RMC – why it matters
- Illustrative indicators for RMC – at different levels
- Data sources
- Challenges and way forward
Consented care
Confidential care
Non-abandonment in care
No physical abuse
No abuse related to cost, including detention
Equity in access

### FIGO Medical Code of Ethics: Guiding Principles

<table>
<thead>
<tr>
<th><strong>PRINCIPLE</strong></th>
<th><strong>DEFINITION</strong></th>
<th><strong>LINK TO RMC</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficence</td>
<td>Maximize the best health outcomes</td>
<td>Dignified care, RMC as a larger part of quality of care framework</td>
</tr>
<tr>
<td>Non-maleficence</td>
<td>Do no harm</td>
<td>No physical abuse, ensures the safety of women, Non-abandonment of care</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Ensure rights of persons to make informed choices about their own health care</td>
<td>Consent and information exchange for informed decision-making, confidential care</td>
</tr>
<tr>
<td>Justice</td>
<td>Distribute the burdens and benefits of new or experimental treatments equally among all groups</td>
<td>Equity in access, No abuse related to cost including detention</td>
</tr>
</tbody>
</table>

**DEFINITION**
- **Consent** and information exchange for informed decision-making, confidential care
- **Equity in access, No abuse related to cost including detention**
- **Dignified care, RMC as a larger part of quality of care framework**
- **No physical abuse, ensures the safety of women, Non-abandonment of care**
RMC— why does it matter?

- Reputation, Professionalism and Quality of Care
- Patient Safety, Service Use and Health Outcomes
- Provider Satisfaction and Retention
RMC – why does it matter?

- Reputation, Professionalism and Quality of Care
- Patient Safety, Service Use and Health Outcomes
- Provider Satisfaction and Retention
  - Disrespect among providers is a threat to patient safety
  - It inhibits collegiality, cooperation, compliance with and implementation of new practice.
  - 6 types of disrespect among provider teams

A culture of respect, part 1: The nature and causes of disrespectful behavior by physicians.
*Academic Medicine*, 87(7), 845-852.
Illustrative Indicators for RMC

- Number of women who were asked their preferred birth position
- Number of women who had a companion present in labor or delivery
- Number of women able to explain the reason for receiving a treatment for complication (cesarean section, episiotomy, etc.)
- Number of women who were draped during examinations
- Number of providers and staff who rate the work environment as respectful
Illustrative Indicators for RMC

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- Number of staff who rate the work environment as respectful
### Measure Indicators at Different Levels
**“Before” and “After”**

<table>
<thead>
<tr>
<th>Context</th>
<th>Inputs / Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol for obtaining patient consent exists</td>
<td>Number of trainings and supervision visits</td>
<td>Number of providers competent at RMC standards (in simulation)</td>
<td><strong>Labor and Delivery</strong>&lt;br&gt;Number of women able to explain the reason for receiving a treatment</td>
<td>Number of clients intending for future births at the facility</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Number of women who returned for postnatal care (PNC)</td>
</tr>
</tbody>
</table>

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**Before**

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**After**
What sources should be used to collect data on RMC?
Data from client or community

- Exit interviews with clients
- Companion interviews
- Community interviews, focus groups, “town halls”
- Feedback from community health management board
Data from Facilities

- Document review
- Facility readiness checklist/reports
- Training records and RMC competency assessments
- Supervision checklist/reports
- Labor & Delivery Provider interviews
- Observation of labor and births
- Service data
How to make data sources routine?

- Include in the work plan and budget
- Data collection by local organizations, local universities, or facility community boards
- Have short checklists and tools
- Feedback via mobile phone data/SMS (anonymity ensured by 3rd party)
Challenges in RMC Measurement

- Lack of consensus on definitions and criteria of RMC – *but getting there*
- Lack of dialogue on RMC on why it matters, what to do, what to measure?
- Lack of dialogue with community
- Tools and indicators are emerging, not yet validated or in widespread use
Key Points

- RMC aligns with the FIGO Medical Code of Ethics
- Hold dialogues and listen to patients/clients, community AND providers & staff
- Develop RMC work in your context
- Collect illustrative indicators at different levels (context/policy, outputs, outcomes, impact)
  - consider feasibility of routine collection
- RMC measurement is a new area – be a pioneer
Thank you

Respectful care, respectful work environment – FOR ALL

eva.bazant@jhpiego.org
Appendix: What makes a good indicator?

Indicators should
- Map to the program theory of change / logic model
- Include both outputs and outcomes for program objectives / activities
- Be collected from sources with clear data flow pathway
- Be practical, useful for program decision-making, attributable to program efforts
- Be discussed for importance and feasibility
- Be Validated

Criteria:
- Maximization of existing data
- Minimization of burden on country programs
- Monitoring over the life of the program
- Contribution to the global learning agenda

Sources:
MCHIP, USAID,
United Nations Foundation,
MAMA M&E Framework