RESPECTFUL MATERNITY CARE IN HUMANITARIAN SETTINGS

CONSULTATION FOR CHANGE

BACKGROUND

At the core of our field, we are all driven by a desire to effect positive change and to ensure that the best services are delivered to those we serve. However, an array of challenges exist that have not allowed us to live up to that standard when it comes to childbirth. We are now seeing a diverse pool of actors across UN agencies, INGOs, and health and protection advocates demonstrating increasing interest and momentum to address mistreatment in childbirth in humanitarian settings. Amidst growing evidence of mistreatment in childbirth, in 2011, the White Ribbon Alliance led a group of global organizations to develop a ground breaking consensus document, the Respectful Maternity Care (RMC) Charter. This document demonstrates the legitimate place of maternal health rights in the broader context of human rights.

There is concern that the resource constraints and security challenges found in humanitarian settings may exacerbate the systematic causes of mistreatment in childbirth, including underlying social determinants and gender norms that perpetuate violence against women (both those giving birth and the providers that serve them). Given that the number of people affected by humanitarian crises is increasing, it is critical that humanitarian, maternal and newborn health, and protection communities identify effective strategies for ensuring safe, timely, respectful, and culturally appropriate maternity care across the continuum of humanitarian crises.

Implementation research studies in low and middle-income countries have suggested several promising approaches to address the drivers of mistreatment and to promote RMC. The protection community also has highly developed theories of change to address the underlying factors of violence against women. Other communities of practice, including human rights, HIV, private sector, and others, also have approaches to working with vulnerable populations that may be applicable in the childbirth setting. With the confluence of these events, the opportunity now exists to make significant progress to prevent mistreatment and promote RMC in humanitarian settings. This Consultation for Change was organized to bring attention to this and to define an action agenda that moves forward key priorities around this topic.

The Consultation for Change was organized by members of the Interagency Working Group for Reproductive Health in Crises (IAWG) and the Global Respectful Maternity Care Council, and it was funded by the White Ribbon Alliance and the American Refugee Committee.

Eighty-five attendees from UN agencies, international non-governmental organizations, maternal and newborn advocacy groups, and human rights organizations gathered on July 10-11, 2018 at the National Union Building in Washington, DC.
PURPOSE

The Consultation for Change convened a first-of-its kind group of unique and distinct actors across the traditional and non-traditional universe of global health to begin to formulate a new direction for the childbirth experience in humanitarian settings. It aimed to construct an initial framework and process for understanding drivers of mistreatment in pregnancy and childbirth in humanitarian contexts. to jointly determine the significance of mistreatment and RMC across phases and types of emergency settings and to synthesize learning from implementation research to begin discussing how to design and implement interventions in humanitarian settings. The consultation specifically intended to develop research and advocacy agendas and to define immediate actions for responding to mistreatment and fostering respectful care in childbirth.

PROCEEDINGS - DAY 1

Heather Howard, Senior Global Health Advisor at the American Refugee Committee, moderated Day 1 of the event. Importantly, she framed RMC as an accessibility issue—women who have poor experiences at facilities are less likely to return to healthcare settings and may relay their experiences to others. which could discourage them from seeking facility-based perinatal care. Patient experience—specifically kind treatment by the health worker—is known to affect healthcare seeking behavior (e.g. Larson, et al. 2015), yet measures of clinical quality of care focus primarily on technical procedures and supply chain issues.

THOUGHT CATALYST

Stela Osmancevic Center, a former Bosnian refugee and currently Director of Advancement at Wallin Education Partners in Minneapolis, Minnesota, set the stage for the consultation by providing a personal account of her experience as a refugee and reflections on motherhood. She recounted her family’s experience of fleeing from Bosnia at age 10 when war broke out between Serbs and ethnic Muslims in the 1990s. They went on to live in three different refugee camps in Croatia and Hungary, where they quickly learned that the very people who were supposed to protect them instead took advantage of their vulnerability. She described her mother as a fierce protector, ensuring her family’s needs were met despite a lack of healthcare services in the camps, and that they were safe, including wielding a cooking pan to fight back the peacekeeper who sexually assaulted Stela. Stela went on to recount her experience of childbirth in the US, where the healthcare system was fast-acting when she had an obstetric emergency and where her care providers were kind and supportive. She reflected on how this may have been a vastly different experience had she delivered in a refugee camp. ‘The courage of motherhood needs to be honored,’ Stela declared, and went on to emphasize that high quality, respectful care is a right for all women, regardless of where they are in the world or whether they have been displaced by emergency. ‘I hope that you will think of this widespread problem [disrespect and abuse of women in pregnancy and childbirth] not in terms of thousands and millions, but as one unique, courageous woman, one child, and one mother, a mother like mine, who can move mountains for her child, but only with others, like you, standing by her.’

DEFINING THE ISSUE

Mary Ellen Stanton, Senior Maternal Health Advisor at the USAID Bureau for Global Health, explained that RMC is not simply the lack of disrespect and abuse, it encompasses all aspects of the Global RMC Charter. She noted that disrespect and abuse in childbirth is normalized so that people who experience it do not see it as disrespectful and in fact see it as necessary for the childbirth process (e.g. ‘slapping a woman is necessary to get the baby out’). Tackling this issue needs to come from listening to those we are caring for. Experience has shown strong examples of compassion and respect in the midst of conflict; we should build from these examples.
Elena Ateva, Maternal and Newborn Health Policy & Advocacy Advisor of the White Ribbon Alliance and Global RMC Council Coordinator, added that RMC is even more important in humanitarian settings, as disrespect and abuse in childbirth can compound the trauma that has already been experienced by women exposed to conflict. She went on to explain that women affected by emergencies may experience even subtle violations as harsh because they are extremely vulnerable. She stressed that dignity is essential to human rights, and that childbirth needs to be established as a safe zone.

ASSUMPTIONS AND REALITIES OF HUMANITARIAN SETTINGS

Next, Sonia Walia, Public Health Advisor at USAID’s Office of Foreign Disaster Assistance; Sandra Krause, Reproductive Health Program Director at the Women’s Commission for Refugee Women and Children; and Reem Khamis, Women’s Protection and Empowerment Technical Advisor at the International Rescue Committee explained the realities of humanitarian settings so as familiarize attendees new to emergency response with the operational structures, context, and constraints. They provided statistics on the magnitude of the problem (68.5 million displaced people worldwide), and the importance of reaching women with health services, as they comprise the majority of those displaced and are the main caretakers of their families. Ms. Walia acknowledged that donors impact the provision of services due to their decisions regarding geographic focus of funding, length of funding cycles, and technical focus of interventions. Ms. Khamis emphasized that understanding gender dynamics and the risks women face in humanitarian settings is crucial for any discussion about RMC, as violence is both a cause and consequence of gender inequity. Ms. Krause, a founding member of the Inter-Agency Working Group for Reproductive Health in Crises (IAWC), explained that a priority package of sexual and reproductive health (SRH) services in the initial weeks/months of a crisis—known as the MISP (minimum initial services package)—has been developed to prevent excess maternal mortality and morbidity, and a revised version will be released later this year. The MISP is intended to address the acute phase of an emergency, while the broader inter-agency field manual (IAFM) for reproductive health in crises describes the suite of comprehensive SRH services that should be available in a stable emergency and the process to transition from MISP to comprehensive SRH services.

WOMEN’S AND PROVIDERS’ PERSPECTIVES

Massoma Jafari, Midwifery Advisor at Jhpiego, and Bushra Al-Makaleh, Medical Doctor and Academic Teacher at the Yemeni Board of Medical Specialization, added further insight into the experiences of both women seeking delivery services and health care workers providing childbirth care in humanitarian settings. Dr. Al-Makaleh’s animated video especially highlighted the challenges providers face in delivering respectful care, as they themselves face gender-based discrimination, are affected by conflict and face serious security risks just to get to work and are forced to provide care in extremely resource-limited facilities, all of which can impede their ability to deliver childbirth services in a respectful manner. Audience members went on to stress that it is important to recognize that trauma and stress impacts the entire system—not only women in the community, but also health system infrastructure and administration, as well as health care providers. RMC needs to be translated to humanitarian settings in actionable and reasonable ways.

GLOBAL EVIDENCE ON MISTREATMENT

Dabney Evans, Associate Professor of Global Health, Director of the Center for Humanitarian Emergencies, and Director of the Institute for Human Rights at Emory University, explained that although evidence exists on gender-based violence (GBV) in humanitarian settings, the prevalence of obstetric violence in humanitarian settings—physical, verbal, or psychological abuse perpetrated against women during childbirth—is unknown. The term “obstetric violence” came out of grassroots movements in Colombia and Venezuela. On the continuum of RMC, obstetric violence is at one very negative end of the continuum. She explained that different women face different risks, those at high risk include adolescents, single women, low socio-economic status, ethnic minorities, migrants, and people living with HIV. She encouraged GBV researchers and advocates to reframe obstetric violence as a form of GBV, noting that even the most comprehensive GBV frameworks do not include obstetric violence. The audience noted the importance of recognizing that humanitarian structures are perpetrators of violence themselves, thus normalizing violence from the very top of the system.
Loulou Kobeissi, Scientist in the Department of Reproductive Health and Research at the World Health Organization, presented the WHO systematic review of 65 studies that documented the experiences of disrespect and abuse among women across 34 countries. She stressed that quality of care matters more than ever. as facility-based childbirth is increasing globally—we cannot increase demand for facility deliveries and provide disrespectful or abusive care that may counteract demand generation. Furthermore, quality of care and a positive care experience is considered key to achieving the goal of universal health coverage. One study focused on the development and validation of tools to measure mistreatment during childbirth. Without this research, the WHO would not have been able to develop guidance on intrapartum care for a positive childbirth experience. In order to translate this work into humanitarian settings. Ms. Kobeissi suggested expanding research, adapting or updating current guidelines, building awareness and advocacy, and strengthening capacity of front line health providers.

Betsy McCallon, CEO of White Ribbon Alliance, presented the global consultation[4] of 2,470 midwives from 93 countries. Midwives’ Voices, Midwives’ Realities. This report shows that there is a need to redress complex hierarchies of power and transform gender dynamics that play a critical role in the provision of maternity services. The interplay of social, economic, and professional barriers results in burn out and moral distress for midwives. Midwives highlight that power, agency, and status are important to them so that they can be supported to provide high-quality care. This presentation complemented Dr. Al-Makeleh’s presentation of powerful personal anecdotes regarding systemic factors and other challenges that providers in humanitarian settings must overcome to provide respectful, dignified maternity care.

GLOBAL GUIDANCE

Kate Brickson, Senior Program Officer for Maternal Health at Maternal and Child Survival Program (MCSP)/Jhpiego, outlined the operational guidance document Moving Respectful Maternity Care into Practice in Comprehensive MSCP Maternal and Newborn Programs. Though specifically developed for MSCP programs, the document could be used by other agencies implementing maternal and child health programs/services. The document emphasizes process, and the detailed appendices distill promising approaches and provide research tools and methodology in RMC. The audience agreed it could be an excellent starting place for the humanitarian community looking to advance this work.

Hannah Tappis, Senior Monitoring, Evaluation. and Research Advisor at Jhpiego, picked up Sandy Krause’s introduction of the MISP to describe the recent revisions to the Inter-Agency Field Manual for Reproductive Health in Crises. The recent revision, which will be released in late 2018, has a greater emphasis on human rights and respectful partnerships. Though the maternal and newborn health chapter mentions RMC principles and the WHO guidance that Loulou Kobeissi highlighted, it was unable to identify—and thus does not include—programmatic examples of quality of care improvements in humanitarian settings. Ms. Tappis went on to note that the focus on respectful, dignified care through maternal health is an entry point that will hopefully elevate the quality of care across all sexual and reproductive health services.

SERVICE MODELS, SYSTEMS APPROACHES, AND OPERATIONS RESEARCH

Emily Peca, Implementation Research Scientist and Technical Advisor at University Research Corporation, and Kate Ramsey, Senior Technical Advisor for Maternal and Newborn Health at Management Sciences for Health presented learnings from some of the larger implementation research studies conducted in stable, developing country settings. They explained that RMC should be an integral, holistic approach that necessarily addresses not only mistreatment of women in childbirth, but also mistreatment and disrespect of health providers and the environment in which they work. Through the Heshima Project, STAHA Project, and others that have explored drivers of and tested interventions to address mistreatment in childbirth, it has been found that leaders and managers need to be supported to own and address the problem themselves. while recognizing that health providers cannot take and sustain action if they are not supported by the larger system or administrator. They also stressed the importance of developing feedback and accountability mechanisms to be able to report mistreatment.
Lynn Freedman, Director of the Averting Maternal Death and Disability Program at Columbia University, spoke from a strong reproductive justice lens, noting that pregnancy and childbirth carry profound symbolic meaning for women and communities. In humanitarian crises, the identity of a community may be destroyed (e.g. ethnic cleansing, genocide), and women are often ascribed the role of upholding community norms. She went on to describe that health systems are social institutions that communicate the values of a state (or set of actors. In the case of humanitarian emergencies). Birth, therefore, becomes a political event where the holders of power use the health system to silently communicate and reinforce hierarchies of power. Disrespect and abuse in childbirth are fundamentally about both explicit and implicit power structures; disempowerment (especially among women and other vulnerable groups) is deeply internalized and normalized. Documenting how power works in health systems and establishing accountability mechanisms are ways to put pressure on the institutions/actors that exert power and control. Reproductive justice is a grassroots movement and a prism for understanding how historical injustice works.

Audience members noted that power dynamics may differ based on the type of humanitarian setting (e.g. camp-based contexts vs. urban refugee settings) and who delivers what services in each setting. They also suggested integrating the reproductive justice movement and the humanitarian community, noting that reproduction can be used as a weapon of war. Finally, a great deal of conversation focused on the importance of accountability mechanisms, particularly developing real-time mechanisms that can be responded to quickly.

**DIVERSE PERSPECTIVES = ROBUST SOLUTIONS**

Chaitra Shenoy, Gender Advisor at USAID, challenged the group to think about how to implement RMC in an inherently flawed system. She suggested that as a community, we should view the issue of mistreatment in childbirth holistically, give the system permission to say, “Yes, we are at fault”, and to empower people at all levels to change—donors, governments, and health systems. She also suggested this community use the UN code of conduct as an opportunity to incorporate RMC, for example, as USAID updates grants and contracting language or in implementing agencies’ prevention of sexual exploitation and abuse (PSEA) policies. Such policies must protect both women and staff as care providers. The landmark June 2018 G7 statement can also be used as a strong reference point for advocacy, as one of the main themes focused on advancing gender equality and women’s empowerment.

Skye Wheeler, an Emergencies Researcher with Human Rights Watch, provided a unique perspective based on her experience documenting human rights abuses against women throughout the world. She gave a positive example from South Africa where she witnessed collaboration between health workers and human rights workers resulting in improvements in health care. But more generally, she noted that her experiences have led to the conclusion that women are lacking agency and voice—they can’t ask for what they need (again, underscoring the importance of establishing accountability mechanisms for mistreatment during childbirth). She challenged the group to think about using shame as a powerful tool to motivate organizations and policies that do not support women and girls to change for the better.

**Karla Koons**, Senior Interior Designer and Medical Planner at RSP Architects in Minneapolis, Minnesota, described the importance of recognizing how spaces in which maternity services are provided can facilitate or hinder the provision of respectful care. Importantly, she stated, “Design is not about the space. It’s about the people.” Health facilities, in particular, are where the most important life events—life and death—often occur. She went on to describe her process of designing a new maternity center for the American Refugee Committee in Mahama Refugee Camp in Rwanda, and emphasized the importance of consulting with refugee women to design the space.
V I S I O N F O R T H E F U T U R E

Betsy McCaillon, CEO of White Ribbon Alliance, delivered Day 1 closing remarks. She stated that RMC must be everyone’s business, and it will take a myriad of skills coming together to make progress on the issue. We need to cross borders, cross sectors, and work across the continuum of the root causes of violence. Women don’t have to know the intricacies of the public health sphere, but they must know they have agency and the ability to make change.

P r o c e e d i n g s - D a y 2

Day two of the Consultation for Change was focused on developing action plans to advance the RMC in humanitarian settings agenda. Participants divided into three workstreams. 1) Immediate Actions, facilitated by Dina Abbas, Global Health Advisor at the American Refugee Committee; 2) Research Priorities, facilitated by Paul Spiegel, Director of the Center for Humanitarian Health at Johns Hopkins University; and 3) Advocacy Priorities, facilitated by Elena Ateva, Maternal and Newborn Health Policy & Advocacy Advisor of the White Ribbon Alliance and Global RMC Council Coordinator.

T H O U G H T C A T A L Y S T

Blair Palmer from the Innovation Team at UNICEF, kicked off Day 2 of the consultation by stating that UNICEF is in attendance to ensure the newborn is given sufficient attention in the promotion of respectful maternity care. She focused on the value of human-centered design in developing solutions to promote RMC. Human-centered design authentically engages the people/community for whom you are designing, and begins at the point of desirability, rather than funding (viability) or feasibility. Using techniques like immersion and analogous inspiration help understand the user to provide new insights that shape better solutions. When a design idea begins to resonate is when feasibility and viability can be explored. Ms. Palmer provided some process guidance about pursuing discovery through human-centered design, explaining the difference between traditional interviewing and design research. She also explained that human-centered design has a demonstrated business case for work in the social good arena, and it is particularly well-suited for private sector partnerships.

W O R K S T R E A M 1: I M M E D I A T E A C T I O N S

This workstream developed recommendations that humanitarian agencies could implement immediately, without knowing the answers to the larger research questions, that would not cause harm and would still promote RMC and/or reduce mistreatment and abuse in humanitarian settings. The group recommended the following:

- Create a culture of respect throughout health systems—not only in maternity care. This can be accomplished by: a) conducting Values Clarification and Attitude Transformation Trainings (VCAT) sessions; b) conducting flash trainings with health providers on RMC; c) integrating “respectful care” language into basic service practices; d) involve leadership in quality improvement.

- Include RMC as an everyday component of maternal health work, from design to evaluation.

- Disseminate the global RMC charter throughout the humanitarian community, specifically targeting agencies implementing maternal health programs/services.

- Introduce providers to the global RMC charter, and conduct community sensitization sessions so they can be informed about its components and hold providers accountable.

- Develop and post a “patient promise” that describes what patients should expect during delivery (e.g. clean bathroom, clean sheets, no hitting/slapping, etc). Orient ANC patients to this.
Host open maternity/open birth days where women and their birth companions learn about what to expect when they deliver in the health facility to increase their expectations for quality, respectful care.

Support and value childbirth care providers, including: a) ensuring the availability of mental health care/psychosocial support to help them cope with the humanitarian crisis; b) ensuring they are paid regularly and on-time; c) ensuring the infrastructure, equipment, and supplies are in place for providers to do their job.

Give further thought to preparedness, and how humanitarian actors can be ready to provide RMC in settings in which they have less control.

WORKSTREAM 2: RESEARCH PRIORITIES

This workstream identified research questions/priorities, the answers to which would help guide the adaptation of RMC initiatives from developing country settings to humanitarian settings. This group recommended the following:

- There is a need to come to a consensus on definitions (e.g., contexts (natural disaster vs. conflict. acute vs. protracted), disrespect, quality of care, respectful maternity care, so there is an ability to compare across contexts and facilitate better collaboration/integration.

- Determine whether the drivers of mistreatment are different across humanitarian settings (acute, protracted, recovery), as well as whether these drivers are more or less common/pronounced depending on the type of setting.

- Determine the drivers of mistreatment in humanitarian settings, including: a) provider-level factors, keeping in mind attacks on health care workers, safety within clinics, harassment, supervisory structures, attitudes of provider to patients, compensation, language, etc.; b) how infrastructure shapes RMC, such as number of patients seen, supports for providers, time to see patient, etc.; c) places of vulnerability along the perinatal continuum, e.g., antenatal care vs. labor & delivery; d) norms that facilitate mistreatment at the point of care; e) normalization of violence, particularly in conflict settings, and as perpetrated by humanitarian structures/actors.

- Understand what women expect in terms of RMC in humanitarian settings. External views of what is acceptable may be different than women’s actual expectations. It seems likely women’s expectations may be lower, due to poor treatment of women and normalization of violence in these settings, so research should identify ways in which to increase these expectations.

- Conduct implementation research, using “promising approaches” in RMC programming established in developing country settings to determine what types of adaptations need to be made for humanitarian settings and how they vary according to type and stage of the emergency.

- The group did not come to a consensus on whether it is important to conduct studies on the prevalence of mistreatment and varying types of disrespect and abuse. Some argued it is important for advocacy efforts and funding applications, as well as to determine a baseline measure for understanding program impacts. Others argued it is reasonable to assume prevalence is at least similar, if not greater than, developing country settings where prevalence studies have already been conducted, and that resources would be better directed towards implementation research for more action-oriented research results.
W O R K S T R E A M 3: A D V O C A C Y P R I O R I T I E S

This workstream developed advocacy priorities in order to advance the RMC in humanitarian settings agenda. This group recommended the following:

- Raise awareness among donors, governments, and other stakeholders about the need to prioritize quality of care in all programs, project design, monitoring, and evaluation.

- Engage diverse communities on the issue—humanitarian, development, maternal health, newborn health, human rights, protection/GBV—and develop specific messaging targeted to each of these communities.

- Identify key events where it may be a natural fit to include messaging/advocacy around RMC in humanitarian settings, through panels, side events, etc.

- Integrate reproductive justice into humanitarian settings. Aim to shift the narrative surrounding reproductive rights in humanitarian settings, since the issue is easily buried when it is lumped in with basic human rights. This could be accomplished by documenting and presenting reproductive health and justice as a human right to groups such as the Inter-Agency Standing Committee and InterAction. Important to consider which groups may respond better to rights-based advocacy vs. evidence-based advocacy.

- Get women to the table as active participants in advocating for RMC in humanitarian settings, so as to share what reproductive justice issues are affecting them most. This participation must evolve into leadership—empowering women leaders in humanitarian settings will help change the power dynamics within humanitarian settings, structures, and organizations.

- Share information with implementing agencies about how RMC can be incorporated in practice.

- Work with IAWG on integrating RMC messaging into the MISP, which is currently being revised. MISP e-learning module could include ideas around respect.


- Continue advancing these advocacy efforts in the advocacy subcommittees of IAWG and the Global RMC Council.

HOSTED BY

American Refugee Committee