



National Strategy

Respectful Maternity Care:

Findings & Recommendations of Stakeholder Alliance

A participatory structured process with stakeholders



National Strategy for

Respectful Maternity Care:

Findings & Recommendations of an Interagency Alliance

Through a participatory structured process with stakeholders



#RespectfulMaternityCare #RespectfulBirths

#QualityStandards #BestClinicalPractice

Table of contents

In lieu of a preface	5
Cyprus RESPECT team	6
General Part.....	7
A. Respectful Maternity Care.....	7
A1. The RESPECT project.....	7
A1.1. RESPECT research study.....	7
A1.2. Other RESPECT project actions.....	9
Table 1: Summary of main findings from the quantitative component of the RESPECT study	10
A2. Official perinatal health statistics	13
A3. Other research findings from Cyprus	14
A4. Conceptual definitions.....	20
A4.1. Disrespect and abuse - Mistreatment	20
A4.1. Charter of Rights of Respectful Maternity Care	22
A4.2 Obstetric violence	23
Box A: Special reference to the Reports on Obstetric Violence	25
A5. Legal framework for Respectful Maternity Care (RMC)	27
A5.1. International legal framework.....	27
A5.2. European legal framework	28
A5.3. National legal framework	28
Special Part	29
B. Methodology.....	29
B1. General description of the process.....	29
B2. Structure, objectives and results of series of activities	31
B2.1. Preparatory coordination meeting with professional-scientific societies (closed group).....	33
Aim-Objectives	33
Results.....	33
Figure 1 - Photos from the first stakeholders' meeting	36
B2.2. Second extended meeting of stakeholders on "Respectful Maternity Care"	37
Aim-Objectives	37
Figure 2 - Photos from the second stakeholders' meeting.....	38

Results	39
B2.3. Third stakeholder meeting on "Quality Standards for Respectful Maternity Care"	41
Aim - Objectives	41
Results	42
Figure 3 - Photos from the third stakeholders' meeting	43
C. Mapping the current state and determinants of quality of maternity care	44
C1. Description of process	44
Figure 4 - Instructions to participants for the mapping exercise	45
Figure 5 - Diagrammatic representation of the Socio-Ecological Model's concentric circles.	45
Box B: Socio-ecological model	46
C2. Mapping exercise results	47
C3. Data Processing-Analysis	47
Figure 6 - Mapping the current situation - determinants of the quality of maternity care.	48
C4. Main findings	48
C5. Conclusion	51
D. Working Groups' Suggestions and Recommendations	52
D1. Description of process	52
D2. Main findings	53
D2.1 WORKING GROUP 1: CLINICAL PRACTICE AND POLICY	54
D2.2. WORKING GROUP 2: CLINICAL TRAINING - CONTINUING PROFESSIONAL DEVELOPMENT	57
D2.3. WORKING GROUP 3: INFORMATION - PUBLIC AWARENESS	59
D2.4. WORKING GROUP 4: RESEARCH AND DATA RECORDING	62
Figure 7 - Research priority pillars	63
Box C: The APEASE criteria	66
D3. Conclusions	67
D3.1. Development of training programmes for Healthcare Providers	67
D3.2. Establishing quality standards and adopting set of quality indicators	69
E. World Health Organization Quality Standards	72
E1. Guiding framework	73
C1.2. Definitions	73
C1.2. Adaptation of the Quality Standards in a national context	75
E2. Description of the stakeholder consultation process	77

Box D: Brief description of the WHO Quality Standards for Maternity Care.....	80
Box E: Instructions for reviewing and assessing the transferability of WHO quality measures	81
E3. Main findings.....	82
E4. Conclusions	84
E4.1. Checklist for Maternity Clinics	86
F. Recommendations and next steps.....	88
F1. Policy and clinical practice	88
F2. Education and Professional Development	88
F3. Research and Data Recording	89
F4. Informing women/families and raising public awareness	89
F5. Obstacles and threats	90
In lieu of an epilogue.....	91
Bibliography	92

Note: The series of Appendices has not been included in the English (translated) Strategy. All material is recorded in Greek since they mainly pertain to the proceedings of the Stakeholder Meetings and material produced during these meetings, documenting the discussion and/or further processed by the RESPECT team for the purpose of preparing this Strategy. However, this material has been included in full in the original Strategy document (Greek language version) and can be made available to any interested party upon request. Other than this, the rest of the English version of the document is a direct translation of the Greek equivalent document of the National Strategy for RMC in Cyprus.

In lieu of a preface

The development of the **Strategy for Respectful Maternity Care** provided an opportunity to develop an **open dialogue** with professional, scientific, academic and other stakeholders, the clinical community and civil society and promote **constructive synergies** in the context of formulating a common goal of ensuring and improving the quality of care provided to mothers and newborns in Cyprus.

The process of development of the Strategy followed a participatory approach to ensure inclusiveness, the relevance of the findings, reflecting the views and perceptions of all stakeholders, and the sustainability of the recommendations. By involving stakeholders in the series of workshops and other activities and events that were organised, the ultimate **aim** was, in the first instance, to open channels of communication in a participatory and inclusive way, since the cultivation of **a shared understanding** of the issues at hand and the need to take action is the foundation of quality improvement efforts.

The **specific objectives** were:

- **Mapping** the current situation and identifying gaps, weaknesses and barriers, adopting a holistic (socio-ecological) approach, drawing on the views and perceptions of stakeholders and any interested parties, as well as identifying the healthcare system strengths, opportunities as well as recent developments expected to contribute positively towards the enhancement of quality assurance and continuous quality improvement of maternity care (*Section C - Mapping*)
- **Recording** suggestions and recommendations for strengthening quality improvement efforts in maternity care in terms of policy and clinical practice, continuing education and professional development, public awareness, research and data monitoring (*Section D - Working Group Suggestions and Recommendations*)
- **Reviewing** the extent of alignment of current arrangements, practices and other structural elements of the healthcare system and maternity care services with international quality standards and measures (WHO) in order to comprehensively identify and record areas for improvement (*Section E - Cultural transferability and current degree of implementation of Quality Standards*).

The **RESPECT** project team.

Cyprus RESPECT team

Cyprus University of Technology, School of Health Sciences, Department of Nursing

Eleni Hadjigeorgiou	Assistant Professor, Midwifery
Emmanuela Manoli	Special Teaching Staff, Midwifery
Iraclidia Papaclidiou	Midwife, Researcher-Trainer, RESPECT
Nicos Middleton	Associate Professor, Health Research Methodology in Health, Project Coordinator, RESPECT
Maria Karanikola	Associate Professor, Mental Health Nursing
Ourania Kolokotroni	Assistant Professor, Pathophysiology, Paediatrician
Paraskevi Kinni	Administration Officer, Research Associate, RESPECT
Prodromoula Zisimou	Midwife, Researcher-Trainer, RESPECT
Christiana Nicolaou	Assistant Professor, Pediatric Nursing

Birth Forward

Ioli Orphanides Eteocleous	Press representative
Christine Mavrou	Advocacy and Communications Coordinator
Margarita Kapsou	Project Manager, RESPECT, CEO Birth Forward
Panagiota Doukanari	President

Mediterranean Institute for Gender Studies -

Susanna Pavlou	Director
Christina Kaili	Senior Researcher, Project Manager
Daphne Demetriou	Researcher and Project Coordinator
Athena Venetiade	Project Officer

Federation of Cyprus Patients' Associations – OSAK

Andreas Christodoulou	Director of Operations
Marios Charalambidis	Secretary
Michaela Markou	Legal Officer

Parent Advisory Group

Tatiana Michael Mateou
Vasiliki Erotocritou
Marianna Moore

Maria Stavrou

Afroditi Anatolitou

Theodora Filippidou

Ekaterina Miroshnichenko

Ioli Orphanide

Panagiota Doukanari

Emmanouela Manoli

General Part

A. Respectful Maternity Care

A1. The RESPECT project

The **RESPECT** project, entitled "*Toward a culture of Respectful Maternity Care-RMC: Enhancing Shared Decision Making and Informed Choice*" (April 2023-March 2025), is co-funded by the CERV (*Citizens, Equality, Rights & Values*) programme of the European Union, with host organization the Department of Nursing, CUT and project partners in Cyprus (Birth Forward, Mediterranean Institute for Gender Studies, Federation of Cyprus Patients' Associations - OSAK), Croatia (RODA Parents in Action) and Italy (Faculty of Medicine, University of Genova).

The project is a part of the broader efforts by these organisations to uphold women's right to a positive childbirth experience. It seeks to promote quality standards based on the principles and requirements for Respectful Maternity Care (RMC) set by the World Health Organization^{1 2}, the White Ribbon Alliance Charter of Rights³, the Ethical Framework for Respectful Maternity Care of the

¹ 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)

² WHO (2018). intrapartum care for a positive childbirth experience. WHO recommendations. available online: <https://www.who.int/publications/i/item/9789241550215> (last accessed: Jan 2025)

³ White Ribbon Alliance. respectful maternity care. universal rights of mothers and newborns. available online: <https://whiteribbonalliance.org/resources/rmc-charter/> (last accessed: Jan 2025)

International Federation of Gynecology and Obstetrics (FIGO)⁴ and other international and European scientific and professional bodies.

A1.1. RESPECT research study

The first phase of the project (Work Package 1 – Research) focused on exploring and depicting the experiences of women in Cyprus from the care they received during pregnancy and childbirth. The study collected quantitative data through a questionnaire survey, as well as qualitative data through a series of focus groups with new mothers.

The first public presentation of the research findings to stakeholders was held in the presence of Professor Marzia Lazzerini, Director of the WHO Collaborating Centre for Maternal and Child Health.

Indicatively, the findings suggested that one of the aspects regarding RMC with the greatest room for improvement based on women's reported experiences was "*Communication and Autonomy*", namely ensuring the right to active participation in decision-making and obtaining informed consent for procedures and interventions, which confirms the project's initial intention to simultaneously focus on actions that strengthen the clinical communication skills of Health Professionals to actively promote and effectively support shared decision-making.

An infographic presentation of the research findings of the study on women's experiences of maternity care in Cyprus can be found at the link below, with embedded quotes from the women's 'voices' from the qualitative part of the study: <https://my.visme.co/view/4djrvjoy-respect-infographics-cyprus>.

The table below (*Table 1*) presents a summary of the main research findings based on the responses of the 516 women who participated in the survey (November-December 2023). The results presented are mainly based on one of the five questionnaires-scales used in the study, namely the Person-Centred Maternity Care – US version (PCMC-US) developed by the Person-Centered Equity Lab, University of San Francisco California⁵. The tool includes 35 items (questions), which are grouped into three domains of

⁴ FIGO (2021). Ethical Framework for Respectful Maternity Care During Pregnancy and Childbirth. FIGO Statement. International Federation of Gynecology and Obstetrics. Available online: <https://www.figo.org/resources/figo-statements/ethical-framework-respectful-maternity-care-during-pregnancy-and-childbirth> (last accessed: Jan 2025)

⁵ Afulani PA, Altman MR, Castillo E, Bernal N, Jones L, Camara T, Carrasco Z, Williams S, Sudhinaraset M, Kuppermann M. Adaptation of the person-centered maternity care scale in the United States: prioritizing the experiences of Black women and birthing people. *Women's Health Issues*. 2022; 32(4):352-61. Person-Centered Equity Lab Birth Place Lab (<https://personcenteredequitylab.ucsf.edu/measurement>). Permission to translate and use the scale was granted by the developers through personal communication.

care: Communication and Autonomy, Dignity and Respect, and Responsive and Supportive Care. In the table, the findings are grouped according to 7 Rights for Respectful Maternity Care of the White Ribbon Alliance's Charter of Rights. Each questionnaire item was classified under one of the seven Rights, as per best conceptual match.

Responses to the questionnaire items are given on a 4-point scale, referring to how often this aspect of care was safeguarded: "always", "most of the time", "some of the time", and "never". Optimal implementation of care standards would require full adherence to these practices (i.e. "always"). However, in this case, a less stringent definition was given, so as to consider that this aspect of care was (and, hence, this right was safeguarded) if this aspect of care was satisfactorily implemented "most of the time", even if not "always". There were some exceptions to this rule, for instance, in the case of physical or verbal abuse or any form of coercion, where zero tolerance should be applied. It should be, thus, noted that the percentages reported in the Table would be lower had the definition of full implementation been applied. Note also that the table shows the 'positive' side. The remaining percentage corresponds to the 'negative' side of the issue - i.e. the percentage of women who say that this 'good practice' was 'never' or only 'sometimes' applied.

In the first stakeholder meeting, in the context of Work Package 2 activities – Stakeholders' Alliance for Respectful Maternity Care, data were also presented from the **IMaGiNE EURO** (*Improving Maternal and Newborn Care*) study. Currently, this is the largest study in the European region to evaluate the quality of maternal and newborn care services through women's self-reported experiences (as well as healthcare providers' perspectives). Cyprus joined this European network late compared to other countries, through the RESPECT project.

The comparative results of the pan-European **IMaGiNE EURO** study, as presented at the conference and submitted for publication in a peer-review journal, suggest that comparatively Cyprus ranks close to the European average in terms of women's experiences of maternity care based on a set of 40 WHO Quality indicators, which formed the basis of the questionnaire.

A1.2. Other RESPECT project actions

As part of the wider [RESPECT](#) programme, a series of educational and awareness-raising activities were implemented in parallel, including:

- Design and delivery of a training programme for perinatal healthcare providers, focusing on enhancing clinical communication skills, with emphasis on principles, values and skills necessary to support shared decision-making. In parallel, a series of empowerment workshops were developed and implemented for pregnant women and new mothers to support their effective participation in decision-making (Work Package 3); and
- Public information and awareness campaigns on the essential components of Respectful Maternity Care, with emphasis on the right for a positive pregnancy and childbirth experience, the right to information and informed choices and active participation in decision-making (Work Package 4)

Table 1: Summary of main findings from the quantitative component of the RESPECT study

Charter of Rights for RMC (White Ribbon Alliance)	Ethical Framework for RMC (FIGO)	RESPECT survey study results (indicative results mainly from the responses to the Person-Centered Maternity Care – PCMC questionnaire items).
Right to Dignity and Respect , incl. Right to Companionship	Ethical principle of Nonmaleficence (Do No Harm)	82.4% reported that healthcare providers treated them, their partner/ companion and their family with respect <u>at least most of the time</u>. 76.0% did <u>NOT</u> feel that health professionals considered them "demanding" 72.3% were allowed to have a birth partner/companion of their choice during childbirth, <u>at least most of the time</u>. 61.2% felt that their experience and knowledge were valued by healthcare providers, <u>at least most of the time</u> 47.3% reported that providers <u>ALWAYS</u> introduced themselves fully, e.g. name and role, when providing care
Right to be free from harm and ill treatment		98.3% reported that healthcare provider has <u>NEVER</u> threatened them in any way 85.3% reported that they were <u>NEVER</u> physically abused (the item in the PCMC questionnaire refers to "<i>handled roughly, held down or physically restrained</i>") 84.7% said that they were <u>NEVER</u> verbally abused (the item in the PCMC questionnaire refers to being "<i>shouted at, scolded, talked to rudely, insulted or threatened in any way</i>") 76.2% reported that they <u>NEVER</u> felt that care providers avoided or neglected in any way (the item in the PCMC questionnaire refers to "<i>healthcare providers avoided, ignored or otherwise neglected you</i>") 66.3% reported that they <u>NEVER</u> had a procedure done on them or the baby without permission or consent (<i>*vaginal examination, induction, administration of oxytocin, episiotomy, giving formula to the baby, etc.</i>)
Right to timely healthcare and highest attainable level of care	Ethical principle of Beneficence (Do Good)	79.1% reported that care providers responded in a timely manner when requested assistance, <u>at least most of the time</u>. 77.1% reported that <u>at least most of the time</u> healthcare providers made an effort to provide the best possible care, 75.0% reported that <u>at least most of the time</u> health professionals did everything they could to help manage pain

		74.0% reported that health professionals were <u>NOT</u> in a hurry when they wanted to ask questions or discuss their concerns with them 63.4% reported that healthcare providers showed interest in their emotional well-being <u>at least most of the time</u>
Right to Information, consent/refusal , respect for choices and preferences	Ethical principle of Autonomy	85.1% reported that <u>to some extent</u> they felt comfortable asking questions 73.2% reported that <u>at least most of the time</u> health professionals explained the different tests or procedures to them 70.1% felt they were aware of what was happening during childbirth <u>at least most of the time</u> 67.3% reported that, <u>at least most of the time</u>, their birth plan or preferences (e.g. <i>freedom of movement, pain management, music, birth position</i>) were respected 62.5% reported that, <u>at least most of the time</u>, healthcare providers helped them to understand all the relevant information
Right to liberty, autonomy, self-determination and freedom from		71.1% reported that the care choices they received were, <u>to some degree</u>, their own choices 70.3% reported that they felt comfortable, <u>to some degree</u>, turning down care options offered to them 63.4% have <u>NEVER</u> felt coerced or pressured into making a decision 59.7% reported that, <u>at least most of the time</u>, care providers asked for permission and consent before carrying out a test or procedure. 44.4% reported that healthcare providers <u>ALWAYS</u> included them in decisions about the care they would receive
Right to Equality , freedom of Discrimination , and Equitable	Ethical principle of Justice	95.1% reported that they have <u>NEVER</u> been discriminated against (<i>because of race, ethnicity, culture, gender, sexual orientation, language, language, immigration history, religion, income, education, age, marital status, number of children, insurance status or anything else</i>). 83.3% reported that their customs and culture, were respected <u>at least most of the time</u> 74.2% did <u>NOT</u> want maternity care that differed from what health professionals were prepared to provide

Right to Privacy & Confidentiality		● 94,6% did <u>NOT</u> report the presence of trainees (e.g. medical residents, nursing, midwifery students) during childbirth without their consent ● 88.4% felt that, <u>at least most of the time</u>, personal data was kept confidential and private and the confidentiality of information was protected by healthcare providers and other staff ● 87.2% did <u>NOT</u> feel that their privacy was violated, for example by having people in the examination or delivery room without their consent ● 78.5% reported that measures were taken, <u>at least most of the time</u>, to avoid feeling exposed during examinations and procedures ● 71.9% felt that healthcare providers were supportive, <u>at least most of the time</u>, in creating a generally friendly and supportive environment that made them feel comfortable
--	--	---

A2. Official perinatal health statistics

The number of births in Cyprus in 2023 was 10487. Regarding the country of origin of the mother, 61.7% were Cypriot women, 10.2% were European citizens and 28% were from third countries.⁶ On the topic of gestational age, 13.3% were before 37th weeks gestation (prematurity), which is considered high based on international data, with an increasing trend in recent years.

With 60.7% of children born by caesarean section in Cyprus, according to the latest data for 2023 from the Perinatal Health Report of the Health Monitoring Unit of the Ministry of Health, Cyprus seems to continue to hold one of the top positions in Europe, rising from 56.9% recorded in 2015. A percentage of 19.5% of all deliveries were emergency caesarean deliveries (i.e. 32.1% of all caesarean deliveries), which is considered a particularly high rate. It should be noted that, although it has been included in the Recommendations of the National Committee for the Promotion of Natural Childbirth (and reduction of C/S), which nevertheless it does not seem to have been implemented yet. The recording of C/S in Cyprus is not based on the Robson classification system. The percentage of deliveries that were recorded as planned caesareans was 41.1% of all deliveries (i.e. 67.8% of all caesareans). It should be noted that the term “elective C/S” continues to be used incorrectly in the report, as all planned C/S are classified as elective, thus effectively not distinguishing between caesareans which were planned due to medical indications and those at the request of the mother (elective). In fact, it appears that 37.6% of all “elective” C/S, as per the term used in the report for all C/S that were not emergency C/S, were performed before (16.8%) or at 37th week (20.8%). The proportion of vaginal delivery after caesarean (VBAC) was only 4.0%, and, in fact, recording a small decrease based on earlier years, confirming that “once a caesarean, always a caesarean” is the biggest challenge to reduce the rate of caesarean sections in a country with a particularly high caesarean rate, such as Cyprus, as per the aim of the recent National Strategy to promote vaginal (normal, as per the term in Greek) birth.

Apart from the high rate of caesarean sections, other perinatal health indicators raise questions as to the adherence to guidelines, such as the very high recorded percentage of episiotomies (69.8%). However, it should be noted that the latest statistics for episiotomies seem to be a decade old (2014), and the latest data do not seem to be systematically included in Perinatal Reports. Furthermore, initiation and

⁶ Health Monitoring Unit, Important Perinatal Health Indicators for the years 2015-2023, Maternity Units of the Cyprus Government Controlled Areas, Cyprus Ministry of Health, .February 2025

exclusivity of breastfeeding remains low (with only a slight increase in recent years), despite the existence of a National Strategy for the protection and promotion of breastfeeding for more than a decade.

A3. Other research findings from Cyprus

According to the World Health Organization (WHO, 2018), Respectful Maternity Care (RMC) is defined as care that ensures dignity and respect, privacy and confidentiality and adheres to ethical principles of beneficences and nonmaleficence (*"do good, and do no harm"*) during pregnancy, labour and childbirth. It promotes autonomy, human rights, informed decision-making, and continuity of care.

The research study conducted in the context of the RESPECT project is the first comprehensive effort to explore the experiences of women in Cyprus based on the above definition of Respectful Maternity Care, covering all aspects of RMC. However, a number of previous research studies from Cyprus have explored various aspects of care that are directly or indirectly related to RMC. Some of the issues that have been explored to date at the national level include women's overall experiences during pregnancy, childbirth, and the transition motherhood, satisfaction with care and support for Breastfeeding (BF), the relationship and quality of communication with health care providers and, more recently, the impact of Covid-19 and related restrictions on maternity care.

Consistent with international literature, both the findings from the RESPECT study and the previously available research evidence indicate that there is significant room for improvement in the quality of Maternity Care. This applies both in terms of clinical practices and specific aspects of care, most notably the need to improve service-users (pregnant women and new mothers) and healthcare providers. Although research findings from Cyprus on the quality of maternity care and women's satisfaction with the care provided are scarce, they suggest a general need for action.

In a recent study, using mixed (quantitative and qualitative) methodology to investigate mothers' experience of overall perinatal care, it was reported that 24.2% of mothers (1 in 4) had a poor experience of care. The percentage of women who reported that the overall experience was very good was only 13.3%, with a further 11.1% reporting that care was good. The main factors identified for positive experiences were the good relationship with health care providers (HCPs), the general birth environment and supportive care during delivery and assistance with Breastfeeding (BF) and infant care. These aspects of care (the quality of relationship with HCPs, BF support and the supporting environment during

delivery) were also identified as important in the qualitative component of the study (Hadjigeorgiou *et al.*, 2023).

In terms of the birth environment, an earlier study by Hadjigeorgiou *et al* (2011) on the choice of place of birth suggested that, even though it is one of the issues that concerns Cypriot women, the option of home birth (*extremely rare and not supported by the system in Cyprus*) did not seem to be a preferred choice by Cypriot women, as it was rejected by 95% of the women in the study. However, the majority of women expressed a wish for midwifery-led care and hoped for the establishment of birthing centres.⁷ This highlights the need to re-thinking the model of care, especially in the wider context of medicalization of childbirth that has been prevalent in Cyprus in recent years, with the rate of caesarean sections reaching or exceeding 60% for several consecutive years, based on national data collected by the Health Monitoring Unit of the Ministry of Health. At the same time, the actual physical environment appears to play an important role in the women's choice and experience. The physical environment and labour/childbirth spaces in the Private Sector were generally considered by women to offer more comfort and privacy as well as being more aesthetically pleasing. However, in the same study, some other mothers reported being dissatisfied with the clinic environment:

"the environment was not suitable at all... you walk down corridors or into the operating theatre... and you wait for hours...".

The relationship between mothers and the HCPs involved plays a key role in the experience of motherhood, but depending on where women gave birth, there are more or less likely to develop a relationship with the midwives. Women who gave birth in private maternity hospitals were often unaware of the midwife's role, as contact was almost exclusively with the ObGyn. In contrast, women who gave birth in public maternity hospitals were more familiar with the role of midwives. Women who had childbirth experiences in other healthcare systems abroad - where midwifery-led care is the norm - reported that they sought midwives in Cyprus but found this unfeasible due to the structure of the healthcare system and broader cultural norms. Some women even reported that was disagreement

⁷ It should be noted that there is only one such Birthing Centre in Cyprus (at Limassol General Hospital) which was only launched in 2019 (many years after the study reported here), as part of the overall efforts to promote natural childbirth and to reduce the rate of caesarean sections in Cyprus (before the establishment of the National Committee). In the post-COVID era, it is not clear what percentage of pregnant women choose the Birthing Centre, especially since with the recent reforms in the health sector and the transition to a General Healthcare System (GeSY), a further reduction in the percentage of women choosing public maternity hospitals was recorded with now over 85% of deliveries being carried out in maternity hospitals and clinics in the private sector.

and pressure from their social environment against the preference for a midwife-led birth, raising safety issues, to quote: *'there are so many doctors and you want a midwife... if something happens...'* (Hadjigeorgiou *et al.* , 2011)

Regarding the quality of the relationship developed with healthcare providers, a study by Stylianidis and Raftopoulos (2014) recorded that mothers were generally satisfied with the cooperation they had with healthcare providers, both midwife and obstetrician, during pregnancy and childbirth. However, it is important to note that this study is over a decade old and predates the introduction of the General Healthcare System (GeSY). Furthermore, the study focused solely on public maternity hospitals at a time when the number of births in the public sector was much higher than it is today.

In relation to Obstetricians, women in the study reported feeling generally respected and well-informed about the purpose of the various examinations, procedures and the progress of labour and delivery. However, study participants noted that the necessity of certain devices and instruments used during childbirth was not explained to them. Moreover, they did not always feel included in decision-making regarding their delivery.

Regarding the care provided by the midwives, women reported feeling respected during the various examinations and procedures. They were informed about alternative methods of pain relief (e.g. movement, breathing) and were able to freely express their feelings. However, two areas that were identified as problematic in that study were (a) the lack of birth plan discussions with the midwife and (b) insufficient explanations regarding the necessity of certain devices and instruments used during birth. Women who gave birth by normal delivery had statistically significantly better cooperation with the midwife compared to those who gave birth by caesarean section.

A more recent study on the quality of communication with health professionals as well as women's views and experiences of informational support and active participation in informed decision-making, produced less encouraging results (Koliandri *et al* 2023). Qualitative data analysis revealed seven main themes and several subthemes. The study presents the findings in a short narrative referring to the seven main themes: in a generally *'unsupportive environment'*, lacking adequate informational support, pregnant women struggle to gain a *'confident voice'*. But, they find themselves *"self-navigating in parallel worlds"*, between formal and informal sources of information. Women tend to *'supplement and filter'* the information, often instinctively and selectively, remaining in a state of *'doubt and faith*

'questioning not only the validity of the information but also the reliability of healthcare professionals. The quality ('the art') of communication with healthcare providers is essential to break this repetitive cycle on information searching. However, it appears to be largely dependent on the self-efficacy of the women themselves. Women '*deconstruct and re-imagine*' their experiences, often blaming themselves because they were not better prepared.

In addition to the major changes brought about by the transition to GeSY, as previously mentioned, the Covid-19 pandemic has had a significant impact on the quality of maternity care. In particular, it seems to have affected both the actual provision of care to women and newborns as well as the experience of care. In a cross-sectional study, which investigated the impact of Covid-19 on the birth experience, concerns and individualized needs of pregnant Cypriot women, found that the strict measures and restrictions imposed during the pandemic had an adverse impact on women's experience both before, during and after childbirth. The majority (80.9%) of participants in the study (Hadjigeorgiou *et al.*, 2022) reported that their experience was affected to some extent by the pandemic. The findings suggested that 74.1% of pregnant women were concerned about changes in pandemic measures and how these would affect the presence their partner or other family members at the birth. Additionally, 57.2% were concerned about the baby's health and 43.1% about changes related to postnatal care. Women's postpartum concerns were primarily related to the well-being and health of the infant (70.3%). A percentage of 49.1% also expressed concern about the care of the infant in view of changes in care arrangements due to the pandemic. Mothers emphasized the need for the development of specialized evidence-based support systems that are essential in pandemic situations that may disrupt normal healthcare delivery processes.

In addition, in a cross-country cross-sectional study, involving 12 countries, that explored the effect of Covid-19 on perinatal mental health and the prevalence of anxiety and depression symptoms during pregnancy and postpartum. A key finding was that 1 in 4 Cypriot women experienced symptoms of anxiety and depression (Mesquita *et al.*, 2023)

In terms of breastfeeding, Cyprus has consistently ranked among the lowest in Europe over the last decade (EURO-PERISTAT, 2013), despite the Ministry of Health recognizing breastfeeding as a public health priority. To address this issue, a National Committee for the protection, support and promotion of breastfeeding to tackle the issue has been established. Although based on data from the Perinatal Health Report, there appears to have been a slight improvement since then, the prevalence of

breastfeeding initiation and exclusivity in Cyprus remains low , even within the first 48 hours while at the maternity clinic.

According to a study by Economou et al., (2018) which included a sample of 586 mothers-baby dyads, the prevalence of exclusive breastfeeding in Cyprus appears particularly low, even while still at the clinic. Specifically, for every ten Cypriot new mothers, two did not breastfeed at all during their stay at the maternity hospital/clinic, while among the rest who initiated breastfeeding, only two exclusively breastfed⁸ and only 10% breastfed up to the first six months. Furthermore, among women who breastfeed, even not exclusively, a sharp drop decline was observed between the second and fourth month postnatally.

The study also found that age, educational background, income, occupational status and type of delivery (Economou *et al.*, 2018) , as well as low self-efficacy for breastfeeding (Economou et al, 2021) were associated with early cessation of breastfeeding in Cyprus. The main reasons reported by mothers in the study were returning to work, as well as concerns about "insufficient milk supply" and "doubt about whether the infant is full". These reasons , aside from reinforcing common misconceptions, highlight the general lack of breastfeeding support and problematic informational support from health professionals.

In a qualitative study by Papairakleidiou, Middleton and Hadjigeorgiou (2020) mothers described experiencing confusion from the inconsistent information they received from midwives about breastfeeding. This confusion was often a result of the imposing attitudes but unsupportive practices by midwives and the absence of a framework for continuous midwifery care in the community. Several women in the study emphasised their desire to breastfeed but also the need for more information and support, based on their own needs and, ideally, from one midwife:

"...sometimes she doesn't see you herself... you just want some guidance" - Mother 2

⁸ Based on the most recent data from the Health Monitoring Unit, YY, the percentage of mothers who exclusively breastfed in the maternity in the year 2023 was 27.1%, while the percentage who did not breastfeed at all was 12.6%.

Women also stated that support in the first days when they are back home with the baby was the most important factor for establishing and continuing breastfeeding, identifying the lack of community midwifery as a key issue⁹:

"...is where you need help..." "...it's where you need all the support" - Mother 9

"if we had community midwifery ..I think it would change a lot... say, if I had a problem, they would be there , they would encourage me, tell me what I was doing wrong and motivate me to keep going, I think it would be very good" - Mother 10

It has been also documented by Hadjiona et al (2016), that breastfeeding support at maternity clinics is not standardized and that the implementation of the Baby-friendly Hospital initiative's 10-Steps for successful breastfeeding is fragmented. For instance, the study found that while 51.5% and 25.7% of mothers in the public and private sectors respectively,¹⁰ had been informed about the importance of skin-to-skin after birth for at least one hour or until first breastfeeding; only 29% of mothers in the public and 25.4% in the private sector stated that it was actually implemented. The extent of which new mothers report that they did not experienced or only experienced partly the 10-steps "good practices" while at the maternity clinic has been associated with early cessation of breastfeeding (Economou et al, 2024).

Undoubtedly, the relationship with healthcare providers, as well as the level of trust and alliance between mothers and HCPs, is a key factor in ensuring RMC. However, there is also evidence to support that even HCPs face problems and barriers to ensuring the provision of good quality care. In a qualitative study which explored the perceptions of twenty midwives on advocacy for natural childbirth, it was shown that lack of professional recognition and deficiencies in basic or continuing education presented barriers to adopting an advocacy role. Furthermore, '*power imbalance/doctor dominance*', '*medicalisation of childbirth*' and '*lack of institutional support*' were identified as the main difficulties midwives face in performing their professional role and advocating for normal delivery in Cyprus (Hadjigeorgiou and Coxon ., 2014).

⁹ A positive development with the GeSY reforms is the introduction of Community Midwifery and direct access to a midwife for a total of 6 visits, which can be distributed with quotas in the pre- and post-natal period.

¹⁰ It is noted that based on the Perinatal Health Report 2015-2023 of the Health Monitoring Unit, in 2023, 83.2% of deliveries in Cyprus were in the private sector, and the remaining 16.8% were in the public sector. No further break-down is made in report between private clinics that operate within and out of GeSY.

In a recent study regarding midwives' perceptions of their educational role and the extent to which they can engage effectively in that role to “make every contact count”, it was found that although midwives in Cyprus strongly believe in the importance and necessity of antenatal education in the context of supporting women’s informed decision-making, they face multiple challenges and barriers across various dimensions. Although antenatal education is viewed as a core function of their professional role, it was perceived as a 'bad fit' with routine practice. In addition, medicalization of birth and related socio-cultural norms, pertaining to users and providers, are sustaining alienation of the midwife and conditions of existing power dynamics (Middleton et al 2022).

Finally, it should be mentioned there is limited literature available on perceptions of Cypriot women of vaginal delivery after caesarean section (VBAC). In a qualitative study on the experience of VBAC in Cyprus, 4 main themes were reported: medicalization of childbirth, preparation for VBAC, birth environment and therapeutic impact of VBAC success (Hadjigeorgiou *et al.*, 2021). The findings suggest that women need more personalized, evidence-based information aligned with guidelines and protocols regarding childbirth options and care. Misinformation and unsubstantiated information remain the primary factors influencing the choice of delivery type.

As previously mentioned, an important milestone in the field of maternity care was the launch of the new General Health System (GeSY) in Cyprus in 2019. The new system provides equal access and free choice of provider. Under GeSy, pregnant women are entitled to up to a total of 15 visits to the ObGyn, along with two more visits are covered for antenatal ultrasounds. Notably, GeSY also introduced Community Midwifery in Cyprus for the first time. Community midwives provide antenatal and postpartum support, and GeSY covers up to 6 visits to a midwife (Republic of Cyprus, 2019).

A4. Conceptual definitions

Ensuring women's right to a positive childbirth experience must be a priority for all stakeholders. In Cyprus, the absence of quality standards creates several problems and barriers to achieving *Respectful Maternity Care*. If Respectful Maternity Care describes the highest professional and ethical standards, then what is Disrespectful Maternity Care?

A4.1. Disrespect and abuse - Mistreatment

Nearly a decade ago, in 2014, the World Health Organization (WHO) issued a statement on the prevention and elimination of “*disrespect and abuse*”, urging on all actors and stakeholders to take

action¹¹, enhance the dialogue, and strengthen research and advocacy on the issue. The WHO statement positioned any form of "mistreatment" during pregnancy and childbirth as a violation of rights and a weakening of women's trust in care providers.

Describing it as a systemic problem in maternity care services, Freedman et al (2014)¹² illustrated a range of phenomena to describe 'Disrespect (lack of Respect) and Abuse' in the provision of maternity care. These encompasses a range of behaviours, practices and/or circumstances, some of which deemed unacceptable by both women and health professionals, while others are perceived by as problematic by women, but remain entrenched as 'standard practice' for healthcare providers. Indeed, the spectrum may even include phenomena that neither women nor health professionals recognise as problematic in a given socio-cultural context, yet, they still deviate from professional and ethical practice standards. They provided the following concise definition of "disrespect and abuse":

"any interactions [with health professionals] or conditions [in the care environment in general] that, based on local (in the given cultural context) consensus, are considered humiliating or undignified, as well as those interactions or conditions that are intentionally humiliating or undignified or that are experienced [by women] as such [even if not intentional]".

While concise, it is important to highlight that the definition emphasizes that "intent" alone does not determine whether these "interactions and conditions" constitute disrespect and abuse. If women or service users experience these interactions as such, they qualify as mistreatment regardless of whether healthcare providers recognise them as problematic to the same extent, or not at all.

Choosing the term "mistreatment", in 2015, Bohren et al¹³ described the different types of phenomena and developed a typology, which has greatly influenced subsequent approaches to developing theoretical and conceptual frameworks for Respectful-Disrespectful Maternity Care. This typology takes into account both the direct interaction between women and care providers, factors related to health care systems,

¹¹ WHO (2014), The prevention and elimination of disrespect and abuse during facility-based childbirth, 2014. Available at: <https://www.who.int/publications-detail-redirect/WHO-RHR-14.23> (last accessed 7/3/2025).

¹² Freedman LP, Ramsey K, Abuya T, Bellows B, Ndwiwa C, Warren CE, et al. Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. *Bull World Health Organ.* 2014; 92: 915-7.

¹³ Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med.* 2015;. 12(6): 1-32.

and the broader socio-cultural influences that play a role in the emergence of problematic and unacceptable phenomena. The typology consists of seven domains:

- Sexual abuse,
- Physical abuse (including interventions or procedures without permission or consent, restriction of freedom of movement, etc.),
- Verbal abuse (such as use of harsh language and threats),
- Stigma and discrimination (such as discrimination based on socio-demographic characteristics as well as medical conditions),
- Failure to meet the highest professional and ethical standards of care (e.g. problematic procedures for obtaining informed consent, maintaining confidentiality and privacy, etc.)
- Poor rapport between women and providers (such as ineffective communication, lack of responsive and supportive care, lack of respect for autonomy, etc.),
- Wider conditions constraints in the health system (such as lack of resources, non-implementation or absence of clear policies, guidelines and protocols, wider organisational culture of health services, etc.).

A4.1. Charter of Rights of Respectful Maternity Care

Combining the above frameworks, along with other established definitions and conceptual frameworks, the White Ribbon Alliance and a broad coalition of actors representing research, clinical practice, human rights and advocacy - went on to formulate the Charter of Rights for Respectful Maternity Care,¹⁴ which includes 7 fundamental Rights

The key distinction in the White Ribbon Alliance Charter's approach is that the proposed framework is framed from an affirmative "*positive*" perspective, i.e. as **Rights** of women-newborns while receiving maternity care within a healthcare facility. More importantly, this approach clearly highlights that Respectful Maternity Care is not merely the lack of *negative experiences* or the absence of extreme and unacceptable phenomena (e.g. mistreatment, violence and abuse), but several conditions need to be met and the highest professional and ethical standards of care are needed to uphold women's Rights to a positive childbirth experience - see *Table 1* above for White Ribbon Alliance's Charter of Rights for RMC.

¹⁴ Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns
<https://whiteribbonalliance.org/movements/respect-campaign/> [accessed: 19/07/2023]

Subsequently, in 2018, WHO issued its Recommendations on intrapartum care for a positive childbirth experience¹⁵, highlighting the importance of women-centred care in optimising women's experience during childbirth through a holistic, rights-based approach. This includes the provision of Respectful Maternity Care (RMC), which adopting the White Ribbon Alliance framework, is defined as:

"care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality; ensures freedom from harm and mistreatment; and enables informed choice and continuous support during labour and childbirth".

Although conceptually, Respectful Maternity Care is not merely the converse or absence of *negative experiences* (e.g. *disrespect, abuse, mistreatment, trauma, violence*), the *"positive dimension"* of RMC is nevertheless not well-conceptualized. There is currently no *consensus* on RMC standards and there are *several interlinked frameworks*, especially with regard to quality indicators that fully correspond to the concept of Respectful Maternity Care. The most measurable framework available is the WHO Quality Standards for Improving Care for Mothers and Newborns, with the domain of "Experience of Care" being particularly relevant.

Of course, several other frameworks have been proposed, many of which overlap. But unlike the WHO Quality Standards, they tend to be more theoretical and lack concrete measurable quality indicators. One of these, which is based on the WHO and White Ribbon Alliance frameworks, combined with an original review of 67 qualitative studies on the topic, is the RMC framework proposed by Shakibazadeh et al (2018)¹⁶. This framework describes an integrated typology with 12 third-order domains, and many sub-domains at the second- and first-order levels.

A4.2 Obstetric violence

The term *"obstetric violence"* remains contested within the clinical community, however it has a significant historical background with clear professional, ethical and legal-political dimensions. It is widely used both in academic literature and among civil society groups in the context of developing advocacy for women's rights. Notably, while the term *'obstetric violence'* appears, only recently, in

¹⁵ World Health Organization. Intrapartum care for a positive childbirth experience. WHO recommendations. WHO, 2018. available online: <https://www.who.int/publications/i/item/9789241550215> (last accessed: Jan 2025)

¹⁶ Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Nogueira Pileggi V, Madeira S, Leathersich S, Tunçalp Ö, Oladapo OT, Souza JP. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2018; 125(8):932-42.

official documents and reports submitted to the European Parliament¹⁷ and the European Commission¹⁸ (*specific reference in Box A below*). In a Joint Statement, the European Scientific Societies in Perinatal Health counter-proposed an alternative descriptive term '*suboptimal and disrespectful care*', rejecting the term '*violence*'.¹⁹ The main argument put forward is the absence of an intention to cause harm on the part of health care providers. It is also argued that the term '*violence*' refers to an '*extreme*' behaviour and a '*physical*' dimension, based on the interpretation proposed in the position statement. In particular, it is argued that even if the term is used in 'academic and other circles' to also include the psychological dimension as well as cases of 'unintentional manifestations of aggression', this interpretation of the term, to quote, '*has not been adopted by the general population, which still considers it to be an extreme form of aggression carried out with the intention of causing harm*'.

It should also be noted that while the term proposed in the Joint Statement retains reference to "*disrespectful*", the term "*abuse*" has been omitted, even though this term usually accompanies and completes the most widely used term by international organisations (i.e. *disrespect and abuse*). Interestingly, however, the statement includes a table in the main body of text, which refers to the range and types of phenomena that are considered "suboptimal and disrespectful care", where the abuse is included explicitly as one such time, in line with Respectful/Disrespectful Maternity Care frameworks.

The reference to common dictionaries, rather than to academic scientific literature, to give a definition of "violence" in this Joint Statement was largely the inspiration behind the "*Lexicon of Respectful Maternity Care*" prepared by the RESPECT team as part of the public campaign to inform and raise awareness of the multiple aspects of RMC.

"Positive" and affirmative terms were, of course, chosen to be included, primarily, but not exclusively in the lexicon, which refer to the Rights of Respectful Maternity Care, such as dignity, respect, consent, informed choice, etc.

¹⁷ Brunello S, Gay-Berthomieu M, Smiles B, Bardho E, Schantz C, Rozee V. (2024) *Obstetric and gynaecological violence in the EU-Prevalence, legal frameworks and educational guidelines for prevention and elimination*. European Parliamentary Research Service, requested by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM)

¹⁸ European Commission: Directorate-General for Justice and Consumers and Quattrocchi, P., *Obstetric violence in the European Union - Situational analysis and policy recommendations*, Publications Office of the European Union, 2024.

¹⁹ Ayres-de-Campos D, Louwen F, Vivilaki V, Benedetto C, Modi N, Wielgos M, Tudose ME, Timonen S, Reyns M, Yli B, Stenback P. European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA). Joint position statement: substandard and disrespectful care in labour—because words matter. *European Journal of Obstetrics & Gynecology and Reproductive Biology*. 2024 .May 1;296:205-7

Box A: Special reference to the Reports on Obstetric Violence

As mentioned above, the term "*obstetric violence*" appears in official documents submitted to the European Parliament and the European Commission. It should be noted that, although there was no representation from Cyprus in the group of national representatives listed in the report,²⁰ the report submitted to the European Parliament, mentioned above, includes references to both the RESPECT²¹ and RESPECTWatch²² projects. In the footnotes, these references are quoted in full.

It is worth noting that in the case of the RESPECT project in particular, it is mentioned that the project "chooses" not to use the term "Obstetric or Gynecological Violence" in order to focus on women's fundamental right to Respectful Maternity Care as a form of primary prevention of "disrespect and abuse", which is the term used by the WHO to describe the various phenomena that do not ensure Respectful Care and their systemic nature. It is not clear whether this reference is made in a critical spirit, but this can only be inferred from the fact that the subject of the report is obstetric violence.

It should also be mentioned that this report refers to a study by SPAVO, which was included in the annual activities to combat violence against women and "chose", in contrast to the RESPECT study, to use the term "obstetric violence". The SPAVO study was conducted in a similar time period as the RESPECT study²³, and addressed a similar target population (women who gave birth in Cyprus in the last 10 years or 5 years, respectively).

It is notable that although the first study (SPAVO) asked women to record their experiences of obstetric violence, while the RESPECT study phrased the question in a neutral way ("*experiences of maternity care*"),

²⁰ Cyprus seems to have been represented by the same person who represented Greece.

²¹ "In the context of the European funded (CERV) project RESPECT "Toward a culture of Respectful Maternity Care: Enhancing Provider-Client Shared Decision Making and Informed Choice"(2023-2025) led by the Cyprus University of Technology (CUT, 2023), an online survey on Respectful Maternity Care was launched in October 2023. Women who gave birth in Cyprus in the last 5 years are asked to fill in an anonymous online survey in English or in Greek. Instead of using the terms of obstetric or gynaecological violence, the project chooses to use the term Respectful Maternity Care in order to focus on the fundamental right of women to information and informational support as a form of primary prevention of disrespect and abuse".

²² "In **Cyprus**, the Birth Forward, an NGO has been granted a funding in 2023 in order to implement the Respect WATCH project. It aims to establish a national advocacy and a watchdog mechanism to monitor if perinatal care is delivered with respect. As stated in the projects' summary, its target is to establish "*tools, systems and procedures to systematically record, code, analyze in order to identify patterns and gaps, advocate for redressing those gaps through reporting and recommendations to stakeholders*"

²³ "In **Cyprus**, where limited information has been found on obstetric and gynaecological violence, a conference that addressed the issue of obstetric violence presented the results of a prevalence study carried out in 2023 (see section 2). In addition to the study results, testimonies from women victims of obstetric violence were presented by the "Birth Forward" NGO."

the results of the two studies are largely consistent, especially with regard to the aspects of care that emerge as comparatively more problematic.

As was also explained in the meeting with stakeholders, even if we consider that the sample (in either of these two studies) is not representative, since it is likely that women with negative experiences are more likely to want to participate in such a study to report their experiences (volunteer selection bias), a number of points are important to emphasize regarding the RESPECT study:

- the results record a variety of experiences across the continuum from very positive to very negative experiences.
- the study does not aim to estimate the frequency of these experiences, which methodologically the study design does not allow due to the non-random sampling method and voluntary nature of participation, even though a mixed recruitment strategy was employed whereby about half of the sample came through online participation, while the other half was recruited through face-to-face contact with participants in pediatricians' surgeries and other community settings
- Respectful Maternity Care, as a concept, includes many dimensions and individual aspects, and therefore the study is able to highlight which of these aspects are comparatively more problematic than others, and finally
- compared to the findings of similar studies in the international literature, the frequency of "negative experiences" recorded in Cyprus are relatively lower. Combined with the fact that the study sample in RESPECT appears to have a comparatively higher socio-economic profile than the actual profile of the target population based on official data recorded by the MoH (e.g. higher educational attainment), it would be possible to hypothesize that the findings may even be an under-representation of reality.

Finally, it should be mentioned that the European Parliament's report makes two more references to Cyprus.

- The first concerns the mechanism for submitting complaints to the Pancyprian Medical Association, and in particular the provision for payment of a fee for the examination of the complaint²⁴,

²⁴ "In **Cyprus**, submitting a complaint to the Cyprus Medical association costs 100 euros, which can present a barrier to accessing justice".

- while the second relates to the Observatory run by the Federation of Patients' Associations (OSAK), a RESPECT partner²⁵

Regarding the second report (to the European Commission), the only reference to Cyprus concerns the high rate of caesarean sections (53.1% with reference to 2019), as well as the high rate of episiotomies (75%, although the figure provides is, strangely, from the year 2007).

Surprisingly, Cyprus is also mentioned in this report as one of the 7 countries (along with the Netherlands, France, Spain, Finland, Italy, Bulgaria, Denmark, and the Netherlands) that in the period 2017-2022 implemented a 'formal' training programme for perinatal health professionals on Obstetric Violence. The definition used for 'formal' training includes courses, seminars and workshops organised by universities or other higher education institutions. It is not clear to which programme the report refers, to whom it was offered, or by which institution. It is possible that it refers to the adaptation and delivery by the Cyprus University of Technology of the RESPECT training workshops by the International Confederation of Midwives (ICM). However, this was an one-off activity and it is certainly not a training course that is regularly offered providing an opportunity for more healthcare providers to attend.

A5. Legal framework for Respectful Maternity Care (RMC)

A5.1. International legal framework

Respectful Maternity Care (RMC) is firmly grounded in international human rights law. The Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) establish the right to the highest attainable standard of health, including maternal healthcare. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) explicitly calls for equal access to healthcare services, including maternity care, free from discrimination and mistreatment. Furthermore, the World Health Organization (WHO) has issued guidance on the prevention and elimination of mistreatment during childbirth in health facilities, reinforcing the obligation of states to ensure dignified and respectful care for all birthing individuals.

²⁵ "In Cyprus, the Federation of Patients' Associations (CyFPA) runs an Observatory for Patients' Rights and complaints can be filed either via a helpline (1403) or by filling in an online form. CyFPA Observatory's data are published in monthly reports. According to October's report (CyFPA Observatory, 2023), one of the 53 recorded complaints of the month concerned a gynaecologist who recommended an unnecessary (as it turned out later) surgery"

A5.2. European legal framework

At the European level, the European Convention on Human Rights (ECHR), under Article 3, prohibits inhumane or degrading treatment, which is directly relevant to cases of obstetric violence. The European Social Charter guarantees the right to health protection, including maternal healthcare. Additionally, the European Parliament Intergroup on Sexual and Reproductive Health and Rights (SRHR) has recognized obstetric violence as a violation of women's rights and has urged member states to implement measures ensuring RMC. Recent reports from the European Parliament and case law from the European Court of Human Rights (ECtHR) highlight the systemic issues of obstetric mistreatment across various member states, including Croatia and Italy.

A5.3. National legal framework

Within the national context, patient rights in maternity care are protected under the National Patient Rights Law, which aligns with the European Charter of Patients' Rights and international human rights standards. However, gaps in implementation persist, necessitating continued advocacy and legal reforms to ensure comprehensive protection in the context of maternity care settings, as well as in the context of all setting of patient care in general.

The Table in *Appendix A* presents extracts from the Patients' Rights Law²⁶, as protected by Cypriot law, classified according to the White Ribbon Alliance's Charter of Rights for Respectful Maternity of Care.

²⁶ The Protection and Safeguarding of Patients' Rights Act 2004 (1(I)/2005)
https://www.cylaw.org/nomoi/enop/non-ind/2005_1_1/full.html

Special Part

B. Methodology

For the development of this National Strategy for enhancing the quality of maternity care, a structured participatory process was followed with the active involvement of stakeholders, including representatives of governmental authorities, regulatory bodies and independent agencies, academic institutions and social partners. Activities were coordinated by the members of the RESPECT project team under the guidance of project coordinator at the Department of Nursing, School of Health Sciences, Cyprus University of Technology.

The overarching purpose was that the actual process of co-creating the Strategy should function as a platform for cultivating fruitful collaboration and productive dialogue among the professional clinical community, the scientific academic community, civil society and other stakeholders, with the aim of promoting quality standards and best practices in Maternity Care.

The methodological approach is briefly described below, followed by a detailed presentation of the main stages of the process, together with relevant findings and tangible deliverables.

B1. General description of the process

The development of this national strategy to strengthen the quality of maternity care is aligned with the conceptual framework of Respectful Maternity Care (RMC), ensuring women's Rights to a positive childbirth experience, as defined by WHO, the White Ribbon Alliance and other international organizations. A participatory approach was adopted, bringing together all relevant stakeholders in a structured and inclusive manner. This process was preceded by a detailed mapping of stakeholders and interested parties in a closed workshop among RESPECT project partners.

A dual approach was followed, combining a targeted approach (by invitation) as well as an open call for participation (through press releases). This ensured the inclusion of all parties directly or indirectly involved or interested in maternal-child care. Participants included professional and scientific bodies in mother-child care, governmental departments and other competent authorities, policy-makers, and other governmental and non-governmental bodies, independent regulatory bodies and commissioners'

offices, academic and research institutions, NGOs, community groups and women's groups from civil society.

The multidisciplinary and multisectoral nature of this '*social alliance*' aligns with the World Health Organization's recommendations on the need to adopt an *inclusive process* in initiatives to improve the quality of maternity care by respecting the different perspectives, opinions, ideas and suggestions on the various aspects of the issue, which, as stated, is achieved through “[...] *the participation of women, communities, healthcare providers, managers, health professional training, education and certification bodies, professional associations, governments, health systems stakeholders, researchers, civil society groups and international organizations*”.²⁷

Stakeholders were invited to participate in an advisory role in the planned activities, contributing with their expertise and experience, each within their role and competences. Through a written **Joint Mission Statement** (see attached Joint Mission Statement and list of stakeholders who participated actively in the project's activities and/or were included in the mailing lists to distribute project outputs as part of the wider public consultation process - Appendix B), the stakeholders were informed about the vision and mission of the Stakeholder Advisory Group, committed to participate in the project activities in an advisory capacity, and pledged to provide their expertise and experience to support the implementation of planned activities and the advancement of RMC principles.

The role of the multisectoral multidisciplinary Stakeholders Advisory Group entailed:

- participating in plenary and/or working group meetings, with designed representative/s,
- contributing intellectually and providing constructive input and feedback towards shaping project outputs, results, and conclusions,
- offering critical insights and suggestions into project deliverables in the process of public consultation,
- engaging in conferences, seminars and/or other project-related events and activities, and
- identifying opportunities for improving the quality of maternity care and enhance the effectiveness of the joint initiatives of the Stakeholder Alliance.

²⁷ **WHO REFERENCE NUMBER:** WHO/RHR/14.23. World Health Organization., 2014. <https://www.who.int/publications-detail/who-reference-number-who/rhr/14.23>

This approach was fundamental to fostering an integrated and shared understanding of the various underlying issues involved in improving maternity care. It also promoted collaboration between the various and diverse actors involved, as a necessary pre-requisite to defining and aligning common goals towards sustainable improvements in Maternity Care.

The public consultation process, conducted through both face-to-face stakeholder meetings and in-between communication whereby output was forwarded for review, comments and suggestions, facilitated the formulation and examination of different views and approaches, helped to identify gaps and barriers while ensuring that any proposed recommendations were relevant, acceptable and practically feasible. This inclusive and structured approach has been instrumental in shaping a shared vision for improving the quality of maternity care.

To guarantee every stakeholder's right to submit their views at any stage of the process, the consultation included both those stakeholders who were systematically and actively involved in the various activities that evolved in tandem (conferences, stakeholder meetings, working groups and workshops), as well as all other stakeholders who were invited from the outset but did not respond to the initial call or did not participate in all Advisory Group meetings. All written comments submitted during the consultation were reviewed and integrated into the materials. . In every contact, it was communicated to all stakeholders in the RESPECT mailing list that, should they wish to withdraw and receive no further information on the project activities and/or participate in the feedback process, they could request to be removed from the list of recipients.²⁸

B2. Structure, objectives and results of series of activities

The co-design process for the National Strategy was structured through three successive meetings of the Advisory Stakeholder Group, each with a specific focus and objective - as described below. Where necessary, this was followed by Working Group meetings and/or closed meetings of project stakeholders to clarify and further elaborate the material.

²⁸ Note that no organization or representative has formally informed the consortium that they wish to withdraw from the public consultation process and/or do not wish to be informed further about project activities and output. With regard to the scientific - professional bodies, with the exception of the Society for Perinatal Medicine, which participated with two representatives only in the first preparatory coordination meeting, the remaining professional associations-scientific societies participated in all subsequent meetings of the Stakeholder Advisory Group.

Each Stakeholder Advisory Group meeting followed a standardised format and usually had two main components. The morning session took the form of a conference, with seminar presentations and panel discussions, while the afternoon session involved interactive workshops, the nature of which depended on the issue at hand. The typical structure was as follows:

- Presentation of the objectives of the meeting and sharing relevant input with the participants based on what data, evidence or other information was deemed necessary for the topic under discussion (e.g. Definitions of Respectful Maternity Care -RMC and related terms, including more controversial terms with "negative" connotations and differential levels of acceptance among members of the clinical community; reference to the multiple operational definitions of RMC, depending on the intended goal, for example, whether this refers to quality assurance activities and the definition of measurable quality indicators, whether it refers to capturing women's experiences in a research context, or whether it refers to defining the necessary skills and competences of perinatal healthcare providers).
- Experiential workshops with active participation of the participants on the basis of structured activities on the meeting's themes (e.g. mapping the current situation and identifying determinants of quality of care, assessing the cultural transferability and applicability of quality standards and indicators, etc.).
- Recording of views, perspectives, positions suggestions, recommendation and any other contributions and, where necessary, sending the output (findings, results, conclusions, etc.) with further instructions for providing any further comments and suggestions in writing. In addition, as mentioned above, public consultation included forwarding this material to the full list of stakeholders and potentially interested parties, regardless of whether they participated with representative/s in the relevant workshop that gave rise to this output.

B2.1. Preparatory coordination meeting with professional-scientific societies (closed group)

The first meeting took place on the 29 February 2024 in a closed circle. In this meeting, only the professional associations - scientific bodies in the field of perinatal healthcare provision were invited - *attached is the programme of the day - Appendix C.*

Specifically, in addition to the Cypriot project partners (Department of Nursing, CUT, Cyprus Federation of Patients' Associations, Birth Forward and Mediterranean Institute for Gender Studies - MIGS), the first stakeholders' meeting was attended by representatives from the following associations-bodies:

- Cyprus Gynaecological and Obstetric Association,
- Midwives Committee, Pancyprrian Association of Nurses and Midwives (CyNMA-PASYNM),
- Cyprus Paediatric Society,
- Cyprus Society of Perinatal Medicine,
- Ministry of Health, National Committees for Breastfeeding and Promotion of Normal Childbirth.

Aim-Objectives

The aim of the first closed meeting of the directly involved stakeholders from the side of the providers of maternal and newborn care was to communicate the objectives of the wider RESPECT project, as well as, in particular, to inform the stakeholders about the planned activities and expected output of Work Package (WP) 3 for the formulation of a National Strategy for Respectful Maternity Care (RMC), through an inclusive and participatory process.

Results

This exploratory “feel the mood and intentions” meeting, as it was termed, was considered crucial, as the discussions around the Respectful Maternity Care framework- whether it concerns the presentation of research results on women's experiences of maternity care in Cyprus, or it concerns the discussion around Quality Standards and Quality Measures, as proposed by international organizations- inherently touch on the prevention of undesirable and unacceptable phenomena. These phenomena have been described by a series of terms, some of which are widely accepted by all relevant international scientific-professional bodies, such as “*disrespect and abuse*”, “*mistreatment*”, as well as other terms, most characteristic of which is “*obstetric violence*”, which cause reactions and are not universally accepted by members of the clinical community.

The first meeting laid the foundations of the proposed collaboration with relevant professional actors in maternal-newborn care, and addressed, as far as feasible, any initial concerns or misconceptions expressed about the project's objectives, the process to be followed and the expected outcomes. Although disagreements, and even tensions, regarding the use of terms were not avoided, at the first as well as subsequent meetings, it is interesting to note that reactions and expressions of disagreements or disapprovals were not limited to the term "*obstetric violence*", but were extended to several other terms and included general exhortations on language use (including the phrase "*medicalisation of birth*"). Nevertheless, the meeting was productive, and collaboration with the Professional Associations-Scientific Societies continued productively throughout the project, maintaining a professional-academic climate.

In response to expressed criticisms that, as an academic institution, the Cyprus University of Technology and the RESPECT project team, cannot proceed to the formulation and implementation of an Action Plan, it was indeed explained that CUT and the RESPECT research team intend to implement a structured and inclusive approach, methodologically-guided by the principles of participatory approaches to research, with the aim of consulting with all stakeholders, recording their views, perspectives and suggestions, and thus co-creating a first National Strategy for Maternity Care, with no intention to proceed to an Action Plan as it falls outside the remit of its role and reach.

Following, adapting and refining the usual process of stakeholder workshops that the Cyprus Ministry of Health and the National Committees follow for the development of National Strategies, this is the first attempt to gather views and contributions from all stakeholders, in an inclusive manner, with the aim of cultivating a common understanding around the underlying issues, in an attempt to bridge perspectives where these do not align. However, without this diminishing the value of this process, it was explained to the stakeholders that this effort takes place only within the sphere of influence of the academic-research team, and requires the collaboration of professional bodies and all other stakeholders in an inclusive environment, respectful of different perspectives, views and ideas, so that through the collective effort the goals will be realized and the impact and sustainability of the results can be maximized.

In the same meeting, there was also a discussion with representatives of professional associations-scientific societies about the knowledge, skills, attitudes and behaviours, that are necessary for a perinatal healthcare professional in order to provide Respectful Maternity Care. A structured approach was used to record participants' views and perceptions on this topic (*Appendix D*), and by the end of the process

the key role played by effective clinical communication skills, both as a skill and as a professional value, was highlighted.

In the absence of an institutionalized framework for continuing education and professional development in Cyprus, the views and suggestions of stakeholders were sought regarding the need to design and provide training programmes to enhance clinical communication skills with emphasis on shared decision-making. There was a high degree of consensus among the meeting participants regarding the need to strengthen clinical communication skills, with a focus on Shared Decision Making, so that perinatal healthcare providers can effectively promote (values) and support (skills) women's active participation in the informed decision-making process. This requires:

- further strengthening communication skills training in existing curricula of clinical education programmes (currently exhibiting large differences across the various academic institutions in Cyprus, with communication skills being taught at varying degrees and extent, as well as following different pedagogical approaches across clinical curricula (medicine, midwifery, nursing),
- incorporation of such training activities into the Specialization Training programmes for Gynaecology-Obstetrics as well as other medical specialties (currently the responsibility of the Ministry of Health, and not hospitals, a provision that may change in the immediate next period after the approval of the bill by the Parliament for the creation and regulation of University Clinics/Hospitals), and also
- development and delivery of structured training opportunities for perinatal health professionals to cultivate and enhance communication skills, which, especially in the absence of an institutionalized framework for in-service training, continuing education, and professional development, can be achieved through partnerships with academic institutions.

This was one of the aims of the RESPECT project, which was implemented with great success and large-scale participation, but mainly by midwives, health visitors, and Gynaecology and Obstetrics specialty trainees, but not at this stage by Medical Specialists.



Figure 1 - Photos from the first stakeholders' meeting

B2.2. Second extended meeting of stakeholders on "Respectful Maternity Care"

The second stakeholder meeting was extended and it was attended by 54 participants, representing 35 organisations and institutions - including professional associations-scientific societies in Maternal-Child Healthcare, Directorates and Sectors of the Cyprus Ministry of Health and other governmental agencies, the Health Insurance Organization (HIO) responsible for GeSY, Quality Assurance Offices of the State Health Services Organization and other relevant policy-makers, academic institutions with clinical study programmes (medicine - nursing - midwifery), Commissioners Offices (Administration and Protection of Rights, Gender Equality, Supervision of GeSY) and other independent agencies, NGOs, women's organizations and other civil society groups - *attached the programme of the day - Appendix E.*

A full list of invited stakeholders and their representation at the meeting appears as an attachment to the Joint Mission Statement of the Stakeholder Advisory Group (*Appendix B*).

Aim-Objectives

The meeting, which was combined with the first National Conference for the public presentation of the RESPECT research study findings, took place on Thursday, 21 March 2024, at the University of Nicosia.

The **objectives** of the extended stakeholder meeting were:

- The presentation of an overview of the RESPECT project and activities (to date and planned) to all stakeholders, and consultation with stakeholders on the next steps
- The presentation, analysis and discussion of the results of the RESPECT mixed-methods study on the experiences of women in Cyprus from Maternity Care and cultivation of healthy reflection on the findings, especially in a comparative approach through the presentation of the findings of the pan-European study of the IMAGiNE EURO network on the quality of maternity care across Europe, in which Cyprus joined, albeit late compared to other countries, through the RESPECT project.
- Gathering views of all stakeholders and partners on the current situation regarding the quality of maternity care, with the aim of identifying weaknesses and challenges, as well as strengths and opportunities.
 - The tangible result of the above activity was the **mapping** of the determinants of the quality of care on the basis of the socio-ecological model, capturing a combination of factors that operate at the intra-personal (e.g. attitudes, perceptions, behaviours and skills of health

- professionals) and inter-personal level (e.g. quality of cooperation between service-users and providers, inter-professional collaboration, etc), factors related to the level of the healthcare system and services, with its organizational gaps and deficiencies, but also factors that operate at the wider societal and community level, including perceptions, beliefs and social norms and influences, which shape attitudes and behaviours, but are also shaped by the broader socio-cultural and socio-political level.
- The recording of suggestions and identification of priorities to improve and enhance the quality of maternity care in Cyprus with **proposed actions** along 4 thematic areas:
 - o Clinical Practice and Policy,
 - o Clinical Education and Continuing Professional Development,
 - o Public Awareness and Education, and finally,
 - o Research and Data Recording.



Figure 2 - Photos from the second stakeholders' meeting

Results

The presentation of the research results at the stakeholders' meeting aimed at promoting reflection on the recorded experiences of women in maternity care in Cyprus and identifying the relatively more problematic aspects of the care provided, as well as raising awareness of the need to take action and the targeted use of the available research knowledge to formulate relevant proposals and suggestions.

Dr Marzia Lazzerini, Professor of Global Child Health and Director of the WHO Collaborating Centre for Maternal and Child Health, was the guest of honour at the event. Professor Lazzerini is also the coordinator of the European network **IMAGiNE EURO** (*Improving Maternal and Newborn CarE*), involving over 60 stakeholders from 22 countries. The network has performed the largest study to date evaluating the quality of Maternal-Newborn care services in the European Region. For the purposes of providing comparative results with the rest of Europe, Cyprus has recently joined the network as part of the wider RESPECT project activities.

At the time of the meeting, the study IMAGiNE EURO had recorded data from > 60000 women and >10000 healthcare providers, with the aim of contributing to the strengthening of quality standards of maternity care in the WHO European Region. At the meeting, Professor Marzia Lazzerini, presented the WHO Quality Standard Framework, as well as research data from the **IMAGiNE EURO** (*Improving Maternal and Newborn CarE*) study, providing a European perspective on the issue and comparative results.

The **IMAGiNE EURO** study found large disparities between the 26 countries participating in the study in women's experiences of maternity care, as well as wide within-country differences. The overall assessment is a combination of women's self-reported experience of care based on a set of 40 WHO Quality Indicators, with a similar set of indicators relating to the views of healthcare providers.

The comparative results show Cyprus ranking close to the European average in terms of women's experiences. It is important to note that no country recorded high scores on all indicators, while a systematic pattern emerges with countries consistently recording higher or lower scores on all indicators.

The presentation of the comparative results of the IMAGiNE EURO study had a significant impact, as it strongly conveyed the message that there is room for improvement even in countries that have generally higher performance on the WHO Quality Indicators ("*There is no country without gaps*") and highlighted that the most important first step of any quality improvement initiative is self-awareness ("*awareness is*

the first step"). The key principle is an open dialogue between all stakeholders and the intention to work together towards a common goal.

In the context of the workshops that followed, the following activities were implemented:

- mapping the current situation in terms of maternity care provision in Cyprus in order to identify weaknesses and challenges as well as strengths and opportunities,
- a list of proposed actions in 4 thematic areas
 - Clinical Practice and Policy,
 - Clinical Education and Continuing Professional Development,
 - Public Awareness and Education, and finally,
 - Research and Data Recording.

The results of the **mapping** exercise (Section C) and the **contributions** (Section D) of the working groups in the four thematic areas, which form the main body of the Strategy, are presented in detail below in separate sections.

B2.3. Third stakeholder meeting on "Quality Standards for Respectful Maternity Care"

The third meeting of the Stakeholder Advisory Group was held on Thursday, 26 September 2024, at the University of Nicosia - *attached is the programme of the day - Appendix F.*

Aim - Objectives

The purpose of the meeting was to gather and record the views and suggestions of stakeholders regarding the quality of maternity care and ensuring the rights to a positive childbirth experience.

During the morning conference session, three discussion panels were organised at plenary on different aspects around quality assurance of maternity care, where relevant stakeholders were invited to participate with a representative to discuss the role of their organisation in ensuring Quality Standards of Maternity Care and the relevant actions they are developing and/or involved in.

Specifically, the three panels were organised, as follows:

- Panel 1 – Professional Associations-Scientific Societies: Clinical practice and quality standards in maternal-newborn care
 - with invited speakers from the Gynaecological and Obstetric Association, Paediatric Society, of Midwifery Committee of the Cyprus Nurses and Midwives Association,
- Panel 2 - NGOs and social partners: Ensuring the rights of women users of maternity care services
 - with invited speakers from project partners Cyprus Federation of Patients' Associations (OSAK) and Mediterranean Institute for Gender Studies, as well as Association for the Prevention and Treatment of Violence in the Family – SPAVO (which performed a study on obstetric violence in Cyprus), and University of Cyprus - Department of Law (with expertise in the legal framework around Maternity Care rights and violations of rights).
- Panel 3 - Competent regulatory authorities: Systems, Mechanisms and Procedures for Quality Assurance of Maternity Care Services
 - with invited speakers from the Health Insurance Organisation, Quality Assurance of the State Health Services Organization, Breastfeeding/Natural Childbirth National Committees, Ministry of Health of Cyprus

During the afternoon session, the workshops focused on the discussion on Quality Standards and related quality measures/indicators for Maternity Care at national level.

Two workshops were organised with two parallel working groups:

- Working Group 1: Quality Standards and Quality Measures in the WHO framework (under the project RESPECT),
- Working Group 2: Quality Assurance Mechanisms and Procedures (in the context of the related project RESPECTWatch which is running in parallel and concerns the development of an Observatory for monitoring the quality of maternity care and reporting complaints).

Results

In the first working group, the cultural adaptation of the **Quality Standards** for Maternity Care proposed by the World Health Organization (WHO)²⁹ was discussed. The absence or at least the non-existence of a comprehensive and standardized Quality framework for maternity care and the non-universal implementation of systems and/or mechanisms for recording and monitoring quality, at national level³⁰ and/or at the level of maternity units,³¹ and therefore the need to define quality criteria was one of the main recommendations that emerged in the previous workshop.

The process, findings and conclusions are discussed in **Section E**

For preparation purposes, the WHO report, specially prepared tables with the selected Quality Measures, along with specific instructions, had been sent to stakeholders via email in advance.

The instructions were:

(a) the assessment of the current situation with regard to the extent to which the quality requirements and criteria as described in or derived from the WHO Quality Standards framework are implemented; and

²⁹ 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)

³⁰ With the exception of some national-level data, but with limited use and/or usefulness for quality assessment purposes, such as, for example, the data recorded for purposes of reimbursement of care services by the Health Insurance Organisation (HIO), or the set of indicators recorded for purposes of the Perinatal Health Reports by the Health Monitoring Unit of the Ministry of Health. An notable exception is the recent initiative for the cultural contextualization of the NICE Guidance for C/S to the Cypriot context, as part of the actions of the National Committee's Strategy for the promotion of natural childbirth (reduction of caesarean sections) and the prevention of prematurity. The process, which is coordinated by HIO under the academic coordination of the Medical School of the University of Cyprus, is expected to propose specific indicators for monitoring the implementation of the Guidance.

³¹ With the exception of some maternity clinics that seem to have a relatively more developed internal data recording and quality monitoring system; however, even in this case neither the methods and frequency of data recording are currently clear, nor if and how the information is used for the purpose of quality improvement of health care services.

(b) the evaluation of the degree of relevance and applicability of select quality measures from the Quality Standards framework (mainly regarding the “Experience of Care” domain) in the organisational context of the health services of Cyprus.

Stakeholders who could not attend the meeting had the option to submit comments, suggestions and/or questions in writing before the meeting. As part of the wider public consultation, a specially-designed form was developed to and forwarded at the end of the meeting to all stakeholders for their comments and suggestions, whether or not they had attended that or any previous workshops.



Figure 3 - Photos from the third stakeholders' meeting

C. Mapping the current state and determinants of quality of maternity care

At the workshop, a structured research exercise was carried out to map the current state regarding the quality of Maternity Care, based on the views and perceptions of the participants. The participatory and inclusive process that was adopted enhanced the effectiveness of the approach, deepening the level of analysis of this complex issue and ensuring the parallel representation of multiple views, experiences, and perspectives.

C1. Description of process

The process focused on the specific socio-cultural and socio-political context of Cyprus, visually capturing the complex nature of the issue under discussion on the basis of the socio-ecological model (*see Box B for more information*), tapping into

- factors operating at the intra-personal and inter-personal levels (e.g. quality of cooperation between service users-providers, inter-professional collaboration, etc.)
- factors at the level of the healthcare system and services, organisational gaps and deficiencies,
- factors at the societal level that shape perceptions and beliefs, influencing attitudes and behaviours, which are also shaped by
- factors operating at the broader socio-cultural and socio-political level.

In particular, the participants were asked the following question

"If you consider the current situation in Cyprus, what would be 1-2 actions that, in your opinion, would enhance the Quality of Maternity Care (in the context of Respectful Maternity Care - RMC)

- *You may think of weaknesses or challenges that need to be addressed*
- *Or, strengths and opportunities that can be reinforced*

The participants were asked to write down their views in short phrases or sentences on post-it notes (*figure 4*), and following a round-robin session, all contributions were mapped on the concentric circles of the socio-ecological model (SEM) drawn on a whiteboard.

Structured mapping exercise:

❑ Thinking of the current situation in Cyprus, what would be **1-2 actions** that, in your opinion, would enhance the Quality of Maternity Care (*in the context of RMC*)

➤ You may think of **weakness or challenges**, that need to **be addressed**

➤ Or, current **strengths or opportunities** that need to **be reinforced**



Figure 4 - Instructions to participants for the mapping exercise

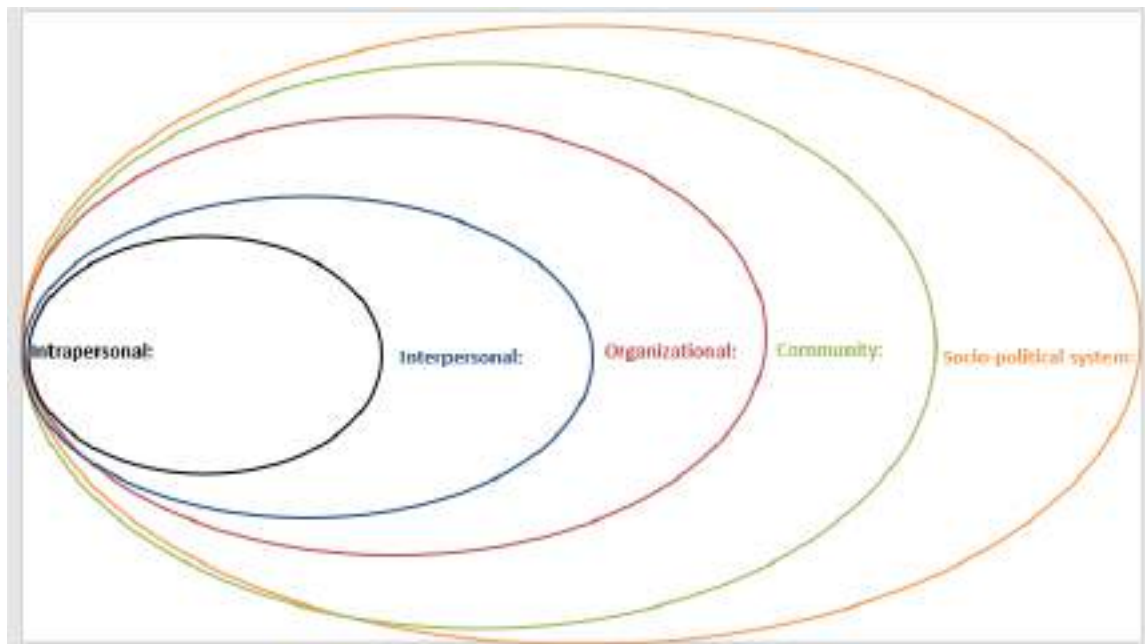


Figure 5 - Diagrammatic representation of the Socio-Ecological Model's concentric circles.

Box B: Socio-ecological model

The Socio-Ecological Model recognises the direct interconnection and interaction between various determinants of a phenomenon, a situation, an outcome, an experience (in this case, the quality and experience of Maternity Care), which operate at different levels.

This is illustrated diagrammatically by the overlapping rings, starting from the individual level, with the characteristics, attitudes and behaviours of individuals themselves and interpersonal processes, which are shaped, influenced and/or sustained by situations, conditions and forces in the wider socio-political and socio-cultural context (*figure 5*).

This approach serves to better understand the interaction between determinants operating at different levels. The phenomenon of interest is complex and shaped by a multitude of factors, all of which potentially contribute to the overall situation to a greater or lesser degree.

Below, are some examples of the interaction of factors operating at different levels as identified at the workshop.

C2. Mapping exercise results

In total, 54 people, representing 35 different bodies and organisations, participated in the mapping exercise. By the end of the structured mapping exercise process, 146 post-it notes were collected in total. Many of the contributions were multifaceted and referred to more than one concept, resulting in a much larger sample of “meaningful units” for analysis.

Although the instructions given required participants to write only one suggestion (short phrase or sentence) per post-it note, the rule was not strictly adhered to by all participants. Furthermore, while participants were instructed to use post-its of different colours depending on whether their contribution to the discussion referred to weaknesses/challenges or strengths/opportunities, this was not implemented properly. In fact, many of the contributions/postings were worded in a way that could be interpreted as both positive and negative elements, depending on the interpretation assigned by the contributor.

The contributions were roughly mapped on a whiteboard while the process was developing to provide a first visual representation, but were subsequently entered into a table verbatim for further processing.

C3. Data Processing-Analysis

Further analysis of the contributions followed deductive content analysis and included:

- reading and becoming familiar with the content of the contributions as they were formulated,
- attribution of codes based on the main concept(s) referred to,
- thematic grouping of common or related concepts,
- interpretation at a higher-order/latent level; and,
- finally, categorization of issues and sub-issues at the levels of the socio-ecological model.

The qualitative method followed does not allow nor does it aim to quantify the degree of agreement among participants or to determine the importance of each factor, but rather to deepen the understanding across all aspects of the phenomenon under study.

The results are very rich and are presented in detail in the table in *Appendix G*. Below, a visual illustration is presented of some of the main points identified based on the views and perceptions of stakeholders (*Figure 6*), accompanied by a narrative description of some illustrative examples that highlight the interconnection and interaction between different determinants operating at different levels of the SEM.

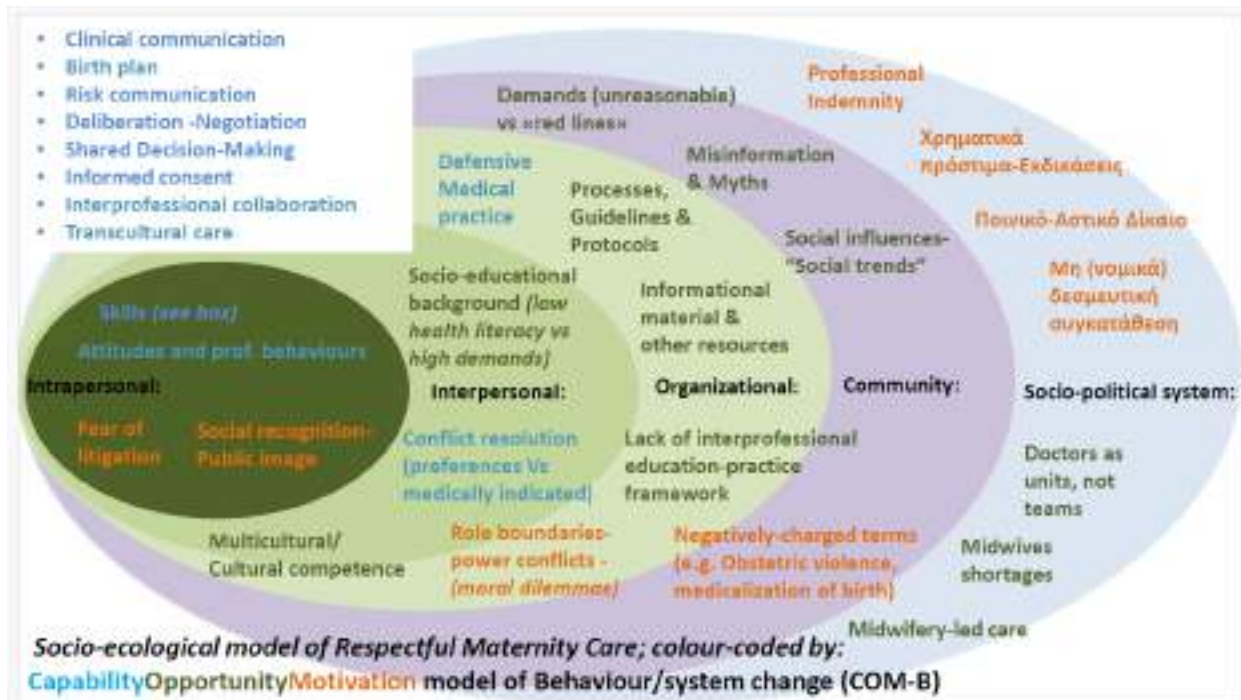


Figure 6 - Mapping the current situation - determinants of the quality of maternity care.

C4. Main findings

- The absence of an institutionalised framework for continuing education and professional development, and the lack of in-service training arrangements or requirements (*organisational level: system/health services*), determines to a large extent the educational opportunities for the development and enhancement of knowledge and skills of care providers (*intra/inter-personal level*).
- As a result of the lack of institutionalized quality assurance systems, mechanisms and procedures (*broader socio-political context*), as well as the non-formal adoption of clinical guidelines/ protocols/ quality standards at national or local level (*society: scientific societies and organizational level: health system*), there are no clinical supervision and mentoring or quality assurance mechanisms at the level of hospitals/ clinics (*organizational level: health services*).
- The absence of a comprehensive educational policy for development of Health Literacy in Reproductive Health/ Maternity Care from young age/adolescence (*broader socio-cultural socio-political context*) in combination with prevailing social norms on childbirth and patent rights

(*Community and Social context*), and the low attendance/ reduced access-opportunities/ non-targeted topics / pedagogical approaches at antenatal classes (*organizational level: Health services*) determines and/or sustains beliefs, perceptions, attitudes and behaviours of women/service-users of maternity care services (*intra-personal level*) and the interaction and quality of communication between women/service-users and providers (*inter-personal level*)., due to different degrees of knowledge and skills, self-efficacy and assertiveness, socio-cultural background, etc. (*intra-personal level*).

- The practice of 'defensive medicine' is probably, at least in part, a consequence of the existing legal framework on medical liability and the fact that medical malpractice is liable under criminal rather than civil law (*broader socio-legal context*), which shapes the perceptions, attitudes and behaviour of healthcare providers (*intra-personal level*) and therefore also the interpersonal interaction processes (*interpersonal level*) with women-beneficiaries of maternity health care services.
- Active advocacy by civil society for ensuring women's rights to a positive childbirth experience (*community*) may lead to conflicts and polarization, often as a result of non-shared meaning of underlying concepts and issues (*interpersonal level*) and emotional responses (*intra-personal level*), especially to negatively-charged terms, no matter if these terms appear in the international literature and in official reports of European and international organizations and institutions (such as "obstetric violence", "disrespect and abuse". "mistreatment"), especially in a socio-cultural context where interdisciplinary - intersectoral collaboration and the participation of 'patients' – service-users in the health policy-making process are neither institutionalised nor are common practice (*organisational level: health system*).

The analysis proceeded to further categorizing and assigning the various factors to the domains of the COM-B model of behavior and system change (Capability, Opportunity, Motivation - Behaviour),³² as also shown in the illustrative example in the diagram above (*figure 6*), with each factor colour-coded depending on which dimension of the COM-B model the factor falls into.

In brief, based on the COM-B model-B, determinants of behaviour relate to:

³² Michie S, Atkins L, West R. The behaviour change wheel. a guide to designing interventions. 1st ed. Great Britain: Silverback Publishing; 2014.

- **Capability(s)** of the individual(s)/group(s)/system (procedural, cognitive and psychological, i.e., "can/cannot" perform a behaviour or modify a behaviour)
- **Opportunity(s)**: "conditions, circumstances or the broader context", as determined by the physical built, material, technical and/or socio-cultural environment allow/facilitate or not this behaviour or modifying this behaviour
- **Motivation**: "wanting" to engage in this behaviour or modify this behavior, either as an automatic emotional response or through a reflective process.

This approach adds practical value by broadening the discussion on the most appropriate form and nature of the necessary actions, measures or interventions. For example, an educational intervention is considered more appropriate if the aim is to enhance the "Capability" of individuals to perform or modify a behaviour (e.g. designing and implementing training programmes and experiential workshops to enhance knowledge and cultivate effective communication skills of healthcare providers to actively seek and support the participation of women in decision-making).

However, if the issues identified as a priority relate to the "Opportunities" dimension, then more appropriate interventions would be the provision of resources and tools that will support the improvement of the quality of maternity care services (e.g. guidelines, protocols, quality standards, tools and resources to support the educational role of healthcare providers), and/or efforts to influence and reshape the wider clinical care environment (e.g. Baby-friendly Hospital certification) as a means of creating settings that support the Maternity Care quality), and/or tackling current unfavorable conditions (e.g. dealing with staff shortages, strengthening inter-professional collaboration, clarifying roles and role boundaries within an interdisciplinary team, strengthening and promoting antenatal education programmes) and/or influencing and change prevailing perceptions and beliefs around Maternity/ Maternity Care/ Maternity "patient" rights (e.g. awareness campaigns) etc.

Similarly, for factors falling under the "Motivation" dimension, interventions that provide incentives (or create disincentives) for individuals (or the system) to adopt or not to adopt changes (e.g. institutionalised quality assurance systems and mechanisms, recording, monitoring and reporting quality indicators, etc.), might be required.

C5. Conclusion

The mapping exercise has generated valuable and insightful material regarding the various interrelated factors (based on the socio-ecological model) that may influence, shape and/or are associated with the quality of provision and/or experience of Maternity Care.

In addition to gathering views and perceptions on the important factors through a participatory process, this approach of categorizing and mapping factors within the Socio-Ecological Model highlights that a single action or intervention can rarely be effective unless it is combined with other relevant actions to tackle factors that operate in parallel at different levels.

Participating in the mapping exercise was experiential in nature and the exercise contributed to shaping a common and expanded understanding among stakeholders of the multi-level factors affecting the current state of maternity care, and the complex interdependence and interplay between factors operating at a different levels, highlighting the issue as systemic, thus underscoring that systemic changes would be required to improve the quality of maternity care provided.

D. Working Groups' Suggestions and Recommendations

After experiencing the mapping exercise, the participants were divided into four working groups, ensuring a multidisciplinary composition with representatives from all stakeholder "categories".

D1. Description of process

The working groups engaged in a group discussion, moderated by a member of the RESPECT team, on their assigned theme. The aim was to exchange views and formulate suggestions and recommendations for possible actions, measures, interventions, policies and/or mechanisms to enhance the quality of maternal-child health care services in Cyprus.

Four important themes were identified in advance and each thematic working group discussed and **proposed actions** within their assigned theme:

Thematic Working Groups	Group Coordinators
1. Clinical Practice – Policy	Dr. Eleni Hadjigeorgiou
2. Clinical Education - Continuing Professional Development	Dr. Ourania Kolokotroni
3. Information - Public Awareness	Dr. Christiana Nikolaou
4. Research - Data Recording	Dr. Maria Karanikola

The groups were not asked to evaluate the appropriateness or any other aspect of the proposed actions or to identify priorities, but only to compile a list of suggestions and recommendations, which were then presented to the plenary by the working group coordinator.

The full list of proposed actions was then emailed to all stakeholders – whether or not they participated in the workshop with a representative/s – for comments and suggestions. At the same time, the participants/ recipients were instructed to review each recommendation and consider their suitability on the basis of APEASE³³ (*see information in Box C below*). The aim, again, was not to prioritise the suggestions per se, but to cultivate a common understanding of various important considerations that

³³ Michie S, Atkins L, West R. The behaviour change wheel. a guide to designing interventions. 1st ed. Great Britain: Silverback Publishing; 2014.

need to be taken into account for the adoption and successful implementation of any action, measure and/or intervention – for example, practical applicability, acceptance by the all stakeholders/ those affected or called upon to implement it, the expected degree of success and/or effectiveness and/or any unintended consequences, whether desirable or not.

D2. Main findings

Below, the contributions of the working groups are listed in fill in the form of a list by thematic area, with additional comments where necessary. It is noted that, due to the direct link between the broader Respectful Maternity Care framework with making Informed Choices in Childbirth and the need to promote Natural Childbirth in Cyprus (as a measure to address the high rate of caesarean sections), some of the recommendations are similar or related to recommendations included in the relevant National Strategy for the promotion of Natural Childbirth and reduction of prematurity,³⁴ which is currently underway by the Ministry of Health.

Although some of the stakeholders (e.g. scientific societies and representatives of academic institutions) participated in the corresponding process for the formulation of the recommendations for the National Strategy for Normal Childbirth/Caesarean Sections, the participation of stakeholders in the RESPECT workshops was significantly broader.

³⁴ Available online at: <https://www.gov.cy/moh/documents/ethniki-stratigiki-gia-tin-proothisi-toy-fysiologikoy-toketoy-kai-ti-meiosi-tis-proorotitas-2024/>.

D2.1 WORKING GROUP 1: CLINICAL PRACTICE AND POLICY

- Establishment of a **multidisciplinary team** to document existing practices and identify/evaluate needs based on evidence-based practices, best practices, and quality standards/indicators in Respectful Maternity Care.
- Acceleration of the procedures for establishing the **National Centre for Clinical Documentation and Quality Improvement** and establishment of role and responsibilities.
 - Funded by an EU recovery fund. Legislation is expected to be finalized soon, after which there should be a stakeholder consultation process before submission to the legal department/ parliament for approval.
 - The process is coordinated by the Ministry of Health – need for wider stakeholder involvement: OSAK, academic institutions, HIO, Cyprus Medical Association, CyNMA etc.
 - Institutionalization and delineation of responsibilities, and definition of procedures – National Framework: clarify the role and responsibilities (national coordinating role in accordance with legislation)
 - The processes have been slow so far and, additionally, it would require the inclusion of a special focus on Clinical Practices related to Respectful Maternity Care, which necessitates a political decision to establish this as a priority area.
- Implementation of **Clinical Audit** to ensure high quality of care
 - Currently, it is not implemented on the basis of any regulatory requirements and, where it is applied by one's own initiative, it is not done in a systematic and transparent way.
 - The need has been identified and included as priority area of the National Centre for Clinical Documentation.
 - There is a need for the employment of permanent staff at the Documentation Center, as well as the involvement and support of expert specialists in its work.
- **Clinical Guidelines:** Adaptation/Contextualisation and adoption of guidelines, as well as protocols, clinical pathways etc., relevant to Respectful Maternity Care e.g. Caesarean section, episiotomy, etc.

- o The recent example of national contextualization of the NICE Guidance on C/S offers a good model to replicate for other areas of priority. A necessary, but slow process.
 - o Designation of a competent body: National Centre for Clinical Documentation (not yet established) or HIO (based on the current process of contextualisation of the above and other NICE guidelines, which is already underway). Clear definition of roles is required.
- Setting **Quality Standards and related quality measures/indicators** in relation to the provision and experience of Respectful Maternity Care
 - o Establishing a framework for the operation of Quality Assurance Offices in a unified manner across the public and private sector
 - o Selection and categorization of quality indicators of RMC (with the contribution of the academic-research community) to select the most appropriate set of indicators, which is expected to include indicators from all categories - input/structural indicators, process/output indicators, as well as outcome indicators, including measures of self-reported experience and satisfaction with the care provided.
 - o Developing a mechanism for recording quality indicators (At the national level? By which body? At the clinical level? Both require the operation of Quality Assurance Offices in maternity hospitals/ clinics).
 - o It should be noted that the Baby-Friendly Hospital Certification process (currently underway) is expected to have a positive impact beyond its immediate goal, as it is likely to generate interest from maternity hospitals seeking certification. This, in turn, will assist to accumulate tangible expertise in maternity hospitals/ clinics regarding quality assurance processes and compliance with quality requirements.
- Linking quality to **maternity services reimbursement**
 - o HIO: It has been implemented for caesarean sections based on the recommendations of the National Strategy. It could potentially be expanded for other aspects related to quality assurance of care provided.
 - o However, this requires the definition of specific performance indicators which should be derived from guidelines (or at least a national strategy) and/or agreed with the clinical community.

- Development and completion of a detailed **action plan** for the full implementation of the two relevant National Strategies, as they are expected to have a positive impact on maternity care services, both in terms of their immediate objectives and more broadly
 - National Strategy for the protection, support and promotion of Breastfeeding
 - National Strategy for the promotion of natural childbirth and reduction of prematurity
- Completion and implementation of **Baby-Friendly Hospital Certification process**
- Strengthening **central coordination** of relevant actions between agencies, departments and ministries to avoid wasting resources and time and implement coordinated health policies.
- Provide **incentives** and **rewards** to maternity hospitals/ clinics and maternity healthcare providers for continuous quality improvement
- Full utilisation of **Community Midwifery** (both private sector and through the State Healthcare Services Organisation) and informing pregnant women about the right to direct access to a midwife through the General Healthcare System (GeSY)
- **Health literacy** policies: strengthening policies that aim to enhance health literacy among women, with a focus on information about quality standards and rights.
 - Good examples: OSAK programme in relation to medication management
- **Rights of healthcare service users:** Need for a central policy with coordinated actions
 - informing and empowering women about their rights
 - establishing a unified framework for informed consent processes
- Legislation on **medical malpractice**: civil rather than criminal law
- Strengthening clinical communication skills to support **shared decision-making**
 - Development of training programmes in partnership with academic institutions and hospital Research and Education offices
 - Embedding educational and other resources in clinical practice to assist healthcare providers education role (e.g. patient information leaflets, decision aids, etc)
- Coordinated central policy for the development of new and/or the identification and better use of existing ones e.g. **information and educational material** to be made available to the public

D2.2. WORKING GROUP 2: CLINICAL TRAINING - CONTINUING PROFESSIONAL DEVELOPMENT

- **Continuing Education for Health Professionals** with a direct link to clinical practice / renewal of professional license/ registration in the practice registry.
 - Developing a framework for mandatory documentation of training and professional skill development through Continuing Education Credits
 - Already in place for Nurses/Midwives. No equivalent for other health professionals
 - There is a need for a more targeted selection of topics/ areas of priority and broadening the educational opportunities (currently both limited).
 - The lack of training opportunities can be compensated for, by the creation of an e-learning platform and use of other online training resources.
- Development of targeted needs-based tailored training programmes on **topics** relevant to the WHO Quality Standard for Maternity Care – Respectful Maternity Care and provision of accredited training opportunities by academic institutions and other organisations.
- Need for **experiential workshops** (not just theoretical training) to cultivate skills and competences, including clinical communication skills
 - for balanced information-sharing for effectively supporting the active participation of women in decision-making based on the values, principles and techniques of the shared-decision-making communication approaches,
 - developing a “mindset”/culture and related skills for conflict resolution – both between health professionals/ colleagues, as well as between service users-providers-users,
 - managing “*difficult patients*” (admittedly, a problematic term, but one that was mentioned several times in the workshops) through the cultivation of communication skills.
- Developing **peer-to-peer feedback** and self-evaluation/evaluation skills, along with related systems and mechanism as “standard practice” for the cultivation of a new “mindset” of feedforward for professional development.
- Actions to inform, educate, and raise awareness among healthcare providers on the **rights of women** as maternity care service-users (and patient rights in general).

- Encouraging, institutionalising, and facilitating the participation of "**experts by experience**"/ service-users' representatives across all activities and levels in co-creation processes
 - in clinical education activities (academic institutions and hospital training units),
 - in the development of clinical/health policy, educational and information material etc. (through proper representation in decision-making bodies)
- Accessibility to **educational opportunities**:
 - Development of an e-learning/information platform for training of healthcare professionals, which includes guidelines and protocols to ensure access for providers in both the private and public sectors
 - Educational needs-assessment exercise and establishment of **Educational Targets and Indicators** for HCP/ maternity clinics (also, necessary for the next entry)
- Development of **in-service** training programmes
 - in partnership with academic institutions and other external actors, if the expertise on certain topics does not exist internally.
- Specially designed training programmes on **cultural competency** of HCPs
 - Intercultural communication skills are important for providing care to all socio-cultural groups in general, as well as to women of different ethnic/religious backgrounds. Providing culturally informed, sensitive and equitable care (1 in 3 births in Cyprus are to non- Cypriot mothers). Even more challenging for vulnerable groups such as asylum seekers and refugees.
- Collaborations between academic departments across different Universities to promote **inter-professional learning and practice** early on among the future generation of healthcare providers
 - between students in clinical curricula from different disciplines in the field of mother-child care (medicine, nursing, midwifery).
- Organisation of **inter-disciplinary conferences** and fostering other interdisciplinary-interprofessional collaborations and partnerships (breaking-down silos)

D2.3. WORKING GROUP 3: INFORMATION - PUBLIC AWARENESS

- **Pre-pregnancy education for young people:** Design and implementation of educational programmes starting before pregnancy (e.g. modules within the Secondary School Health Promotion Education Programmes) to develop better-informed future parents.
 - Cultivating knowledge and skills - Health Literacy - Rights around pregnancy, childbirth and parenthood, to equip individuals with knowledge, tools and resources for the maternal/ parental journey.
 - Cooperation between the Ministry of Health (School Health Service) and the Ministry of Education (Health Education).
 - However, there is a need for teacher training on these issues - involvement of experts in the development of educational material – and participation of guest speakers/organisations.
- Support and proper **promotion** of courses on antenatal/ parenthood preparation courses - increasing attractiveness and accessibility - review and **broadening** of current thematic areas/topics
 - Targeted seminars and workshops for future parents on issues related to Respectful Maternity Care (evidence-based and best practices, quality standards, active participation in decision-making, rights in maternity care/ patient rights, etc.)
- Promotion and more effective use of **existing educational resources** e.g. Baby Buddy Cyprus webapp, as a user-friendly source of valid information and support for new mothers/parents
 - Development of additional material with specific reference to RMC, quality standards, rights, informed consent etc.
 - Further development e.g. conversion to an app and expansion to include more languages
 - Promotion by professional - scientific bodies to increase use by health professionals
 - Notification by HIO after first visit for pregnancy to health services about its availability and option for free registration on the platform
- Creating and/or strengthening informal **peer support networks** for mothers to exchange views and experiences and support each other .

- The creation of peer support groups will enhance solidarity and exchange of views among mothers by providing a platform for sharing experiences, advice and empowerment
 - Recognition (not demonisation) and strategy to use these networks as a useful resources – Integrating them , as is best practice internationally, into maternal-child health services under the coordination and guidance of health professionals (combination of formal-informal support)
- Actions and initiatives to strengthen the **inclusiveness** of the healthcare – welfare – support system e.g. support groups for women-pregnant women-mothers from minority backgrounds, such as "Home for Hope", with a focus on reproductive health – pregnancy – empowerment.
 - Groups in such initiatives include victims of sex trafficking as well as vulnerable and marginalised populations and groups, mainly from non-EU countries.
- **Rural outreach** programmes: Organising (in collaboration with formal agencies) peer-led workshops in rural areas to ensure accessibility to educational opportunities and maternal health resources, as well as support networks to people with unequal access opportunities.
- Use of **innovative tools** and technologies: Using innovative tools and technologies attractive to the future generation of parents, such as gaming to inform and raise awareness among adolescents about reproductive health and maternity care
- Promoting actions on **social media** to disseminate information and introduce reproductive health, maternity and mother-child care issues into the social dialogue.
 - Utilising platforms such as TikTok, Instagram Reels and podcasts to disseminate information and start a societal conversation on reproductive health, reproductive and maternity care rights and other issues related to Respectful Maternity Care.
- Reference to **successful public awareness campaigns** from national and international experience: Drawing inspiration from successful campaigns to adapt and shape appropriate messages around Respectful Maternity Care, with an emphasis on the right to informed choices and participation in decision-making.
 - both in a national context of previous successful campaign, such as those of the Cyprus Family Planning Association (e.g. “think with your upper head”, “sex in like souvlaki”),

- o and from the international experience (e.g. ASK3, BRAIN for participation in decision-making).
- Cultivating a **shared understanding of issues, goals and terminology** to ensure effective and productive communication between stakeholders to avoid conflicts and among the general public.
 - o Clarify and familiarize with the meaning of terms that appear in the international literature/ recommendations of international organisations/ reports of European Parliament and other European institutions (negatively charged terms such as “obstetric violence”, “disrespect”, “abuse”, “mistreatment”, “trauma” as part of the Respectful/ Disrespectful Maternity Care lexicon).
 - o Adoption of a common framework (Rights to a positive birth experience, Respectful Maternity Care) and goal (continuous improvement of the quality of care and birth experience).

D2.4. WORKING GROUP 4: RESEARCH AND DATA RECORDING

- Further development and support of **Research** on Maternal Health/Maternity Care/Perinatal Health/ Reproductive Health - strengthening collaborations with academic institutions.
- Strengthening existing systems, mechanisms and procedures for **data recording and monitoring** (Health Monitoring Unit, HIO, Quality Assurance Offices) and expansion of current capabilities
- Defining a set of **quality indicators** for regular monitoring and publication of comparative results
- Utilising plurality of **research methods** and approaches to both quantify quality measures and indicators (quantitative methods) and enrich understanding of the experience (qualitative methods)
- Adopting **new methodological approaches**, including participatory action research and Implementation Research
- Setting research **priorities** and fostering a culture of research and quality improvement within healthcare services
- Establishing of **Research Centres** for Women/Maternity issues

Alongside the above contributions, Working Group 4 chose to discuss research priorities, which it grouped into 4 priority pillars, as shown in the diagram below (*figure 7*) – *in Greek only*, and gather specific suggestions under these themes, as shown in the table below.



Figure 7 - Research priority pillars

Research

[A] Focus: WOMEN, PARTNERS & PARENTHOOD

Issues related to women's and partners' lived experience in the transition to parenthood – a greater need for qualitative exploration of women's needs and opportunity to talk about issues that concern them.

The following topics are proposed:

- Mental health and well-being during pregnancy and maternity (e.g. postpartum depression) and support mechanisms.
- Trauma (psycho-social) during pregnancy and motherhood.
- Loss and bereavement/ bereavement care, e.g. in cases of stillbirth.
- Sensitive issues, such as the challenges of surrogacy and psychological adjustment.

[B] Focus: MATERNITY CARE PROVIDERS

1. Safety and quality indicators, and interdisciplinary cooperation

Maternity care staff/ Healthcare providers

- Exploring the views, experiences, suggestions of healthcare providers (on quality, safety, rights etc.)
- Designing and evaluating of educational interventions for the enhancement of soft skills
- Developing protocols, quality indicators etc. using priority-setting, consensus-reaching research methods

The following are proposed, as priority:

- Empowering soft skills of health professionals with a focus on empathy and communication skills.
- Working groups to develop clinical practice protocols, guidelines, quality indicators, training curricula, etc. using structure approaches

2. Professional/Occupational issues

- Organisational culture and stressors.
- Exploring continuing education and professional and personal development needs.
- Exploring models of maternity care provision

- Inter-professional Cooperation

The following are proposed, as priority:

- Needs assessment for continuing education and models of maternity care provision.
- Organisational culture and stressors in maternity – qualitative exploration of lived experience care

[C] Focus: GENERAL POPULATION

- Exploring perceptions and choices about childbirth and newborn care.
- Designing (formative research) and evaluating of educational programmes for young people on challenges of parenting, maternity, maternity care issues and rights, etc.
- Mental health screening (research and in routine practice) with a focus on migrant population groups and other vulnerable groups – special antenatal/postpartum support programmes
- Social stigma of mental health – childbirth trauma, perceptions and beliefs around maternity/patient rights – patriarchal-power relations, and other socio-cultural issues related to motherhood e.g. mental health difficulties, experiences of single parenthood, etc.

[D] Focus: MECHANISMS AND PROCESSES FOR DATA RECORDING ON MATERNITY CARE

- Coordination and collaborative data collection between different organisations (MoH, HIO, SHSO, Maternity Hospital Quality Assurance Offices)
- Development of a commonly accepted methodology and formulation/selection of a set of quality indicators
- Improving and expanding data recording systems/ mechanisms/procedures, improving data monitoring and feedback systems
- Improving documentation / electronic recording / data system configuration / data access / data reporting
- Collecting quantitative and qualitative data on the (subjective, self-reported) experience of pregnancy/delivery and satisfaction with the care provided, combined with (objective) perinatal indicators (which should be significantly extended both in terms of scope/ range as well as level of analysis).

Box C: The APEASE criteria

The **APEASE** criteria (acronym) refer to six important parameters that are useful to take into account in the context of the evaluation and adoption of measures, actions and interventions as they are essential elements for their successful implementation.

The six criteria, which are described in detail in the table below, are:

Acceptability - Practicability - Effectiveness - Affordability - Spill-over effects - Equity

Criterion	Description
Acceptability	Acceptability refers to the extent to which an action/measure/intervention has the acceptance and is. Thus, deemed appropriate by the relevant stakeholders. The degree of acceptability may vary between stakeholders.
Practicability	An action/measure/intervention is feasible only to the extent that any obstacles and challenges to its implementation can be overcome, if the necessary means and resources are available, as well as the knowledge, skills, experience of those who will be called upon to implement it, etc.
Effectiveness	Effectiveness refers to the expected degree of success of the action/ measure/ intervention in relation to the desired objectives under real-life conditions. Furthermore, if two actions/measures/interventions are assessed as potentially equally effective, then efficiency (cost-effectiveness) may also be taken into account, if it is a matter of resource allocation and/or one only of the two has to be chosen.
Affordability (cost-resources, etc.)	Affordability refers to the extent to which the implementation of the action/ measure/ intervention is within the means of the system in terms of cost and use of resources. That is, the extent to which the authority/ entity implementing the action is able to meet the financial costs (direct and indirect) and to allocate the necessary resources (human and material) to implement the action/measure/intervention.
Spill-over-effects (desired or undesired)	An action/measure/ intervention may have additional unintended consequences beyond the immediate objectives. These may be positive and therefore desirable (e.g. have a positive "ripple effect" on other aspects that were not necessarily the focus of the action). Conversely, these effects may be negative - undesirable (i.e., have unwanted "side effects").
Equity	Equity refers to the extent to which an action /measure /intervention is socially just , and therefore appropriate, accessible, acceptable, effective for <u>all</u> socio-cultural groups and does not create, maintain or widen social inequalities.

D3. Conclusions

The list of proposed actions includes a wide range of suggestions, some very general and wide in scope (and thus, more difficult to implement) and some more specific, falling within the remit or sphere of influence of different actors and/or requiring coordination and cooperation between actors, with varying degrees of feasibility, necessary resources, expected effectiveness, as well as possibly varying or even competing (between actors) degree of priority and/or acceptance by the different actors.

The successful completion of the workshop and the first documentation of the views and suggestions of the organisations, agencies and bodies that participated is only the beginning of the process. Ongoing dialogue, cooperation and commitment of the stakeholders involved is crucial for the further development of tangible recommendations.

It is noted that the implementation of any of the recommendations is not feasible in practice without the development of a relevant **action plan** by the directly responsible and involved stakeholders (activities, objectives, targets, actions, timeframes, etc.). This was not the subject of the present initiative, and is outside the sphere of direct influence of the RESPECT research team. At the same time, and given that the views of the stakeholders as to the importance and feasibility of any proposed actions may differ, it is expected that at the stage of formulating an Action Plan, the requirements for implementing any given action, along with the Entity responsible for implementation would be identified - this often requires the cooperation between actors. The list is extensive; thus, it is also expected that recommendations will be re-evaluated and prioritised e.g. based on set criteria. The APEASE criteria are proposed as a useful guide in the context of the evaluation, selection and prioritisation of proposed actions.

Although the Strategy did not set out to select any of these actions for implementation, which would anyway be outside the sphere of influence of the RESPECT team, it should be noted that some of the proposed actions, and indeed those that are considered most likely to have a higher degree of success, relate to actions that have been already been developed in the context of the wider RESPECT project and could, given available resources, could be scaled-up - such as, for example, the two actions described below.

D3.1. Development of training programmes for Healthcare Providers.

Training programmes to enhance the **communication skills** of perinatal healthcare providers to effectively support Shared-Decision Making are considered a priority. However, to be effective, any training

programme must be integrated, in the best possible way, into the continuing education of health professionals. At present, given the absence of an institutionalised framework for in-service training and professional development, this can be achieved by fostering synergies between relevant stakeholders and academic institutions.

The responsible body is different depending on the target group. For example, it would be the Ministry of Health with regard to residents in Gynaecology-Obstetrics, Neonatology, Paediatrics. For in-service training programmes, the competent bodies are the Clinical Directorates and Training Offices of individual hospitals. Although this route is considered preferable in terms of its feasibility and potential effectiveness, it excludes a large proportion of care providers who do not work at large hospital-maternity units (mainly, those in the public sector, in which training offices operate). Collaboration with Professional Associations-Scientific Societies to integrate such training programmes within conferences, workshops, or other activities is also a promising avenue, at least in terms of its potential to be inclusive and offer the opportunity to more health professionals to participate in training. However, the size of the audience in such cases is a deterrent.

In the framework of RESPECT, all the above mentioned channels were exploited and tested. Three training programmes were implemented to strengthen communication skills through partnerships with the relevant stakeholders. The training workshops were very successful and well attended, even though they were mainly aimed at midwives and a small number of gynaecology-obstetrics residents. A high level of interest was recorded for this training programme, which highlights its need and usefulness, with requests to repeat it in order to give a greater number of health professionals the opportunity participate.

It should, however, be mentioned that at the moment, the provision of educational opportunities is mostly an initiative of the academic institutions themselves, and is offered on the basis of their capacities, often on a voluntary basis. For the sustainability of both the training programme in question and any other educational programmes in general, arrangements need to be made by the competent bodies towards this goal, given the current difficulty for them to support educational programmes without the assistance of academic institutions and other external bodies.

It should also be borne in mind that, although a proposal has recently been approved by the Ministerial Cabinet on the need for continuing education for doctors, at present, this is not institutionalized yet. Currently, the only professional group for which continuing education is a requirement for the purposes of renewal of registration is midwives and nurses. This is one of the main reasons why training or other

programmes offered by academic institutions and other extremal actors always attract a large number of midwives and nurses, but not necessarily other health professionals.

However, it is not the only reason, as at least until recently, there has been resistance from the medical community. It is not clear whether this resistance against introducing continuing education provisions is due to objective challenges (the reason commonly projected), or whether there is a deeper issue, such as, lack of recognition of the benefits and necessity for continuing education or, in this case, the usefulness of clinical communication training. This is something that needs to be explored, because targeted interventions would be needed to address the issue depending on whether it relates primarily to providing more opportunities through measures to resolve practical issues (i.e. the dimension Opportunity in the COM-B behaviour change model) or it relates to more general attitudes, beliefs and perceptions, affecting motivation (i.e. Motivation in COM-B), or both.

Equally important is the adoption of peer-to-peer feedback, evaluation and self-evaluation mechanisms. These were key elements of the RESPECT clinical communication skills training programme. Admittedly, these are elements which, in theory at least, can be more easily adopted in clinical practice, even if they do not form part of a training programme. This can be done through introducing formal mechanisms of supervision and mentoring (for which, effective leadership is required) or even through informal arrangements (which again may run up against a lack of motivation).

Nevertheless, the identification of the educational needs and priorities by the maternity hospitals themselves is a prerequisite both for the design of any education/ training programmes and for the adoption of evaluation and feedback mechanisms.

D3.2. Establishing quality standards and adopting set of quality indicators

Adopting **quality standards and quality indicators** in relation to the provision and experience of Respectful Maternity Care is considered a priority. This is not possible without the prior selection of a set of quality indicators and the development of a data recording system. Many unanswered questions remain as to how this can be achieved. If the recording of quality indicators will be at the national level, then, at present, this can only be done by either the HIO and/or the Health Monitoring Unit, MoH given that long-awaited National Centre for Clinical Documentation and Quality Improvement is not yet operational .

In each case, further questions arise regarding the scope of responsibilities and objectives of the data recording whether it is done by the HIO (e.g. linking reimbursement of services to quality indicators) or by the MoH (e.g. monitoring perinatal health indicators, like currently, for policy and priority-setting purposes, without the authority to take direct action). Moreover, any data recording, even if it is at the initiative of maternity clinics themselves, without any legal or other requirement from a competent authority, requires the operation of Quality Offices in the hospitals. Indeed, if this effort is to be at a national level, then it requires the institutionalisation and adoption of a framework for the operation of Quality Offices in both the public and private sector (within and outside GeSY).

It is noted that the Baby-friendly Hospital Certification is expected to have a positive impact beyond the immediate objective as it will generate interest from maternity hospitals/clinics wishing to be certified as Baby-friendly. Through this first initiative, tangible expertise will be generated in relation to quality assurance and compliance procedures.

Along with the above, which mainly concern the essential administrative mechanisms that need to be introduced and/or expanded, it is necessary to select and categorise the set of quality measures and indicators to be monitored as related to Respectful Maternity Care. It is deemed necessary that this would require the assistance of the academic-research community in order to select the most appropriate set of indicators, depending on the priorities and the desired objectives to be set. The set of quality indicators is expected to include measures from all categories - input/ structural indicators, process/ output indicators, and outcome indicators, which need to include some measures of self-reported experience and satisfaction with the care provided.

Generally speaking, this critical quality assurance parameter has only recently been integrated for the first time in the Cyprus health services system through the beneficiary satisfaction surveys conducted by the HIO. Although it is currently restricted to surveying patient satisfaction with in-patient hospitalization, it has national reach; however, it is not specific to the case of childbirth for the estimation of specific indicators proposed by the WHO. Furthermore, this service satisfaction data collection mechanism is so recent that it is still not clear to what extent and at what level the data are processed, if and how the data is used, and towards what purpose.

As part of the activities of the RESPECT project, a first assessment of the relevance and applicability of the WHO quality indicators was carried out, adopting a structured process with the stakeholders (*section E*). Even though the health system (national) and healthcare services (local level) in Cyprus are currently not

in the position to implement a unified and comprehensive framework based on the WHO Quality Measures, the WHO Quality Standards framework in combination with the mapping exercise carried out in RESPECT can provide a basis for this discussion and the gradual integration of quality evaluation into existing systems for monitoring a small set of indicators based on priorities and objectives to be identified at national and/or maternity unit level.

The main objective of the participatory process that was developed within the RESPECT project was not to select any specific indicators, but to initiate this necessary dialogue with stakeholders around the requirements for the provision of Quality Maternity Care (in the framework of RMC) and the promotion of a shared understanding of the required actions. As a first step, however, it was deemed necessary to formulate a comprehensive "*Checklist for Maternity Clinics*" based on WHO Quality Standards.

For maternity clinics wishing to ensure the quality of the care they provide to mothers and newborns, this "*Checklist*" is a tool to self-evaluate current practices, but primarily it is a structured and easy-to-use educational tool to assist maternity clinics become familiar with the WHO Quality Standards and the necessary documentation that is expected to be available for quality monitoring and improvement purposes. Even though many, if not all, of the proposed indicators may not currently be practically measurable based on existing recording systems, the Checklist can serve as a source of reflection, since quality improvement and assurance always starts with data recording.

E. World Health Organization Quality Standards

The assessment of the cultural relevance of the WHO Quality Standards to the existing socio-organizational context of maternity care services and the wider health system in Cyprus is the product of the participatory process developed in the third workshop of the Advisory Group - as described above.

The **WHO Quality Standards (2016)** constitute a comprehensive and integrated framework for recording, evaluating and monitoring the quality of care provided to mothers and newborns.

The framework contains 31 domains, in the form of Quality Statements that must be in place to assure Quality, organised into 8 Quality Standards. For each of the domains, a set of 6-18 Quality Measures, i.e. criteria for assessing and monitoring quality in relation to each domain is provided

It is a product of consensus of an international expert committee, and according to the WHO, it can serve as a guide for the formulation of national quality standards; though, its cultural adaptation to the socio-organizational context of care services in each country is necessary, which was the main objective of the workshop with the stakeholders.

The full WHO (2016) report "*Standards to improve the quality of care for mothers and newborns in health facilities*" is available online. The Report, in addition to tables of Standards/Statements and set of Quality Measures discusses the importance, rationale as well as the methodology for selecting the measures.

Below, a brief description of the guiding framework, definitions as set out in the report, as well as the WHO recommendation for the cultural adaptation of the Quality Standard to national contexts.

For full details, please refer to the original text (in English). The full publication can be accessed here: <https://www.who.int/publications/i/item/9789241511216>.

E1. Guiding framework

According to the WHO guidance framework, Quality of Care is a combination of three interrelated dimensions - see diagram in the original WHO report.

These dimensions are:

[A] Provision of care

This refers primarily to the medical-clinical aspects of care e.g. clinical protocols, mechanisms and/or procedures - described in Quality Standards 1, 2 & 3.

[B] Experience of care

This refers mainly to the quality of communication, the quality of interaction of care providers-users and other non-clinical aspects of care which determine the experience of women and their families - described in Quality Standards 4, 5 & 6. providers-users

[C] Availability of Resources

on which the other two dimensions largely depend on - are described in Quality Standards 7 & 8.

C1.2. Definitions

Quality of care is defined by the WHO as: *"the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred"* (pp.14)

Regarding Quality Care for Mothers-Newborns, the WHO framework adopts the following definitions

- **"Quality Standard"** is defined as: "a description of what is expected to be provided to achieve high-quality care around the time of childbirth" (pp.18). Each standard has two main components:
 - o **"Quality Statements"**. specific markers of quality, in the form of concise Statements, that must be in place to measurably assure Quality; and
 - o **"Quality Measures"**, criteria for assessing, measuring and monitoring the quality of care as specified in the quality statement.
- **'Quality statements'** are concise statements that outline priority areas for measurably improving quality, mainly adapted from NICE quality standards They define the markers of quality derived from

research evidence and set out the minimum requirements and resources required.

- **"Quality measures"** are the criteria for assessing, measuring and monitoring the quality of care, as specified in the Quality Statement and, thus, provide objective data to determine whether or not the minimum requirements are met and therefore form the basis for determining improvement measures and taking action in the context quality improvement.

The quality indicators (more than 300 in total) are classified into 3 types:

- **Input measures** (e.g. necessary building blocks and available resources), refer to key conditions, provisions and requirements that must be in place to ensure the desired quality of care. In essence, they identify the key building blocks that must be in place to provide the desired and optimal care, such as physical and human resources, equipment and supplies, policies, guidelines, protocols, systems and mechanisms, continuing education and professional development, etc.
- **Output (or process) measures**, which capture existing procedures and other processes in the delivery of care, and essentially relate to measuring the extent to which the desired process of care was delivered as expected. They may include
 - objective indicators as recorded by the data recording system, for example, the percentage of women who gave birth by caesarean section or the percentage of interventions without medical indications, as well as,
 - measures of compliance with procedures (through observation or self-report) addressing both staff-care providers and women-care recipients, for example, whether healthcare staff provided comprehensive information to women or the proportion of women who report that they were cared for with dignity and respect.
- **Outcomes measures**, which refer to the recorded outcomes of provided care and/or the assessment of the impact of the provision and experience of care on the health and well-being of women and newborns, whether these relate to
 - objective performance indicators (for example, the percentage of mothers who exclusively breastfed until discharge), or
 - women's self-reported satisfaction with the services provided (for example, the proportion of women who report they were actively involved in making decisions about their care and their preferences were respected), or even,

- o the results of continuous quality improvement processes at management level (for example, the degree of compliance with the recommendations of previous quality assessment reports, or the percentage of staff reporting job satisfaction).

C1.2. Adaptation of the Quality Standards in a national context

The WHO Quality Standards have been developed through a structured research approach with the participation of an Expert Group from stakeholders with international representation. Therefore, they have an international dimension and applicability, as they are based on research evidence on best practices. The framework brings together the desired standards of care, capacities, services and resources needed to provide optimal care for mothers and newborns within the context of a functional and efficient health system. The quality framework is accompanied by a comprehensive set of indicators which it would be desirable to apply as a coherent whole, rather than selectively.

However, recognising the differences between countries, both in terms of the organisational structure of health care services and in terms of the health care staff within the various national health systems, the WHO recommends that quality measures (*quality assessment criteria*) be adapted to the existing national context, since their suitability and in particular their applicability and/or measurability may vary considerably. The aim would be to adapt or even select a number of indicators to ensure that they can be effectively applied and achieve the desired results for mothers and newborns.

Especially in countries without developed quality control systems and mechanisms, the standards and proposed quality measures may provide a useful reference framework for setting priorities and preparing national standards and related indicators for assessing, monitoring and improving the quality of care provided to mothers and newborns. Admittedly, in some healthcare systems, many of the proposed quality indicators, however relevant and appropriate, are not recorded due to the absence of systems and mechanisms for regular recording quality either at the national level or at the level of maternity units.

A more characteristic example, in the case of Cyprus, is the absence of institutionalised mechanisms for regular service-user satisfaction surveys, both at national and unit level. Apart from isolated data from academic institutions collected within a research context, as in the case of the RESPECT project, currently there is no system of recording, either on a systematic or opportunistic basis, the experience of care provided.

Experience of care forms the basis for many of the WHO's proposed quality measures;; thus, by default, many of the proposed indicators cannot be evaluated in Cyprus. This gap has already been identified in the process of developing the National Strategy for the promotion of normal childbirth and prevention of prematurity and the need to take corrective measures in this direction was appropriately noted in the National Committee's recommendations (Ministry of Health Cyprus, 2024).³⁵

Of course, the problem is wider and not restricted to maternity care services, since self-reported measures from the service-users (patient-reported outcomes and experience – PRO/PRE) are not an integral part of the evaluation of the quality of care provided in Cyprus, even in health care facilities that have comparatively more developed quality recording systems.

³⁵ Available online at: <https://www.gov.cy/moh/documents/ethniki-stratigiki-gia-tin-proothisi-toy-fysiologikoy-toketoy-kai-ti-meiosi-tis-proorotitas-2024/>.

E2. Description of the stakeholder consultation process

The RESPECT project focuses on the experience of maternity care based on the WHO framework for Respectful Maternity Care. Therefore, the evaluation of Quality Standards and related measures focused in the first instance primarily to the dimension of “Experience of Care” i.e. Quality Standards 4, 5 and 6.

Furthermore, the selection largely focused on quality measures which relate to basic requirements and conditions e.g. structures, infrastructure, skills, etc. (*input indicators*), and less so on *process* and *outcome measures* with some exceptions.

However, Provision and Experience of Care are interrelated dimensions, and both are dependent on the availability of Resources (physical, material, technical and human resources).

Therefore, it was deemed necessary to include some quality measures from other dimensions, while considering the degree of relevance to the principles and requirements of Respectful Maternity Care (RMC) and/or the research findings of the RESPECT and IMAGiNE studies on the experience of maternity care in Cyprus.

The procedure followed is described in the steps below:

- The full WHO report (2016), which describes the framework, quality standards, statements and measures for maternal-newborn care, was sent to all workshop participants in advance. This is available online at the following link: <https://www.who.int/publications/i/item/9789241511216>.
- Also, a first selection of quality measures was forwarded in tabular form in a Word file, prepared by the RESPECT team. This was accompanied by a brief description of key elements of the WHO Quality Standard for Maternity Care - *more information in Box D*.
 - It should be noted that not all WHO's proposed quality measures were considered. Consistent with the project's objectives, quality measures that were more closely related to Respectful Maternity Care concepts were selected, rather than clinical aspects of care provision; these were primarily, but not exclusively, quality measures under the Experience of Care domain as defined by the WHO.
 - In addition, the selected set of quality measures included several input measures, some output/process measures, and some but fewer outcome measures. The first selection was made by the RESPECT team.

- Finally, it is noted that although the original English text was translated into Greek by the RESPECT team for the purpose of facilitating the process, it was also considered important to quote the original English text as it appears in the WHO report without any modifications alongside the Greek translation.
- Instructions were provided to participants to review the material before the workshop and reflect on the cultural transferability of the quality measures to the Cypriot context, noting their comments - *more information in Box E*.
- During the workshop, a discussion was developed with the participants around the suitability and applicability of the quality measures, and the views of the participants were recorded, mainly regarding current practices and prevailing conditions and the extent to which these support or would support the implementation of these quality standards and the assessment of the proposed measures.
 - It was stated that the aim was neither to select a specific set of measures and/or to prioritise specific issues and aspects of care, nor to attempt to quantify the potential divergence of current practices from the proposed quality framework.
 - The aim was for the framework to serve as a basis for a fruitful dialogue with stakeholders on quality of care, and to take stock of the current situation, to identify the reasons why some of the quality measures (or the requirements underpinning them) are not applicable, to identify the challenges, with an emphasis on the necessary quality assurance mechanism that need to be in place,
 - whether these relate to structural elements (such as, for example, policies, protocols, procedures, etc.), or
 - to mechanisms for recording and processing data, regular monitoring and taking measures and actions in the context of an integrated quality improvement system.
- At the end of the process, and due to lack of time, a complete inventory of the identified current challenges was formulated based on the discussion and further processing by the RESPECT team and this was sent to the stakeholders for additional comments and suggestions, which were subsequently incorporated.

The output from the above process with reference to the current divergence and/or identified challenges in the socio-organizational context of Cyprus are recorded in detail at the level of each proposed quality measure in *Appendix H*.

Box D: Brief description of the WHO Quality Standards for Maternity Care

The WHO Quality Standards Framework (2016) includes 31 Quality Statements, organised into 8 Quality Standards. For each Quality Statement, a set of 6-18 Quality measures is provided. Quality Measures or indicators are markers or criteria for assessing, recording and monitoring quality.

According to the WHO framework, Quality of Care is a combination of 3 interrelated dimensions:

- [A] Provision of care, which refers primarily to the medical-clinical aspects of care e.g. clinical protocols, mechanisms and/or procedures - described in Quality Standards 1, 2 & 3.
- [B] Experience of care which refers mainly to the quality of communication, service provider-user interaction and other non-clinical aspects of care - described in Quality Standards 4, 5 & 6.
- [C] Availability of Resources (physical, technical, material and human) on which the other two dimensions depend on - described in Quality Standards 7 & 8.

The emphasis within the RESPECT project is on the experience of maternity care. As such, Quality Standards and related Quality measures related to the 'Experience of Care' dimensions (i.e. WHO Quality Standards 4, 5 and 6) were primarily considered. The selection of quality measures by the RESPECT team also largely focused on aspects and elements related to key requirements and conditions e.g. structures, infrastructure, staff skills, etc. (*input quality measures*). Of course, it was considered important to also include some *output/process indicators*, as well as *outcome* indicators, but to a lesser extent.

Furthermore, Provision of Care and Experience of Care are interrelated dimensions, and are both dependent on the availability of Resources. Therefore, it was also deemed necessary to include some quality measures from domains, other than Experience of Care, always based on the degree of relevance to the principles and requirements of Respectful Maternity Care (RMC) and/or the research findings of the RESPECT and IMAGiNE studies recording the experiences of women in Cyprus from maternity care, guided by the aspects of care that emerged as potentially more problematic.

Box E: Instructions for reviewing and assessing the transferability of WHO quality measures

Instructions for use

- Please study the entries in the Tables in the attached Word file and, in each case, consider the relevance and applicability of the quality standards/quality measures at national level.
 - Some of the entries refer to markers (statements) for quality assurance (*quoted texts from the original WHO Quality Standard report*), which admittedly should have international applicability since they are based on evidence-based and best practices.
 - Entries underneath the statements relate to proposed quality measures (*i.e. quality assessment criteria and indicators to assess, measure and monitor quality*). It is expected that the process of cultural adaptation should focus on these quality measures (rather than standards and statements), since their suitability and applicability may vary considerably depending on the national context, and, indeed, their actual measurability, even if they are deemed suitable and applicable.
- The tables give the possibility to assess the suitability and applicability on the basis of a simple approach: drop - adapt - adopt , as follows:
 - 1 = Not suitable/applicable (drop),
 - 2= Some modifications are required for suitability/applicability (adapt), or
 - 3= Suitable/Applicable - no modifications required (adopt).
- Therefore, you are not expected to comment on all entries. Only where you identify a need for modifications, minor or major, to ensure relevance (suitability and applicability) in the Cypriot context. Where you consider that a quality measure can be adopted as exactly formulated (by WHO), no comments are needed.
- Space is provided in the table for comments and suggestions (*column on the right*).
 - In cases where you identify a discrepancy of suitability and applicability for Cyprus, please provide a justification,
 - In cases where you consider that modifications are required, please clarify the specific points that need attention and propose an alternative wording.

E3. Main findings

The overall **conclusion** of the RESPECT project is that most of the indicators are relevant (suitable) and would theoretically be appropriate (applicable) in the context of monitoring and improving the quality of care provided. These indicators would be applicable either without modifications (provided, however, that there were developed mechanisms for recording and/or utilising the data) or, at least after minor necessary adjustments primarily to align with the specific characteristics of the Cypriot healthcare system.

However, the vast majority, if not all, of the proposed indicators are not recorded, or are not recorded systematically. At the national level, no relevant data exist or, if they do exist, they are not reported publicly, while it is currently not clear whether any maternity clinics are implementing on their own initiative, or could implement on their own initiative through their existing recording system, the assessment of at least some, and certainly not all, of the proposed indicators.

In fact, this would not apply to any of the measures relating to women's self-reported experience of the care they received, which not only highlights technical shortcomings, but raises questions about the broader philosophy of improving the quality of care and the weight given currently to the beneficiaries' own experience of the care provided. Service-user satisfaction surveys from maternity care are not currently supported by the existing data recording systems and the only available data originate from research studies, for example the RESPECT project study.

More generally, only recently this critical quality assurance parameter was introduced and incorporated into the health services system of Cyprus, through the satisfaction survey conducted by the HIO, which, although it concerns satisfaction with in-patient hospitalization, it is not specific to the case of childbirth, in order to allow the estimation of some of the self-reported experience measures proposed by the WHO. This satisfaction data collection mechanism is so recent that it is still not clear to what extent and at what level the data are processed, how and if the data are used and towards what purpose, by whom and how.

At the same time, while there are plans to expand the recording of user satisfaction to outpatient health services (which could cover women's interaction with the obstetrician- gynaecologist, community midwife and other healthcare providers during pregnancy), this has not yet been initiated. The need to institutionalise mechanisms "to assess satisfaction with health services through implementation of a system for capturing treatment outcomes as recorded by patients" has also been identified and included

in the recommendation of the recently published Strategy for the Promotion of Normal Childbirth and Prevention of Prematurity. In addition, the Strategy recognises that an in-depth understanding of the experience of women and their families of maternity care is needed through, to quote,

"the adoption of mixed research methods to identify and quantify outcomes (quantitative methods) and to enrich our understanding of the phenomena (qualitative methods)", as was indeed the case of the protocol applied in the RESPECT study.

The availability of data seems to be lacking even for issues where it would be expected to have better data recording processes, due to the fact that they have been identified as priority issues, such as for example the high rate of caesarean sections. Currently, the Health Monitoring Unit does not record data on caesarean sections based on the Robson classification system, and it is unclear whether some maternity clinics are doing so on their own initiative.

It should be mentioned, of course, that the need to *"implement and expand the electronic recording of perinatal health data that is collected and to configure the system to allow automatic categorisation of caesarean sections according to the Robson classification"*, to quote, has been included in the recommendations of the National Committee for the Promotion of Natural Childbirth and, therefore, an action plan is expected to be developed for this issue.

More generally, at the level of maternity units, it remains unclear whether any such data recording system goes or can go beyond the formal requirements set by HIO and the Health Monitoring Unit for their own purposes, and whether is or could be aligned with WHO recommendations, i.e. which or how many of the quality measures are or could be recorded with relative ease, and if and where they are recorded, whether and how these are being used in the context of a broader policy for quality assurance in maternity care.

Of course, it should be noted that during the workshop, there was a pervasive impression that the usual practices of maternity clinics did not deviate from the WHO Quality Standards framework; however, this could not be substantiated on the basis of concrete evidence and data.

It should be mentioned that some of the WHO's proposed quality measures could not be implemented without adaptation, in some cases significant modifications, due to conflict with the existing framework of health services. A typical, although not the only, example of significant inconsistency of the organisational framework, as it is currently in place in Cyprus, with WHO's quality requirements concerns the issues of continuing education and professional development activities of maternity care staff.

Based on the WHO framework, professional development relates to a range of issues, including issues directly relevant to Respectful Maternity Care and specific aspects of care, whether these relate to clinical practice or relate to attitudes, behaviours, skills and competences, including the professional and ethical responsibility of ensuring the rights of women, newborns and families.

This is due mainly to the absence of mechanisms for regular and systematic in-service training and/or systems in place for supervision and mentoring, as required by the Quality Standards framework. In addition to the fact that continuing education and professional development is not institutionalised for all health professionals, even in those professional groups where continuing education at regular intervals is a prerequisite for re-registration (e.g. nurses, midwives), training opportunities are limited, usually offered by external providers (e.g. academic institutions) and the topics are not specifically selected on the basis of enhancing Quality Standards or even on the basis of a needs assessment exercise.

It should also be mentioned that the very concept of “in-service training” could not be universally applied in Cyprus, except perhaps in larger hospitals and maternity clinics with a significant number of staff, due to the decentralised structure of healthcare services (e.g. small maternity clinics, clinics working with external partners, but also absence of a framework for inter-professional cooperation, etc.).

E4. Conclusions

As part of the RESPECT project activities, a first assessment of the suitability and applicability of a set of quality measures was undertaken in a structured process with national stakeholders. Even with the inability of the health system and healthcare services in Cyprus to currently implement a uniform and comprehensive framework based on the WHO Quality Standards, the WHO framework in combination with the first mapping exercise carried out in the RESPECT project, can form the basis for further discussion and the gradual integration of quality into existing assessment systems and programmes at national level or at the level of maternity units.

In the first instance, this would require an assessment of the measurability of the proposed quality measures. If it is found that some (or even most, as perhaps it is true in the case of Cyprus) are not currently measurable based on existing recording systems, this would, in a second phase, require **action** to:

- (a) **set priorities and select a set of indicators** (e.g. selection of the most appropriate and easily measurable indicators in a national context in the first phase) and the intention to expand the recording to more indicators over time,
- (b) the development of necessary **mechanisms for recording the selected indicators at one or more levels** (at central level by the Health Insurance Organisation -HIO, and/or by the State Health Services Organisation in the case of public-sector maternity hospitals, and/or at local level by specific maternity hospitals /clinics - something that in theory could already be done on their own initiative since it could be solely views as a decision of the unit's management and does not require any legal or regulatory act), and
- (c) the **design and definition of an action plan for monitoring and evaluating progress** in relation to the above at national/central level and/or at the level of maternity units wishing to develop a quality improvement programme.

The participatory process developed within the RESPECT project had as its main objective the development of a dialogue with stakeholders around the requirements for the provision of Quality (Respectful) Maternity Care and the cultivation of a shared understanding of the actions required to move towards this direction in order to assess, record and monitor, rather than assume, this Quality.

Due to the fact that the "starting point" in terms of quality assurance provisions may vary considerably between maternity clinics, the overall conclusion was that a structured process of assessing the current situation and identifying priorities was necessary. Awareness raising is the first step to quality improvement, and recording existing practices in a systematic way is the first step as it allows for informed decisions to be made.

As the most widely known saying related to quality improvement goes, "***what cannot be measured cannot be improved***".

Therefore, the tangible deliverable of the above process was the preparation of a comprehensive "*Checklist for Maternity Clinics*" based on WHO Quality Standards.

E4.1. Checklist for Maternity Clinics

The '*checklist*', which accompanies the National Strategy, includes four sections, each with a series of questions that a maternity clinic can review and answer to assess its own 'starting point' in terms of quality assurance processes.

With the exception of some questions (data exercises) concerning the quantitative assessment of indicators, provided that the data are available and sufficiently documented, answers to the remaining generally follow the traffic-light system

- in green, where the indicated arrangements exist and are in force,
- in orange, where there are procedures under way to adopt these arrangements or to improve existing procedures and processes, and
- in red, when no such arrangements exist at the moment, and need to be developed.

The sections covered by the **Checklist** are:

- **Module A: "Clinical practices"**

In this section, a maternity clinic is required to record data on the frequency of specific practices and interventions for women (e.g. caesarean sections, episiotomies, etc.) or newborns (e.g. skin-to-skin, delayed cord clamping, exclusive breastfeeding, room-in) and, in general, to document, through the data recording system, other indicators of the extent to which evidence-based practices are implemented and provide evidence that unnecessary or harmful interventions are avoided.

Documentation implies the systematic collection and recording of statistical data for the assessment of the proposed indicators, provided that the data are available, adequately documented, and in an easily processable format.

- **Module B: Structural and organisational readiness of the obstetric clinic**

This section assesses the policies, protocols, systems and quality control mechanisms that ensure the provision of Respectful Maternity Care (RMC), including the wider quality assurance processes, which include mechanisms for filing complaints and providing redress in the case of violation of rights and other building blocks and elements that support and ensure the delivery of high-quality care.

- **Section C: Training and continuous professional development of staff**

This section contains issues related to the training of healthcare staff both in terms of the necessary structural characteristics that need to be in place (e.g. training opportunities, supervision and mentoring, reward system etc) as well as in terms of training needs, which include both clinical topics around appropriate and inappropriate clinical practices, as well as the necessary skills for effective communication and support of women's active participation in decision-making, the correct procedure for obtaining informed consent, and more generally in ensuring women's rights.

- **Section D: Women's self-reported experience of care**

This section is based on the proposed outcome measures from the WHO Quality Standards Framework, and examines whether the maternity clinic collects and evaluates (e.g. through regular satisfaction surveys or other methods) information on women's experiences of maternity care and other self-reported outcomes (Patient Reported Experiences/Patient Reported Outcomes)

In case, such data are not currently available, the maternity clinic is asked to consider how to develop mechanisms to capture women's self-reported experience, proposing specific indicators to prioritise.

F. Recommendations and next steps

To effectively implement the Respectful Maternity Care Strategy, further evaluation and elaboration of the findings and recommendations are necessary to develop a comprehensive Action Plan through a structured approach involving all stakeholders, as applied in the process of developing the Strategy.

Below are just some of the areas that have emerged as **priorities** for discussion categorised by thematic area. For some of these areas, significant developments are already being recorded, some of which are indicated in brackets, although it is still too early to assess the progress towards successful completion, implementation, enforcement and/or effectiveness of these actions.

F1. Policy and clinical practice

- Development, adaptation and/or adoption of guidelines and clinical protocols and other mechanisms to ensure the implementation of evidence-based clinical practice (although an isolated action, the adaptation/ contextualisation process of the NICE guidance on caesarean sections is underway)
- Development and strengthening of quality assurance systems and mechanisms, including systems for recording and monitoring quality indicators (National Centre for Clinical Documentation, Quality Offices, University Hospitals).
- Establishment and regulation of systems for the submission and examination of complaints and strengthening of existing accountability mechanisms (Rights Officers, Patient Advocate, OSAK Observatory).
- Legal framework for the rights of patients – including health care beneficiaries and professional conduct regulations.

F2. Education and Professional Development

- Strengthening and regulating continuing education and professional development for health professionals, and providing educational/ training opportunities through in-service training and/or synergies with academic institutions in the context of professional skills-building training, as well as adopting mechanisms for supervision, mentoring, evaluation and feedback (Training Offices, partnerships with academic institutions, legislation on continuing education for doctors, etc.).

- Strengthening clinical curricula (Medicine, Nursing, Midwifery) by incorporating principles and skills of clinical communication, shared decision-making and integration of RMC principles, including Professional Ethics on protection and advocacy for patients' rights, as well as integration, where not applicable and reinforcement, where applicable, of "experts by experience" in the teaching/learning process.

F3. Research and Data Recording

- Strengthening systems, mechanisms and procedures for recording and monitoring data and defining quality measures and indicators in relation to Respectful Maternity Care (MoH Health Monitoring Unit data collection, HIO recording system, establishment of Hospital Quality Assurance Offices, first-time introduction of user satisfaction surveys, on-going partnerships with academic institutions)
- Promoting the utilization of findings from research studies conducted by academic institutions and further supporting and developing research on Maternity Care and the quality of care, setting research priorities in direct collaboration with Healthcare Services, adopting new methodological approaches, including participatory action research and Implementation Research, and fostering a culture of research and quality improvement within healthcare services (Research and Innovation Office, Hospital Research Offices, existing collaborations with academic-research institutions, University Clinics).

F4. Informing women/families and raising public awareness

- Awareness raising campaigns on maternity care rights, and patients' rights in general, highlighting the direct link and placing the issue in its broader context of patients' rights (OSAK, Patient Advocate)
- Collaborations with civil society, developing advocacy and undertaking collaborative initiatives (health services - academic institutions - NGOs) for the empowerment of pregnant women, in educational, research and other contexts (research projects, participation of patient representatives in decision-making bodies)
- Developing educational and other resources and/or making more effective use of existing resources from research programmes (RESPECT deliverables).

F5. Obstacles and threats

Through this initiative, some anticipated obstacles and threats have emerged, which are expected to hinder or, at least, not facilitate substantial progress in the protection, support and promotion of Respectful Maternity Care, which are worth mentioning briefly:

- Generalised resistance to change from usual practices and to adopting new practices and approaches that support even partial implementation of the provisions and conditions of the RMC, considering them unnecessary or even subversive,
- Reluctance to recognise gaps, weaknesses and system deficiencies; absence of a broader culture and quality improvement mindset, as well as lack of the basic building blocks and components needed to record, monitor, evaluate and take action for quality improvement, and resistance to transparency and accountability mechanisms,
- Failure to cultivate a common understanding of the underlying issues, focusing solely and excessively on issues of "terminology", preventing constructive dialogue, with negative and emotionally charged reactions against certain terms, whether these are terms that are indeed not widely accepted by the clinical professional community, such as "*obstetric violence*", or they are terms that are widely used by international bodies and organisations, such as "*disrespect*", "*disrespectful*", "*abuse*", "*mistreatment*", "*maltreatment*" "*medicalisation of childbirth*", "*violation of rights*" and many others that make up the framework of Respectful Maternity Care.
- Institutional and systemic barriers: which compose a generally difficult context for action and implementation of any measures and reforms, and include: specificities and particularities in the architecture of the healthcare system, absence of institutionalised quality monitoring mechanisms, absence or non-universal acceptance of policies, guidelines and protocols and/or inconsistent implementation, where these exist, multiple bureaucratic obstacles, limited resources or inefficient allocation and utilisation of these resources, staff shortages, burnout and frustration due to lack of motivation for improvement, reward and opportunities for professional development, power imbalance with no clear framework for inter-professional cooperation and role responsibilities and boundaries, multiple objective challenges in the face of an ineffective or weakened leadership in the relevant institutions and bodies, lack of political will, but also competing priorities and issues of conflict of interest.

In lieu of an epilogue

The RESPECT project on *Respectful Maternity Care* set as its main objective the formulation, promotion and implementation of strategies that promote the Quality Standards of the WHO (WHO, 2016) and other international organizations for Respectful Maternity Care (RMC) and improve the experience and outcomes for mothers, children and families in Cyprus.

The project is coordinated by the Cyprus University of Technology (Department of Nursing, School of Health Sciences) and co-funded by the European Union under the Citizens, Equality, Rights, and Values programme (CERV-2022-DAPHNE) .

To achieve these objectives, a key prerequisite is the strengthening of communication channels between all stakeholders, the cultivation of synergies and the development of alliances based on a common understanding of concepts, needs and possible actions within a common framework.

Through interdisciplinary and intersectoral collaboration of maternal-child healthcare providers, academics-researchers, educators, health policy makers, service users, civil society and other actors and organisations directly or indirectly involved or with a stake in the Provision and/or Experience of maternity care, the RESPECT project has developed new participatory approaches, introduced novel ideas and best practices of collaborative and inclusive collaboration, based on the principles of Participatory Action Research.

By cultivating an inclusive environment, respectful of diverse perspectives, opinions and ideas, the rich material gathered can form the basis for further elaboration and for the formulation of an **Action Plan**, by prioritizing those actions that are expected to have the greatest degree of success in order to maximize the impact on improving and ensuring the quality of Maternity Care and the sustainability of the results.

Bibliography

Afulani PA, Altman MR, Castillo E, Bernal N, Jones L, Camara T, Carrasco Z, Williams S, Sudhinaraset M, Kuppermann M. Adaptation of the person-centered maternity care scale in the United States: prioritizing the experiences of Black women and birthing people. *Women's Health Issues*. 2022; 32(4):352-61.

Ayres-de-Campos D, Louwen F, Vivilaki V, Benedetto C, Modi N, Wielgos M, Tudose ME, Timonen S, Reyns M, Yli B, Stenback P. European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA). Joint position statement: Substandard and disrespectful care in labour-because words matter. *European Journal of Obstetrics & Gynecology and Reproductive Biology* . 2024;296:205-7.

Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med*. 2015; 12(6): 1–32.

Brunello S, Gay-Berthomieu M, Smiles B, Bardho E, Schantz C, Rozee V. *Obstetric and gynaecological violence in the EU-Prevalence, legal frameworks and educational guidelines for prevention and elimination*. European Parliamentary Research Service, requested by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM), 2024.

Economou M, Kolokotroni O, Paphiti-Demetriou I, Kouta C, Lambrinou E, Hadjigeorgiou E, Hadjiona V, Tryfonos F, Philippou E, Middleton N. Prevalence of breast-feeding and exclusive breast-feeding at 48 h after birth and up to the sixth month in Cyprus: the BrEaST start in life project. *Public Health Nutrition*. 2018; 21(5): 967-80.

Economou M, Kolokotroni O, Paphiti-Demetriou I, Kouta C, Lambrinou E, Hadjigeorgiou E, Hadjiona V, Middleton N. The association of breastfeeding self-efficacy with breastfeeding duration and exclusivity: longitudinal assessment of the predictive validity of the Greek version of the BSES-SF tool. *BMC Pregnancy and Childbirth* . 2021;21(1):421.

Economou M, Kolokotroni O, Paphiti-Demetriou I, Kouta C, Lambrinou E, Hadjigeorgiou E, Hadjiona V, Middleton N. Associations between breastfeeding and self-reported experience of the "10 Steps to Successful Breastfeeding": a cross-sectional and longitudinal study of maternity clinic practices in Cyprus. *Frontiers in Global Women's Health* 2024;5:1420670.

European Commission: Directorate-General for Justice and Consumers and Quattrocchi, P., *Obstetric violence in the European Union - Situational analysis and policy recommendations*, Publications Office of the European Union, 2024.

FIGO (2021). Ethical Framework for Respectful Maternity Care During Pregnancy and Childbirth. FIGO Statement. International Federation of Gynecology and Obstetrics. Available online: <https://www.figo.org/resources/figo-statements/ethical-framework-respectful-maternity-care-during-pregnancy-and-childbirth> (last accessed: Jan 2025)

Freedman LP, Ramsey K, Abuya T, Bellows B, Ndwigwa C, Warren CE, et al. Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. *Bull World Health Organ*. 2014; 92: 915–7.

Hadjigeorgiou E, Katsie C, Papadopoulou M, Christofi MD, Christoforou A. Women's experiences of VBAC in Cyprus: a qualitative study. *BMC Pregnancy and Childbirth* 2021;21:1-2.

Hadjigeorgiou E, Vogazianos P, Christofi MD, Motrico E, Domínguez-Salas S, Mesquita AR, Christoforou A. Experiences, concerns, and needs of pregnant and postpartum women during the Covid-19 pandemic in Cyprus: a cross-sectional study. *BMC Pregnancy and Childbirth* 2022;22(1):685.

Hadjigeorgiou E, Andreaki M, Koliandri I, Spyridou A, Balaam MC, Christoforou A. Exploring mothers' experiences of perinatal care in Cyprus: Babies Born Better survey. *BMC Pregnancy and Childbirth* 2023 ; 23(1):487.

Hadjigeorgiou E, Coxon K. In Cyprus, 'midwifery is dying...'. A qualitative exploration of midwives' perceptions of their role as advocates for normal childbirth. *Midwifery* . 2014;30(9):983-90.

Hadjiona V, Middleton N, Kouta C, Hadjigeorgiou E, Lambrinou E, Kolokotroni O. Cyprus mothers' breastfeeding self-efficacy and their perceptions about the implementation of the '10 steps' in the first 48 hours after birth. *Midwifery* 2016;36:43-52.

Koliandri I, Hadjigeorgiou E, Karanikola M, Kolokotroni O, Nicolaou C, Christodoulides V, Papadopoulou M, Kouta C, Middleton N. Informational support and information-seeking during transition to parenthood: Baby Buddy Forward's focus groups with pregnant women and new mothers in Cyprus. *European Journal of Midwifery* 2023;7:29.

Mesquita A, Costa R, Bina R, Cadarso-Suárez C, Gude F, Díaz-Louzao C, Dikmen-Yildiz P, Osorio A, Mateus V, Domínguez-Salas S, Voursoura E. A cross-country study on the impact of governmental responses to

the COVID-19 pandemic on perinatal mental health. *Scientific reports* . 2023;13(1):2805.

Middleton N, Hadjigeorgiou E, Kolokotroni O, Christodoulides V, Koliandri I, Nicolaou C, Papadopoulou M, Kouta C, Karanikola M, Baum A, Baby Buddy Forward team. Identifying barriers to the educational role of midwives in Cyprus and defining determinants in behaviour terms using the Behaviour Change Wheel: a mixed-method formative study. *BMC Health Services Research* 2022;22(1):1233.

Michie S, Atkins L, West R. The behaviour change wheel. a guide to designing interventions. 1st ed. Great Britain: Silverback Publishing; 2014.

Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns

<https://whiteribbonalliance.org/movements/respect-campaign/> [accessed: 19/07/2023]

Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Nogueira Pileggi V, Madeira S, Leathersich S, Tunçalp Ö, Oladapo OT, Souza JP. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2018; 125(8):932-42.

White Ribbon Alliance. respectful maternity care. universal rights of mothers and newborns. available online: <https://whiteribbonalliance.org/resources/rmc-charter/> (last accessed: Jan 2025)

World Health Organization, The prevention and elimination of disrespect and abuse during facility-based childbirth. WHO, 2014. available at:

<https://www.who.int/publications-detail-redirect/WHO-RHR-14.23> (last accessed 7/3/2025).

World Health Organization. standards for improving quality of maternal and newborn care in healthcare facilities. WHO, 2016. available online: <https://www.who.int/publications/i/item/9789241511216> (last accessed: Jan 2025)

World Health Organization. intrapartum care for a positive childbirth experience. WHO Recommendations. WHO, 2018. available online:

<https://www.who.int/publications/i/item/9789241550215> (last accessed: Jan 2025)

Republic of Cyprus. YESY - General Health System of Cyprus. 2019. Available at:

https://www.gesy.org.cy/sites/Sites?d=Desktop&locale=el_GR&lookuphost=/el-gr/&lookuppage=home.

Papairakleidiou, H., Mitchell, N. and Hadjigeorgiou, E. *Exploring Cypriot mothers' experiences of early cessation of breastfeeding*. Cyprus University of Technology ., 2020

Stylianidis, K. and Raftopoulos, V. *Evaluation of lechonas' satisfaction with the cooperation with the gynecologist and midwife in Cyprus. Pilot study. Archives of Hellenic Medicine* 2014; 31(3) 327-335:
Available at: www.mednet.gr/archives.

Hadjigeorgiou, E. *et al.* Investigation of Cypriot Women's Views on the Right to Choose the Place of Childbirth. A Phenomenological Study. *Nursing* ? 201251(1): 104–114.

 RESPECT

Co-funded by the European Union

Funded by the European Union.

Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union or the European Commission – EU [granting authority]. Neither the European Union nor the granting authority can be held responsible for them. **Project: 101096681 - RESPECT - CERV-2022-DAPHNE**

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