Respectful Maternity Care and Human Resources for Health

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This brief is intended for the Respectful Maternity Care (RMC) and the Human Resources for Health (HRH) practitioner and research communities. Though these two fields are natural allies, there are few formal efforts to integrate the two program areas. The brief provides background on each field and suggests how these two communities can work together to advance human resources for respectful maternity care. We suggest ways that RMC practitioners could incorporate principles of RMC into existing human resource structures and vice versa.

Respectful Maternity Care

A growing body of evidence reveals that women worldwide are subjected to disrespectful and abusive treatment at the hands of maternity care providers. In addition to causing psychological distress, this treatment can discourage women from accessing facilities for maternity care, and may ultimately result in avoidable death and disability (Ogangah et al., 2007; Bowser & Hill, 2010; Freedman & Kruk, 2014; Abuya et al., 2015; Bohren et al., 2015). Disrespect and abuse (D&A)—also referred to as mistreatment, obstetric violence, and dehumanized care—can manifest in many forms, including physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between women and providers; and health systems constraints. Health system constraints include lack of resources, such as infrastructure to ensure privacy, supplies to ensure standards of care are met, and personnel to ensure that providers are not overly stressed and can effectively attend to the needs of each woman and baby (Bohren et al., 2015).

In light of this evidence, health and human rights organizations have deemed D&A during maternity care a violation of women's human rights. When defining D&A, it is important to note that the absence of D&A does not equal respect; respectful, quality, woman-centered care requires conscious effort and should be prioritized by care providers, administrators, and policy-makers (Freedman & Kruk, 2014). Thus, campaigners have called for respectful care and protection of all childbearing women, especially the marginalized and vulnerable, such as adolescents, minorities, and women with disabilities (Amnesty International, 2010; White Ribbon Alliance, 2011; World Health Organization, 2015). Although there is no consensus on what constitutes respectful care, the emerging respectful maternity care (RMC) movement generally advocates for a patient-centered care approach based on respect for women's basic human rights and clinical evidence. The RMC Charter, a normative document that was developed collaboratively by researchers, clinicians, program implementers, and advocates, outlines a rights-based approach to many aspects of care. The Charter is based on universally recognized international instruments to which many countries are signatories, such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social, and Cultural Rights; and the Convention on the Elimination of all Forms of Discrimination against Women.

The seven rights of childbearing women it describes are the rights to:

- freedom from harm and ill treatment;
- information, informed consent, and refusal, and respect for choices and preferences, including the right to a companion of choice wherever possible;
- confidentiality and privacy;
- dignity and respect;
- equality, freedom from discrimination, and equitable care;
- timely healthcare and the highest attainable level of health;

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- and liberty, autonomy, self-determination, and freedom from coercion (White Ribbon Alliance, 2011).

Efforts to flesh out the content of these rights have identified the importance of services such as continuous care during labor and birth, freedom of movement during labor, freedom to eat and drink during labor, and non-separation of mother and newborn (USAID MCHIP, n.d.; Positive Birth Movement, n.d.). The content of RMC will vary in different contexts, and more research is needed to define and promote effective RMC behaviors.

Research has shown that the issue of D&A in facilities is complex, as it is shaped by a multiplicity of factors and it occurs at various levels of the health care system (Bowser & Hill, 2010; Freedman & Kruk, 2014; Bohren et al., 2015). Thus, D&A can best be reduced through multi-pronged approaches that address different levels of the health system and that engage allies from the government to address the larger health system factors that contribute to D&A, including human resources for health challenges (Abuya et al., 2015; Bohren et al., 2017).

Human Resources for Health

Gaps in human resources for health (HRH)—including health worker shortages, maldistribution of health workers, poor governance of HRH, and otherwise negative or stressful working conditions—limit the capacity of facilities and health workers to provide RMC (Bohren et al., 2015; Vogel et al., 2015; Chen et al., 2004; Center for Reproductive Rights, 2008; Bowser & Hill, 2010). The impacts of such health system constraints on the quality of care health care workers provide are well documented in global reports including the World Health Organization et al.'s **Midwives' Voices, Midwives' Realities** report (2016) and the Center for Reproductive Rights' **Broken Promises: Human Rights, Accountability and Maternal Death in Nigeria** report (2008), as well as the scholarly literature (Bowser & Hill, 2010; Mselle et al., 2013; Jewkes & Penn-Kekana, 2015).

D&A is generally not perpetrated by "a few bad apples," though there are of course examples of individual providers engaging in particularly abusive behavior that their fellow providers would condemn. D&A can most fairly be described as a widespread phenomenon deeply rooted in overtaxed health systems (Freedman & Kruk, 2014). As described by Freedman and Kruk (2014):

> D&A represents a breakdown in accountability of the health system not only to its users but also to the women and men it employs as service providers. Themselves subject to degrading and disrespectful working conditions, providers' professional ideals often succumb to the pressure of emotional and physical survival strategies—a midwife providing compassionate care at one moment might be overwhelmed by the stress of unmeetable demands in the next and lash out at the women she attends. (pg. e43)

When the demands of the job begin to overwhelm the perceived rewards, motivation issues can arise and manifest in disrespect toward patients, tardiness, absenteeism, and delays and shortcuts in care (Mathauer & Imhoff, 2006). In Tanzania, for example, health workers have a right to a promotion and salary increase every three years; however, there is widespread dissatisfaction because many go ten or more years without a promotion (Manongi & Marchant, 2006). In addition, inadequate supervisory and accountability systems can create environments where D&A is more likely to occur and more likely to be overlooked or accepted; in some cases, disrespectful care may even be modeled by superiors, such as supervisors, trainers, or senior-level staff (Bowser & Hill, 2010; Bohren et al., 2015; Vogel et al., 2015), or covered up due to a "conspiracy of silence" in the system (Goer, 2010). All of these factors contribute to the normalization of disrespectful and abusive behaviors. It is thus essential that there are mechanisms in place that allow providers to safely and confidentially raise issues, without putting themselves or their jobs at risk (Freedman & Kruk, 2014).

Because of the systemic nature of the problem, efforts to address D&A cannot focus only on individual providers; they should also address the realities of the health systems that lead providers to treat patients in such a manner (Freedman & Kruk, 2014).

Human Resources for Health and Gender

Cultural and historic gender norms play a critical role in HRH in that they "[affect] how work is recognized, valued, and supported with differential consequences at the professional level […] and at the personal level" (George, 2010, p. 210). Despite making up the majority of the health labor force in many countries, women are often conferred lower status in the health system; they are more likely to hold positions that require fewer years of education and training, earn lower pay, and are less secure (George, 2010; Langer et al., 2015). Gupta et al. (2003) argue that "certain female-dominated occupations, notably in nursing, are not often given a market value commensurate with their skill level, as the work is seen simply as 'women's work'" (n.p.). In many societies, care work is expected of women, and therefore not adequately supported, recognized, or remunerated. At the same time, because they are perceived to be naturally caring, female health workers may be held to a higher standard of interpersonal care than their male colleagues, who are valued instead for their technical skills (Langer et al., 2015). In short, female health care workers may face disproportionate expectations and constraints.

Because of their low status in the health system and the pervasive stereotypes of women as care providers, there are few efforts to address or protect the unique needs of women health workers—such as childcare and protection from violence and sexual harassment—or provide women with opportunities for job advancement (George, 2010; Langer et al., 2015). Globally, there is a lack of female representation at the executive and managerial levels of healthcare. In Sudan, for instance, women doctors were passed over for promotions because of assumptions that they lacked the desire or skills to advance (Langer et al., 2015). According to Langer et al. (2015), this lack of support prevents female health care providers from achieving their full potential, and the poor employment conditions "hinder the quality and e□ectiveness of women's contributions to health care" (p. 1166). Midwives across the globe, for example, attribute their lack of status and recognition, subordination by the medical profession, lack of autonomy, and verbal, physical, and even sexual harassment to pervasive gender inequality in health systems and communities; some have said that this degradation affects their ability to provide quality care (World Health Organization et al., 2016).

HRH Interventions to Promote RMC

Potential solutions to address HRH challenges that influence RMC include:

- improving work force measurement and evaluation;
- training new health workers;
- providing in-service training to existing health workers;
- task shifting/sharing;
- enhancing accountability structures and promoting a model of supportive supervision;
- improving transparency and accountability in health facilities and systems;
- addressing gender inequality in health systems and communities;
- and boosting morale through positive work environment, compensation, and incentives.

Below are selected examples of interventions and a description of how they might affect RMC.

Supervision

Without effective supervision, workers may neglect their responsibilities or lose morale, and if supervisors are negligent in their duties, workers may adopt similar bad behaviors. Effective supervision, on the other hand, can improve performance, job satisfaction, and motivation amongst health workers (Rowe et al., 2005; Mathauer & Imhoff, 2006). In rural Guatemala, performance was strongly influenced by the "nature of relationships across hierarchical levels," and participants noted that patient satisfaction begins with auxiliary nurses' sense of well-being, which is dependent on their relationship to their managers. District managers' sense of wellbeing too is shaped by their relations to regional managers: "the regional nurse managers

pointed out that because the nature of relationships operates in a chain reaction, it was possible to improve patients' satisfaction by modelling respectful treatment and responsive support at the top level of the regional health system" (Hernandez et al., 2015, as cited in George et al., 2017, p.303).

Supportive supervision: A supportive supervision model is one proposed way to strengthen supervisory structures. Also referred to as facilitative supervision, supportive supervision emphasizes communication, teamwork, problem-solving, support, and ongoing assessment to motivate and empower health workers and improve quality of care (Marquez & Kean, 2002, pg. 1). Engender Health's COPE process, a quality improvement process implemented in over 45 countries, identifies supportive supervision as one of the key needs of health care staff in developing countries (Engender Health, 2003). In Kenya and Guinea, COPE was found to open channels of dialogue between different levels of health workers, lead to greater staff interaction and cooperation, and promote self-confidence, self-reflection, and acceptance of constructive criticism; COPE also encouraged common commitment to improving and providing quality services, and led workers to center clients' rights, respect, and equality in their interactions with clients (Bradley et al., 2002). Supportive supervision is not easy to implement in contexts where lack of support and overstretched health systems are the norm (Clements et al., 2007). Although supportive supervision is meant to promote meaningful interactions, in practice, "detached inspection and assessment" is often the reality (Bradley et al., 2013, as cited in George et al., 2017). When implementing a supportive supervision approach, it is important that it not reinforce hierarchical structures or be used as a way to limit or control the supervisees.

Social Accountability

Bottom-up citizen monitoring approaches have been introduced to increase health worker accountability. Citizen monitoring can be carried out by village health committees, facility committees, local NGOs, or by service users themselves. In Peru, a group of trained community monitors assess staff availability, wait times, users' experiences with providers, and the quality of the information provided by providers (Frisancho & Vasquez, 2014). In countries around the world, including India and Uganda, community members are able to report disrespect and abuse, such as provider absenteeism or exploitative demands for informal payments, via mobile phone (Cummins & Huddleston, 2013; Chai & Cummins, 2014; Nazdeek et al., 2015; Dasgupta et al., 2015). These programs can impose reputational costs or professional sanctions on providers and managers who fail to ensure RMC. For more on social accountability efforts in maternal health, see our RMC and Social Accountability factsheet.

Improving Morale

Rewarding and supporting health workers can boost morale, mitigate burnout, and improve job motivation and satisfaction. Rewards can be financial—allowances, bonuses, housing benefits, free transportation, paid vacations, insurance coverage—though nonmonetary incentives such as continuing education, opportunities for professional advancement, personalized feedback, and recognition of work can be strong motivators as well (Willis-Shattuck et al., 2008; Araujo & Maeda, 2013). A review of incentives in east and southern Africa found that both financial and nonfinancial incentives positively impacted health worker retention and performance in various contexts (Dambisya, 2007). However, there is concern that performance-based financing, one type of financial incentive, does not necessarily ensure quality, especially when necessary "social, organizational, and cultural cues" are lacking (George et al., 2017, p.82). An emphasis on meeting global standards and indicators can "decontextualize and oversimplify aspects of health worker practice, are punitive in approach, […] focus on negative indicators, [and] overshadow locally acknowledged need for investment in other aspects of health system operations" (George et al., 2017, p.82-83). Context, including local priorities and health system governance structures, should therefore be taken into consideration in the use of human resource incentives and other performance improvement measures (George

et al., 2017).

Conclusion

RMC and HRH are inextricably linked. Effective and meaningful efforts to promote RMC address both patients and frontline providers as people who suffer the consequences of under-resourced, hierarchical health systems. Their input and experiences are central to addressing the root causes of D&A.

To Learn More

For more information on respectful maternity care, please refer to the following resources:

- Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Coneglian, F.S., Diniz, A.L.A., Tuncalp, O., Javadi, D., Oladapo, O.T., Khosla, R., Hindin, M.J., & Gulmezoglu, A.M. (2015). The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. **PLoS Medicine**, 12(6), e1001847.
- Bowser, D., & Hill, K. (2010). **Exploring evidence for disrespect and abuse in facility-based childbirth.** Boston: USAID-TRAction Project, Harvard School of Public Health.
- Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., Kujawski, S., Moyo, W., Kruk, M.E., & Mbaruku, G. (2014). Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda. **Bulletin of the World Health Organization**, 92(12), 915-917.
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- World Health Organization. (2014). **The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement.** Geneva: WHO.

For more information on human resources for health and HRH interventions, please refer to the following resources:

- George, A., Scott, K., & Govender, V. (Eds.), (2017). **A Health Policy and Systems Research Reader on Human Resources for Health.** Geneva: WHO.
- World Health Organization Global Health Workforce Network (previously Global Health Workforce Alliance)
- Human Resources for Health journal
- World Bank Human Resources for Health brief
- Integrare
- Engender Health for publications and resources on facilitative supervision and other quality of care interventions.

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