



Protocol of

Respectful Maternity Care:

A checklist guide for maternity healthcare facilities

Based on the WHO (2016) Quality Standards for Improving Maternal-Newborn Care



Πρωτόκολλο της

Φροντίδας Μητρότητας με Σεβασμό:

Λίστα Ελέγχου για μαιευτικές κλινικές

Βασισμένη στα Πρότυπα Ποιότητας για τη Μητρική-Νεογνική Φροντίδα του ΠΟΥ (2016)

#RespectfulMaternityCare #RespectfulBirths

#QualityStandards #BestClinicalPractice #Respectisnotafeeling

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Preface

This checklist is based on the **WHO Quality Standards for Maternal-Newborn Care in healthcare facilities (2016)**, focusing on aspects most closely related to the **Experience of Care** and its alignment with the **Respectful Maternity Care (RMC)** framework. While not all proposed WHO Quality Measures have been included, this checklist prioritizes those measures that ensure dignity, respect, and the fundamental rights of women during childbirth.

The WHO defines **Respectful Maternity Care (RMC)** as “*care that is organized and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support*”. This definition is consistent with the White Ribbon Alliance **Charter of Rights** and FIGO’s **Ethical Framework for RMC**.

There have been significant efforts to translate this framework from a theoretical concept into an operational definition that facilitates measurement and implementation. The **qualitative evidence synthesis by Shakibazadeh et al. (2018)** has contributed significantly to identifying the key elements of RMC. Various methodologies have also been used to measure women's experiences (**outcome measures**) through validated scales, such as **Person-Centered Maternity Care (PCMC)**, **Mothers Autonomy in Decision Making (MADM)**, **Mothers on Respect Index (MORI)**, and **Mistreatment Index (MIST)**, which have been incorporated into the **RESPECT survey**. Additionally, other approaches focus on defining necessary **skills and competencies for health care staff** or developing **sets of indicators for monitoring and evaluating clinical practices** (see Jolivet et al. (2021) and Afulani et al. (2020)). For easy reference, these operational definitions of RMC have been included in the *Appendix*, alongside each other, classified according to the White Ribbon Alliance **Charter of Rights** and FIGO’s **Ethical Framework for RMC**.

Indeed, RMC is a **complex and multidimensional concept**, making it challenging to measure and implement in practice. While different approaches provide valuable insights, none are sufficient on their own. To ensure clarity and applicability, this checklist is grounded in the **WHO Quality Standards**, which were developed through international expert consensus and offer a framework of **input, process, and outcome measures**. These elements create a tangible **starting point** for assessing and improving the quality of maternity care, recognizing that further aspects of RMC could be included in future iterations.

WHO (2016). Standards for improving quality of maternal and newborn care in healthcare facilities.

❖ Available online: <https://www.who.int/publications/i/item/9789241511216> (last accessed: Jan 2025)

Instructions for use

Purpose of the RMC Checklist

Ensuring high-quality maternal and newborn care is fundamental to safe and respectful childbirth. This checklist has been developed to help maternity clinics assess their alignment with the **WHO Quality Standards for Maternal-Newborn Care (2016)**, identifying strengths and areas requiring improvement. By systematically evaluating policies, practices, and women experiences, clinics can take concrete steps toward enhancing care quality.

Awareness is the first step to quality improvement—knowing what is happening in practice enables informed decision-making for change. As the saying goes, **what is not measured cannot be improved**—this checklist serves as a tool for tracking progress and making informed and targeted enhancements.

Understanding Quality Measures

Quality in maternal and newborn care (and in general) is assessed through three key types of measures: **input, process, and outcome indicators**.

- ❖ **Input measures** ensure the foundational structures are in place, such as policies, protocols, systems, processes, mechanisms and resources. Structural and organizational context, a “quality improvement” mindset and readiness, and above all good leadership is usually the key to ensuring the foundation is in place.
- ❖ **Process measures** track the implementation of care practices and the extent to which they are properly monitored and documented.
- ❖ **Outcome measures** reflect the actual results of care, including maternal and newborn health outcomes, self-reported experiences and satisfaction with care.

While outcomes are the ultimate goal, they cannot be achieved without strong inputs and well-monitored processes. Ensuring all three are in place is essential for quality assurance processes and sustainable quality improvement.

Structure of the RMC Checklist

Following the above structure (Input-Process-Outcome measures), the checklist is divided into three sections:

- **Section A: Evidence-Based Clinical Practices (process measures)**

This section assesses the implementation of recommended maternal and newborn care practices and the avoidance of unnecessary or harmful interventions. Questions focus on the routine application of these practices and whether they are adequately recorded and documented. Some responses may involve statistical data collection where available.

- **Sections B and C: Structural and Organizational Readiness (input measures)**

This section evaluates the clinic's policies, protocols, systems, and quality control mechanisms (section B) that ensure the provision of respectful maternity care (RMC). It includes staff training, professional development (section C), and institutional structures that support high-quality care. Responses generally follow a **traffic-light system**:

- **Yes/Fully** – Arrangements are in place.
- **Partly/In Progress** – There are ongoing efforts to establish or improve them.
- **No** – No such arrangements exist and need to be developed.

- **Section D: Women's Experience and Patient-Reported Outcomes (outcome measures)**

This section captures the perspectives of service users—women's satisfaction with care and the extent to which their voices are heard. It also looks at whether the clinic collects and reviews patient-reported experiences and outcomes (PRE/PRO).

How to Complete the RMC Checklist: step-by-step guide

Follow these steps when completing the checklist:

1. **Read each question carefully** and determine the most accurate response based on current practices, policies, or data.
2. **Use the traffic-light system** for responses: Yes/Fully, Partly/In Progress, or No/Not yet.
3. **Provide statistical data where applicable** in designated sections (Data Exercises).
4. **For all responses, utilize the comments section** to:
 - Record observations or concerns.
 - Note and prioritize areas requiring improvement.
 - Identify necessary actions or follow-up steps.
 - Raise any questions for further clarification.
5. **If unsure about a response**, you may want to consult with colleagues, review records, or discuss with relevant stakeholders.
6. **After completion, review the responses** to identify priority areas for action and quality improvement.

Call to Action

By systematically using this checklist, maternity clinics can gain critical insights into their maternal and newborn care practices, ultimately contributing to safer, more respectful, and high-quality care for all women and newborns.

Improving maternal and newborn care is a collective responsibility. This checklist is not about pointing fingers—it is about demonstrating commitment to high-quality, respectful care. By engaging with this process, clinics document their efforts, showcase their strengths, and identify opportunities for improvement.

Quality improvement starts with understanding where we stand today—only then can we build a better tomorrow for mothers and newborns. **Every step taken toward measuring and improving care is a step toward ensuring respectful Maternity Care.**

Let this checklist be a tool for progress, not a burden, and a means of demonstrating that maternity care providers are dedicated professionals striving to offer the best possible care.

Section A: Evidence-based practices (process measures)

A1. Evidence-based clinical practices

A1.1. Are evidence-based clinical practices practiced consistently in the maternity clinic?

Before answering, you need to read the list of recommended evidence-based practices based on the WHO Quality Standards, in Table 1 below.

Answer “YES, fully”, if the clinic’s practices align with all the recommendations below, as a set.

Answer “YES, partly”, if the clinic’s practices align with some, but not all of the recommendations below, or aligns with all or most, but with some minor deviations. Think of what the differences are. And, what is the justification.

Answer “NO”, if there are larger deviations with many or most of these recommendations.

Given that all of the recommendations in the table below are consistent with Recommendations or Guidance on maternal-newborn care of other international organizations (NICE, RCOG, ACOG, ICM, FIGO etc), think of why. Does the clinic follow Recommendations or Guidance of some other organization – national, European or international? Which?

Before answering, you may also need to consider:

- How do we know these recommendations are “usual practice”? Is their implementation of these practices secured by a policy or protocol?
- Are these policies and/or protocols communicated to all healthcare staff? Are they practiced consistently by all? If not, what needs to be done?
- If the clinic’s practices differ to some degree or a lot from those listed below, why is that? Are there different protocols the clinic follows?
- Are these different practices the clinic adopts based on some other organization’s Recommendations or Guidance?
- Which organization? National, International? Or, were they developed by the healthcare facility? What was the process?

1. Evidence-based clinical practices YES, fully ☐ YES, partly ☐ NO ☐	<u>Comments:</u> Did you identify any practices in the healthcare facility that differ from the recommendations below? You may list:	
	(a) which practices are not adopted (and justification), or	(b) practiced with some modification (and justification)

A1.2. Are evidence-based practices implemented, recorded and documented properly for all women and newborns ?

If the answer is yes, then there must be estimates **for all** or **at least some** of the Quality Measures in Table 1 below.

If not, then why not? Are these practices maybe generally implemented, but data are not recorded consistently? Or, if they are perhaps recorded (e.g. on paper), they cannot readily be extracted from the data information system to provide evidence of adherence to these RMC recommendations? Are there documented data for at least some? **Or, none?**

2. Implemented	ALL ☐ SOME ☐ NONE ☐	3. Recorded	ALL ☐ SOME ☐ NONE ☐	4. Documented	ALL ☐ SOME ☐ NONE ☐
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A1.3. Does the clinic have a policy against unnecessary and harmful practices?

The WHO Quality Standards state that “No woman or newborn is subjected to unnecessary or harmful practices during labour, childbirth and early postnatal period”. Before answering, you need to read the list of unnecessary or harmful practices in Table 2 below.

A number of practices, such as enema, shaving and fundal pressure, are recognized as unnecessary or even harmful, and should be thus be avoided, while a number of practices are recommended only if medically indicated, and not as routine, such as episiotomy, and, of course, caesarean sections.

Does the clinic have a clear policy with regard to these practices? When any of these are implemented, are indications recoded properly and documented fully?

Before answering, you may also need to consider:

- What is the caesarean section rate at the clinic? Are indications for C/S recorded? Is the Robson classification used?
- Are episiotomies practiced as routine, even if not medically indicated? Are these recorded and documented?
- What about augmentation of labour? What is the proportion of women who have augmentation of labour with oxytocin with no indication and confirmation of delay in progress of labour?

5. Unnecessary and harmful practices	NEVER ☐ SOMETIMES ☐	6. Indications recorded	ALWAYS ☐ NOT CONSISTENTLY ☐	7. Documented fully	ALWAYS ☐ NOT CONSISTENTLY ☐
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Data exercise 1: Evidence-based RMC practices

Table 1 below summarizes clinical practices recommended in the WHO Quality Standards for Improving Maternal-Newborn care. It is not a complete list– a complete list of Recommendations appear in WHO (2018) Intrapartum care for a positive childbirth experience. WHO recommendations. Below, only select practices are listed as per most relevant to the Respectful Maternity Care framework.

Furthermore, *Table 2* summarizes non-recommended practices. These should not be implemented as routine, but only if medically indicated.

All these practices should be recorded properly and documented fully. In that case, there should be a record for these practices.

Instructions for use:

- ❖ *If there are records for all or at least some of the practices, you can record in the Tables below an estimate of the percentage of all women and newborns in the facility who experienced these evidence-based practices (Table 1), and these unnecessary practices, unless medically indicated (Table 2).*
- ❖ *Do any current “routine” practices need improvement?*
- ❖ *If there are no records of all of these practices, starting to record these practices is a good start.*
- ❖ *An even better start is to develop a clear policy about these practices (see Section B1.3) and ensure that all healthcare staff receive necessary training (see Section C1.2).*

Table 1: Recommended evidence-based Respectful Maternity Care practices for birthing women and newborns, as per WHO Quality standards.

The following are practiced by the healthcare facility:	Quality measure	Quality Standard	Quality Statement	Write %, if measured	
Progress in labour monitored and documented with a partograph and a 4-h action line	% of all women who gave birth in facility ...	QS1 Evidence-based practices: Every woman and newborn receive routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period	1.1a: Women are given timely, appropriate care .		
Pain relief is offered during labour and childbirth, according to mother’s choice					
Spontaneous vaginal birth supported and guided by the mother’s urge to push					
Active management of third stage of labour <i>with intravenous or intramuscular oxytocin given within 1 min of birth.</i>	% of all newborns in facility ...		1.1b: Newborns receive routine care immediately after birth.		
Newborns dried thoroughly and placed in skin-to-skin contact with mother immediately after birth					
Newborns in skin-to-skin contact (with head and body covered) with mother for at least 1 h .					
Breastfeeding supported in the first hour after birth.					
Clamping of umbilical cord delayed until 1–3 min after birth	% of all newborns on postnatal care wards in facility...		1.1c: Mothers and newborns receive routine postnatal care		
Routine suctioning in babies born through clear amniotic fluid not practiced (unless indicated)					
Exclusive breastfeeding from birth to discharge is supported (<i>refers to stable newborns</i>). <i>No food or drink other than breast milk, unless medically indicated.</i>					
Complete physical assessment to newborns, incl. eye and umbilical cord care <i>Not applying substances to cord</i>					
Vitamin K and vaccines , as per national guidelines.	% of healthy mothers/ babies on postnatal wards in facility ...				
Bathing delayed for 24 h. <i>% of babies who received early bathing and removal of vernix within 6 h of birth</i>					
Rooming-in practiced and enabled to allow mothers-babies to remain together 24h/day <i>refers to well babies and there are no contra-indications</i>					
Breastfeeding counselling and support provided by a skilled health care provider					
No pacifiers and teats to breastfeeding babies					
Feeding of infant formula demonstrated to mothers and family members of <i>newborns</i> <i>only when needed, with full explanation of hazards of improper use</i>					

Table 2: Unnecessary and harmful practices and practices not recommended as routine, unless medically indicated, as per WHO Quality standards.

The following are NOT practiced by the healthcare facility:	Quality measure	Quality Standard	Quality Statement	Write %, if measured
Unnecessary and harmful practices and interventions are not used or practiced. These include: • routine enemas at any time before vaginal birth • pubic or perineal shaving before vaginal birth • augmentation of labour with oxytocin with no indication/confirmation of delay in progress • fundal pressure to facilitate second stage of labour	% of women giving birth in facility who received any of these:	QS1 Evidence-based practices: Every woman and newborn receive routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period	1.9: No woman or newborn is subjected to unnecessary or harmful practices during labour, childbirth and early postnatal period.	
The following practices and interventions are not used or practiced as routine, unless medically indicated: • episiotomy (<i>among uncomplicated, spontaneous vaginal births</i>) • uterine packing to control bleeding • instrumental vaginal childbirth • caesarean section (<i>reported according to Robson classification groups</i>)	% of women giving birth in facility who received any of these with no indications...			

Section B: Structural and Organizational readiness (input measures)

B1. Policies and Guidance

B1.1. Does the maternity clinic have a policy in place for the following issues?

If not, is the clinic in process of developing these policies? Then, select “in progress”.

1. Staffing policy	YES ☐ NO ☐ In progress ☐	2. Triage & waiting times	YES ☐ NO ☐ In progress ☐	3. Payment	YES ☐ NO ☐ In progress ☐
4. Breastfeeding	YES ☐ NO ☐ In progress ☐	5. Quality improvement	YES ☐ NO ☐ In progress ☐	6. Mistreatment	YES ☐ NO ☐ In progress ☐

B1.2. Does each of these policies align fully with the Quality Standards requirements listed in the Table below?

If yes, then select “fully”. Or, does it align “partly”? If there is no policy in place, select N/A.

Before answering, you need to read the minimum requirements for each policy listed in the Table below:

- If there is a policy in place but does not fully align with the requirements, you may record what improvements are needed.
- If there is no policy on this topic/ theme, you may consider developing a policy.

The Table below provides space for comments. You may want to record what improvements are needed and identify relevant actions.

1. Staffing policy	Fully ☐ Partly ☐ N/A ☐	2. Triage & waiting times	Fully ☐ Partly ☐ N/A ☐	3. Payment	Fully ☐ Partly ☐ N/A ☐
4. Breastfeeding	Fully ☐ Partly ☐ N/A ☐	5. Quality improvement	Fully ☐ Partly ☐ N/A ☐	6. Mistreatment	Fully ☐ Partly ☐ N/A ☐

B1.3. Are these policies or guidance available in writing?

And, are they communicated to all staff? This is either a YES or a NO. Of course, even if these policies are in writing, they may need updating.

The Table below provides space for comments. You may want to consider:

- If they are available in writing, when was the last time they were reviewed? Does any of them need updating?
- If they are not in writing, you may consider developing a record for these policies, so that it may be communicated effectively to all healthcare staff.
- If there is no policy on this topic/ theme, you may consider developing a policy.

1. Staffing policy	YES ☐ NO ☐ Updating ☐	2. Triage & waiting times	YES ☐ NO ☐ Updating ☐	3. Payment	YES ☐ NO ☐ Updating ☐
4. Breastfeeding	YES ☐ NO ☐ Updating ☐	5. Quality improvement	YES ☐ NO ☐ Updating ☐	6. Mistreatment	YES ☐ NO ☐ Updating ☐

Table 2: Minimum requirements for each policy listed above as per WHO Quality Standards

Type	Theme/Topic	Quality measure	COMMENT: What improvements are needed?
Policies and guidance	1. Staffing policy 1.1 Does it list numbers, types and competence of staff ? 1.2 Does it provide for sufficient number of staff to allow facility to provide 24-h service ? 1.3 Does it provide for appropriate skills mix , working in multidisciplinary teams ? 1.4 Is it reviewed continuously according to work load ? 1.5 Does it provide for recording posts filled by staff with necessary competence for job description? 1.6 Does it describe standard procedures and plans for recruitment, deployment and retention of all staff?	Health facility has written, up-to-date policies, at least for each of the following:	
	2. Triage and waiting times policy 2.1 Does it cover emergency consultations and treatment? 2.2 Does it cover non-emergency consultations and treatment?		
	3. Payment policy 3.1 Does it include a standard fee structures for maternity/newborn care? 3.2 Are fees equitable, affordable and clearly displayed? 3.3 Does it specifically preclude detention of a woman or baby for non-payment ?		
	4. Breastfeeding policy 4.1 Is it aligned with the Baby-friendly Hospital breastfeeding policy? 4.2 Does it incorporate clear reference to the International Code (ICMBS) against advertising and promotion of breastfeeding substitutes and bottle-feeding? 4.3 Does the clinic adhere to the Code (e.g. no breast milk substitutes displayed on posters or placards, not distributing samples to mothers or staff, etc)? 4.4 Is the Breastfeeding Policy known and routinely communicated to all health care and support staff? 4.5 Is the Breastfeeding policy communicated to women/ families ?		
	5. Quality Improvement Policy or Guidance 5.1 Is there a overall programme for improving quality of care and patient safety? 5.2 Does it list clear goals , operational plans, procedures and monitoring mechanisms? 5.3 Does it include provisions for staff performance monitoring, supervision and feedback? 5.4 Does it cover activities to promote interpersonal communication and counselling skills of staff? 5.5 Are there provisions for staff to provide feedback to the management on quality improvement? 5.6 Does it provide guidance on increasing motivation among staff (e.g. recognition and reward schemes)?		
	6. Mistreatment Policy and related guidance to staff 6.1 Does it clearly define mistreatment in terms of harmful practices and unnecessary interventions during labour, childbirth and early postnatal period? 6.2 Does it adopt a zero-tolerance, non-discriminatory stance on mistreatment? 6.3 Are processes on obtaining informed consent before examinations and procedures clear?		

B2. Clinical and other protocols and Standard forms

B2.1. Does the maternity clinic have a set of clinical protocols in place for the following?

You may want to think of what protocols are currently available. If not available, is the clinic in process of developing protocols? Then, you may select “in progress”. If a complete set of protocols are not available, you may want to consider which ones to prioritize based on needs and, of course, capacity.

Before answering, you may need to consider the following:

- Is the set of clinical protocols complete? Which areas do they cover? Are there areas that are not covered? Which?
- Are these national protocols? Were they developed or adopted by the national relevant professional association?
- Where they developed by the clinic? What was the process? Where they developed by a multi-disciplinary team?
- Are they evidence-based? Are they up-to-date? Do they need updating? Do they need improvements?
- Are they consistent with WHO guidelines or other international organization's guidance and recommendations? Which one?
- Are they well known and regularly communicated to healthcare staff? Are there arrangements in place for training staff on these protocols?
- If some areas/ topics are not covered, is there a priority-setting plan? Is there capacity in the clinic to develop them?
- If there are no protocols, is there a plan how to develop them or adopt and adapt protocols based on international guidance and recommendations?

1. Antenatal care YES ☐ NO ☐ In progress ☐	2. Perinatal care YES ☐ NO ☐ In progress ☐	3. Postnatal care YES ☐ NO ☐ In progress ☐
<u>Comments:</u>		

B2.2. Does the maternity clinic have protocols in place for the following?

If not, is the clinic in process of developing protocols for these issues?

Before answering, you may need to read the footnotes:

4. Clinical notes and Hand-over ¹ YES ☐ NO ☐ In progress ☐	5. Privacy & Confidentiality YES ☐ NO ☐ In progress ☐	6. Filing complaints ² YES ☐ NO ☐ In progress ☐
7. Supporting normal labour ³ YES ☐ NO ☐ In progress ☐	8. Birth companion of choice ⁴ YES ☐ NO ☐ In progress ☐	9. Informed consent process/forms ⁵ YES ☐ NO ☐ In progress ☐
<u>Comments:</u>		

¹ Protocol and standard forms for recording clinical notes and monitoring events during labour, birth and after birth and protocol for verbal and written clinical hand-over of women and newborns (a) at shift changes, (b) during intra-facility transfer, (c) on referral to other facilities and (d) at discharge.

² Protocol protecting the right to make a complaint about the care received and clearly describing the process,

³ Protocol to (a) support normal labour, (b) minimize unnecessary interventions, (v) strengthen woman's capability to feel in control of her childbirth experience

⁴ Protocol for encouraging companion of choice and actively incorporating, according to woman's preference, to the care process.

⁵ Protocol on correct process of obtaining informed consent along with necessary standard forms and necessary resources (e.g. information leaflets) which helps health care staff to provide easily understandable information to women and ensures their fully informed consent.

B3. Arrangements and Resources

B3.1. Are the following arrangements in place?

If not, are there plans for working towards these arrangements or improving existing? Then, select “in progress”. There is also space to write comments.

Before answering, you may need to read the footnotes:

1. Leadership & Governance ⁶ YES ☐ NO ☐ In progress ☐	2. Skilled birth attendants ⁷ YES ☐ NO ☐ In progress ☐	3. Supportive birth environment ⁸ YES ☐ NO ☐ In progress ☐
<u>Comments:</u>		

B3.2. Does the clinic have the following resources in place?

If not, are there plans for working towards developing or improving existing?

Before answering, you may need to read the footnotes:

4. Educational material YES ☐ NO ☐ In progress ☐	5. Breastfeeding support at clinic ⁹ YES ☐ NO ☐ In progress ☐	6. Breastfeeding & postnatal care ¹⁰ YES ☐ NO ☐ In progress ☐
<u>Comments:</u>		

If you answered YES above in terms of educational material, you need to also consider the following:

- Is this material available and accessible to all staff to support their educational role? What topics do they cover? Is there need to develop more?
- Are these in written or pictorial format to aid understanding? Are they available in all languages of the communities served by the facility?

If you answered NO above in terms of educational material, you may need to consider the following:

- Are there plans to develop such material? Is there capacity? Is there readily-available material and/or other resources (e.g. digital material) that may use?
- Would you consider developing a list of websites with valid information to recommend to women and their families?

⁶ Standard governing procedures accessible to all staff, with clear leadership structure and procedures, with defined roles and responsibilities, and lines of accountability for reporting

⁷ Skilled staff available at all times, in sufficient numbers to meet anticipated workload, with roster displayed (names of staff on duty, times of shifts and specific roles and responsibilities), and clear communication channels to reach staff on duty at all times

⁸ Physical environment and labour/childbirth areas organized in such a way as to allow: (a) privacy and respectful, confidential care, including availability of curtains, screens, partitions & sufficient bed capacity, (b) a physical private space for the woman and her companion at the time of birth

⁹ Local arrangements to inform women about (a) benefits and management of breastfeeding, (b) alternative feeding methods, including cup or cup-and-spoon feeding, avoiding bottle-feeding.

¹⁰ Arrangements, either in-house or in partnership with other community agents to provide breastfeeding support and postnatal care after discharge from the hospital

Question 1: Have you heard of the Baby Buddy Cyprus webapp platform?

The **Baby Buddy Cyprus** webapp educational platform for the “*journey to parenthood*” was developed locally by the Cyprus University of Technology (CUT) and Birth Forward, by culturally adapting the original Baby Buddy UK app, developed by project partner Best Beginnings).

It was funded by the EU Erasmus+ programme as part of the **Baby Buddy Forward** project coordinated by the Department of Nursing, School of Health Sciences, (CUT). The partnership included all relevant national scientific bodies and associations in Cyprus:

- Cyprus Gynaecological and Obstetrics Society,
- Midwives Committee of the Cyprus Nurses and Midwives Association,
- Society for Perinatal Medicine,
- Cyprus Paediatric Society,
- Ministry of Health, and the National Breastfeeding Committee.



It is free to use by registration, at www.babybuddy.com.cy and there is a separate track for women/partners and healthcare providers. Only an email address is needed. By providing the expected day of birth or day of child’s birth for pregnant and new mums respectively, the webapp platform tracks the stage of pregnancy or age of baby and provides day-to-day “messages”.

It contains a wealth of information and educational material (text and video) covering pregnancy, labour and the first six months of the baby’s life.

There is also a library of over 250 short videos (a total of more than 12 hours of watch time). In some of the videos, doctors, midwives and other health professionals from Cyprus and the UK (in partnership with Best Beginnings, UK) give advice and in other videos pregnant women and new mums share their experiences, offer practical tips and emotional support.

The videos are also available on YouTube, where they are getting millions of views worldwide (<https://www.youtube.com/@BabyBuddyForward>).

Baby Buddy always reminds users of the importance of direct communication with your healthcare providers and even suggests specific topics to discuss with healthcare providers. It also has a FAQ section and provides short answers to a wide range of Frequently Asked Questions,.

All information is based on evidence-based and best clinical practice and it comes in bite-size pieces, easy-to-understand and at the right time.

Furthermore, all material is available in Greek, English, Turkish, Russian and Arabic.

Since launch (March 2020 amidst the first lockdown of the COVID19 pandemic, registered users on the Baby Buddy platform exceed 4500, with about 60-80 new registrations every month.

B4. Systems, processes and mechanisms

B4.1 Are the following recording and monitoring systems in place and used routinely?

If not, are there plans towards developing these? There is space for comments, if necessary.

Before answering, you may need to consider the following:

- What is recorded in the registers? What is the quality (completeness, accuracy) of recording systems?
- Other than data and information required by competent authorities (OAY, MoH, OKYPY etc), are there more indicators recorded?
- Which data collections forms and/or clinical charts are in use currently? Is there need for more? Which?
- What is not recorded currently? What would be useful to start recording?
- Is there a process for verification of what is recorded? Are care processes systematically monitored? Are they reported internally?
- Are there standard operating procedures and protocols for checking, validating and reporting data?

7. Registers	YES ☐ NO ☐ In progress ☐	8. Data collection forms	YES ☐ NO ☐ In progress ☐	9. Clinical charts	YES ☐ NO ☐ In progress ☐
<u>Comments:</u>					

B4.2. Is there an established system for collecting, analyzing, timely-reporting and monitoring data?

These are four different processes – collecting, analyzing, reporting and monitoring. They indicate a different degree of readiness. All are necessary and all need to be in place in the context of effective Quality Improvement. If not, are there plans towards developing or improving?

Before answering, you may need to consider the following:

- All four stages (collecting, analyzing, and reporting) are in place for monitoring performance?
- What is the range of data recorded currently? What set of indicators are/can/could be calculated from these data?
- Are these indicators calculated on a systematic basis? How often? On paper, digitally, or both?
- Do the data that are recorded currently, allow the calculation of all or some of the WHO Quality Measures? Which ones? Which ones not?
- Are reports on monitoring performance prepared? How often? Which key metrics do they include? Are there any visual outputs?
- Is there a established process of reviewing performance? Who is responsible? Who else does the process involve?
- Are there established mechanisms for communicating performance to all relevant staff. (e.g. dashboard of key metrics)?
- Is reviewing performance, part of a wider quality improvement programme?

10. Collecting	YES ☐ NO ☐	11. Analyzing	YES ☐ NO ☐	12. Reporting	YES ☐ NO ☐	13. Monitoring	YES ☐ NO ☐
<u>Comments:</u>							

B4.3. Specifically for C/S sections, are these recorded and reported according to the Robson classification system?
If not, why not?

14. Robson classification system for C/S section	YES ☐ NO ☐ In progress ☐	Comments:
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B4.4. For procedures that require written consent, is there an associated record of consent signed by the woman/family member?

15. Records of written consent forms	YES ☐ NO ☐ In progress ☐	Comments:
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B4.5. Specifically for women and families with complex emotional needs, are there mechanisms in place for referral to specialist care?

16. Referrals to specialist care	YES ☐ NO ☐ In progress ☐	Comments:
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B4.6. Are there mechanisms for regular collection of information on women's experience and satisfaction with provided care?

If yes, what information is collected? How is it collected? If not, why not? *Also see Section D for recommended measures of service-user satisfaction.*

17. Service-user experience and satisfaction	YES ☐ NO ☐ In progress ☐	Comments:
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B4.7. Is there a mechanism for (a) filing complaints and (b) for redress in the event of mistreatment?

If yes, what is the actual process? If not, why not? *Before answering, you may need to read the footnotes:*

18. Complaints ¹¹	YES ☐ NO ☐ In progress ☐	19. Accountability ¹²	YES ☐ NO ☐ In progress ☐	Comments:
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B4.8. Are there mechanisms for periodical staff appraisals and collecting information on staff satisfaction?

If yes, what information is collected? If not, why not? Is there a staff appraisal? Are there incentives? Is good performance recognized?

20. Staff satisfaction	YES ☐ NO ☐ In progress ☐	21. Appraisal	YES ☐ NO ☐ In progress ☐	22. Recognizing performance	YES ☐ NO ☐ In progress ☐
Comments:					

¹¹ Mechanisms for handling in complaints, that is easily accessible to service-users e.g. complaints box that is periodically emptied and content reviewed

¹² Accountability mechanism for redress in the event of mistreatment, violations of privacy and confidentiality, and/or consent processes

B5. Quality improvement processes and leadership

B5.1. Is there a quality improvement team in place? What about other arrangements, such as professional development training and interprofessional practice?

If **not** or **only partly**, are there plans towards developing or improving these processes?

Before answering, you may need to consider the following:

- *Is there a dedicated quality improvement team with responsible personnel and leadership? Does it need strengthening?*
- *Are they trained in quality improvement and leading change (e.g. use of information, enabling behaviour, continuous learning)?*
- *Does the clinic provide an enabling and supportive environment for professional development?*
- *Is there regular supportive supervision and mentoring? Are there opportunities for professional and skills development training?*
- *Is there a structured programme for continuing professional and skills development? Is it available to all staff?*
- *Does the clinic promote and support inter-professional practice? Is there training for inter-professional practice?*
- *Is there good inter-professional collaboration? Are roles and responsibilities clear?*
- *Do all staff practice the full scope of professional practice to provide care during labour, childbirth and early postnatal period?*

1. Quality improvement team YES ☐ NO ☐ Improvements needed ☐	2. Continuing professional skills development opportunities – also see Section C YES ☐ NO ☐ Improvements needed ☐	3. Inter-professional practice YES ☐ NO ☐ Improvements needed ☐
<u>Comments:</u> 		

B5.2. Are there clearly defined and established quality improvement processes? Which ones?

If **yes**, which of the following? If **not**, are there plans towards **developing** these?

4. Regular reviews of data and use of recommendations YES ☐ NO ☐ Improvements needed ☐	5. Mentoring system for staff performance YES ☐ NO ☐ Improvements needed ☐	6. Monitoring improvement performance YES ☐ NO ☐ Improvements needed ☐
<u>Comments:</u> 		

B5.3. Is healthcare staff involved and actively participate in quality improvement? In what way?

If **yes**, how many of the following aspects are addressed? How regularly? Do all staff have the opportunity?

If **not**, why not? Are there plans towards **developing** these aspects and actively involving staff in quality improvement processes?

7. Staff performance assessment, appraisal and feedforward	YES ☐ NO ☐ Improvements needed ☐	8. In-service training and mentoring based on identified needs	YES ☐ NO ☐ Improvements needed ☐
9. Involved or participate in quality improvement team meetings	YES ☐ NO ☐ Improvements needed ☐	10. Implement or participate in quality improvement activities	YES ☐ NO ☐ Improvements needed ☐
<u>Comments:</u>			

B5.4. Are there regular meetings between managers-healthcare staff to review process and outcome data and monitor performance?

If **yes**, how many of the following aspects of quality improvement are addressed? How often? Monthly? Every three months? Less regularly?

If **not**, why not? Are there plans towards **introducing** them or making current processes more regular or more effective?

11. Regular monitoring performance and improvement of performance	YES ☐ NO ☐ Improvements needed ☐	12. Making recommendations to address identified issues	YES ☐ NO ☐ Improvements needed ☐
13. Recognizing and honoring those who have performed well	YES ☐ NO ☐ Improvements needed ☐	14. Encouraging staff who are struggling to improve	YES ☐ NO ☐ Improvements needed ☐
<u>Comments:</u>			

B5.5. Are stakeholders involved in quality improvement processes?

If **yes**, are stakeholders involved in all phases of the quality improvement cycle - from review to recommendations and taking action?

If **not**, why not? Are there plans to **move towards** this direction? If not, why wouldn't you?

Before answering, you may need to consider the following:

- Have stakeholders been identified, including competent authorities, professional associations, NGOs, community groups, and service-users?
- Are there regular meetings? How often? At least once annually? More often? Occasionally? If not, why not?
- Are all stakeholders involved in this process? Who is? Who is not? Who else should be? What is the purpose of these meetings?
- Are community/ service-users representatives included in this process, as per quality improvement requirements? If not, why not?

15. Review performance	YES ☐ NO ☐ Improvements needed ☐	16. Make recommendations	YES ☐ NO ☐ Improvements needed ☐	17. Take joint action	YES ☐ NO ☐ Improvements needed ☐
Comments:					

Question 2: Have you thought of who the stakeholders are? Do you have a stakeholder map?

Across all socio-organizational levels – competent authorities, commissioners and other independent bodies, professional and scientific associations, research and academic institutions, service-users and community groups, NGO and advocates? You can group them in terms of category. You can also cross-classify them in terms of low-high interest and low-high influence.



Section C: Training for professional skills development and strengthening

C1. Training of health-care staff

C1.2. Are there opportunities for continuing education and professional development of staff?

If **yes**, which of following channels exist? Are there opportunities available equitably to all members of staff?

If **not**, are there plans towards **developing** these internally or in collaboration with external actors?

Before answering, you may need to consider the following:

- Is there in-service training, organized or co-organized by the clinic/ hospital? How regularly?
- Is there orientation for new staff? Are there refresher sessions for older staff?
- Is there a supervision and mentoring programme? Is it effective?
- Do training activities address the identified needs for performance improvement?
- Are there external opportunities for training (e.g. conferences, workshops, seminars etc) organised by other institutions and bodies? Are they relevant?
- Is the staff interested and motivated to seek continuing education and professional development opportunities? If not, why not?

1. In-service/ In-hospital training	YES ☐ NO ☐ Improvements needed ☐	2. Supervision & mentoring	YES ☐ NO ☐ Improvements needed ☐	3. External training opportunities	YES ☐ NO ☐ Improvements needed ☐
<u>Comments:</u> 					

C1.2. Does the healthcare staff receive training related to core aspects of Respectful Maternity Care?

If **yes**, how many of the following core aspects of RMC (see Table 3 below) are addressed in the professional training of staff? If **not**, why not?

What percentage of maternity-newborn healthcare staff received training on any of these topics in the past 12 months?

Is there a record? If not why not?

Before answering, you may need to consider the following:

- Are there locally training opportunities in these topics? If yes, what would be needed for staff to receive training?
- Health care staff shows or takes initiative to receive training in these topics? Is there motivation? If not why not? Is it a matter of leadership?
- If not, are there plans towards creating opportunities to provide training on these topics internally or in collaboration with external actors?

Data exercise 2: Staff training

Table 3 below summarizes some of the training needs listed in the WHO Quality Standards for Improving Maternal-Newborn care. It is not a complete list—only topics that were most relevant to the Respectful Maternity Care framework were selected.

Instructions for use: If there are records on the percentage of staff who received training, supervision or mentoring on any of these core RMC topics, completing the Table will help identify gaps and where there is more pressing need for improvement. This will also allow to think of what might be the best way to provide such training for more healthcare staff.

Note that the recommendation is for in-service training every 12 months while for some key topics, the Quality Standards measures call for more frequent supervision and monitoring. Even if training in these topics does not occur in this frequency, you may still try to identify what percentage of maternity-newborn healthcare staff has ever received training in these aspects of RMC. You may also want to classify the staff by professional group (specialist doctors, trainee doctors, midwives, nurses, other healthcare professionals).

Table 3: Recommended staff training on Respectful Maternity Care, as per WHO Quality Standards.

Type	Frequency	Themes/Topics	Quality measure	Write %, if measured
In-service training (incl. orientation for new staff and regular refresher sessions)	At least once every 12 months	1. oriented to functions, roles and responsibilities in the facility/unit assigned	Proportion among all health-care staff in the labour/childbirth areas of the maternity unit who received training in these topics as stated...	
		2. essential newborn care and breastfeeding support		
		3. harmful practices & unnecessary interventions		
		4. interpersonal communication and counselling skills		
		5. cultural competence		
		6. providing respectful care and respecting rights of mothers and newborns and		
		7. accountability mechanisms		
		8. effective informed consent procedures		
		9. women's right to choose care at childbirth		
		10. nonpharmacological and pharmacological pain relief		
		11. evidence for and positive impact of the presence of chosen companion during labour/birth.		
Supervision & mentoring (incl. drills & simulations)	At least 1-3 months	1. essential newborn care and supporting breastfeeding		
		2. harmful practices & unnecessary interventions		
		3. providing respectful care and respecting the rights of mothers and newborns		
		4. accountability mechanisms		
		5. interpersonal communication and counselling		
		6. cultural competence		
		7. effective informed consent procedures		

C1.3. Do healthcare staff engage in effective communication and counselling with women and their families?

If **yes**, what percentage of healthcare staff at the clinic, across all occupational groups, demonstrate the following core aspects of effective communication (see table 4 below)? How was that estimated?

Before answering, you may need to consider the following:

- Has healthcare staff received structured training in any of these aspects of communication in the past 12 months?
- Is there a supervision and mentoring system in place to assess these important skills in effective communication?
- Are there locally training opportunities in these topics? If yes, what needs to be done for staff to receive such training?
- If not, is there a way to create such opportunities through establishing collaborations and partnerships with external actors (e.g. Universities)?
- Is there motivation? If not why not? Is it a matter of leadership?

Data exercise 3: Staff's communication and counselling skills

Table 4: Minimum skills and competences for Respectful Maternity Care, as per WHO Quality Standards.

Type	Frequency	Themes/Topics	Quality measure	Write %, if measured
Skills and competences	During all aspects of care	1. Effective communication: 1.1 active listening, asking questions, responding to questions, 1.2 verifying the understanding of women and their families, 1.3 supporting women in problem-solving. 1.4 orient companion on his/her role in supporting the woman during labour and birth 1.5 interpersonal and cultural competence in providing emotional support	Healthcare staff demonstrate the following skills and competences (based on supportive supervision and mentoring)	
	Before discharge	2. Written and verbal information and counselling on the following elements: 2.1 exclusive breastfeeding and maintaining lactation, 2.2 keeping baby warm and clean, 2.3 communication and play with the baby, 2.4 danger signs for the mother and newborn. 2.5 where to go in case of complications 2.6 nutrition and hygiene, 2.7 birth spacing and family planning,		

Section D: Women's experiences and satisfaction with care (outcome measures)

D1. Exit surveys on reported experience and satisfaction with care

D1.1. Are there mechanisms for regular collection of information on women's experience and satisfaction with provided care?

What did you answer on question B4.4 above? If yes, what information is actually collected? How is it collected?

1. Service-user experience and satisfaction	YES ☐ NO ☐ In progress ☐	Comments:
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D1.1. Are surveys performed periodically with a sample of women who gave birth in the clinic?

If surveys are performed by the clinic, which patient-reported outcomes (PRO) and experience (PRE) measures were selected? How?

If no surveys are performed, is any information on the experience of women collected in any other way (e.g. focus groups, interviews)?

If no information is collected directly from women, why not? How can this change?

Does the clinic have access to Health Insurance Organization's (HIO-OAY) satisfaction (inpatient or outpatient) survey data? At unit level? At provider level?

Before answering, you may need to consider the following:

- Are questionnaire surveys performed periodically in a sample of women who gave birth in the facility?
- If not, why not? Is there no Capacity? Is it a matter of procedural knowledge on research methods/study design (e.g. sampling, questionnaire design)?
- Have you consider collaborating with an academic-research institution to help you set-up an experience and satisfaction survey?
- Is it a matter of culture of the facility? Is it not a good fit with the policies, structure and/or management style? Is there a Quality Improvement team?
- Is there no need or benefit from such surveys? The satisfaction from the provided care is expressed directly to the providers? There are no complaints?
- These surveys would have no real value in quality improvement because there is lack of an overall quality improvement programme?

2. Questionnaire surveys	YES ☐ NO ☐ In progress ☐	3. Focus groups/ interviews	YES ☐ NO ☐ In progress ☐	4. Direct observation	YES ☐ NO ☐ In progress ☐	5. HIO patient satisfaction	YES ☐ NO ☐ In progress ☐
Comments:							

Data exercise 4: Women's experience and satisfaction with care

The *Table* below summarizes some of the Quality Measures tapping on effective communication, coordinated care, respect, dignity and person-centered support recommended by the WHO framework on Quality Standards for Improving Maternal-Newborn care. It is not a complete list – only measures most relevant to the experience of Respectful Maternity Care were selected.

Instructions for use: If there is information on the experience of women who gave birth in the healthcare facility for any of the measures below, collected recently in any way (e.g. sampling survey, focus groups, interviews), completing the Table with the “best” estimate of the percentage/ proportion of women who report satisfaction with that aspect of care, will help identify gaps, set priorities and take relevant action. There is always room for improvement.

If there is no such information currently, and, thus, no way to provide estimates for these key measures, other than personal opinion, impressions, or other anecdotal evidence, then, there is always a start!

Table 5: Set of recommended self-reported experience and satisfaction with care, as per WHO Quality Standards.

Quality Standard	Quality Statement	Themes/ Topics	Quality measure	Write %, if measured
QS4 Effective Communication Women should receive all information about their care and feel involved in all decisions taken regarding their treatment.	4.1: Information about provided care and effective interactions with staff. 4.2: Coordinated care , with clear, accurate information exchange between health/ social care professionals	Health care staff introduced themselves (i.e. name, role, reasons for examination/procedure etc)	% of women who gave birth in facility who report experiencing these good practices referring to effective communication, coordinated care, respect, dignity and person-centered support...	
		Received attention within appropriate time for their condition (as per facility policy on triage and waiting time)		
		Health care staff showed good knowledge of woman's history and the care that had been given to date.		
		Felt adequately informed by care provider(s) about examinations, actions and decisions taken for their care.		
		Satisfaction with health education and information received from care providers		
		Given opportunity to discuss their concerns and preferences		
		Needs and preferences taken into account during labour, childbirth and postnatal care		

QS5 Respect and Dignity <u>Privacy and confidentiality should be respected at all times, and any kind of mistreatment, should be avoided.</u>	5.1: Privacy around the time of labour and childbirth, and confidentiality respected. 5.2: No mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services. 5.3: Informed choices about services received, reasons for interventions or outcomes clearly explained.	• Permission was sought before any examination or procedures were performed		
		• Treated with respect and their dignity was preserved		
		• Physical, verbal and/or sexual abuse during labour childbirth or after birth		
		• Made a complaint, and complaints acted upon without repercussions		
		• Were aware that they had the right to accept or refuse treatment		
		• Felt they had shared decisions about their labour, birth and postnatal care		
		• <i>[if giving birth by C/S]</i> aware of the reason for the caesarean section		
QS6 Person-centered emotional support to strengthen the woman's <u>own capability and confidence</u>.	6.1: Option to experience labour/ childbirth with companion of choice. 6.2: Support to strengthen capability during childbirth	• At least one person of their choice, as culturally appropriate, with them during labour, childbirth and the immediate postnatal period		
		• Reported having sufficient food and drink during labour		
		• Ambulatory during the first stage of labour		
		• Gave birth in the labour position of their choice		
		• <i>[if undergoing bereavement or adverse outcome]</i>, received additional emotional support from facility staff		
		• Overall satisfaction with health services		

Question 3: Have you seen the findings of the RESPECT (Cyprus) and IMAGiNE (pan-European) surveys on RMC?

If you have participated in any of the RESPECT stakeholder meetings, then you would have seen the RESPECT and IMAGiNE survey results on the experiences of women in Cyprus and Europe respectively on Respectful Maternity Care, and which aspects of care need strengthening.

If there are two **key messages** from both these research studies, these are:

- there is no country/clinical setting without **gaps**, and
- **awareness** is the first step to quality improvement.

If you haven't had the opportunity to see the research findings of the **RESPECT** national survey and focus-groups about the experience of women from maternity care in Cyprus, you can see some of the main findings in an infographic presentation here: <https://my.visme.co/view/4djrjoy-respect-infographics-cyprus>

A battery of internationally-used validated questionnaire scales were used to depict several aspects of women's experiences according to the Respectful Maternity Care framework. Many of the above indicators (or similar) were included in the questionnaire.

Do you think the care provided in our maternity care facility compares favourably to the experiences depicted by the research study?

You might be tempted to think that the results are not representative because women with negative experiences might be more likely to respond to a call to participate in a survey about experiences of maternity care, even though the call to participate was framed in a neutral way (i.e. *"Every birth experience is unique – add your piece to the puzzle – tell us about your maternity care"*). While selection (volunteer) bias, as it is called in research methodology, cannot be ruled out entirely, it is important to note that the experiences recorded in the survey range along the full negative to positive experiences continuum.

Furthermore, the aim of the survey was not to estimate the frequency (prevalence) of negative experiences, but to provide a relative comparison of several aspects of Respectful Maternity Care, and identify which aspects appear more problematic than others. For example, while discrimination was not frequently reported, the findings with regard to several core aspects of **"Communication and Autonomy"** do not allow complacency, especially related to women's participation in shared decision-making.

Also, note while the percentage of women who reported having procedures without informed consent, any form of physical or verbal abuse, neglect or coercion might appear surprisingly high, it is actually was not as high as the percentages recorded in similar studies internationally. However, even 1% would be too many, given that there should be a zero-tolerance policy.

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Appendix A: Expanded typology of Respectful Maternity Care

This expanded typology of Respectful Maternity Care is based on Shakibazadeh's et al (2018) qualitative evidence synthesis of the literature and other operational definitions and indicators, by Jolivet et al. (2021) and Afulani et al. (2020). These have been adapted from the original sources and presented here side-by-side, classified according to White Ribbon Alliance's Charter of Rights and FIGO's Ethical Framework for Respectful Maternity Care.

It was deemed important to include here as **point of reference**. But they only serve the purpose of convenience, and it is preferable to search for the full-text publications listed in the References.

If you do not have access to bibliographic databases, you can request them from the RESPECT research team: respect@birthforward.com.

E Shakibazadeh et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. <i>BJOG</i> 2018; 125: 932–942.			Charter of Rights based on White Ribbon Alliance RMC Framework	FIGO Ethical Framework for RMC	Jolivet et al (2021). Operational definitions of RMC based on systematic scoping review	Afulani et al (2020). Indicators for routine monitoring & evaluation of RMC
Third-order themes	Second-order themes	First-order themes				
(1) Being free from harm and mistreatment	Not shouting and screaming at women	Speaking with women in calm , measured, respectful manner	Right to be free from harm (violence) and ill treatment (physical, sexual and verbal abuse)	Principle of nonmaleficence - avoid harmful practices – procedures with insufficient evidence of benefit outweighing risk for routine or frequent use - avoid disrespect and abuse – devote attention to defining, identifying and eliminating disrespect and the abuse	- Protect from individual and institutional violence so no client is subjected to - physical, - sexual, or - verbal abuse or mistreatment - Only medically-indicated evidence-based interventions - Avoid harmful practices including (a) overuse of interventions, drugs, technology, (b) unnecessary separation of mother-baby - Provide (a) food & liquid to women in normal labour and (b) Encouragement of skin-to-skin and early, breastfeeding - Supportive care to strengthen women's capabilities incl. pharmacological/ non-pharmacological pain relief options	No abuse - No verbal abuse (insults, intimidation, shouting, scolding, threatening) - No physical abuse (slapping, hitting, pushing, pinching, restraining etc) - No episiotomy given or sutured without anaesthesia
		Treatment by competent professionals				
	Providing safe, supportive and secure care	Providing psychosocial support to the women including praise, companionship, and empathy				
		Providing a confident and caring relationship				
		Collaboration between caregivers to provide a secure and continuous care				
		A safe and secure environment				
				Principle of Justice Under no circumstances is physical, verbal or emotional abuse of women, their newborns and their families ever allowed		

(2) Maintaining privacy and confidentiality	Ensuring privacy during <u>physical examinations and procedures</u>	Ensuring women are not physically exposed to others when performing vaginal or abdominal examinations	Right to Privacy & Confidentiality		1. Visual and auditory privacy during labor and birth (private room, curtains, screens, or drapes, and limiting the people present to those clinically indicated or desired by the woman).	Privacy and Confidentiality
		Avoiding or minimizing other patients' ability to observe				
		Shielding women from visitors of other women				
		Where possible, accommodating women's preferences for staff gender				
		Limiting the number of attending persons performing examinations and procedures				
	Maintaining the confidentiality of women's <u>personal information</u>	Maintaining confidentiality throughout all aspects of care			2. Keep patient information confidential and do not share unless indicated for the provision of effective care	1. Physical privacy ensured (screens, curtains, visual barriers) 2. Auditory privacy ensured (private health information) 3. Records and medical files confidential
	Giving women the feeling of being welcomed	Providing the feeling of acceptance in the health facility				
		Providing a positive environment that helps women to feel they are welcome in the labour environment				
	Considering women as a "human being" and not a "thing"	Providing and empowering emotional or psychological dignity or 'personhood'				
		Seeing women as individuals with unique fears and desires , and addressing these in a respectful way				
		Not speaking about women as an "object"				

(3) Preserving women's dignity	Promoting dignified care in <u>high- and low-risk</u> clinical situations	Providing personalized care for women regardless of their risk status (high- or low-risk)	Right to Dignity and Respect	Principle of Justice • Provide respect, dignity and informed choice – maternity care incorporates a rights-based approach, preventing exclusion and maltreatment of individuals that are marginalised and socioeconomically disadvantaged.	1. Culturally competent care, incl. respect for beliefs, traditions and culture 2. Treat with respect, incl. personhood, experiences, and feelings 3. Treat other staff with respect 4. Communicate effectively 4.1 using respectful and positive language, 4.2 language they can understand 4.3 Greeting and addressing women politely and by name, and 4.4 Providing verbal support & encouragement 5. Provide positive, supportive non-verbal communication 6. Demonstrate sensitivity and empathy for women and partners experiencing loss and bereavement	Dignified care 1. Treated with respect (subject to women's/ local interpretation) 2. HCP introduce themselves 3. Treated in friendly manner (subject to women'/local interpretation) 4. Women called by name
		Transparency in providing knowledge to women with risk factors for complications				
		Conducting vaginal examination with permission and in a gentle manner				
	Respecting cultures, values and beliefs of individual women and local communities	Providing culturally sensitive care				
		Respecting local beliefs				
		Providing knowledgeable healthcare that takes different women's physical and spiritual needs into account				
	Being <u>sensitive</u> to the wishes and needs of the women	Supporting women's use of safe alternative therapies				
		Planning birth individually in accordance with women's wishes				
		Being sensitive to each woman's needs				

(4) Prospective provision of information and seeking informed consent	Providing information about the environment, labor process/ procedures and care plan <u>clearly and neutrally</u>	Clear expression of what will happen during stay in health facility	Right to Information, consent/refusal, respect for choices and preferences	Principle of Autonomy • Listen to what women and their families say –communicate in a culturally safe and sensitive manner, and in a language that the woman and family understand. • fully inform and communicate with the woman/family in decision making, ensuring her the right to informed consent and refusal. • Decision making should be a collaborative effort between the pregnant woman, family and health care providers	1. Encouragement and support to women to: 1.1 Move freely during labor and 1.2 Assume position of choice for birth 2. Offer women the option to experience labor/birth with companion of choice and involve family in care and decisions if desired 3. Information about health and care options, incl: 3.1 What to expect during labor/birth/postpartum & newborn care 3.2 Proposed interventions, tests and treatments, 3.3 Any out-of-pocket costs of care 4. Encourage to: 4.1 Ask questions 4.2 Express opinions or concerns 5. Decision-making/Consent: 5.1 Honest and complete information, 5.2 Involve in decision making about care, 5.3 Solicit consent for all interventions, and 5.4 Respect choices incl. refusal of interventions	Communication 1. Encouraged to and able to ask questions 2. Speak to women in language they understand Autonomy 1. Explain what to expect, medication administered, procedures performed 2. Informed consent prior to procedures/ examinations 3. Involved in care – decision-making 4. Allowed to assume position of choice during labour and delivery
		Providing information about <u>birth processes and all issues</u> relating to childbirth				
		Providing information about <u>how to cope with labor</u>				
		Providing information about <u>breathing and relaxation techniques, ambulation, and pushing</u>				
		Providing information about any <u>interventions</u> that women are about to undergo				
	Providing information about women's rights	Providing information about <u>rights</u> as a patient				
		Providing information about <u>standard care</u> during labor and birth				
	Asking permission to carry out labour and childbirth procedures	Asking permission to perform <u>vaginal examinations</u>				
		Asking permission to <u>physically touch</u> the woman				

		Asking permission before performing <u>minor procedures</u>				
	Obtaining informed consent for any interventions, and explaining the reasons for intervention or outcomes clearly	Providing information about available birth options and choices to enable women to <u>make choices</u>				
		Obtaining informed consent for <u>interventions</u> like episiotomy, Cesarean section				
		Explaining the <u>risks and benefits</u> of interventions or outcomes clearly				
	Women informed on how to report incidences of violations or abuse	Providing information about where to report to when <u>incidences of violations or abuse take place</u>				
		Providing information about availability of counseling services for when they have experienced a violation				
(5) Engaging with effective communication	Talking and listening to women	Providing verbal praise and encouragement during labor and birth				
		Listening to women's concerns and trying to solve				

		issues and addressing concerns				
		Being sensitive to women's wishes and needs				
	Practicing and encouraging effective non-verbal communication	Acknowledging the importance of body language, nonverbal communication, gestures, and expressions.				
		Providing passive support by being present				
	Being honest	Valuing honesty , even in <u>challenging situations</u>				
		Saying " I don't know " and knowing when to call for help				
	Availability of interpreters due to language proficiency and cultural differences	Having interpreters to translate and explain procedures				
		Ensuring quality of care given to women with language difficulties				
	Providing empathy	Showing compassion for what women are experiencing				
		Presenting willingness to provide support and help by being <u>warm, calm, patient, kind, tactful, smiling, and having</u>				

		a warm voice all through taking care of women				
		Giving women full attention and true assistance				

(6) Respecting women’s choices that strengthen their capabilities to give birth	Facilitating and promoting women’s empowerment	Addressing women's doubts	Right to liberty, autonomy, self-determination and freedom from coercion	Principle of Justice - Provide respect, dignity and informed choice – incorporate rights-based approach, preventing exclusion and maltreatment of individuals that are marginalised and socioeconomically disadvantaged - Free or affordable care with cost transparency – respect every woman’s right to access and receive non-discriminatory and free or affordable care.	1. Not illegally detain or physically restrain in facility for any reason, including inability to pay 2. Do not prevent from seeing or holding babies for any reason, including inability to pay	Autonomy 1. Explain what to expect, medication administered, procedures performed 2. Informed consent prior to procedures/ examinations 3. Involved in care – decision-making 4. Allowed to assume position of choice during labour and delivery	
		Providing trust to women					
		Providing humanistic care with gentleness and good behaviours					
		Ensuring that the best maternity care is done for mother and baby					
	Encouraging active participation and decision making by women	Empowering women by <u>giving accurate, clear information</u>					Principle of Autonomy fully inform and communicate with woman and family in decision making ensuring the right to informed consent and refusal.
		Encouraging women to use their own emotional resources, and strengthening their self-confidence					
		Supporting women to be in control of labor					
		Giving women confidence in their <u>ability as mothers</u>					
		Facilitating women's participation in and responsibility for their childbirth					
		Ensuring freedom of choice , comfort, and providing encouragement		<u>Supporting and respecting</u> women's decisions and desires			
	<u>Implementing and upholding</u> women’s preferences and choices						
	<u>Valuing and respecting</u> women’s feelings and choices during labor and birth						

		Defending women's rights to control their bodies, to relieve pain, and to give birth according to her wishes				
	Allowing preferred position for birth	Allowing women to give birth in their chosen position				
	Encouraging mobilization	Allowing and encouraging women to be able to get out of bed and move around				

(7) Providing equitable maternity care	Availability of equitable services for all , regardless of age, ethnicity, religion, or other subgroups	No discrimination based on <u>ethnicity/ race/ religion</u>	Right to Non-discrimination, Equality and Equitable Care	Principle of Justice	1. Adhere to policies on non-discrimination 2. Treat every client with equal respect and dignity, regardless of any specific personal attributes, including but not limited: to age, wealth, class, education, race or ethnicity, religion, LGBTQ+ , HIV or other health status	Equity/Non-discrimination 1. Payment/ equity/ cost 2. No discrimination or poor treatment based on ethnicity, race, economic status etc 3. Bribes/ informal payments 4. Detained in facilities due to inability to pay 5. Healthcare services affordable to all
		No discrimination based on <u>age</u>				
		No discrimination based on <u>socioeconomic status</u>				
		No discrimination based on <u>medical conditions</u>				
		No discrimination based on <u>language</u>				
	Non-judgmental care	Providing equal chances of receiving the same standard of dignified care for those with <u>special needs</u> (e.g. poor awareness of their rights, and language difficulties)				
		Ensuring women with different ethnic, social and cultural backgrounds all received same high standard of care				

(8) Ensuring continuous access to family and community support	Family attendance and presence of labor companions of choice	Permitting women's companions to accompany them in labor ward (if woman desires)	Right to timely healthcare and highest attainable level of care	Principle of Beneficence - supportive, individualised and value-based – best served as a partnership model. - ensure practices are driven by health needs and expectations, as well as by health outcomes and cost-effectiveness based on optimising the normal processes of childbirth.	- Prompt attention and responsive to needs for: - Medical care and - Comfort care - Ensure that every woman has a skilled attendant present at her birth - Ensure no client is neglected or denied needed care, regardless of ability to pay - Ensure continuity of care by coordinating effectively across settings and between providers	Family environment - Cleanliness - Safe facility - Non-overcrowded - Electricity/. Water - Enough providers Supportive care - Companion of choice during labour/delivery - Not refusing care for any reason - Not abandoning – not responding calls for help - Ask about emotional feeling and concerns
		Welcoming the women’s partner, family and/or friends to the facility				
		Helping women receive support, encouragement and reassurance from labor companions				
	Providing space for partners, family and friends	Promoting companion presence by facilitating rules and regulations of the facility				
		Providing space and comfort for partner, family and/or friends’ visits and stay				
(9) Enhancing quality of physical environment and resources	Providing a comfortable, clean, and calming birth environment	Providing a comfortable and relaxing environment, supporting physical comfort and physiological needs		Principle of Justice follow evidence-based practice – promote practices proven to be beneficial in supporting the normal physiology of labour, birth and the postpartum and neonatal periods.		
		Providing a calm, clean environment during both labor and birth				
		Limiting ward visiting hours so women can rest				
	Ensuring access to essential	Access to necessary medical investigations and medications				

	resources , such as medication and equipment	Access to necessary <u>medical technologies</u>				
(10) Availability of competent and motivated human resources	Adequate competent staff committed to their professional responsibilities are available	Adequate staffing levels to support women		- Promote wellness and the prevention of illness as the foundations of improving maternal and newborn health - implement educational and public health measures that enhance wellness and prevent illness and complications for mother-baby		10. Trust staff (subject to women's interpretation) Responsiveness 11. Perception of wait time 12. Actual wait time
		Taking responsibility for the needs of women with special needs				
		Providing professional competence in relation to childbirth				
	Capacity and awareness of professionals about humanization during childbirth	Having a strong professional education on how to provide humanized care to women				
		Providing continuing training for professionals about humanization during childbirth				
		Being aware of respectful maternity care and promoting respectful care				
	Supportive supervision from managers	Making decisions to ensure provision of humanized care				
		Playing a supervisory, monitoring and problem solving role to ensure that the facilities are operating well				
		Taking issues related to mistreatment of women seriously, and				

		handling reported cases with diligence				
		Facility management resolves staff shortages				
		Facility management takes initiative to introduce humanized care and support healthcare providers to practice humanized care				
		Facility management positively recognize the activities of providers and staff practicing humanized care				
(11) Provision of efficient and effective care	Promoting team-based care , involving the woman, partner, midwife, assistant nurse and other health care providers	Building and supporting teamwork				
		Not treating women as routine , or examining all women in a routine manner				
	Avoiding unnecessary examinations and procedures	Not subjecting women to unnecessary procedures and interventions				
	Managing pain	Providing instructions, support and advice to allow women to find the best way/s to cope with discomfort during labor				

		Ensuring access to pain relief methods						
	Encouraging rest and recuperation after birth	Being able to rest and recuperate from birth						
		Postnatal ward environment that is conducive to recovery from birth and promotes breastfeeding						
	Timely provision of care	Waiting times not unnecessarily prolonged						
		Providing on-time and continuous maternity healthcare						
(12) Continuity of care	Continuity of care throughout pregnancy and childbirth to provide focused care and advice	Not refusing admission to facility or sending home without explanation						
		Supervision of women during pregnancy and birth by a familiar midwife or same group of midwives (the named midwife)						
		Efforts to connect women with their preferred care providers						
	Continuous presence of staff throughout labor and childbirth	Continuous presence of a health worker throughout labor and childbirth						
		Access of women to a call button when assistance is needed						

		Health workers available to women on demand				
	Supportive care during and after the childbirth	Promotion of mother and child bonding				
		Respecting women's decisions in breastfeeding				
		Providing help and support with breastfeeding in postnatal ward				
		Providing support in caring for the baby				
		Letting women talk to other postpartum women who have experienced childbirth				

Shakibazadeh et al (2018) three-level typology, presented in this table, is a qualitative evidence synthesis of how women can be respected during childbirth in health facilities. A number of frameworks were used as a starting point to inform the development of this typology including: (1) WHO Quality of Care Framework for Pregnant Women and Newborns; (2) Mistreatment of women framework; (3) Health system responsiveness domains; and (4) White Ribbon Alliance's 7 Rights of Childbearing Women.

As Shakibazadeh et al (2018) describe in their article, to quote: "The first-order themes are identification criteria describing specific respectful care activities. The second- and third-order themes further classify these first-order themes into meaningful groups based on common attributes. The third-order themes are ordered from the level of interpersonal relations through the level of the health system"

RESPECT



**Co-funded by
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Project: 101096681 - RESPECT - CERV-2022-DAPHNE]



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GENDER STUDIES**

Project name:	Toward a culture of Respectful Maternity Care (RMC): Enhancing Shared Decision Making and Informed Choice in Cyprus and Croatia
Project acronym:	RESPECT
Project number:	101096681
Project duration:	1/4/2023-31/3/2025 (24 months)
Call:	CERV-2022-DAPHNE