Compendium on respectful maternal and newborn care

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ISBN 978-92-4-011093-9 (electronic version)
ISBN 978-92-4-011094-6 (print version)

Suggested citation. Compendium on respectful maternal and newborn care. Geneva: World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data.
CIP data are available at https://iris.who.int/.

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Design and Illustrations by Ina Fiebig/Sonder Collective .

Contents

Foreword

This compendium on respectful maternal and newborn care has come at a critical juncture – marking 10 years since the 2014 WHO statement on the prevention and elimination of disrespect and abuse during childbirth. It reaffirms a global commitment to ensuring that maternal and newborn care is not only clinically sound but also grounded in dignity, compassion, and respect. Quality, respectful, person-centred care is not a luxury or an optional add-on – it is a fundamental human right and a cornerstone of effective health systems.

The urgency of this issue is clear. Mistreatment of women continues to undermine health outcomes, violate rights, and erode trust in health services. Without respectful care, we cannot achieve global health targets, including those outlined in the Sustainable Development Goals. Respect must be embedded in every interaction, across the full continuum of maternity care – from antenatal to childbirth and postnatal services.

Over the past decade, a growing body of evidence has highlighted the widespread impact of mistreatment and the necessity of centring respectful care in all maternal and newborn health strategies. This compendium outlines the core concepts and evolving global understanding of respectful care, offering a shared language and vision for action.

It also explores the many forms of mistreatment and the systemic drivers that perpetuate them – ranging from structural inequalities to gaps in policy, training, and accountability. Addressing these root causes is essential to creating enabling environments where respectful, person-centred care can thrive.

The compendium highlights key intervention areas and provides practical, adaptable approaches for designing and implementing respectful care strategies across different levels of the health system. It emphasizes the importance of engaging all stakeholders – from health workers to women in communities – and using routine data and documentation to drive accountability, learning, and sustainable change.

This resource is designed to support programme managers, policy-makers, and practitioners in translating principles into action. By offering practical guidance based on research and programme experiences and implementation tools, it empowers health systems to uphold dignity, improve outcomes, and ensure that every woman and newborn receives the care they deserve.

Let this be a renewed call to action to: prioritize respect, protect rights, and ensure that all maternal and newborn health care is safe, supported, and empowering.

Dr Jeremy Farrar
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Acknowledgements

The World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Jhpiego and USAID MOMENTUM Country and Global Leadership project, gratefully acknowledges the contributions that many individuals and organizations have made to the development of this compendium, as listed in the Annex.

Work on this compendium was initiated and coordinated by Hedieh Mehrtash and Özge Tunçalp from the United Nations Development Programme (UNDP)/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), and Anayda Portela from the Department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA).

A technical working group developed the draft content of the different sections including: Patience Afulani (University of California at San Francisco (UCSF)), Kwame Adu-Bonsaffoh (University of Ghana Medical School/Korle-Bu Teaching Hospital), Meghan Bohren (University of Melbourne), Tamar Kabakian-Khasholian (American University of Beirut), Kathleen Hill (Jhpiego and USAID MOMENTUM Country and Global Leadership project – US collaboration concerned preceded 20 January 2025), Rachael Hinton (RH edit Consulting, Switzerland), Shanon Mcnab (Jhpiego and USAID MOMENTUM Country and Global Leadership project – US collaboration concerned preceded 20 January 2025), Katie Moore (Anthrologica), Helen Smith (Anthrologica), Charlotte Warren (Population Council), and Melanie Wendland (Sonder Collective).
The methods used to develop the compendium are detailed in Annex 1. A list of participants in all content review meetings, along with the external reviewers, is provided in Annex 2.

This work was funded by the United States Agency for International Development (USAID) and the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), a cosponsored programme executed by WHO and through a grant received by WHO/MCA from Merck Sharp & Dohme (MSD) for Mothers. The views of the funding bodies have not influenced the content of this compendium.

1

Introducing the compendium

Why focus on respectful maternal and newborn care

Respectful maternal and newborn care means person-centred care organized for, and provided to and with, all women, gender-diverse people, newborns, parents and families throughout the antenatal, childbirth and postnatal periods (see Box 1. A note on inclusive language). It prioritizes dignity, protects against harm and mistreatment, and ensures freedom to make informed choices.

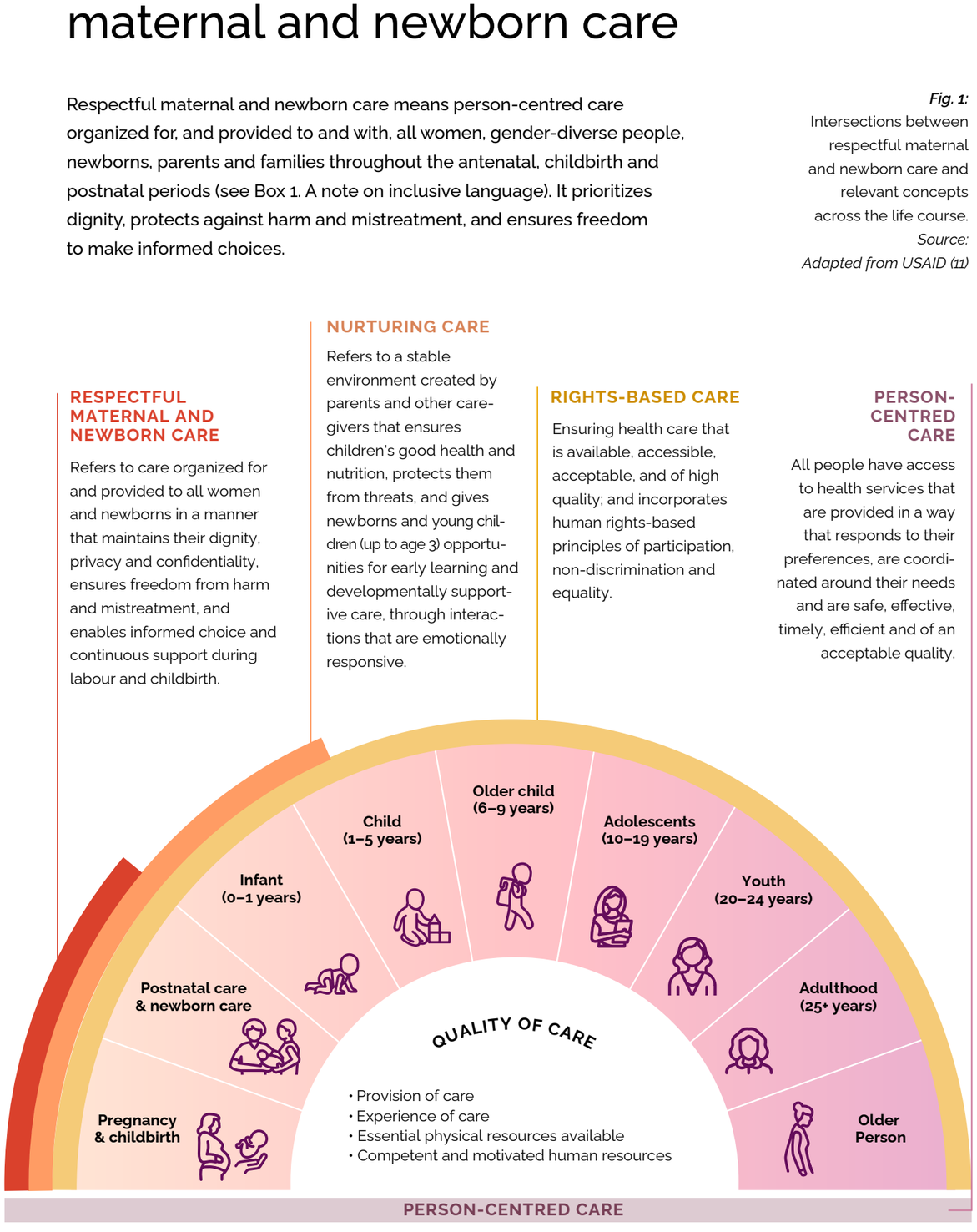


Fig. 1: Intersections between respectful maternal and newborn care and relevant concepts across the life course. *Source: Adapted from USAID (11)*

Pregnancy, childbirth and the transition after birth are significant life events, with the health and well-being of women, gender-diverse people and their newborns closely intertwined. Respectful care is linked to other key concepts, such as high-quality, person-centred and rights-based care across the life course, as well as nurturing care for newborns and young children (*Fig. 1*).

The World Health Organization (WHO) has developed a quality-of-care framework for maternal and newborn health that addresses both the provision and experience of care *(1, 2)*. Respectful maternal and newborn care is central to this framework. WHO standards for improving the quality of maternal and newborn care in health facilities *(1)* and the care of small and sick newborns *(3)* also emphasize respectful care.

However, in many settings, quality care standards are not being met. Gains in respectful care can be undermined by health system pressures, as seen during the COVID-19 pandemic or in conflict settings *(4)*. Many women, gender-diverse people and their newborns continue to experience mistreatment, including physical and verbal abuse, stigma and discrimination, non-consented care, lack of dignity and confidentiality, detention, abandonment, delays and neglect *(5–10)*. Without addressing the quality of services, including experience of care for the 140 million women giving birth annually, global and national targets for reducing maternal newborn and child mortality will not be met.

Box 1. A note on inclusive language

The terms "women and gender-diverse people" inclusively refer to individuals with the reproductive capacity for pregnancy and birth, including cisgender women, and people who are transgender, non-binary, gender-fluid, two-spirited, intersex, and gender non-conforming. The term "women" is used alone when reflecting existing data sources, which predominantly derive from maternal health studies conducted with cisgender women. The limitations of these data sources are acknowledged.

Lesbian, bisexual, queer, transgender, non-binary, gender-fluid, two-spirited, intersex or gender non-conforming people face unique challenges navigating pregnancy, childbirth and the transition to parenthood, as well as in their interactions with health services. Ending mistreatment and achieving respectful maternal and newborn care requires addressing these needs and providing equitable, high-quality care for all.

Many individuals receiving maternity care are adolescents, who often face a higher risk of mistreatment due to their age. While their specific needs are sometimes highlighted, the terminology "women and gender-diverse people" is used throughout the compendium and is not intended to exclude adolescents experiencing pregnancy, childbirth or the transition to parenthood.

Midwife Zetoon Abdullah speaks with a new mother at the maternity ward at the Juba Teaching Hospital, Juba, South Sudan.
Photo: © UNICEF/Naftalin

Core principles for ending mistreatment and achieving respectful caree

This compendium emphasizes the goal of "**ending mistreatment and achieving respectful care and for all women, gender-diverse people, newborns, parents, and families**". This goal is underpinned by six core principles:

1 Be aspirational	Respectful care is the standard. This aspiration is turned into action by setting national goals, strengthening systems for routine data collection and review, and implementing interventions for ending mistreatment and achieving respectful care.
2 Uphold rights-based care	Delivery of care is grounded in human rights, paving the way for a future where respectful high-quality care is universally accessible.
3 Achieve equity and non-discrimination	Respectful, high-quality care is the standard for everyone regardless of social, ethnic, economic or gender identities, backgrounds or experiences.
4 Focus on person-centred care	Care is tailored to the needs and preferences of women and gender-diverse people and their newborns, while inclusively supporting parents and families.
5 Ensure safe and confidential care	Care prioritizes physical and emotional safety, guarantees confidentiality and prevents harm in all interactions.
6 Address complexity	Maternal and newborn health care is multi-faceted, as individuals may experience both mistreatment and respectful care. Ending mistreatment alone does not ensure respectful care. Achieving respectful care means actively identifying and tackling instances of mistreatment, whether intentionally or by omission.

About this compendium

Target audience

This compendium is primarily for **programme managers** responsible for maternal, newborn and child health initiatives and services within ministries of health at national, subnational, facility and community levels. Since health systems vary, these roles may also be referred to as coordinators, directors or other titles. "Programme manager" is used inclusively to encompass these roles, as well as senior-level managers overseeing financing, training and medical education for programming. The compendium applies to all income settings and to both government and non-government organizations. It is also useful for policy-makers and stakeholders working to improve respectful care, including professional associations, international and community organizations and researchers.

The compendium serves as a practical guide for understanding, designing, implementing and monitoring interventions to end mistreatment and achieve respectful care based on current evidence. This work can be carried out in collaboration with teams focused on maternal, newborn and child health as well as quality-of-care initiatives. While programme managers may initiate or lead these efforts, activities for ending mistreatment and achieving respectful care can also be integrated into facility-level quality improvement processes led by health workers or service users.

Embroidery on women's birthing experiences, South Africa.
Copyright: Intuthuku Embroidery Project

Scope of this compendium

The compendium supports efforts to end mistreatment and achieve respectful maternal and newborn care, marking a decade since the WHO's 2014 statement on the prevention of disrespect and abuse during facility-based childbirth. Despite substantial progress in understanding and measuring respectful care, large-scale implementation remains limited. Emerging research has highlighted small-scale interventions, but there is still much to learn about the most effective approaches.

Another major challenge is the lack of documentation of many respectful care initiatives, limiting knowledge-sharing and the scaling of interventions. Additionally, ending mistreatment and achieving respectful care is complex, and requires multilevel coordination within health systems. Addressing these challenges demands engagement among various stakeholders – including women, gender-diverse people, families, communities, civil society groups, policy-makers, health workers and researchers – to identify barriers, tailor interventions and measure impact.

The compendium underscores the importance of data-driven decision-making, offering validated tools and key indicators to track progress, refine strategies and sustain impact. It also recognizes that health systems vary in the progress they have made to end mistreatment and achieve respectful care: some countries having already established programmes, while others are only just beginning. It also offers essential context, evidence and guidance to support implementation in diverse settings. It outlines key concepts, terminology and the evolution of global thinking on respectful care, providing a foundation for designing and implementing interventions.

In the mother and child corner in the Tabanovce refugee and migrant centre, five-day-old Syrian baby Iliyas is getting dressed after a bath. Photo: © UNICEF/ Tomislav Georgiev

Young mother breastfeeding in a park in Moldova. Photo: © WHO/Sergey Petkoglo

Much of the current literature on mistreatment and respectful care focuses on childbirth and the immediate postnatal period. However, the compendium emphasizes that the core principles extend across the entire maternal and newborn care continuum – including antenatal, childbirth and postnatal care – and apply to all interactions women, gender-diverse people and newborns have with sexual and reproductive health services.

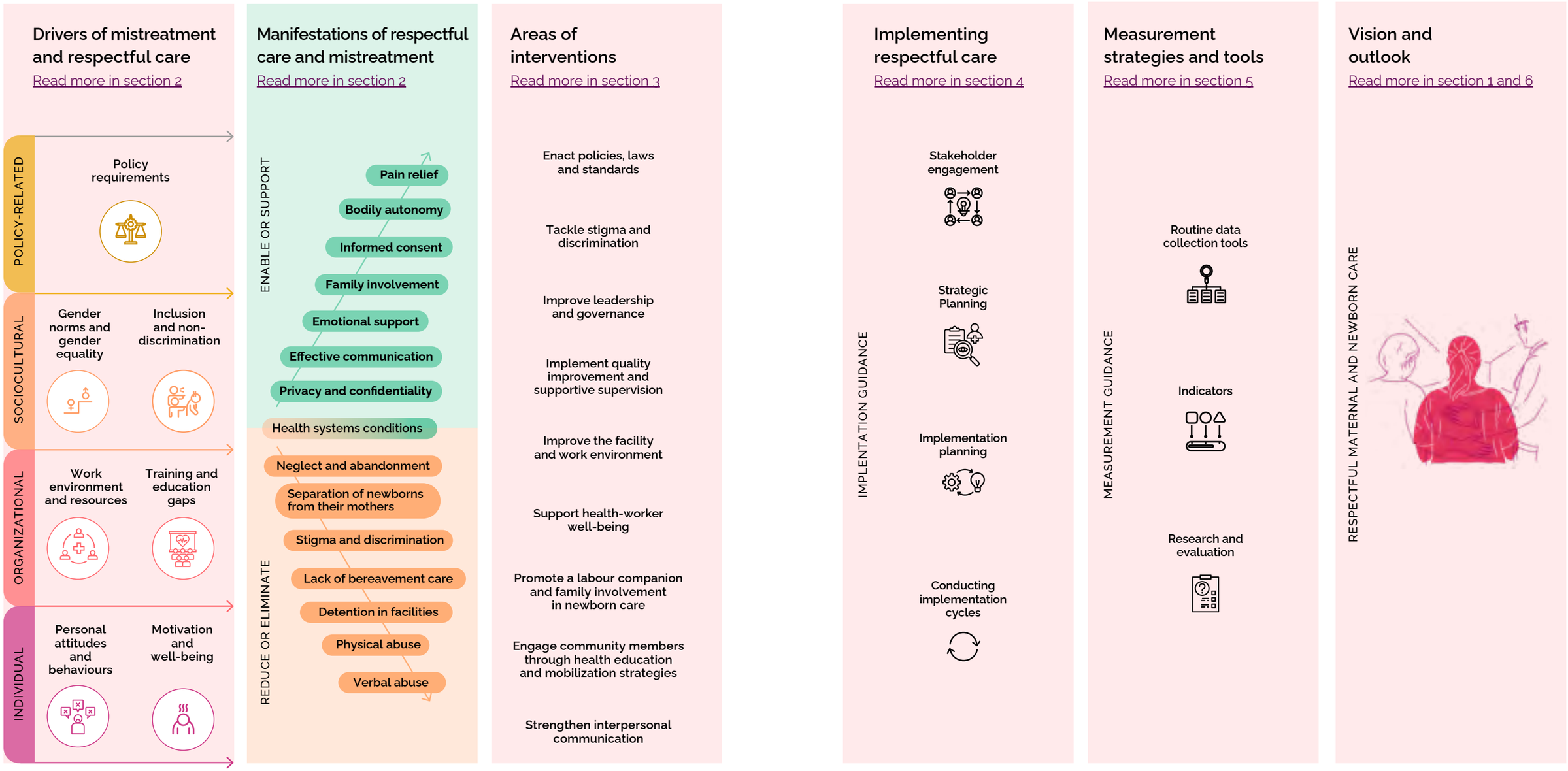
Objectives of this compendium

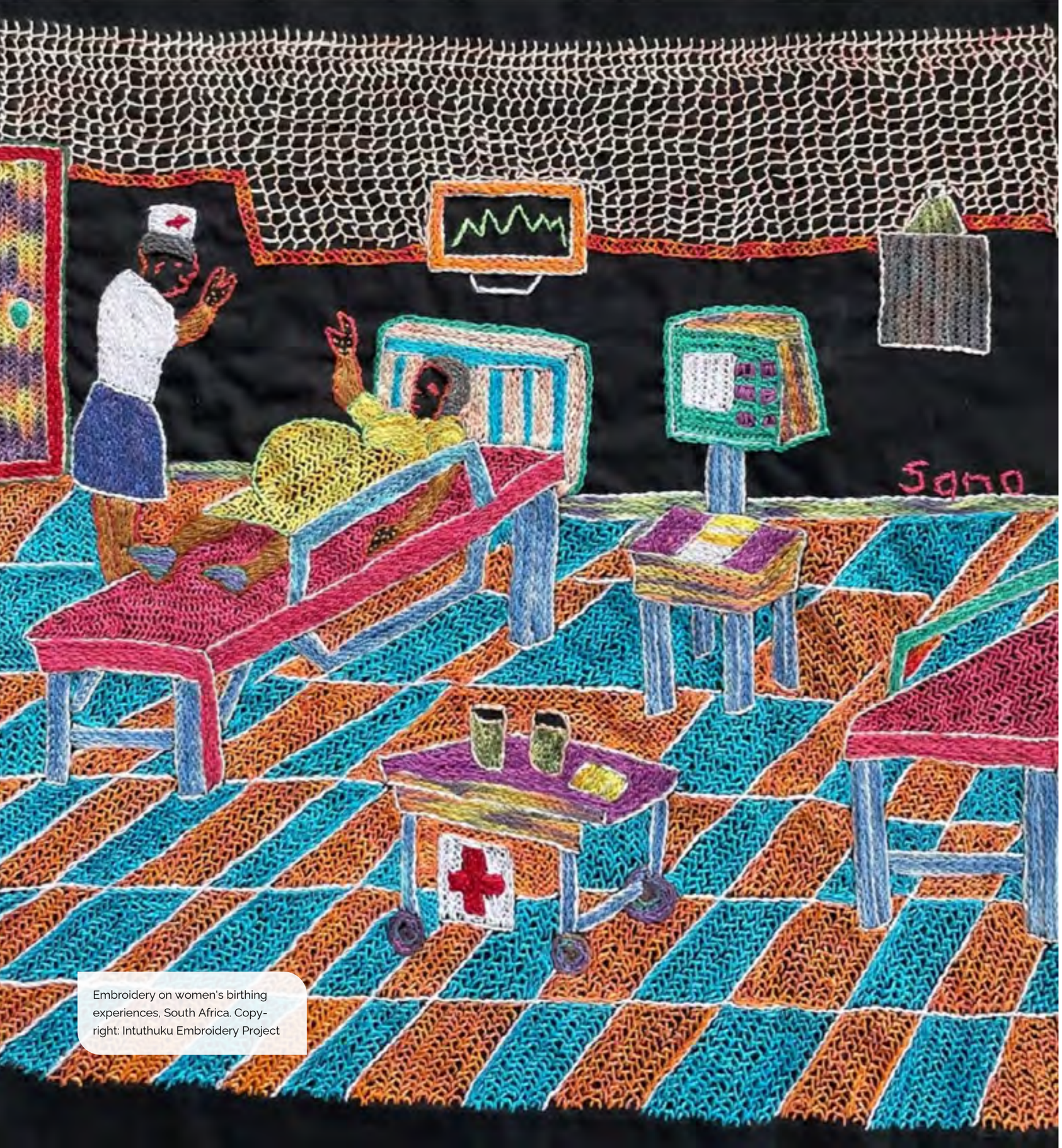
The purpose of the compendium is to consolidate key evidence, tools and resources to support the practical implementation of respectful maternal and newborn care across different contexts. It provides programme managers with essential background to build a foundational understanding of mistreatment and respectful care. As such, it serves as a comprehensive resource that integrates theory with practice. While not an implementation guide, the compendium supports programme managers to incorporate respectful maternal and newborn care into existing quality-of-care initiatives, ensuring it becomes a key component of maternal and newborn health efforts.

A roadmap for this compendium

The figure below gives an overview on the terms used in the compendium and explains how the elements are interconnected with each other in relation to respectful maternal and newborn care.

Fig. 2: Roadmap for this compendium





Embroidery on women's birthing experiences, South Africa. Copyright: Intuthuku Embroidery Project

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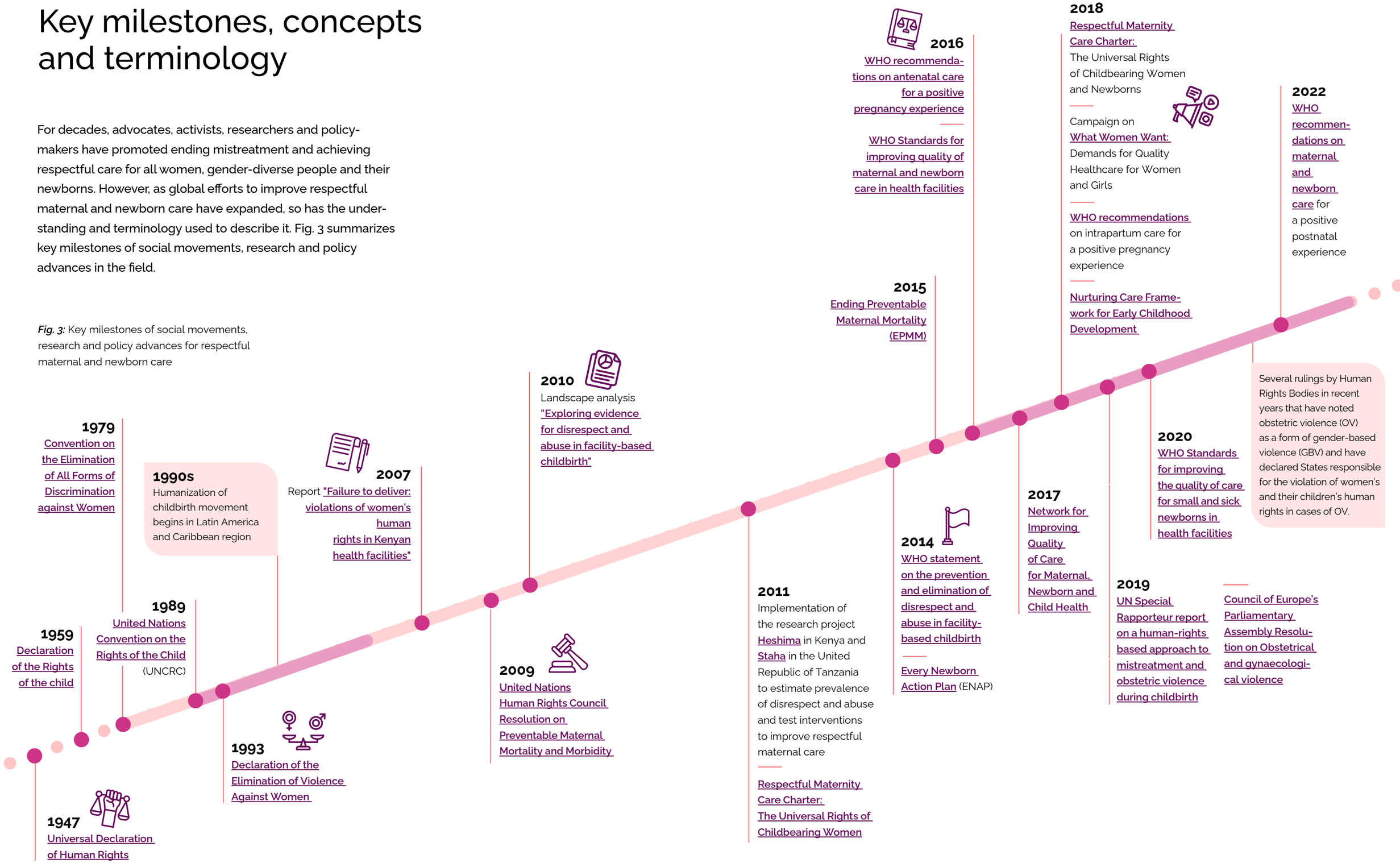
2

Understanding the history and terminology of respectful maternal and newborn care

Key milestones, concepts and terminology

For decades, advocates, activists, researchers and policy-makers have promoted ending mistreatment and achieving respectful care for all women, gender-diverse people and their newborns. However, as global efforts to improve respectful maternal and newborn care have expanded, so has the understanding and terminology used to describe it. Fig. 3 summarizes key milestones of social movements, research and policy advances in the field.

Fig. 3: Key milestones of social movements, research and policy advances for respectful maternal and newborn care



Brief history of respectful maternal and newborn care

The rise of medical technology and facility-based births in the mid-20th century contributed to the increased use of interventions such as episiotomy and fundal pressure. While these interventions can be life-saving in certain situations, their routine use without consent or consideration of the medical context, individual needs, choices and preferences, can undermine both health benefits and rights.
In the 1960s and 1970s the "humanization of childbirth" movement emerged, emphasizing a more holistic, woman-centred approach that recognized the importance of emotional, psychological and social factors during childbirth. It opposed the routine use of interventions without medical justification, highlighting the dangers of over-medicalization, including the overuse of caesarean sections, unnecessary episiotomies and other interventions that could harm both women and newborns.

The humanization of childbirth movement in Latin America was particularly strong. It championed culturally sensitive care that respected diverse traditions and beliefs associated with pregnancy, birth and care of the newborn, including family involvement, safe traditional practices, and spiritual and cultural rituals. The movement also challenged social inequalities and the power dynamics between health workers and women, particularly within the strongly hierarchical health system.
The movement coincided with a broader feminist response in the United States of America and elsewhere against the medical appropriation of women's bodies. This push-back paved the way for various initiatives that challenged disrespect and abuse in medical care.

In the early 2000s, the term "obstetric violence" emerged, referring to both the overuse of medical interventions during childbirth and the mistreatment of women, including experiences of physical, verbal, sexual and psychological abuse and discrimination and stigmatization. Obstetric violence also covered violations of women's autonomy, decision-making and informed consent *(1)*.
The term continues to be used globally to describe and raise awareness about these violations, particularly in some legal contexts in Latin America *(2)*. Argentina, Venezuela and parts of Mexico have passed laws against obstetric violence as a form of gender-based violence, outlining measures to prevent, punish and eradicate it.

In 2010, a landscape analysis of evidence of mistreatment in facility-based childbirth introduced the phrase "disrespect and abuse during childbirth". The aim was to highlight the poor treatment some women face, often due to health system conditions and constraints *(3)*, and to increase understanding of actions that constitute disrespectful and abusive care. This framing brought the issue to the forefront of efforts to improve skilled birth attendance, as called for in the Millennium Development Goals (2000–2015).

A 2015 systematic review synthesized evidence from 65 studies from 34 countries and proposed a typology, or classification, of common behaviours and characteristics, of the "mistreatment of women during childbirth" in health facilities *(4)*.
By focusing on women's experiences, this terminology confirmed how mistreatment can occur within

Mother Kadidia Sangaré (37) holds her newborn daughter Nahawa Kone, 10 days old, at the Referrence Health Center in Bougouni, Mali. Photo: © UNICEF/Ilvy Njiokiktjien

a broader context of gender inequality and violence, spanning individual interactions between women and health workers all the way through to the health system itself, where systemic failures occur. Compared to terms like obstetric violence or disrespect and abuse, mistreatment was found to be less inflammatory, making it a more useful starting point for discussions with health workers and policy-makers.

Since 2011, the concept of "respectful maternity care" has promoted a positive approach to the global maternal and newborn health agenda and facilitated engagement with health workers who provide maternity and newborn care services. The 2011 White Ribbon Alliance Respectful Maternity Care Charter exemplified this by highlighting women's rights in maternity care *(5)*.

Human rights advocacy for respectful maternity care has also clarified the entitlements of women. Similarly, "person-centred maternity care (PCMC)" promotes positivity and inclusivity in maternity care that is respectful to the needs of all individuals who become mothers, aligning with broader trends in person-centred care. In 2019, two prominent human rights entities also undertook comprehensive examinations of mistreatment during childbirth: the United Nations (UN) Special Rapporteur on violence against women and girls, and the Council of Europe's Parliamentary Assembly, through its resolution on obstetrical and gynaecological violence. Both concluded that this mistreatment constitutes a violation of women's rights and called for laws to prevent and combat such abuses, with an emphasis on tackling structural inequalities within health systems *(6, 7)*.

The concept of respectful newborn care has followed a different trajectory than respectful maternal care. Many aspects of respectful newborn care have long been embedded in global initiatives such as the Baby Friendly Hospitals Initiative (1991), which was revised in 2018, the Neonatal Integrative Developmental Care Model's emphasis on family-centred care *(8)* and the Nurturing Care Framework *(9)*. These initiatives do not specifically refer to mistreatment but highlight responsive high-quality health care from birth throughout childhood, with respect and dignity as core concepts. The right to high quality, respectful care also extends to newborns. The 2018 update of the White Ribbon Alliance Respectful Maternity Care Charter included specific statements related to the rights of the newborn, such as their right to identity and nationality from birth, and to be with their parents or guardians *(10)*.

The types of mistreatment experienced by women during pregnancy and childbirth also apply to newborns. Common forms of mistreatment of newborns include abandonment and neglect at birth, non-consented care, stigmatization and physical abuse, which can include slapping, rough handling, denial of medical care and physically inappropriate practices, such as around feeding. Mistreatment can also involve lack of bereavement care, unnecessary separation from mothers and detention in health facilities *(11-15)*. These practices all violate the universal rights of the newborn to respectful care *(10)*. Furthermore, since newborns cannot communicate verbally, non-verbal and heightened physiological cues, such as behavioural responses and pain profiles, provide valuable insights into their experiences and should be closely observed *(16)*.

Table 1 presents key concepts and terminology used to describe and understand respectful maternal and newborn care across major global documents, highlighting both similarities and differences in their definitions and framing.

Table 1:
Different concepts, terminologies across key global documents for respectful maternal and newborn care.

MATERNAL				MATERNAL AND NEWBORN		NEWBORN
Person-centred maternity care (PCMC) *(17)*	Mistreatment of women during childbirth *(18)*	Obstetric violence *(1)*	Respectful maternity care *(19)*	Universal rights of child-bearing women and newborns *(10)*	WHO standards for improving the quality of maternal and newborn care *(20)*	Defining disrespect and abuse of newborns *(11)*
Dignity and respect	Physical abuse	Physical abuse	Being free from harm and mis-treatment	Freedom of harm and ill-treatment	Respect and preservation of dignity	Physical abuse
	Verbal abuse	Non-dignified care	Preserving women's dignity	Treatment with dignity and respect		Verbal abuse
				Right to health care and to the highest attainable level of health		
Communication and autonomy			Engaging with effective communication	Liberty, autonomy, self-determina-tion and freedom from arbitrary detention	Effective communication	
			Provision of efficient and effective care			
			Respecting wom-en's choices that strengthens their capabilities			
Supportive care	Poor rapport between women and providers		Ensuring continuous access to family and community support	Right to be with their parents or guardians	Emotional supportive care	Poor rapport between provider and newborn/family
						Bereavment posthumous care
	Stigma and/or discrimination	Discriminatory care	Providing equitable maternity care	Freedom from discrimination and equitable care		Stigma and/or discrimination
				Right to an identity and nationality from birth		
	Failure to meet professional standards of care	Non-confidential care	Maintaining privacy and confidentiality	Information, informed con-sent, and respect for their choices and preferences		Failure to meet professional standards of care
		Non-consented care	Provision of information and seeking informed consent			
		Abandonment (neglected care)		Privacy and confidentiality		
		Lack of privacy				
	Health systems conditions and constraints	Detention at the health-care facility	Availability of competent and motivated human resources	Right to adequate nutrition and clean water	Essential physical resources	Health systems conditions and constraints
		Corruption			Competent motivated human resources	Legal accountability

WHO position on respectful maternal and newborn care

In 2014, WHO published a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth, which has since been endorsed by over 100 professional associations and nongovernmental and international organizations *(21)*. The statement highlighted the importance of respectful maternity care for all and articulated five actions.

1. Increase support from governments and development partners for research and action on disrespect and abuse during childbirth.
2. Initiate, support and sustain programmes designed to improve the quality of maternal health care with a strong focus on respectful care as an essential component of quality care.
3. Emphasize the rights of women to dignified respectful health care throughout pregnancy and childbirth.
4. Generate data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support.
5. Involve all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices.

Building on this statement, in 2016 WHO proposed new standards to improve the quality of maternal and newborn care in health facilities, particularly around the time of childbirth. The standards were aligned with the eight domains of the WHO framework for the quality of maternal and newborn health care, including those related to the experience of care (see Table 1) *(20)*. Current WHO guidelines on antenatal, intrapartum and postnatal care highlight that, when delivered as a package, this will contribute to high-quality and evidence-based care in all settings and should ensure positive care experiences for women and gender-diverse people *(22–24)*. Specifically, in 2018, WHO published recommendations on intrapartum care for a positive childbirth experience, which included three specific recommendations on respectful care (see Table 2) *(23)*.

WHO was a signatory to the 2011 Respectful Maternity Care Charter and its update in 2018, which included statements on the rights of newborns *(5, 10)*. In 2020, WHO published standards for the care of small and sick newborns, including Standard 5, which emphasized the respect, protection and fulfilment of the rights of newborns and preservation of dignity *(25)*. Further, the 2022 WHO recommendations for the care of preterm and low-birth-weight newborns called for family involvement in newborn care. This was to ensure that newborns are always accompanied by family members who are directly involved in their care and medical decision-making and to reduce parental anxiety and stress *(26)*.

A list of related WHO recommendations on respectful maternal and newborn care is available in Annex 3.

Table 2: Key WHO recommendations related to respectful maternal and newborn care

WHO recommendations on intrapartum care for a positive childbirth experience, related to respectful care *(23)*

Respectful maternity care	Respectful maternity care – which refers to 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 – is recommended
Effective communication	Effective communication between maternity care health workers and women in labour, using simple and culturally acceptable methods, is recommended
Companion of choice during labour and childbirth	A companion of choice is recommended for all women throughout labour and childbirth

WHO recommendations for care of the preterm or low-birth-weight infant *(26)*

Family involvement	Family involvement in the routine care of preterm or low-birth-weight newborn in health-care facilities

Manifestations and drivers

The first part of this section introduced key concepts and terminology related to mistreatment and respectful maternal and newborn care. Building on this foundation, the following part examines the manifestations of mistreatment and respectful care, along with their drivers, which can both contribute to mistreatment and promote respectful care.

Defining manifestations of mistreatment and respectful care

In the compendium the term “manifestations” applies to both positive and negative instances of respectful maternal and newborn care across the antenatal, childbirth and postnatal periods (see Fig. 4). "Negative" experiences refer to mistreatment, such as stigma and discrimination, while "positive" experiences reflect aspects of respectful, person-centred care, such as privacy and confidentiality. Conversely, the absence of these positive manifestations such as lack of privacy or inadequate pain relief signifies mistreatment. The care experiences of women, gender-diverse people and their newborns are also interconnected with those of their husbands/partners, parents and families, requiring a holistic understanding of both mistreatment and respectful care *(16)*.

Both types of manifestations highlight the challenges and critical areas for ending mistreatment and achieving respectful care and reinforce the need for health system conditions and environments that prioritize respectful care.

Mistreatment refers to specific negative instances and actions experienced by women, gender-diverse people and newborns *(2, 11, 18)*.

Respectful maternal and newborn care refers to specific positive instances of care *(19)* as reflected in the WHO framework for the quality maternal and newborn health care *(20, 25)*.

Manifestations in the broader health system

The broader health system environment is a cross-cutting factor that influences both mistreatment and respectful maternal and newborn care.

Health systems conditions:
This encompasses resources, infrastructure and adequate number of human resources needed in health facilities to support safe and effective maternal and newborn care. It includes facilities with a clean and suitable physical environment, enough beds, access to water, sanitation, energy, medicines, supplies and appropriate equipment to manage routine care and complications. Inadequate health system conditions can present serious risks during childbirth. For example, births may occur in unsanitary settings, or health workers may not be able to consistently follow proper hand hygiene protocols as outlined in WHO’s “Five Moments for Hand Hygiene” *(27)*.

Newborns may also be exposed to suboptimal conditions, such as environments with excessive noise and bright lighting. Additionally, there are instances of inadequate preparation for birth and resuscitation, such as the absence of essential equipment for immediate newborn care or the use of adult-sized bag valve masks (ambu bags) for the resuscitation of newborns.

Recognizing the spectrum of manifestations

The global community is using insights from international initiatives and existing literature to address the needs of mothers, newborns, parents and families in the context of respectful maternal and newborn care. However, while the terminology of respectful care promotes human rights and collaboration with health workers, critics argue it may obscure the root causes of mistreatment. Specifically, some contend that framing respectful care as a solution risks overlooking the manifestations of mistreatment, including intentional harm such as discrimination or the withholding of pain relief *(15)*. Mistreatment can be both intentional and unintentional, and it is essential to differentiate between the two.

Acknowledging these concerns and considering the different concepts and terminologies in Table 1, this compendium frames the issue as “**ending mistreatment and achieving respectful care**”. This is because both mistreatment and respectful care can coexist (see Fig. 4). Individuals can experience positive aspects, such as clear communication about their care. They can also experience negative instances, such as a lack of emotional support, including the absence of a companion of choice during labour and childbirth (hereafter called a labour companion) or a baby being separated from its mother/parents. Achieving respectful care requires not only addressing mistreatment but also actively promoting dignity, autonomy and compassion throughout the care experience.

Manifestations of mistreatment

Physical abuse:

Using force or harmful physical actions, such as slapping, hitting, punching and applying fundal pressure during childbirth, rough handling of newborns or slapping the baby on the back to stimulate breathing.

Verbal abuse:

Using harsh or derogatory language, judgemental or accusatory comments, shouting or screaming, also involving threats.

Stigma and discrimination:

Withholding or providing care inequitably based on factors such as age, ethnicity, gender, socioeconomic status, sexual orientation or marital status.

Neglect and abandonment:

Involving prolonged delays in providing care and instances where women are ignored or left without support during their care.

Separation of newborns from their mothers:

Involving the loss of opportunities for bonding and attachment. It disrupts the initiation of early breastfeeding and limits skin-to-skin care, which helps maintain a baby's body temperature.

Lack of bereavement care:

Involving a lack of organized form of bereavement and posthumous care in the case of baby's death, including lack of emotional support and counselling.

Detention in facilities:

Prohibiting women and their newborns from leaving facilities after childbirth due to an inability or failure to pay facility or medical fees.

Health systems conditions

Pain relief:

Offering, discussing and responding to requests for available options, such as medications and other methods, to help women manage pain and discomfort effectively.

Informed consent:

Ensuring the active participation of women in decisions regarding their care and that of their newborn by providing relevant information about tests, procedures and physical examinations.

Effective communication:

Ensuring clear and empathetic dialogue between health workers and women by actively listening and responding to their questions and concerns to foster trust and comfort.

Privacy and confidentiality:

Ensuring information is shared in a private and secure environment to respect confidentiality and maintain privacy.

Emotional support:

Providing time and attention to ensure women feel supported and adequately cared for during physical examinations and procedures. It also includes allowing a labour companion during labour and childbirth.

Bodily autonomy:

Ensuring women have the decision-making authority over their bodies and those of their newborns.

Family involvement:

Allowing families to participate in the routine care of newborns, including preterm or low-birthweight newborns in health facilities.

Manifestations of respectful care

Ending mistreatment

Achieving respectful care

Fig. 4: Spectrum of manifestations of mistreatment and respectful maternal and newborn care

Defining the drivers of mistreatment and respectful care

Having explored the manifestations of mistreatment and respectful care, it is important to examine the factors that drive them.

The term "drivers" refers to underlying factors that influence both the occurrence of mistreatment and the provision of respectful care.

These factors fall into four categories: policy-related, sociocultural, organizational and individual drivers (see Table 3).

In the compendium, drivers are framed as both contributors to mistreatment and enablers of respectful care. For example, policies can promote respectful care when laws, guidelines and accountability mechanisms are in place, such as those supporting a labour companion, family involvement in newborn care and nurturing care. In contrast, the absence of such measures increases the likelihood of mistreatment and non-consented care. Similarly, sociocultural drivers such as gender norms can have both positive and negative influences – supporting women's bodily autonomy in some cases or reinforcing harmful beliefs that devalue women in others.

19-days-old baby Aïcha in the village of Kotare, in the South of Niger. Photo: © UNICEF/ Frank Dejongh

Table 3. Definitions of different types of drivers that can contribute to mistreatment or enable respectful care

POLICY-RELATED			
Laws, guidelines and accountability mechanisms that are in place for respectful maternal and newborn care, and to protect women, gender-diverse people and newborns from mistreatment.	**Policy requirements**		
SOCIOCULTURAL			
Beliefs, practices, gender and social norms, that can impede or promote fair and equal treatment of women, gender-diverse people, newborns and families.	**Inequality, social and gender norms**	**Inclusion and non-discrimination**	
ORGANIZATIONAL			
Factors within the health system, such as the availability of resources, adequate human resources, work environment, super-vision, training and education, and infrastructure, supplies and equipment, which affect the quality of maternal and newborn care.	**Work environment**	**Resources**	**Training and education gaps**
INDIVIDUAL DRIVERS			
The attitudes and behaviours of health workers towards women, gender-diverse people and newborns, as well as the power dynamics and professional hierarchies that influence health-worker motivation and well-being.	**Personal attitudes and behaviours**	**Motivation and well-being**	

SPOTLIGHT:

Perinatal mental health and respectful maternal and newborn care

Nearly one billion people worldwide experience some form of mental illness, with approximately 80% living in low- and middle-income countries *(28–30)*. Women bear a heightened burden as they experience higher rates of mental disorders during the perinatal period *(31, 32)*. Perinatal mental disorders, such as prenatal and postpartum depression, anxiety, and somatic disorders, are among the leading complications of pregnancy and childbirth globally *(33)*. In low- and middle-income countries nearly one in five women suffers from one or more CPMDs, which can have long-term effects on their mental and physical health, functioning and quality of life *(31)*.

Health system factors contribute to this burden. Obstetric trauma such as miscarriage, stillbirth, having a small or sick newborn, and emergency caesarean sections, are risk factors for CPMDs *(31, 34–36)*. Women with limited access to reproductive services are also at greater risk for anxiety and depression *(37–39)*. Moreover, evidence shows that women's experiences of mistreatment during pregnancy and childbirth can lead to mental health issues such as post-traumatic stress disorder and postpartum depression. When health workers face burnout or mental health challenges, they also struggle to offer respectful and dignified care.

Adolescents are particularly vulnerable to CPMDs, and if girls aged 10 to 19 become mothers, they face a 63% risk of experiencing mental health challenges *(41)*. The literature also highlights the stigma and discrimination that adolescent mothers often face, which underscores the urgent need for focused attention on mistreatment of this population.

To address these challenges, it is crucial to ensure that health workers have the appropriate resources and training to provide culturally sensitive, person-centred psychological care.

A 2022 call to action *(42)* emphasized the need for a critical mass of health workers dedicated to addressing the CPMD burden within their local contexts. Additionally, supporting the mental health of health workers is vital, as their well-being directly influences the quality of care they can provide. When they receive support to deliver woman-centred care, it positively impacts women's mental health.

For example, midwife-led continuity of care is linked to improved perinatal mental health, particularly in high-income settings *(43)*.

Given the growing recognition of the connection between respectful maternal and newborn care and perinatal mental health, further research is warranted. While promoting the mental well-being of health workers may contribute to both respectful care and improved perinatal mental health, interventions to address respectful maternal and newborn care across the health system could also have a positive impact on overall CPMDs. A focused research agenda should explore how to successfully implement, measure, evaluate and sustain maternal and newborn health services that support both women's perinatal mental health and health worker mental health, while promoting respectful maternal and newborn care.

The WHO is leading efforts to define maternal well-being and develop globally applicable indicators for measuring perinatal mental health within existing systems (*44*).

Recap and what's next

This section explored the history and evolution of respectful maternal and newborn care, highlighting key concepts and terminology. It also introduced the manifestations and drivers of mistreatment and respectful care. The next section provides a deeper understanding of the specific drivers of mistreatment and how they interact to create an environment where mistreatment can occur.

Mother Delgermurun Tsolomon (32) with her baby Sugarmaa Batjargal (8 days), in the families' ger in the Alag-Erdene area in Mongolia. Photo:© UNICEF/Njiokiktjien

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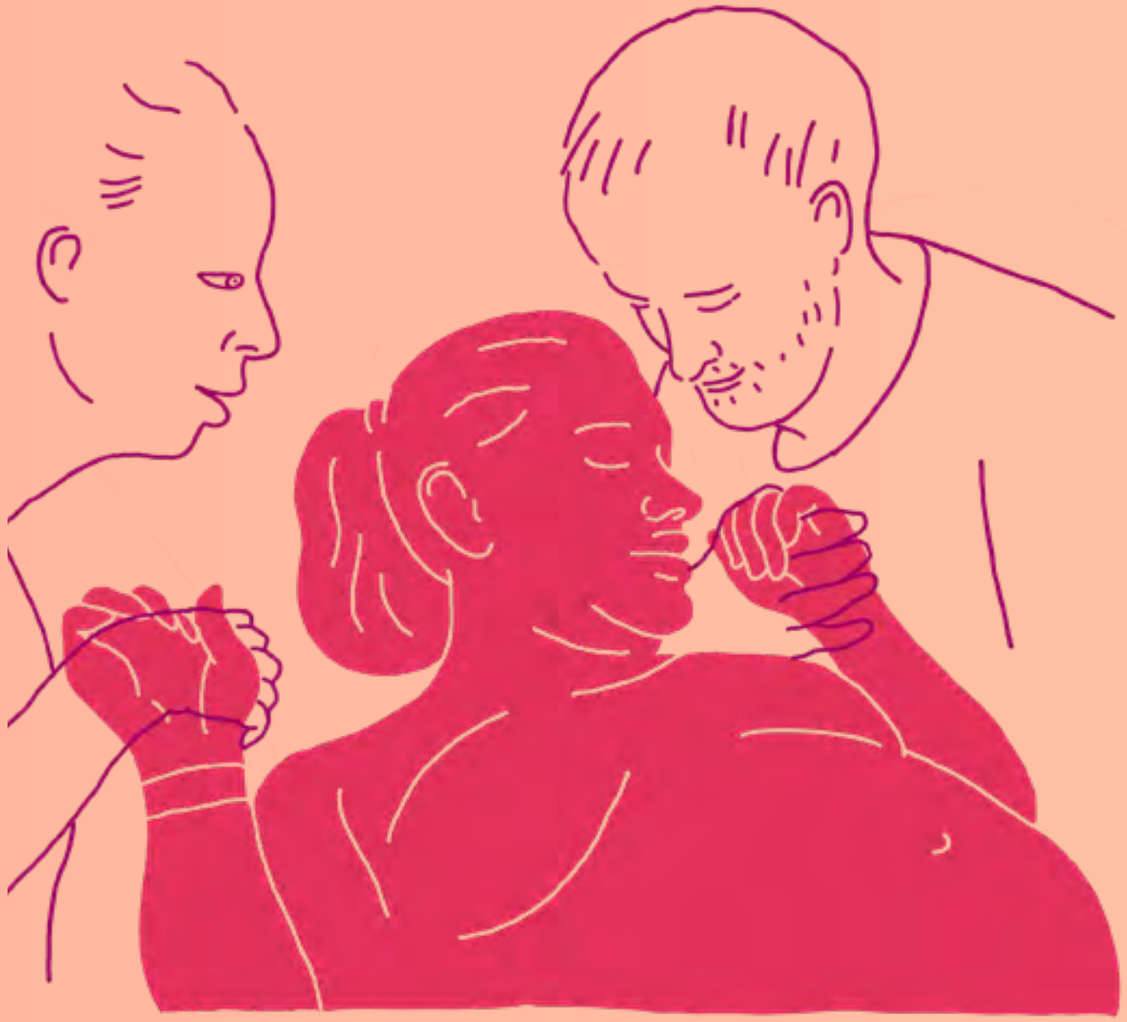
3

Deepening understanding of the drivers and areas of intervention to end mistreatment and achieve respectful maternal and newborn care



Drivers as contributors of mistreatment and enablers of respectful care

As described in Section 2, drivers are underlying factors that influence the occurrence of mistreatment and the provision of respectful care. These drivers, which may be policy-related, sociocultural, organizational or individual, can interact in complex ways to either increase the likelihood of mistreatment or enable respectful care.

Table 5 provides a summary of the types of drivers of mistreatment and respectful care, with examples of how the drivers can contribute to mistreatment. However, the same drivers can also enable respectful care when the right conditions are in place.

For example, policies, laws and guidelines related to labour companions can promote respectful care, but the lack of these can contribute to mistreatment.

By identifying and addressing the types of drivers that lead to mistreatment, it's possible to target the root causes that hinder respectful care as part of developing an implementation plan. With a clear understanding of these drivers, strategies can be implemented to enable respectful care and prevent mistreatment.

Table 5. Summary of the types of drivers of mistreatment and respectful maternal and newborn care

	Type of driver	Description	Examples from the literature
POLICY-RELATED[a]	**Policy requirements**	*Policies and guidelines, on respectful maternal and newborn care, labour companion, family involvement in newborn care, and nurturing care*	Women without a labour companion more likely to report mistreatment or physical abuse *(1)* and non-consented care *(2)* Women typically not allowed a labour companion to act as an advocate and provide emotional support *(3)*
		Laws and guidelines to protect against mistreatment of women, gender-diverse people and newborns during pregnancy, childbirth and the postnatal period	Families denied any physical access to their infants and receive only intermittent verbal updates from health workers *(4–7)* "Rules" around visiting times prevent working fathers from seeing their newborn *(8)* Failure to instate legal and policy frameworks to protect the rights and needs of women and newborns *(9)*
		Mechanisms to hold health programmes accountable	Lack of knowledge about rights among women in labour and early postnatal women and their families *(10)* Lack of mechanisms for women to share dissatisfaction, provide feedback on quality of care or hold health-workers accountable *(11)* Lack of mechanisms for policy-mandated violations of women's reproductive autonomy (i.e. sterilization programmes, policies that allow denial of care) *(12, 13)*

	Type of driver	Description	Examples from the literature
SOCIOCULTURAL[b]	**Inequality, social and gender norms**	*Beliefs and practices that value women, gender-diverse people, newborns, parents, and families*	Social and/or financial reliance on others (e.g. elder women, husbands, neighbours, health workers) for childbirth decisions *(14, 15)* Patriarchal attitudes and cultural practices affect women's ability to register the birth of their child *(16)* Respectful care policies and interventions need to consider the interconnectivity between the local community, the culture of the local institution, and the sociocultural context in which both operate *(17)* Cultural competence and respecting the cultures, values and beliefs of women was highlighted by women and health workers as important in creating a positive atmosphere in the labour ward *(18)* Disempowerment of women due to societal hierarchies *(19)* Structural gender inequality is perpetuated by traditional practices that give women lower status in the family, workplace, community and society *(11)* Normalization of mistreatment influences women's low expectations about maternity care *(10, 14, 20)* Health workers/midwives face same inequalities as women; low social status, disrespect, bullying, inequality and patriarchal structures *(11, 15, 21, 22)*
	Inclusion and non-discrimination	*Whether all women, gender- diverse people and newborns are treated fairly and equally*	Stigmatized groups (e.g. adolescents, ethnic group, racial group, caste, disability, refugee status) and those living in poverty more likely to experience mistreatment and non-consented care *(23-25)* Higher levels of mistreatment among adolescents and marginalized groups *(26)* Segregation of women and babies based on race, ethnicity or medical condition *(9)*

ORGANIZATIONAL [c]

Type of driver	Description	Examples from the literature
Work environment 	*Level of support for health workers*	Disrespected, unsupported health workers; low salaries, physical resource constraints, understaffing, disempowering working conditions and limited scope to alleviate stress and foster motivation *(11, 27, 28)* Health-worker burnout linked to mistreatment *(21)*
	Type of leadership, management and supervision	Health-worker shortages lead to women being mismanaged *(19)* Overworked, underpaid health workers lacking professional autonomy/disempowered *(19, 28, 29)* Inadequate training, poor supervision; women link mistreatment to poor training and overwork *(27, 28)* Mistreatment of women often stems from a lack of compassionate leadership which influences team culture *(15)*
Resources 	*Level of infrastructure*	Lack of privacy, beds, curtains, space for labour companions; stressful work environment due to resource shortages *(2, 11, 14, 19, 26, 28, 30)*
	Availability of supplies and equipment	Lack of educational materials for women and parents; lack of essential medicines and equipment for labour and childbirth and newborn care; lack of informed consent forms.
Training and education 	*Availability of pre- and in-service training on respectful maternal and newborn care principles and practice*	Training norms promote professional distance to secure good outcomes *(29)* and focus on biomedical elements over the rights of women and newborns *(8, 31)* Dehumanization of women begins in pre-service education as a learned behaviour *(15)*
	Level of emphasis on family involvement in newborn care	Reflected in poor communication by staff to parents of newborns *(8)* and lack of organized bereavement care in the case of an infant's death *(24, 32)*
	Strength of interpersonal communication skills	Poor communication, lack of effective understanding and information not in language spoken by client, provided in an inappropriate manner or insufficient to make informed decisions *(9, 19)*

INDIVIDUAL [d]

Type of driver	Description	Examples from the literature
Personal attitudes and behaviours 	*Types of attitude of health workers towards women, gender-diverse people and newborns*	Women's physical appearance and personal hygiene may determine how a woman is treated during childbirth *(15, 24)* Norms and stereotypes about women's decision-making competence, or judgement about fitness for motherhood can affect care provided during childbirth *(9, 10)* Lack of pain relief provided by health workers is related to training, normalization, poor supervision and cultural norms (e.g. expectations that women should "bear pain"; incorrect assumptions about the level of pain experienced by newborns) *(33)* Adolescents' can be judged harshly by health workers *(26)*
	Balance of power and professional hierarchies	Denial of care, refusal of pain relief, segregation, detention or separation of women from their newborns based on lack of economic means to pay and punishment of women for non-payment of fees *(9, 19)* Abuse of the concept of "medical necessity" to justify mistreatment (e.g. non-consented care for women and newborns, withholding information, misleading women, unnecessary clinical interventions) *(9, 20, 34–36)* Women and health-workers deem slapping acceptable to ensure a positive outcome for the baby *(11)* Physical force, pinching women giving birth or holding newborn upside down deemed acceptable *(11, 19, 37)*
Motivation and well-being 	*Level of occupational health of health workers*	Stressful work conditions, including workload, emotional exhaustion, anger and frustration, and inability to manage difficult situations, are linked to poor treatment of women *(15, 21, 28, 38)* Health workers report the effects of emotional exhaustion, depression and burnout on the delivery of maternity care *(21, 35, 38)* Women's perception of staff as verbally abusive, rude, bossy, unhelpful, critical, easily angered and lacking compassion *(14)* and parents' perception of health workers being unhelpful with newborns *(24)*

[a] Policy-related: Laws, guidelines and accountability mechanisms that are in place for respectful maternal and newborn care, and to protect women, gender-diverse people and newborns from mistreatment.
[b] Sociocultural: Cultural beliefs and practices, gender and social norms, that can impede or promote fair and equal treatment of women, gender-diverse people, newborns and families.

[c] Organizational: Factors within the health system such as the work environment, supervision, training and education, and infrastructure, supplies and equipment that affect the quality of maternal and newborn care.
[d] Individual: The attitudes and behaviours of health workers towards women, gender-diverse people and newborns as well as the power dynamics and professional hierarchies that influence health-worker motivation and well-being.

Areas of interventions to end mistreatment and achieve respectful maternal and newborn care

Research on a broad set of effective interventions to improve respectful care policy and practice is rapidly growing, however the evidence base remains limited and varies across interventions. At this stage, a set of promising interventions has been identified to address the drivers of mistreatment and strengthen those that promote respectful care.

The compendium refers to areas of intervention aimed at ending mistreatment and promoting respectful care as promising interventions, where evidence from reproductive, maternal, newborn and child health studies is limited or based on small-scale research. While these interventions show positive outcomes, further evaluation is needed to confirm their effectiveness (see Annex 1 for details on the methodology used to identify interventions). Fig. 5 summarizes areas of intervention across different levels of the health system – national, subnational, facility and community – drawing on recommendations from WHO and the UN, systematic reviews and other literature. These promising interventions are categorized into areas of intervention based on the domains from a published review *(39)*.

Interventions aimed at the national and subnational levels aim to strengthen policies, laws and standards; enhance leadership and governance; support subnational and facility levels; and advocate with partners to raise awareness. At the facility level, interventions centre on quality improvement, health-worker well-being, and engaging with women and gender-diverse people in their care, including ensuring their input on service provision. Community-level interventions include health education, community mobilization and grass-roots advocacy.

Each of the following subsections includes a box that highlights standards, recommendations, best practices and/or promising interventions, with visual keys to aid understanding (i.e. the colour-coded sections and the health system levels of N/S/F/C).

Fig. 5. Areas of intervention to end mistreatment and achieve respectful maternal and newborn care

1. Enact policies, laws and standards
2. Improve leadership and governance
3. Implement quality improvement measures
4. Improve the facility and work environment
5. Promote labour companionship and family involvement in newborn care
6. Support the well-being of health workers
7. Strengthen interpersonal communication
8. Tackle stigma and discrimination
9. Engage community members through health education and mobilization strategies

Explanation of icons and terms used in the following overviews:

Related standards, recommendations, statements, considerations and promising interventions:

WHO or UN standards or recommendations	WHO or UN best practice statements, remarks or implementation considerations	Promising strategies / interventions

Health system level at which intervention is aimed at:

	**National (N)**	This level of the health system encompasses a range of policy, strategy, financing, education and other activities implemented by actors and institutions that operate at national level.
	**Subnational (S)**	This level of the health system encompasses a range of activities that may be implemented at subnational level.
	**Facility (F)**	This level of the health system encompasses a range of activities that are implemented in health facilities where women and newborns receive antenatal, labour, childbirth and postnatal care.
	**Community (C)**	This level of the health system encompasses a range of activities that are implemented at community level.

Ethnic midwife Sung Thi Cua visited Mrs. Sung Thi Ghenh, mother of Hang A Cua at her house, Pu Nhi commune, Dien Bien Dong District.
Photo: © UNICEF/Ho Hoang Thien Trang

1 Enact policies, laws and standards

National and subnational laws can provide the framework and legal basis to create a health system that upholds the rights and dignity of women, gender-diverse people and newborns. Recommendations from the UN and the Council of Europe can guide countries in addressing mistreatment during childbirth using a human rights framework *(9)*. Implementing policies and standards for respectful care and involving civil society in policy dialogue enhances the environment for respectful newborn and maternal care *(39, 40)*.

Drivers addressed:

- **Policy requirements**
- **Inclusion and non-discrimination**

Recommendation: respectful maternal and newborn care – 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 (***Global***; *41)*

A policy of respectful maternity care is in accordance with a human rights-based approach (***Global***; *42*)

Written, **up-to-date standards and benchmarks** that outline clear goals, operational plans and monitoring mechanisms for respectful maternity care (***Global*** *41*)

Integrate standards for respectful maternal and newborn care at all levels, including parental and **family** involvement in all care, non-separation of **mother** and newborn and **communication support for families** (***Global***; *43*)

Review and strengthen **laws and policies to prohibit the mistreatment of women during pregnancy and childbirth**; laws and policies should ensure autonomy in decision-making, free and informed consent, privacy and confidentiality (***Global***; *44, 45*)

Ensure that policies, programmes and budgets promote **health workforce educational and career development opportunities, pre-service education and in-service training of all health workers on respectful maternal care**, in accordance with WHO norms and guidelines (***Global***; *44, 45*)

Improve and standardize the content, curricula and development of competence in neonatal care in pre-service programmes for health workers, emphasizing neglected topics, including family-centred, respectful care (***Global***; *43*)

2 Improve leadership and governance

Organizational factors influence the behaviour of health workers, thus improving organizational structures and processes can enhance respectful maternal and newborn care *(28)*. This can include strategies such as addressing staff shortages, providing supportive supervision and peer support and transforming leadership, all of which can be implemented regardless of resource limitations *(21)*. A combination of interventions targeting structural and normative organizational change may positively influence the ability and willingness of health workers to provide respectful maternal and newborn care *(28)*.

Drivers addressed:

Work environment

Policy requirements

Leadership and governance requirements for respectful maternal, newborn and child health, including: easily accessible mechanisms for service users and providers to submit complaints to management; and establishment of accountability mechanisms for redress in the event of mistreatment or violations (***Global***; *41*)

Continuous policy dialogue in technical meetings with government, civil society and professional knowledge networks to compel critical actors to reflect on disrespect and abuse as a key component of quality of maternity care (part of a multicomponent package, the Heshima project) (***Kenya***; *46*)

Ensure meaningful participation by women and civil society in all levels of legal and policy decision-making, and in monitoring (***Global***; *44, 45)*

Strengthen the capacity of regulatory bodies and health professional associations, including national human rights institutions, to exercise oversight over public and private birthing facilities (***Global***; *44, 45*)

Strengthen mechanisms for the systematic reporting, monitoring and evaluation of mistreatment of women during childbirth in public and private health-care facilities (***Global***; *44,45*)

For example, incorporate survey items on mistreatment domains into ongoing efforts such as demographic and health surveys and more targeted surveys (***Ghana, Guinea, Myanmar, Nigeria***; *30*)

Ensure accountability for mistreatment of and violence against women during childbirth, including by: creating, strengthening and funding accountability mechanisms to foster the accountability of multiple actors at various levels, both within health-care settings and within the justice system (***Global***; *44, 45*)

Leadership transformation via a cooperative inquiry group to identify issues related to organizational culture, and to plan, implement and reflect on organizational changes (***South Africa***; *48*)

Ethical leadership training for nurse managers to improve organizational culture and trust among peers and with supervisors (***Republic of Korea***; *49)*

Leadership development training for frontline maternity care staff addressing organizational culture, leadership skills and interpersonal communication (***Ghana***; *50)*

Health facility committees to monitor quality, identify poor health-worker performance and improve accountability of health services (***Malawi***; *47)*

Citizen Voice and Action – an advocacy approach to transform dialogue between communities and health workers and government by educating citizens on rights and responsibilities and involving them in auditing services to assess whether they meet existing standards set by government (***Global***; *51*)

One week after birth Hiwot is taking care about her baby Elizabeth in Ethiopia.
Photo: © WHO/ Petterik Wiggers

3 Implement quality improvement measures

Quality improvement interventions include evidence-based practices, continuous monitoring, and supportive supervision and feedback. For example, teams can monitor mistreatment cases and address issues related to infrastructure and organizational culture *(46, 52)*.
Quality improvement frameworks, such as Plan-Do-Study-Act (PDSA) cycles, can help facilities identify problems and refine practices to improve care *(41)*. Adopting client service charters and working in partnership with women and communities can help define and monitor care quality *(53, 54)*.

Drivers adressed:

- **Work environment**
- **Training and education gaps**
- **Personal attitudes and behaviours**
- **Motivation and Well-being**

Implementation guidance for improving quality of maternal, newborn and child health across system levels (national, district, facility) with community engagement, using an adapted PDSA model for continuous quality improvement (***Global***; *41)*

Supervision and monitoring requirements for reproductive, maternal, newborn and child health, including: regular supportive supervision by labour ward/facility lead; staff meetings to review respectful maternity care practices; establishment of informed consent procedures (***Global***; *41)*

Use community-based assessment to identify mistreatment domains and hold the health system accountable (***Ghana, Guinea, Myanmar, Nigeria***; *30)*

Adapt a national client service charter and a maternity ward quality improvement process to activate components of the charter; implementation by facility, district and community stakeholders (part of a multicomponent package, the Staha project) (***United Republic of Tanzania***; *53)*

Partnership defined quality – a participatory methodology to improve quality of services with community involvement in defining, implementing and monitoring the quality improvement process (***Global***; *55)*

Supportive supervision training for supervisors (including reproductive and child health staff on district health management teams and obstetric care facility managers), covering human resource management, supervisory and support skills and action learning to improve understanding and application of supportive supervision practices (***United Republic of Tanzania***; *56)*

Team-based quality improvement and "Improvement Collaborative" model to improve women's childbirth experience (***India***; *57)*

Strengthen facility quality improvement teams for monitoring, addressing and resolving disrespect and abuse cases and addressing infrastructure, drugs and commodity supply concerns (Heshima project) (***Kenya***; *46)*

Post-training quality improvement supportive supervision visits to promote routine quality improvement within a respectful maternity care intervention (***Ethiopia***; *58)*

Institutionalized quality improvement processes, quality improvement teams and PDSA cycles to implement maternal and newborn health quality of care standards (***Bangladesh, Ghana, United Republic of Tanzania***; *52)*

Community Health Worker and Mother's Support Group Facilitator Mbalu Turay (right) meets with parents Kankay Suma (left) and Amara Turay in Masiaka Community, Kambia District, Sierra Leone. Photo: © UNICEF/Michael Duff

Patient safety walkrounds to allow frontline staff to improve identification of patient safety incidents and their resolution, improve teamwork and open communication between providers and managers (***Iran (Islamic Republic of)***; *59)*

Mentorship – on-the-job role-modelling of provider behaviour change towards reproductive, maternal, newborn and child health by identified facility champions, as part of routine continuous professional development (part of a multicomponent package, the Heshima project) (***Kenya***; *46)*

4 Improve the facility and work environment

The facility environment significantly affects the well-being, motivation and performance of health workers. In countries with acute resource shortages, issues such as understaffing, heavy workloads and inadequate physical environments all contribute to unacceptable behaviour among health workers, including mistreatment of women and newborns *(28)*. To support respectful care, improvements are needed in facility infrastructure, including private waiting areas, adequate lighting and bathrooms with hand-washing facilities. Additionally, ensuring manageable workloads, reliable access to supplies and equipment and safe working conditions with water and electricity are essential *(39)*. Another important aspect is creating a care environment with the necessary infrastructure and policy changes to make facilities more adolescent-friendly *(26)*.

Drivers addressed:

- **Resources**
- **Training and education gaps**

Infrastructure requirements for reproductive, maternal, newborn and child health, including: clean, appropriately illuminated, well ventilated labour, childbirth and neonatal areas that allow for privacy and are adequately equipped and maintained; clean and accessible bathrooms for use by women in labour; curtains, screens, partitions and sufficient bed capacity and facilities for labour companions, including physical private space for the woman and her companion (***Global***; *41*)

For example, improve facility infrastructure, including establishing a waiting room for pregnant and labouring mothers, screens or curtains to maintain privacy, bathroom and toilet with a door and handwashing sink with soap and water (***Ethiopia***; *60*)

Supplies and equipment requirements for reproductive, maternal, newborn and child health including: provisions for staff in the labour ward (e.g. refreshments); a standard informed consent form; information (written or pictorial, e.g. as leaflets) for the woman and her companion; essential medicines and basic adequate equipment for labour and childbirth available in sufficient quantities at all times in labour and childbirth areas (***Global***; *41*)

Ensure that work processes and organizational management include a manageable workload and working conditions, with adequate facilities, a decent working environment (including water and electricity) and the availability of medications, supplies, equipment, management and treatment guidelines (***Global***; *61*)

Guidance on making health services adolescent-friendly, including dimensions of quality health services for adolescents (i.e. equitable, accessible, acceptable, appropriate, effective) (***Global***; *62*)

For example, implementation of the Adolescent Champion Model to help primary care sites become more adolescent-centred; including a multidisciplinary champion team trained on adolescent-centred care, and policy, attitudinal and infrastructure changes to facilities to make them more adolescent-friendly, especially regarding confidentiality (***USA***; *63*)

5 Promote labour companionship and family involvement in newborn care

Access to a trusted labour companion can improve women's health outcomes and childbirth experiences by promoting autonomy and enhancing the relationship between women and health workers *(3, 43)*. Factors that affect the involvement of a labour companion include the level of awareness, health-worker attitudes, facility regulations and the availability of space and privacy in facilities *(64)*. Similarly, involving families in newborn care improves outcomes, especially for preterm or low-birth-weight babies *(65)*. Strategies such as family-centred care for newborns and zero separation of the mother and baby should be prioritized. Facility policies and administration should ensure that families have access to beds, food and bathing and toilet facilities throughout the infant's facility stay, to enable family support and engagement in newborn care *(66)*. These issues can be addressed through changes to policy-, facility- and community-level activities *(43)*.

Drivers addressed:

- **Policy requirements**
- **Work environment**
- **Resources**
- **Training and education gaps**

Recommendation: a companion of choice is recommended for all women throughout labour and childbirth (***Global***; *43*)

Facilitating a woman's choice with regard to a birth companion is an important component of reproductive, maternal, newborn and child health and is in accordance with a human rights-based approach (***Global***; *42*)

Resource requirements for labour companionship include: staff time to manage the labour companion service; orientation sessions on supportive companionship techniques for companions; information, education and communication materials on supportive techniques; private physical space for the woman and her companion at the time of birth; and time to train the companion of choice to provide support (***Global***; *41*)

Integration of a tailored companionship model into public hospitals, including: (i) identification of a female relative as labour companion by women; (ii) provision of information, education and communication materials to women and companions; and (iii) allowing companions to accompany women throughout the first stage of labour (***Egypt, Lebanon, Syria;*** *67*)

An educational intervention to promote childbirth companions to improve clinical outcomes and quality of care, including: a workshop for maternity staff with an interactive workbook; posters and banners encouraging women to bring a companion; illustrated pamphlets for staff and pregnant women to show how companionship could be promoted locally and a magazine-style video on birth companionship (***South Africa***; *68*)

6 Support the well-being of health workers

Protecting the health, safety and well-being of health workers contributes to improving their productivity, job satisfaction and retention. Health workers have the right to safe and healthy working conditions to protect their own health. However, they often face risks from infections, hazardous substances, psychosocial stress, violence and inadequate sanitation *(43)*. The COVID-19 pandemic reinforced the importance of health-worker mental health, prompting organizations such as WHO and the International Labour Organization to issue recommendations for safeguarding their rights and well-being *(69–72)*. This period also sparked renewed interest in self-care and coping strategies, with interventions such as peer-support programmes designed to bolster resilience, and coping mechanisms, including in humanitarian settings *(46, 73, 74)*.

Drivers addressed:

- **Personal attitudes and behaviours**
- **Motivation and Well-being**

The WHO global health and care-worker compact (i.e. the Global Care Compact) complies with international laws and regulations and includes a framework for action with recommendations and policy actions on: preventing harm, providing support, promoting inclusivity and safeguarding the rights of health and care workers (***Global***; *72)*

Occupational health and safety programmes for health workers
At national level, this can include, for example, a policy statement on occupational health and safety issued and communicated to all workplace levels, and/or a unit/person in the Ministry of Health in charge of the occupational health and safety of health workers

At facility level this can include, for example, focal points for occupational health and safety designated and trained in all health facilities, a regular training programme and safety briefing plan for all health workers, regular risk assessments and prevention and mitigation of occupational hazards) (***Global***; *70)*

Ensure fair salaries and salary incentives are consistently paid, including hardship allowances and family and lifestyle incentives (such as housing and education allowances), with formal employment contracts that state clear roles and expectations (***Global***; *72*)

Ensure that the rights of health workers are fully protected, respected and fulfilled and that health workers are free from discrimination and violence in the workplace (***Global***; *44, 45)*

Peer support to empower and enhance resilience and morale among nursing staff can include off-site reflective sessions and post-work huddle sessions to discuss negative feelings and/or job stress (the Huddling Programme) (***Republic of Korea***; *75*)

Caring for carers – group or individual counselling to support providers with coping mechanisms to overcome experiences of high workload, trauma and critical incidents (part of a multi-component package, the Heshima project) (***Kenya***; *46)*

Recommendations for organizational interventions for the promotion of positive mental health and prevention of mental health conditions:

Universal interventions
Organizational interventions that address psychosocial risk factors, including those involving participatory approaches, may be considered for workers to reduce emotional distress and improve work- related outcomes

Organizational interventions for health, humanitarian and emergency workers
Organizational interventions that address psychosocial risk factors, for example reductions to workload and schedule changes or improvement in communication and teamwork, may be considered for health, humanitarian and emergency workers to reduce emotional distress and improve work-related outcomes

Organizational interventions for workers with mental health conditions
Reasonable work accommodations should be implemented for workers with mental health conditions, including psychosocial disabilities, in line with international human rights principles (***Global***; *72*)

Recommendations for training managers for the promotion of positive mental health and prevention of mental health conditions:

Manager training for health, humanitarian and emergency workers
Training managers to support the mental health of health, humanitarian and emergency workers should be delivered to improve managers' knowledge, attitudes and behaviours for mental health and improve workers' help-seeking (***Global***; *72*)

Recommendations for training workers for the promotion of positive mental health and prevention of mental health conditions

Training for health, humanitarian and emergency workers in mental health literacy and awareness
Training health, humanitarian and emergency workers in mental health literacy and awareness to improve mental health-related knowledge and attitudes at work, including stigmatizing attitudes (***Global***; *72)*

Recommendations for individual interventions for the promotion of positive mental health and prevention of mental health conditions:

Universal interventions
Universally developed psychosocial interventions that aim to build workers' skills in stress management may be considered for workers to promote positive mental health, reduce emotional distress and improve work effectiveness
Opportunities for leisure-based physical activity may be considered for workers to improve mental health and ability to work

Individual interventions for health, humanitarian and emergency workers
Universally delivered psychosocial interventions that aim to build workers' skills in stress management may be considered for health, humanitarian and emergency workers to promote positive mental health and reduce emotional distress
Psychosocial interventions may be made available for health, humanitarian and emergency workers who are experiencing emotional distress

Individual interventions for workers with emotional distress
For workers with emotional distress, psychosocial interventions such as those based on mindfulness or cognitive behavioural approaches, or problem- solving training, may be considered to reduce these symptoms and improve work effectiveness

For workers with emotional distress, physical exercise, such as aerobic training and weight-training, may be considered to reduce these symptoms (***Global***; *72*)

7 Strengthen interpersonal communication

Effective communication is vital for improving the quality of maternal and newborn health services *(76, 77)*. It fosters information exchange, builds trust and involves women, gender-diverse people and parents in decision-making, protecting their rights and ensuring informed consent. Interventions focused on improving interactions between health workers and women, parents and families are more likely to foster positive interpersonal relationships and inclusive decision-making processes *(78)*. Promising strategies targeting health workers include behaviour change interventions, education in family involvement as part of newborn care training, counselling and communication *(11, 78)*, and various models of in-service training on respectful care *(58, 66, 79, 80)*.

Drivers addressed:

- **Training and education gaps**
- **Personal attitudes and behaviours**

Recommendation: effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods (**Global;** *41*)

- Introducing themselves to the woman and her companion and addressing the woman by her name;
- Offering the woman and her family the information they need in a clear and concise manner (in the language spoken by the woman and her family), avoiding medical jargon, and using pictorial and graphic materials when needed to communicate processes or procedures;
- Respecting and responding to the woman's needs, preferences and questions with a positive attitude;
- Supporting the woman's emotional needs with empathy and compassion, through encouragement, praise, reassurance and active listening;
- Supporting the woman to understand that she has a choice, and ensuring that her choices are supported;
- Ensuring that procedures are explained to the woman, and that verbal and, when appropriate, written informed consent for pelvic examinations and other procedures is obtained from the woman;
- Encouraging the woman to express her needs and preferences, and regularly updating her and her family about what is happening, and asking if they have any questions;
- Ensuring that privacy and confidentiality are maintained at all times;
- Ensuring that the woman is aware of available mechanisms for addressing complaints;
- Interacting with the woman's companion of choice to provide clear explanations on how the woman can be well supported during labour and childbirth (***Global***; *41*).

Resource requirements for effective communication include: adequate skilled birth attendants; education curricula in pre- and in-service training on communication that reflects women's social, cultural and linguistic needs; training strategies to promote, sustain and assess the communication skills of maternity care staff; regular in-service training on communication during labour and childbirth; and support for clinical staff who provide care for women in labour to attend communication training (***Global***; *41)*

Simulation-based training for health workers to improve identification and management of obstetric and neonatal emergencies, including components of respectful maternal care (dignity, respect, communication, autonomy, supportive care) (***Ghana***; *81)*

Intervention to improve communication between providers and parents of hospitalized newborns and young children; with a focus on: (i) provision of high-quality respectful care, interpersonal communication and interactions with parents, including fathers and (ii) facilitation of better parent–provider engagement through increased awareness and coaching around essential integrative care elements (***Kenya***; *8*)

Training to improve interpersonal skills of health workers, based on communication theories such as motivational interviewing techniques for counselling on prevention of mother to child transmission of HIV (***Namibia, South Africa, Swaziland***; *48*)

Continuing education on respectful maternity care for midwives using the Intellectual Partnership Model principles and cooperative learning, including lectures, videos, small group discussion and role play to incorporate respectful maternity care principles into clinical management (***United Republic of Tanzania***; *79*)

Training for health workers using a respectful maternity care training manual; topics included human rights and law in the context of reproductive health, respectful maternity care rights and standards, professional ethics and continuous quality improvement. Training delivered via presentations, role plays, demonstrations, case studies, individual readings, video shows and hospital visits (***Ethiopia***; *58*)

Communication training for clinical staff in the maternity department to improve informed consent (***Malawi***; *80*)

Family-centred care to promote health worker–parent and health worker–baby communication, including parent training, demonstrations and skill station, and training for nurses. including communication skills, sensitization on family-centred care and skill-building for mothers (***India***; *82)*

Recommendation: effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods (***Global***; *41)*

In Spain, newborn baby girl Sofia Karapetyan with her mother Lilit Grigoryan poses at the Vall d'Hebron Barcelona Hospital Campus in Barcelona. Photo: © UNICEF/Pau Barena

A student midwife in Masuba, Makeni on placement at Makeni Regional Hospital, Bombali District, Sierra Leone. Photo: © WHO/Abbie Trayler-Smith

8 Tackle stigma and discrimination

Power dynamics, including imbalances where health workers dominate women and restrict their rights, can manifest as mistreatment *(10)*. Professional hierarchies can further contribute to abusive environment, fostering a lack of compassion and reinforcing mistreatment *(15, 83)*. Human rights education, including on gender, values clarification and attitude transformation *(66)*, and dialogue-oriented approaches, can help address these issues *(84–86)*. Other interventions include participatory training for health workers and service users, community-driven empowerment approaches for groups facing discrimination, and policy reform *(87)*. Eliminating stigma and discrimination experienced by marginalized groups requires multilevel interventions, including training, community engagement and policy reform *(87)*.

Drivers addressed:

- **Personal attitudes and behaviours**
- **Motivation and Well-being**
- **Inclusion and non-discrimination**

Values clarification and attitude transformation workshops involving health-worker reflection to mitigate effects of stigma and increase provision and access to care (***Asia, Africa, Latin America***; *88*)

Promoting respectful care based on values clarification and attitude transformation – including training on provider and client rights and obligations, revision of professional ethics and practices, action plans for institutionalization (part of a multicomponent package, the Heshima project) (***Kenya***; *46)*

Reproductive justice-informed training empowers health workers to intervene when mistreatment happens, or to be societal advocates for reproductive justice and policy change *(10)*

For example, a study to design a reproductive justice curriculum to incorporate into medical education (***USA***; *89*)

Implicit-bias training for practicing clinicians offers an opportunity for providers to reflect on their role in upholding inequality (*10)*

For example, a framework for implicit-bias-informed medical education (***Canada***; *85*)

Training workshops to improve the attitudes of health workers towards women; designed for reproductive health-care nurses based on the Health Workers for Change curriculum (***United Republic of Tanzania***; *86*)

Sensitivity training programme for key populations, for health workers to reduce judgemental and discriminatory attitudes towards marginalized groups; topics include social norms and values, human sexuality and sexual behaviour, legal and legal rights context and socio-structural marginalization and prejudice (***South Africa***; *90*)

Empowerment approaches to improve client coping mechanisms to overcome stigma at the health facility level (e.g. bringing together health workers and clients in a workshop setting outside of the facility, to share information, increase contact and use empowerment strategies to challenge stigma related to HIV and intersecting issues) (***USA***; *91)*

Stigma-reduction training programme for sexual and reproductive health providers to improve attitudes and client satisfaction, using participatory activities including sharing personal stories and experiences, value clarification, case studies and writing a charter for a stigma-free service **(*Bangladesh*;** *92*)

Dialogue-oriented approaches that bring together health workers, women and families to discuss quality concerns, bringing experiences / stories of marginalized groups into the discussion (*10)*

For example, an intervention to address structural determinants of HIV and gender-based violence that used dialogue to build critical consciousness (***South Africa***; *84*)

9 Engage community members through health education and mobilization strategies

WHO recommendations for respectful maternal and newborn care emphasize the importance of engaging community members in maternal and newborn care, and raising awareness about respectful care as a human right *(93)*. Activities such as maternity open days and workshops help community members learn about respectful care and their rights to care during childbirth *(46, 94)*. Community involvement in quality reviews, using tools such as scorecards and advocacy strengthens the accountability of services to better respond to community needs *(31)*. There is also some evidence to support social accountability and community monitoring in broader health areas *(95)*.

Drivers addressed:

- **Policy requirements**
- **Inclusion and non-discrimination**

Community-level sensitization activities should be undertaken to disseminate information about:

- respectful maternity care as a fundamental human right of pregnant women and babies in facilities;
- facility-based practices that lead to improvements in women's childbirth experience (e.g. respectful maternity care, labour and birth companion ship, effective communication, choice of birth position, choice of pain relief method);
- unnecessary birth practices that are not recommended for healthy pregnant women and that are no longer practised in facilities (e.g. liberal use of episiotomy, fundal pressure, routine amniotomy) (***Global***; *41*).

Activities working with or involving communities in reproductive, maternal, newborn and child health programmes – categorized into community mobilization, community engagement, community participation and social accountability – many of which have been or could be adapted for promoting respectful care (***Global***; *96*)

Maternity open days – trust-building with local communities during which men and women from the community can visit the nearby facility and learn about procedures in the maternity wards and interact with nurse-midwives (part of a multicomponent package, the Heshima project) (***Kenya***; *46*)

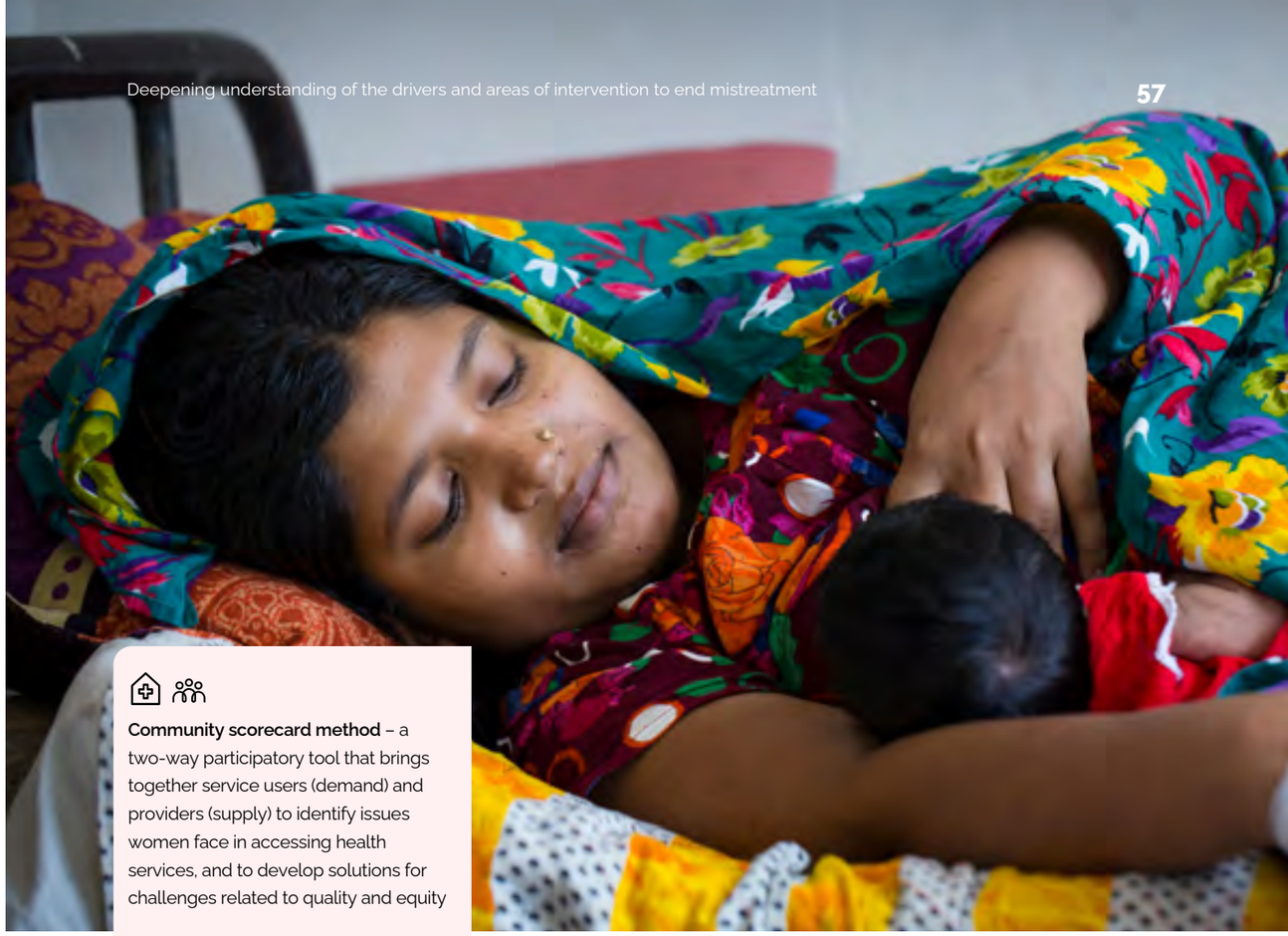
Mediation and dispute resolution – training society leaders (e.g. community health workers and other respected persons) as mediators, to act as intermediaries between community members and the health facility to address disrespect and abuse issues; mediators selected by communities and facilities and trained by the Federation of Women Lawyers–Kenya (part of a multicomponent package, the Heshima project) (***Kenya***; *46*)

Legal empowerment programme to build community capacity to demand quality health care through community paralegals and village health committees (Namati project) (***Mozambique***; *10*)

Counselling of community members who have experienced disrespect and abuse, conducted by the Federation of Women Lawyers–Kenya and other professional counsellors, within the facilities. These would be referrals from community health workers or community legal aids (part of a multicomponent package, the Heshima project) (***Kenya***; *46*)

Community workshops including education on community rights to sexual and reproductive health care, sensitization meetings for community members on respectful care, and deliberate efforts to involve men in workshops as participants and facilitators (part of a multicomponent package, the Heshima project) (***Kenya***; *46*)

Client service charter developed through a participatory process with facility staff and community members, including consensus on rights, responsibilities and accountability, and disseminated to hospital departments and communities in catchment areas (part of a multicomponent package, the Staha project) (***United Republic of Tanzania***; *53*)



Community scorecard method – a two-way participatory tool that brings together service users (demand) and providers (supply) to identify issues women face in accessing health services, and to develop solutions for challenges related to quality and equity

For example, using the community scorecard to address maternal health service challenges experienced by adolescents (e.g. stigma and unfriendly services) (***Uganda***; *97*)

Open birth days – a birth preparedness and participatory antenatal education programme to empower women to advocate for quality health care and orient them to their rights during childbirth (***United Republic of Tanzania***; *94*)

Masuda is breastfeeding her new born baby at the Patuakhali District Hospital maternity ward. Photo: © UNICEF/Mawa

Multicomponent interventions targeting all levels of the health system have been shown to reduce the mistreatment of women and newborns *(98)*. However, many of the promising interventions have been implemented individually rather than as part of a broader package. Few have been tested to measure mistreatment or respectful care, but instead target their drivers and manifestations.

When developing a strategy for respectful maternal and newborn care, interventions can be selected to target the most prevalent drivers. Since these drivers often interact across multiple levels of the health system, the final implementation plan will likely require a combination of interventions across several levels. However, recognizing their strengths and limitations is essential when selecting interventions for the programme context. Ongoing documentation of lessons learned from programmes and further research on their impact are needed to strengthen the evidence, as discussed in Section 4.

Examples from the field

Multicomponent interventions to strengthen respectful maternal and newborn care

Boxes 2–6 illustrate multicomponent interventions that are designed to strengthen respectful maternal and newborn care, including prompts to encourage reflective learning and deeper engagement with the content.

Maurice, a community health worker at Musovu Health Post, gives vitamin A supplements to Dativeis daughter in Bugesera. District, Rwanda.
Photo: © WHO/Isaac Rudakubana

Box 2. Implementing a tailored labour companion model in public hospitals in Egypt, Lebanon and Syria

A labour companion model was introduced in three public hospitals in Egypt, Lebanon and Syria as part of an implementation research initiative. The aim was to assess the impact of labour companionship on various outcomes, including caesarean section rates, satisfaction with childbirth and women's perceived control during labour and childbirth *(67)*.

The model involved these steps:

1. women were invited to choose a female relative as their labour companion;
2. a health worker (such as a resident, intern or midwife) used a flip chart to brief the women and their chosen labour companion;
3. the health worker invited the labour companion from the waiting room to the labour room; and
4. the labour companion could stay throughout the first stage of labour.

FACILITY LEVEL

Several strategies were used to design and implement the labour companion model at the facility level, including the following.

Formation of steering committee
In each hospital, a steering committee was convened, consisting of the head of obstetrics, the head of midwifery, the hospital manager and members of the research team. While committee composition varied slightly by site, each served the same purpose: to design an appropriate implementation process, assign key personnel and establish communication channels.

Reflection prompt: *Who would you include on your steering committee in your context to increase buy-in and improve outcomes for implementing a new model of care, such as labour companionship?*

Seminars
Formative research identified concerns by health workers about the benefits of a labour companion. In response, the steering committee and research team organized seminars targeted at different groups of health workers. These were delivered at various stages of implementation, particularly as there were high levels of staff turnover and rotation. The seminars presented evidence on labour companionship and information about the study.

Reflection prompt: *What role do education and continuous dialogue with health workers play in changing practices?*

Information, education and communication materials
Materials were developed based on site visits, regional team meetings and formative research. Posters were placed in labour rooms, waiting areas and nursing stations to inform health workers, women and labour companions about the importance of labour companionship and labour room regulations, including "do's and don'ts" for labour companions. Health workers were trained to use a flip chart to brief women and their selected labour companions upon arrival at the facility. This briefing educated women and their companions on their role while also addressing the concerns of health workers about potential interference.

Reflection prompt: *What impact would visual aids and materials such as posters and flip charts have on improving communication and understanding between women, their labour companions and health workers?*

Adjustments to labour rooms
Modifications were made to labour rooms, including installing curtains or separators between beds, adding chairs for companions, ensuring access to hot water and toilet facilities and providing disposable gowns and name tags for companions.

Reflection prompt: *How might adjustments to the physical environment of labour rooms in your setting affect women's comfort and improve respectful care?*

Box 3. Heshima – a multicomponent intervention to address disrespect and abuse during childbirth in Kenya

The Heshima project (meaning "dignified" in Kiswahili) aimed to reduce the frequency of disrespectful and abusive behaviours at different types of facilities – public, private and faith-based – and levels of care across Kenya *(46)*. **It implemented complementary interventions at community, facility and policy levels.**

POLICY LEVEL

Continuous policy dialogue
Technical meetings with representatives of government, civil society and professional associations were held to build rapport and a sense of ownership of the project. These meetings encouraged key stakeholders to recognize and reflect on disrespect and abuse as critical issues in the quality of maternity care. A national technical working group, comprising policy-makers, health advocates and legal experts, was formed to guide policy decisions on mistreatment.

? ***Reflection prompt:*** *How can ongoing policy dialogue, involving diverse stakeholders such as government and civil society, help address occurrences of disrespect and abuse in maternity care?*

FACILITY LEVEL

Training for health workers
A three-day training was held on clarifying values and transforming attitudes. It covered the rights and obligations of health workers and clients, and included opportunities to reflect on professional ethics and practices. The health facilities that were involved then developed action plans to institutionalize respectful care in their maternity units.

Quality improvement teams
Quality improvement teams in health facilities, such as health facility management committees were supported to monitor and respond to cases of disrespect and abuse and manage issues related to infrastructure and drug and commodity supplies. The committees were also trained on childbirth-related rights and obligations and developed protocols for reporting disrespect and abuse.

Peer counselling
Counselling services were offered to help health workers develop coping mechanisms for heavy workloads, trauma and critical incidents. Initially, counsellors from the Federation of Women Lawyers–Kenya conducted the sessions while simultaneously modelling the process for trained facility-based counsellors or those available within the reach of the facility. These site-level counsellors then continued providing counselling sessions in their respective facilities.

Establishing and strengthening reporting
Mechanisms were established to report cases of disrespect and abuse, including customer service desks, suggestion boxes and supervision visits by the implementing team. Health teams and facility quality improvement teams also monitored disrespect and abuse as part of routine activities.

Supported supervision and mentorship
Health-worker champions identified at each facility acted as on-the-job role models for behaviour change. This mentorship was integrated into routine continuous professional education to reinforce respectful care practices.

Maternity open days
These days were organized to build trust with local communities. Men and women from the community were invited to visit the local facility, learn about maternity ward procedures and interact with nurse-midwives.

? ***Reflection prompt:*** *Have you and your team reflected on the culture of respect and accountability in your setting? Which of these approaches are you familiar with? Have other sites in your district/province/country had experience with any of these?*

COMMUNITY LEVEL

Community workshops
Community workshops were conducted by partners but led by the Federation of Women Lawyers–Kenya. They provided civic education on rights to sexual and reproductive health, including maternal health care. The trainers were community health workers, opinion leaders and civil and legal aid representatives. They conducted respectful care sensitization meetings for community members, including women, men and youth, with support from their respective health management teams. Deliberate efforts engaged men in community workshops as participants and facilitators, as well as through targeted meetings that urged them to demand respectful care for their wives and partners.

Mediation/alternative dispute resolution
Training on mediation skills was provided by the Federation of Women Lawyers–Kenya for community leaders who would serve as intermediaries between community members and health facilities in response to issues of disrespect and abuse. Mediators were selected based on established criteria by both the communities and facilities. They also worked with the community to raise awareness about their rights in health-care settings and provided support to those who had experienced mistreatment.

Counselling community members
Counselling services were offered to community members who had experienced disrespect and abuse, facilitated by the Federation of Women Lawyers–Kenya and other professional counsellors within the facilities. These referrals for counselling were made by community health workers or legal aid representatives.

? ***Reflection prompt:***
How might a multicomponent approach to community interventions contribute to effectively reducing incidents of disrespect and abuse in your setting?
What collaborative efforts among community members, leaders and health workers would be necessary to create a supportive environment that addresses disrespect and abuse in maternal health care?

Portrait of Grace and her daughter Beauty in rural Lilongwe, Malawi, on the day that Beauty received her third dose of malaria vaccine. Photo: © WHO/Fanjan Combrink

Box 4. Staha – a community and health system intervention to reduce disrespect and abuse during childbirth in the United Republic of Tanzania

The Staha study (meaning "respect" in Swahili) aimed to establish a conceptual approach and evidence base for addressing disrespect and abuse during childbirth in a district in the United Republic of Tanzania, while contributing to the global movement around respectful maternal care *(53)*. **It implemented a series of community and health facility interventions, including the following.**

POLICY LEVEL

Formation of taskforce
Led by the Department of Preventive Services and the Directorate of Quality Assurance within the Ministry of Health, the taskforce comprised key stakeholders such as district and regional health authorities, civil society organizations and international partners. The taskforce coordinated the implementation of study findings and next steps, promoting respectful care as a core standard in the United Republic of Tanzania.

FACILITY LEVEL

Facility-based quality improvement process
Staff from the maternity ward and hospital identified drivers of disrespect and abuse and proposed and prioritized interventions for change, based on feasibility. A quality improvement team, composed of staff from the maternity unit, reproductive and child health unit, pharmacy and facility management, supported the implementation of these interventions and were responsible for tracking weekly progress. Planned interventions included establishing a private admissions area, installing curtains for privacy during examinations and childbirth, posting supply stock-outs, conducting patient surveys on quality of care, providing tea for health workers on shift as a gesture of appreciation, and sharing best practices with other wards and the regional hospital. Unplanned interventions that emerged in response to immediate needs or observations during implementation included health workers reminding each other to ensure respectful care, offering counselling and transferring staff when necessary, and facility management, along with faculty from the nursing school, conducting periodic observations of the maternity ward. This process was key to implementing a national client service charter.

Training for health workers
The project conducted workshops on values and attitudes for health workers, aimed at sensitizing them to the importance of respectful care and reducing bias. Training focused on improving health workers' attitudes, communication skills and empathy during childbirth.

Reflection prompt: *How could a similar quality-improvement process be adapted in your facility to address drivers of disrespect and abuse? What interventions would be most feasible and impactful in your context?*

COMMUNITY LEVEL

Raising awareness of health rights
Community and facility stakeholders, including district health and council representatives, a programme manager (health centre manager/supervisor) and a village executive officer, collaborated to adapt a national client service charter. More than 70 stakeholders reviewed the charter and provided feedback. The process built consensus on norms, standards, responsibilities and accountability for respectful care. The final charter was disseminated to all communities and health facilities in the district.

Reflection prompt: *How could adapting a similar service charter in your own context help in establishing clear expectations and accountability for respectful maternal care in your community or health facilities?*

Midwife Paulina Chepkumun of Kartita Health Centre III walking from the Maternity Ward. Photo: © UNICEF/Jimmy Adriko

Eli Rodriguez Zempahua, 22 with his wife Lucia and newborn baby girl Mage Rodriguez Trinidad at the Zongolica IMSS Prospera hospital. Photo: © UNICEF/Zehbrauskas

Box 5. The "Caring for providers to improve patient experience" intervention in Kenya and Ghana

"Caring for providers to improve patient experience" is a theory- and evidence-based intervention designed to address drivers of poor PCMC *(99)*. **It involved strategies targeting health-worker stress and bias as immediate factors to improve maternity care and address inequities. This included training to enhance health workers' knowledge, skills and confidence in shaping attitudes and behaviours to prevent burnout, reduce bias, and improve person-centred care, alongside other efforts to create an enabling environment for behaviour change.**

FACILITY LEVEL

Embedded champions
Champions in each facility, selected by their peers, led intervention activities in their facility, including facilitating monthly refreshers and peer-support groups.

Mentorship
On-site, peer-driven mentorship paired mentors and mentees based on their needs and preferences, which supported the transfer of knowledge and skills.

Peer support
Monthly cadre-specific peer-support groups were facilitated by a peer leader, to debrief on events at the maternity unit, brainstorm solutions and engage in activities for stress management.

Training
Short, interactive, two-day training and reflective sessions covered PCMC, stress management, dealing with difficult situations and implicit and explicit bias. The content was integrated into emergency obstetric and neonatal care simulations as well as teamwork and communications activities to support the practical application of concepts. The training was followed by monthly refreshers for six months.

Reflection prompt*: Would this kind of training work in your facility context? How would your colleagues react to training that focused on stress management, prevention of burnout and reducing bias? How could this type of training improve respectful care?*

COMMUNITY LEVEL

Leadership engagement
Health-care leaders from the county, regional and facility levels, along with health workers and women, participated in a community advisory board that guided implementation and served as a platform for high-level advocacy.

Reflection prompt*: How feasible would it be to create a community advisory board in your setting, what role would the Board play, and which stakeholders would you invite to be part of it?*

Box 6. A theory-informed health system intervention to promote supportive and respectful maternity care in Sindh, Pakistan

An intervention to promote supportive and respectful care was developed using a human-centred design approach and informed by the capability, opportunity, motivation and behaviour (COM-B) framework. This was consensus-driven and participatory, built on collaboration with health workers and health administrators, and was based on contextual evidence *(100)*. The purpose was to ensure dignity, privacy and confidentiality without discrimination, promote shared decision-making through clear communication and respond to psychosocial needs with coordinated care. The key components of the intervention included the following.

FACILITY LEVEL

Capacity-building of health professionals
All maternity team members, including clinical and non-clinical staff and support and administrative staff, received training in supportive and respectful care, ethical and rights-based care and psychosocial care. Following the training, activities for supportive and respectful maternity care were embedded in facility practices, such as record-keeping, benchmarking respectful care and psychosocial support, establishing a women's complaints system, and conducting exit interviews on supportive and respectful maternity care experiences.

Improvements in governance and accountability
For continuous quality improvement, consolidated data on supportive and respectful maternity care was discussed in monthly performance review meetings, and remedial actions were identified. Job aids for maternity staff were also developed, including record-keeping registers, exit interview forms, monthly report formats and posters promoting supportive and respectful maternity care. This was supported with weekly, then monthly, supervision by maternity team leads and facility managers, to integrate essential behaviours of supportive and respectful maternity care into routine practice.

? ***Reflection prompt:*** *How could a similar consensus-driven and participatory approach be helpful for enabling maternity service health workers to provide respectful care in your setting?*

Isabel Fatima de Deus and her daughter Perpetua Fatima Sarmento (6 month) at the Ossu health center.
Photo:© UNICEF/Soares

SPOTLIGHT:

Newborn right to identity: Birth registration

Globally there are over 167 million unregistered children under 5 years old: 65 million live in Asia and the Pacific, and 91 million in Africa, with around half living in only 5 countries – Democratic Republic of the Congo, Ethiopia, India, Nigeria and Pakistan. Unregistered children are at a much higher risk of statelessness, meaning they do not have legal ties to any country, including a nationality. Even where children are registered – which amounts to around 237 million children under five worldwide – they often do not have a birth certificate or proof of identity.

The gap in birth registration between the richest and poorest children has widened over the last two decades. Only 73% of countries register at least 90% of births *(101)*. Without proof of identity a child is invisible to the authorities and they cannot prove their age, which may prevent them from accessing basic services such as health care, immunization and education, and from exercising their fundamental rights. Birth registration can help protect migrant and refugee children against family separation, trafficking and illegal adoption.

A newborn's right to identity has been enshrined in international covenants and charters for more than 30 years and is also a Sustainable Development Goal target (16.9) – to provide legal identity for all, including birth registration. Articles 7 and 8 of the UNCRC acknowledge the importance of the right to an identity, including name and nationality. The Respectful Maternity Care Charter for Women and Newborns states that every child has the right to an identity and nationality from birth *(102)*. No one is allowed to deny a newborn birth registration, even if the child dies shortly after birth, or deny the nationality to which a newborn is legally entitled. The right to be recognized as a person before the law is critical for lifelong protection and can facilitate access to all other rights.

Even where legal provisions exist, women routinely suffer multiple barriers to birth registration due to local attitudes and discriminatory cultural practices. In many low- and middle-income countries the period of confinement after birth (42 days) is longer than the period given to register the birth (30 days). And often only the head of the household or father can register the birth *(103)*. Furthermore, those living in remote rural areas, on low incomes or with low levels of education are less likely to register their baby's birth. Even where women are entitled to register a birth, prejudice and discrimination on the part of health workers and other government officials make this more unlikely.

In conflict settings, the loss of legal documents such as marriage certificates can be a barrier to birth registration. In addition, where non-state entities may issue birth registrations, these are not recognized by the government or beyond the territories governed by that group. For non-registered/illegal refugees, the fear of approaching legal entities becomes a barrier for registration of births in their host countries *(111)*. Also, among refugee populations, when levels of early marriage increase, children born to refugee adolescents are least likely to have their births registered *(104,105)*.

Concerted efforts are urgently needed to raise levels of birth registration among the poorest children. Accelerating progress could result in 58 million fewer unregistered children in Africa in 2030 than there are today. It is feasible to adopt a one-stop approach for newborn registration *(106)* and certification that is entirely interoperable with health and immunization systems, including in humanitarian contexts *(107,108)*.

Recap and what's next

This section examined the drivers of mistreatment and identified key areas for intervention to help programme managers plan for implementation. Section 4 will provide practical guidance for developing and implementing a strategic vision and plan to end mistreatment and achieve respectful care, and offer actionable steps for implementation in different contexts.

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4

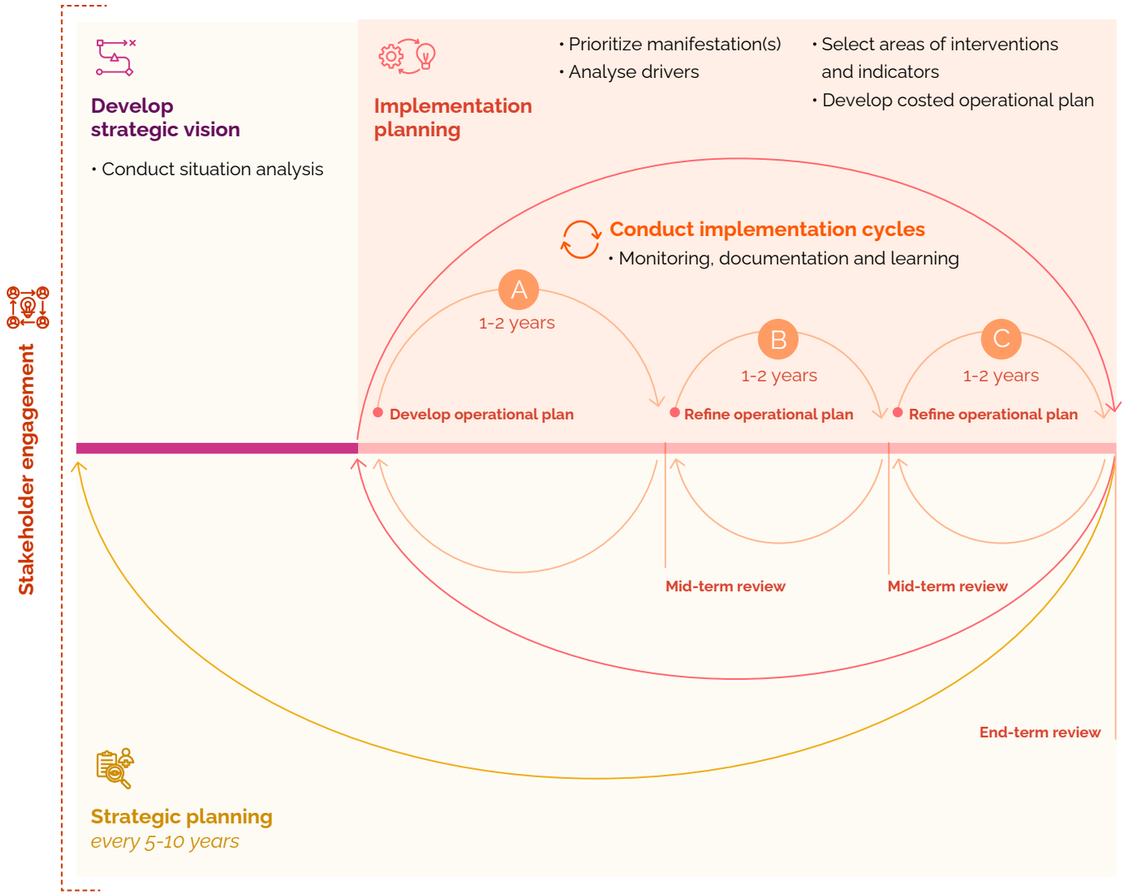
Driving change: Implementing respectful care in practice

Planning for respectful care in the programme context

Individual countries and programmes will be at different stages in their efforts to end mistreatment and achieve respectful maternal and newborn care. Some programmes are only just starting to measure and assess experiences during labour, childbirth and the immediate postnatal period. Others have accumulated more than a decade of information and published studies on the experiences of care of women, newborns and parents. Users of this compendium are encouraged to begin where they can in their programme context *(1)*.

Fig. 6 illustrates that the phases of planning for respectful care start with strategic planning, followed by implementation planning and sequential implementation cycles supported by ongoing stakeholder engagement, monitoring, documentation and learning. The steps, including timelines, are flexible and can be adapted to the programme's specific context and the maturity of existing initiatives.

Fig. 6. Overview of the phases of planning / Source: Adapted from the 2024 WHO Maternal, Newborn, Child and Adolescent Health Programme Review Guide *(2)*.



Amina Shallangwa, a UNICEF-supported midwife, talks with new mothers at a UNICEF-supported health clinic in Muna Garage IDP camp, Maiduguri, Borno State, northeast Nigeria.
Photo: © UNICEF/Naftalin

Stakeholder engagement

A coordinated, participatory approach is essential for bringing together relevant stakeholders to review available information on mistreatment and respectful care and to establish a strategic vision. The vision should reflect collective priorities, available resources and local needs, serving as a road map for improving respectful maternal and newborn care in the years ahead.
These stakeholders should also play a key role in overseeing implementation, periodic reviews of progress and results monitoring.

Engage stakeholders through a participatory process

Relevant stakeholders should be engaged through a participatory process at all phases outlined in Fig. 6. A programme manager may initiate or be assigned to oversee this process, and can facilitate collaboration based on agreed objectives, key milestones and timelines.

A stakeholder mapping exercise helps programme managers identify key individuals and organizations that can commit to and contribute expertise and resources for implementing respectful care. Clearly defining stakeholder roles and contributions, including knowledge, funding, technical assistance and advocacy, is essential (see Box 7)*.

Stakeholders may include maternal and newborn health managers, health workers and representatives from civil society and women's groups, professional associations, local authorities and relevant government programmes and sectors. Meaningful engagement requires considering their diverse experiences, influence and power dynamics. Table 6 outlines potential stakeholders across different system levels.

Key actions that a programme manager can take to actively engage stakeholders throughout planning, implementation and monitoring include the following:

1. **Select stakeholders** who represent individuals and groups with the power and influence to create long-term change, as well as those most directly affected by mistreatment and respectful maternal and newborn care, such as women. It may be necessary to use innovative strategies to ensure that women and other stakeholders who might otherwise be overlooked are included and can effectively engage in the process.

2. **Build on existing structures** where possible, **instead of** creating new ones, such as forming subcommittees within maternal, newborn and child health technical working groups or quality of care technical working groups.

3. **Set clear objectives and create a calendar of activities** to efficiently manage the participatory process and stakeholder expectations.

4. **Feedback information to stakeholders regularly,** including lessons learned and setbacks, to maintain transparency and encourage stakeholders to contribute to programme adjustments.

5. **Engage a skilled facilitator** to guide discussions. This helps ensure that interactions between stakeholders take place in a safe and respectful environment, especially when sensitive topics are discussed or when participants come from different sectors. Stakeholders with diverse backgrounds and expertise may need time to understand each other's perspectives. Building trust and supporting participants from the community to develop the skills and processes needed for effective planning and implementation can also take time.

6. **Establish meeting norms** that ensure everyone can contribute**,** promote active listening and encourage respectful dialogue to maintain constructive and inclusive discussions.

***** For more guidance on stakeholder mapping see the WHO handbook on Integrating Stakeholder and Community Engagement In Quality Of Care Initiatives for Maternal, Newborn and Child Health *(3)*.

Box 7. The essential role of stakeholders

When identifying stakeholders for respectful maternal and newborn care, two important groups must be represented: (i) women and gender-diverse people giving birth, parents and families; and (ii) health workers. Their involvement is essential for successful interventions, as their lived experiences provide valuable insights into social, structural, systemic and political factors that may otherwise be overlooked.

Different stakeholder groups can lead specific areas of implementation. Community health workers and women's groups can drive community advocacy on respectful maternal and newborn care, raising awareness of health and rights. Professional associations can lead on the reform of medical, nursing and midwifery education curricula to include competencies for respectful care.

At the policy level, ministries of health can offer technical support, policy guidance and endorsement for health-sector reforms *(4)*, but this requires collaboration among all actors to create a coordinated plan with shared objectives. For example, partnering with sectors such as water, sanitation and hygiene can improve conditions in maternity wards, improving the overall quality of care and reducing the risk of infection. Gender ministries, where they exist, can work alongside health ministries to address gender-based disparities and promote policies that support equitable care.

MSF medical doctor and midwife checking on a mother post-delivery in the Maternity MSF hospital in Dagahaley.
Photo: © WHO/Paul Odongo

Table 6. Examples of potential stakeholders for respectful maternal and newborn care at each level of the health system

Health system level	Examples of actors or institutions
National	• Policy-makers • Ministry national programme managers (e.g. maternal and newborn health, quality directorate, gender, education, finance) • Pre-service education institutions (e.g. nursing, midwifery, obstetrics and gynaecology, paediatricians, neonatologists, general doctors, anaesthetists) • National civil society organizations, including women and parent groups and patient associations • National human rights organizations • Professional associations (e.g. nursing, midwifery, medical, obstetrics and gynaecology, paediatricians, neonatologists, anaesthetists) • Technical working groups • Implementing partners such as nongovernmental organizations • Private sector services • Facility designers/architects
Subnational (region or district)	• Regional/district health, finance, gender, education and other managers • Subnational civil society, community and other organizations • Pre-service and in-service, continuing education institutions • Subnational representatives of professional associations • Media/journalists • Private sector services • Facility designers/architects
Health facility (providing maternal and newborn health services)	• Health facility managers and maternity ward staff (e.g. health workers, allied staff, housekeepers, registration clerks, etc.) • Health facility committees or boards that include community representatives/ finance managers/risk-reduction managers • Community representatives • Community health workers
Community	• Women's groups • Parents' groups • Local authorities • Community leaders • Religious leaders • Traditional healers and traditional birth attendants • Community-based organizations • Local civil society organizations

Strategic planning

Before developing a strategic vision for the next 5–10 years, stakeholders must collect data and information to clearly assess the current state of respectful maternal and newborn care.

Conduct a situation analysis of respectful maternal and newborn care

A situation analysis helps stakeholders identify, review and synthesize all available information on the drivers and manifestations of mistreatment and respectful maternal and newborn care, and existing resources. It supports informed discussions among key stakeholders to identify priorities and plan for implementation. Regardless of a country's progress, a situation analysis can help stakeholders gain a comprehensive understanding of the context of mistreatment and respectful care, highlighting strengths and gaps in current care practices, resources and policies.

Programme managers can take specific steps to collect information on mistreatment and respectful maternal and newborn care within their context, including the following.

1. **Collect existing data:** Identify and review available data on the manifestations of mistreatment and respectful care that are relevant to the setting (see Sections 2 and 3 for more information on definitions and terminology). Sources may include published studies, health facility reports, household surveys, service-user feedback surveys and existing monitoring data. Synthesize this information in a clear, digestible format for stakeholders to understand both the problem and potential solutions.

2. **Address information gaps:** If data on mistreatment and respectful care are limited, consider the collection of additional qualitative or quantitative information. For example, interviews or focus groups with women, families or health workers can be used to gather insights on specific manifestations of mistreatment and their cultural or systemic drivers. Collaborate with local institutions, such as universities, to facilitate data collection and analysis to reduce resource demands. For more information on different data collection methods, refer to Section 5 on deepening measurement.

3. **Map policies and structures supporting respectful care:** Identify existing policies, regulations related to respectful care, and organizational structures (such as health committees or care protocols) that support or hinder respectful care. Highlight any gaps in these areas. For example, map whether national policies on reproductive, maternal, newborn and child health, local maternal and child health technical working groups, or quality improvement initiatives prioritize respectful care. This assessment will help determine where additional support or policy changes are needed.

4. **Review training and education materials on respectful care:** Review health-worker training materials, such as pre-service education and in-service training curricula, to assess whether respectful care practices are adequately addressed. Assess whether key concepts such as dignity, informed consent and non-discriminatory care are integrated into training for health workers (i.e. midwives, doctors and nurses). Orientation materials for all staff in the health facilities may also need content on respectful care.

5. **Examine professional codes of ethics for respectful maternal and newborn care:** Review the codes of ethics for health professional associations such as midwives, nurses and doctors, including paediatricians and obstetricians, to determine whether they include specific ethical standards that promote respectful maternal and newborn care. These codes can guide professional behaviour and help ensure that practices align with principles of dignity and respect, ultimately improving the quality of care provided to women and newborns.

Box 8 describes part one of a hypothetical implementation story from Zomba District, Malawi. It illustrates stakeholder engagement and data collection for situation analysis, demonstrating that the process does not have to be resource-intensive.

Develop a 5–10-year strategic vision

Strengthening respectful maternal and newborn care for all women, gender-diverse people, newborns, parents and families, and ending mistreatment, requires a bold 5–10-year strategic vision, with ambitious goals, sustained activities, and dedicated time and resources. The vision should incorporate diverse perspectives, including those of women, parents, community members and health workers, and set a clear direction for future activities.

Key steps for developing a strategic vision with stakeholders for respectful maternal and newborn care include the following.

1. **Discuss the results of the situation analysis with stakeholders:** Start by sharing the results of the situation analysis with stakeholders and gathering their perspectives and priorities. This initial step is essential for aligning the vision with the programme context and stakeholder priorities.

2. **Address power imbalances:** Depending on how comfortable they are working together, stakeholders can collaborate in small groups or as a larger group to develop the strategic vision. To minimize potential power imbalances, participants with similar experiences can be organized into separate groups (e.g. service users, health workers, local authorities). Each group can discuss their views before reconvening in a larger setting to exchange insights and draft the revision, later refining it in plenary. This helps ensure all voices are heard and respected.

3. **Facilitate discussions**: Plan small group discussions to encourage informal exchanges and enhance mutual understanding among stakeholders, not all of whom will be from the health sector. Ensure discussions are facilitated by trusted people from the community or reliable facilitators who are well respected by the group.

4. **Develop a vision:** Encourage stakeholders to think boldly about what success would look like in the future, for instance, if mistreatment was eliminated and respectful maternal and newborn care were achieved. Vision statements should be framed in the present tense, using clear and concise language, free of jargon. This is an opportunity to craft an inspiring vision.

Mothers waiting in line for postnatal services at Angal, St. Luke Hospital in Nebbi District. Photo: © UNICEF/Abdul

Policy dialogue

National and subnational polices are essential for promoting and sustaining respectful care. If gaps are identified in policy language on respectful care or mistreatment, stakeholders may need to develop or strengthen evidence-based policies and guidelines. Engaging decision-makers in shaping these policies may require ongoing discussions throughout implementation cycles.

Policy language based on country-specific evidence can be co-created with stakeholders across national, subnational, facility and community levels to ensure support and buy-in. The USAID MOMENTUM Country and Global Leadership project tested a useful approach* to policy dialogues in Kenya and Rwanda. It collaborated with government and key stakeholders to develop evidence-based policies and implementation recommendations for existing policies *(5)*. This process was informed by the WHO State of the World's Nursing Report operational guidance and facilitator's guide and a MOMENTUM Policy Dialogue Guide *(5)*.

In 2022, MOMENTUM supported the Rwanda Ministry of Health in developing a respectful maternal and newborn care policy and integrating it into key national frameworks, including: the updated National Reproductive, Maternal, Newborn, Child and Adolescent Health Policy; Maternal and Child Health Strategic Plan; and national Health Sector Policy. Stakeholders convened to assess respectful care in Rwanda (e.g. they assessed data, gaps and strengths) and to draft policy language for inclusion (and suggest where the language should be placed) in existing policy documents. The agreed-upon language is now being incorporated into the national policy.

Kenya's reproductive, maternal, newborn, child and adolescent health policy has included language for respectful care since 2016, following years of evidence-based advocacy by stakeholders such as the Heshima Project. However, there has been a lag in implementation in health facilities. In 2023, MOMENTUM supported Kenya's Ministry of Health in a policy dialogue process to identify barriers, facilitators and practical steps for county-level governments and facilities to implement respectful care. Rather than drafting a new policy, stakeholders developed recommendations to strengthen respectful maternal and newborn care within existing reproductive, maternal and newborn health programmes.

Implementation planning

After developing a strategic vision, stakeholders can plan sequential implementation cycles to bring it to life. Given the complexity of the drivers and manifestations of mistreatment and respectful maternal and newborn care, (see sections 2 and 3), this approach allows stakeholders to address these factors over time.

Implementation cycles typically range from 6 to 18 months, as shown in Fig. 6, but can be adjusted based on factors such as the:

- timing of regular planning cycles
- maturity of the programme on respectful care
- number of manifestations of mistreatment/ respectful care that are being targeted
- scope and complexity of selected interventions
- availability of resources, including financial and human resources as well as stakeholder support for activities
- geographic scale of the interventions.

Each implementation cycle requires an operational plan outlining key activities, timelines, monitoring and reflection, to support learning and adjustments before the next cycle.

To guide the development of each cycle's operational plan, stakeholders should prioritize the manifestations of mistreatment/respectful care, analyse their underlying drivers, identify promising interventions, and determine appropriate indicators to monitor progress and adjust plans. The learning-driven planning template (Table 7) supports this process and can be adapted to align with existing planning tools. This template will be progressively filled in and expanded upon in the following subsections, illustrating how each component contributes to the development of an operational plan.
The learning-driven planning template is broadly defined, so specific activities must be clearly detailed in an operational plan. Each implementation cycle requires its own operational plan.

Table 7. Learning-driven planning template

Manifestation of mistreatment/respectful care:

Drivers	Interventions	Indicators to monitor outcomes and programme outputs	Strategic vision
	Community level:	*Outputs:*	
	Facility level:	*Outcomes:*	
	Subnational level:		
	National level:		

1 Prioritize the manifestations of mistreatment or respectful care that will be addressed

Section 2 outlines specific manifestations of mistreatment and respectful maternal and newborn care based on existing literature and global experiences. The situation analysis helps stakeholders identify important manifestations of mistreatment/ respectful care in their context, while their own knowledge, experience and insights can guide the setting of priorities. They can prioritize the issues that are most feasible to address in each implementation cycle, starting with one or two manifestations that can be tackled relatively easily within existing structures and programmes. This approach builds confidence in the stakeholder group by ensuring early, tangible impact. Unresolved manifestations of mistreatment/respectful care can be carried over into subsequent implementation cycles and addressed alongside new ones. This allows for continuous learning and adaptation. Over time, as experience grows, more complex issues and interventions can be taken on.

In some cases, different manifestations of mistreatment or respectful maternal and newborn care have common drivers or can be addressed with the same interventions. In those instances, stakeholders may choose to address multiple manifestations in a single cycle (see sections 2 and 3). However, tackling several at once can be challenging and addressing them in successive cycles may be more feasible.

To illustrate this process, the learning-driven planning template will be used in the next subsection to explore verbal and physical abuse as a manifestation of mistreatment. Annex 4 includes additional learning-driven planning templates for other important manifestations of respectful maternal and newborn care: stigma and discrimination, and emotional support and effective communication.

A community nurse examines a newborn baby.
Photo: © WHO/Igor Vrabie

2 Analyse the drivers of the manifestations of mistreatment or respectful care

After selecting the manifestations of mistreatment that will be addressed during an implementation cycle, stakeholders should analyse the drivers of these phenomena using information from the situation analysis along with their own expertise and knowledge. Starting with drivers that are easy to address can build stakeholders' confidence and trust and sustain engagement.

Table 8 shows how the learning-driven planning template can be used to investigate key drivers of verbal and physical abuse. By using this template, stakeholders can actively participate in an iterative learning process, refining their ability to identify patterns, uncover root causes and prioritize the most actionable drivers.

To identify relevant drivers, stakeholders can:

- review the results of the situation analysis
- brainstorm potential drivers based on their experience
- refer to the policy-related, sociocultural, organizational and individual drivers outlined in Section 3.

Table 8. Learning-driven planning template: verbal and physical abuse

2 Manifestation of mistreatment: verbal and physical abuse

Drivers	Interventions	Indicators to monitor outcomes and programme outputs	Strategic vision
– Normalization and tolerance of mistreatment – Health-worker fear of a negative health outcome for the woman, gender-diverse person or newborn – Power asymmetries – Stressful work environments – Poor salaries – Lack of motivation	*Community level:* *Facility level:* *Subnational level:* *National level:*	*Outputs:* *Outcomes:*	All women, gender-diverse people and newborns experience labour, birth and pre-discharge postnatal care that is free from verbal and physical abuse

Grace carries her daughter Beauty home from a health facility in rural Lilongwe after Beauty received her 3rd dose of the malaria vaccine. Photo: © WHO/ Fanjan Combrink

3 Select interventions

After identifying locally relevant drivers of mistreatment/respectful care, stakeholder groups must decide which interventions will be used to address the drivers. This must take into account and make the most of existing local structures, platforms and programmes.

To aid in selecting interventions, stakeholders can consider the following steps.

- Review Section 3 of the compendium for different interventions used to address the **drivers** of mistreatment and respectful maternal and newborn care. Identify those relevant to the selected manifestations and drivers.
- Discuss solutions and interventions from the **situation analysis**, including past successes and challenges, and assess how they can be adopted or adapted.
- Review existing policies, structures and platforms within the programme context that can be leveraged to **implement interventions**.
- Consider the system level at which interventions will be implemented, and the **stakeholders** who will be responsible for implementing them.

When feasible, stakeholders should consider comprehensive approaches that incorporate multicomponent interventions rather than relying on a single intervention. Studies suggest that multicomponent interventions are more effective for improving respectful care (see Section 3). For example, health-worker training alone is insufficient to reduce stigma and discrimination or power imbalances – these require multilevel interventions and strategies involving diverse stakeholders (see Section 3, Boxes 2–6). Examples of multicomponent programmes demonstrating the selection and implementation of interventions have been provided in section 3.

Table 9 presents the learning-driven planning template with an example of how interventions can be selected to address the drivers of verbal and physical abuse, which were introduced in Table 8. This template guides stakeholders to select interventions and to reflect on the link between drivers and interventions.

Doctor Hafiz-ur Rehman examines a 10-day-old girl at a basic health unit in the village of Sahan Wala in Rajanpur District, Punjab Province.
Photo: © UNICEF/ Asad Zaidi

Table 9. Learning-driven planning template: verbal and physical abuse

3 Manifestation of mistreatment: verbal and physical abuse

Drivers	Interventions	Indicators to monitor outcomes and programme outputs	Strategic vision
– Normalization and tolerance of mistreatment – Health-worker fear of a negative health outcome for the woman, gender-diverse person or newborn – Power asymmetries – Stressful work environments – Poor salaries – Lack of motivation	*Community level:* – Implement a community workshop to increase the knowledge of women and families about the rights of women, gender-diverse people and newborns to be free from verbal and physical abuse – Train leaders (e.g. community health workers and other respected persons) in mediation skills to address disrespect and abuse *Facility level:* – Co-develop a client survey charter for health workers and service users – Create a quality improvement team and/or strengthen quality improvement processes with community members to reduce verbal and physical abuse (also see Regional/district level) – Implement mediation/dispute resolution mechanisms (also see Community level) – Improve working conditions, including by ensuring a safe working environment that is free from harm and in which health workers can voice concerns *Regional/district:* – Support district-wide quality improvement initiatives to improve the provision of woman-, infant- and family-centred care – Support mediation/dispute resolutions and mechanisms in maternity facilities – Support counselling mechanisms for health workers (e.g. coping mechanisms) *National/sub-national:* – Reorganize training curricula for medical, nursing and midwifery schools to promote knowledge, awareness and skills for respectful maternal and newborn care	*Outputs:* *Outcomes:*	All women, gender-diverse people and newborns experience labour, birth and pre-discharge postnatal care that is free from verbal and physical abuse

4 Select indicators

Once stakeholders identify drivers and interventions for an implementation cycle, they must define indicators and measurement methods to monitor progress. These indicators, tracked throughout the sequential implementation cycles, contribute to continuous monitoring and learning.
Indicators generally fall into two categories: outcome indicators, which measure mistreatment or the experiences of care of women, newborns and families; and programme output indicators, which measure the implementation or results of activities.

Stakeholders should also define how each indicator will be collected, ensuring data can be disaggregated to identify disparities affecting specific groups such as women of certain ethnicities, age groups or socioeconomic group). To avoid overburdening the system and ensure data quality, a limited number of meaningful indicators should be prioritized. Where possible, existing indicators from the routine health information system should be mapped and used. However, data on women's and families' experiences of care are often not routinely collected. In such cases feasible alternatives, such as regular surveys with women and parents, should be considered.

For a more detailed discussion on indicators and measurement methods for monitoring, see Section 5. Annex 4 provides validated tools for assessing maternal and newborn experiences of care in low- and middle-income countries.

Table 10 builds on the learning-driven planning template introduced in Tables 8–10, incorporating indicators and measurement methods to monitor interventions addressing verbal and physical abuse. As a learning tool, it helps stakeholders assess whether selected indicators effectively track progress, identify measurement gaps and refine approaches for addressing verbal and physical abuse.

5 Develop a costed operational plan

Once interventions and indicators are selected for an implementation cycle, a detailed, costed operational plan, which includes technical and financial resources, is needed.

Key components should include:

- activities to implement prioritized interventions, specifying, for each activity, a timeline, estimated cost, funding source and responsible actor(s)
- activities to monitor selected indicators, including any qualitative methods
- activities to support learning and the adaptive management of interventions
- activities to ensure regular engagement, support and oversight by key stakeholders
- communication and coordination activities to regularly share information and coordinate activities across system levels, leveraging existing roles and structures.

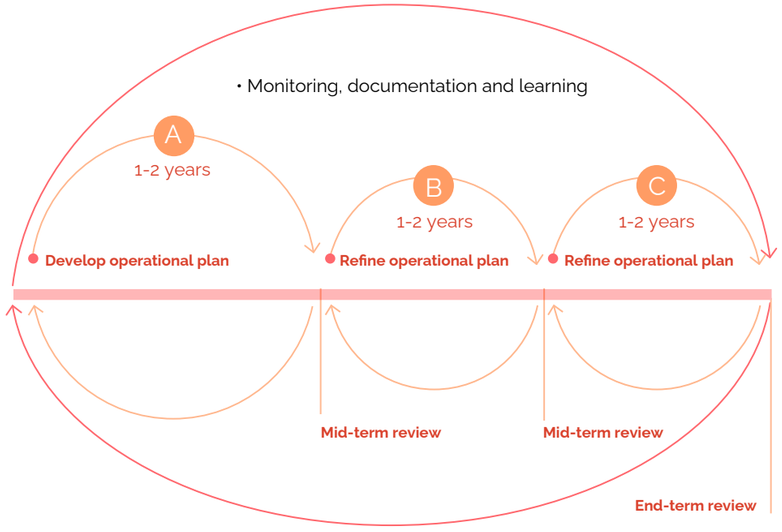
Activities in the costed operational plan should, where feasible, be integrated into existing regional, district and facility annual plans and budgets. Leveraging existing structures and activities – such as supervision visits, technical working group coordination meetings and community outreach – helps prevent stand-alone or vertical programming, maximizes resources and efficiencies and controls costs.

Table 10. Completed learning-driven planning template

4 Manifestation of mistreatment: verbal and physical abuse

Drivers	Interventions	Indicators to monitor outcomes and programme outputs	Strategic vision
– Normalization and tolerance of mistreatment – Health-worker fear of a negative health outcome for the woman, gender-diverse person or newborn – Power asymmetries – Stressful work environments – Poor salaries – Lack of motivation	*Community level:* – Implement a community workshop to increase the knowledge of women and families about the rights of women, gender-diverse people and newborns to be free from verbal and physical abuse – Train leaders (e.g. community health workers and other respected persons) in mediation skills to address disrespect and abuse *Facility level:* – Co-develop a client survey charter for health workers and service users – Create a quality improvement team and/or strengthen quality improvement processes with community members to reduce verbal and physical abuse (also see Regional/district level) – Implement mediation/dispute resolution mechanisms (also see Community level) – Improve working conditions, including by ensuring a safe working environment that is free from harm and in which health workers can voice concerns *Regional/district:* – Support district-wide quality improvement initiatives to improve the provision of woman-, infant- and family-centred care – Support mediation/dispute resolutions and mechanisms in maternity facilities – Support counselling mechanisms for health workers (e.g. coping mechanisms) *National/sub-national:* – Reorganize training curricula for medical, nursing and midwifery schools to promote knowledge, awareness and skills for respectful maternal and newborn care	*Outputs:* – % of women and families who report the verbal or physical abuse of women, gender-diverse people and/or newborns (Measurement method: survey of clients every two months with disaggregation for adolescent clients) – % of providers of maternity care who report verbal or physical abuse of women and/or newborns (perpetrated by peers and/or themselves) (Measurement method: survey of women and health workers every two months) *Outcomes:* – % of facility quality improvement teams that update and publicly display at least two relevant respectful maternal and newborn care outcome indicators on a quarterly basis (Measurement method: district maternal and newborn health managers will collect data during supervision visits) – % of women who report having a labour companion (Measurement method: survey of women every two months with disaggregation for adolescents)	All women, gender-diverse people and newborns experience labour, birth and pre-discharge postnatal care that is free from verbal and physical abuse

Conducting implementation cycles



Strategic planning consists of sequential 6–18 month implementation cycles. An operational plan should be implemented and refined in each cycle to address the drivers and manifestations of mistreatment/respectful care that have been chosen, incorporating lessons from previous cycles.

An implementation cycle comprises three key processes:

1. **Implement:** carrying out the operational plan from the planning template, aligning activities with strategic goals
2. **Monitor:** collecting and analysing data to track progress and guide adjustments
3. **Document and learn:** capturing insights and sharing lessons to inform future cycles

1 Implement

Each implementation cycle starts with developing and implementing the operational plan. This process involves regular coordination of activities, oversight by a stakeholder group, routine check-ins with implementing teams and maintaining flexibility to adapt to unforeseen challenges.

2 Monitor

Monitoring activities for each implementation cycle are detailed in the operational plan and guided by the measurement methods (quantitative, qualitative) and indicators defined during planning (see Section 5 and Annex 4). Monitoring is a continuous process that tracks progress toward the 5–10-year strategic vision and within the individual 6–18-month implementation cycles. Table 11 highlights the purpose and frequency of these two monitoring streams.

When planning for monitoring for individual cycles and the broader strategic vision, start by identifying who needs the information, which data they need and why – this depends on the specific actors, users and activities involved. Additionally, it's important to specify the mechanisms and a timeline for sharing results and learning with the implementing team and key stakeholders.

Typically, monitoring involves regular calculation, visualization and analysis of patterns in selected data, along with activities to support periodic programme reviews and adaptive management activities such as "pause and reflect" sessions with stakeholders. These monitoring activities should be closely linked to intervention-specific activities to track overall progress and guide necessary adjustments.
For more guidance see *Measuring and monitoring quality of care to improve maternal, newborn, child and adolescent health services: a practical guide for programme managers (17)*.

Table 11. Purpose and timeline of monitoring components

Monitoring timeline	Types of indicators	Measurement frequency	Purpose
5-10 year vision and impact goal(s) for respectful maternal and newborn care	Primarily client-reported outcomes for a broad range of mistreatment and manifestations	Approximately **every 12 months** toward achieving the strategic vision	Track progress toward overall vision
6–18 month implementation cycles focused on prioritized manifestations of mistreatment and respectful maternal and newborn care	**Specific to the implementation cycle:** • Programme output indicators based on selected activities and expected outputs of these activities • Outcome indicators for specific manifestations of mistreatment and respectful maternal and newborn care addressed during the implementation cycle	Monthly to quarterly	Monitor and guide implementation in real time during individual implementation cycles

3 Document and learn

Documenting and learning are essential for ensuring continuous improvement in respectful maternal and newborn care. In contexts where the work may be in its early stages, and gaps exist in knowledge and evidence, systematic documentation and reflection on experiences help inform future practices and contribute to a broader knowledge base. Central to ongoing learning is "adaptive management", which enables programme managers and teams to refine their plans and implementation based on emerging challenges and lessons, ensuring integration of learning. Regular programme reviews, along with structured documentation, offer a systematic way to assess progress, share lessons and adjust implementation as needed.

To support this, structured programme reporting standards, such as those developed by WHO *(6)*, can guide documentation. By consistently documenting activities from the operational plan, programme managers can capture both the processes and changes made to the initial plans.

In a health care facility in Nepal, a woman breastfeeds her child. A health worker watches over her.
Photo: © WHO/Christopher Black

Adaptive management

Adaptive management is a systematic, responsive approach that emphasizes continuous learning and adapting. It involves regularly monitoring outcomes, gathering feedback and adapting strategies and interventions in response to changing conditions, new information and implementation barriers. Programme reporting standards can help ensure that relevant information is captured to support this process.

"Pause and reflect" sessions at key junctures within and between implementation cycles, along with specific meetings to assess progress and identify necessary adjustments to implementation, can help ensure that interventions for respectful care remain responsive to challenges and evolving needs. By continually assessing what does and does not work, and adjusting implementation based on real-time data and stakeholder feedback, adaptive management promotes flexibility and course correction throughout each implementation cycle.

Adaptive learning resources are available to support programme managers to formalize these processes and maintain a continuous cycle of reflection and improvement.

Periodic programme reviews

Adaptive management typically occurs in real time during implementation, but periodic programme reviews – such as mid-term and end-term reviews for maternal and child health programmes – can be used to assess progress towards strategic goals and shorter-term implementation cycle objectives. These reviews mainly use data from monitoring and programme reporting. In addition, discussions with implementers and women, parents and families can sometimes help clarify specific implementation challenges.

The WHO 2024 guide for conducting national and subnational programme reviews for maternal, newborn, child and adolescent health services is a useful resource *(2)*. It provides guidance for planning and conducting integrated reviews to assess the results, identify gaps in implementation and generate recommendations for improvement (see Fig. 6). By incorporating respectful maternal and newborn care into these reviews, stakeholders can assess how well interventions for ending mistreatment and achieving respectful care are integrated into broader health efforts.

Programme reporting standards can also be used to capture decisions from the programme review and support the sharing of implementation processes and lessons learned *(6)*.

Undertaking advocacy in support of respectful maternal and newborn care

Advocacy for ending mistreatment and achieving respectful maternal and newborn care is essential given the relative novelty of this programming area and the limited focus it has historically received. Efforts must focus on raising awareness and strengthening the case for investing in respectful care, to ensure that policy-makers, donors and stakeholders recognize its importance alongside other health priorities.

However, advocacy for respectful maternal and newborn care can be challenging, especially in resource-constrained settings with competing health priorities. Structural or organizational constraints may also limit the ability of programme managers to directly advocate for needed investments or resources. Thus, building alliances with external partners who can amplify these priorities and advocate at broader policy levels is crucial. By involving a diverse range of stakeholders – beyond those directly involved with the programme or stakeholder group – programme managers can build a shared understanding of the importance of respectful maternal and newborn care for women, gender-diverse people and newborns. Ongoing engagement with stakeholders at the national, district and facility levels is essential for sustaining commitment and scaling up initiatives for ending mistreatment and achieving respectful care over the long term.

Effective advocacy should include dialogue with policy-makers and health-care leaders to maintain commitment, address emerging challenges and sustain improvements over time. Users of the compendium further strengthen these efforts by partnering with women's rights organizations and other advocates for respectful care, who bring specialized knowledge and influence that is essential for changing policy and practice.

Additionally, community-level advocacy, such as that led by community health workers or women's groups, plays an essential role in raising awareness of rights, empowering individuals and reinforcing respectful care principles. Engaging with these local groups can help build understanding and support, strengthening respectful care within the community and empowering individuals to advocate for themselves within the health system.

As part of these advocacy efforts, tools such as the White Ribbon Alliance Respectful Maternity Care Charter can be widely shared to reinforce the message of maternal and newborn rights in care. For a comprehensive guide to strengthening advocacy and fostering community engagement, the WHO Handbook on integrating stakeholder and community engagement in quality-of-care initiatives for maternal, newborn, and child health also offers valuable strategies *(3)*. By mobilizing community voices and enhancing commitment at all levels, programme managers can cultivate a supportive environment that advances efforts to end mistreatment and achieve respectful maternal and newborn care.

Weight checkup of Prabhas during Maya Mandai session. in Munda Para, Kondagaon Chattisgarh, India. Photo: © UNICEF/ Panjwani

Final reflections for implementation in practice

Implementing programmes to end mistreatment and achieve respectful maternal and newborn care relies on key principles drawn from practice. These include engaging multiple stakeholders, especially women and parents, and prioritizing the complex manifestations and drivers of mistreatment as well as the interventions to address them. Embedding documentation and learning into the implementation process also allows programmes to adapt to changing contexts, scale-up and strengthen the evidence base.

The following reflections offer practical tips for programme managers and stakeholders, and while they apply broadly, they can be tailored to specific needs. Users of this compendium should consider these principles when aligning, incorporating and prioritizing interventions for ending mistreatment and achieving respectful care.

Incorporate multistakeholder approaches in the design, implementation and monitoring of interventions. Using participatory approaches to engage stakeholders is important for effectively addressing mistreatment and strengthening respectful care across different levels of the health system. While maternal and newborn health programmes may already involve key stakeholders, programme managers should ensure the inclusion of women, parents, health workers and human rights groups. Engaging these groups may involve sensitive discussions, so it is crucial to approach conversations with care and skilled facilitation.

Align with existing plans, structures and programmes in the implementation context. When planning for implementation, it is essential to leverage and align with existing plans, structures, platforms and programmes. Understanding contextual factors and available resources will help identify sustainable activities for improving respectful care.

Prioritize the manifestations and drivers of respectful maternal and newborn care, and areas of intervention. The situation analysis identifies various manifestations of mistreatment and respectful care. The first step with stakeholders is to prioritize which manifestations to address, define their drivers and select intervention areas. Key considerations include assessing the importance of these drivers, aligning with community needs and ensuring feasibility within available resources.

Recognize that the drivers of mistreatment and interventions to address them are complex and interconnected. Evidence suggests that multicomponent strategies – combining approaches across system levels and tailored to specific contexts – are more effective in promoting respectful care than singular efforts, such as staff training. While not all issues can be addressed at once, programme managers can develop a broader plan and undertake sequential cycles of implementation, gradually expanding efforts as resources allow.

Embed documentation and learning into the operational plan. Promising interventions have been identified to address the drivers of mistreatment and respectful maternal and newborn care, but gaps in evidence and knowledge remain. Strengthening programme documentation and regularly gathering insights from these efforts is essential for improving implementation and informing scale-up. This approach benefits the current programme, supports adaptation across settings, and through monitoring enables rapid learning by identifying successes and areas for improvement.

SPOTLIGHT:

Stillbirth, early neonatal death, and bereavement

"She went to check on her baby, and the nurse who was on duty that day was very harsh, first she started quarrelling [with] her [about] why she had gone in… Now the nurse knew the baby had died but didn't know how to approach the mother. So, when the mother came to ask, 'where is my baby?' the nurse did not tell her anything, she just left her standing there. That is when another nurse came and told her 'Your baby didn't make it blah, blah', just like that. We didn't see any counselling done."

(Joint in-depth interview, parents of newborn) 2019 Kenya.

Globally, a stillbirth occurs every 17 seconds, involving nearly 2 million babies, and primarily affecting sub-Saharan Africa and South Asia. Despite being preventable with equitable access to quality care, 45% of stillbirths happen after the onset of labour and in full-term babies. Bereavement care for families is often lacking, and cultural norms may hinder women from expressing grief, while health workers may not have the training to support them effectively *(7)*.

Reports of mistreatment are common. Stillborn babies may be abandoned in a side room and their bodies may be disposed of without any recognition, name, clothes or funeral *(8)*. Often there is no organized form of bereavement and posthumous care *(9)* of the newborn and their families often miss the opportunity to hold their baby, leading to feelings of regret and emotional turmoil. Women may experience shock, guilt and shame, resulting in lasting psychological effects. Health workers may be present but often avoid direct communication so they do not have to deliver difficult information. Their limited training in empathetic communication can exacerbate a woman's grief, potentially leading to long-term mental health issues *(10)*.

To improve overall quality of care and address this mistreatment, it is essential to strengthen support structures and accountability mechanisms, such as appropriate reporting and feedback systems *(9)*. Respectful bereavement care should also be provided to bereaved parents to help them deal with the emotional and practical challenges experienced after stillbirth *(11)*. This care includes parents being able to talk about their grief and have access to information, before during and after the experience of a stillbirth. Parents should also have the option to hold their stillborn child.

Training health workers in sensitive communication, psychological support and counselling in decision-making (such as naming the baby, taking photos and burial arrangements), can have a memorable impact *(12)* for women and their families. Additionally, understanding the cultural expectations of both health workers and women is crucial, as many women may feel judged, pressured to suppress their emotions, or worthless for not bringing home a live baby *(13–14)*.

When health workers inform parents and their extended families, including in-laws, about the biomedical causes of stillbirth, it can help reduce stigma surrounding this experience *(15)*.

Person-centred care that addresses physical, mental and spiritual health needs is vital for supporting women and their families during bereavement. Resources from organizations such as the Partnership for Maternal, Newborn and Child Health *(11)* or the Stillbirth Alliance *(16)* offer valuable information on the experiences and rights of parents after stillbirth along with strategies for advocating improved posthumous care. The voices and needs of parents affected by stillbirth highlight the necessity for long-term bereavement support, both within families, across health facilities, and in the wider community.

Stillbirth is defined as a baby born with no signs of life at 22 or more completed weeks of gestation. For international comparisons, 28 or more completed weeks of gestation is used. Early neonatal death is defined as a baby born alive who dies within the first 7 days of birth.

Recap and what's next

This section provided actionable steps for programme managers to develop and implement a strategic vision for ending mistreatment and achieving respectful maternal and newborn care, emphasizing the need for continuous stakeholder engagement and context-specific approaches. It outlined actionable steps, focusing on planning, implementation, monitoring, documentation and adaptive management. The next section will deepen understanding of measurement practices in respectful maternal and newborn care. Users will gain insights into various data collection methods, indicators and validated tools for assessing mistreatment, and ethical considerations in measurement.

Community health worker Azalech Ejigu examines Selamawit Teklu who gave birth to a baby girl five days ago in Ethiopia. Photo: ©UNICEF/ Nahom Tesfaye

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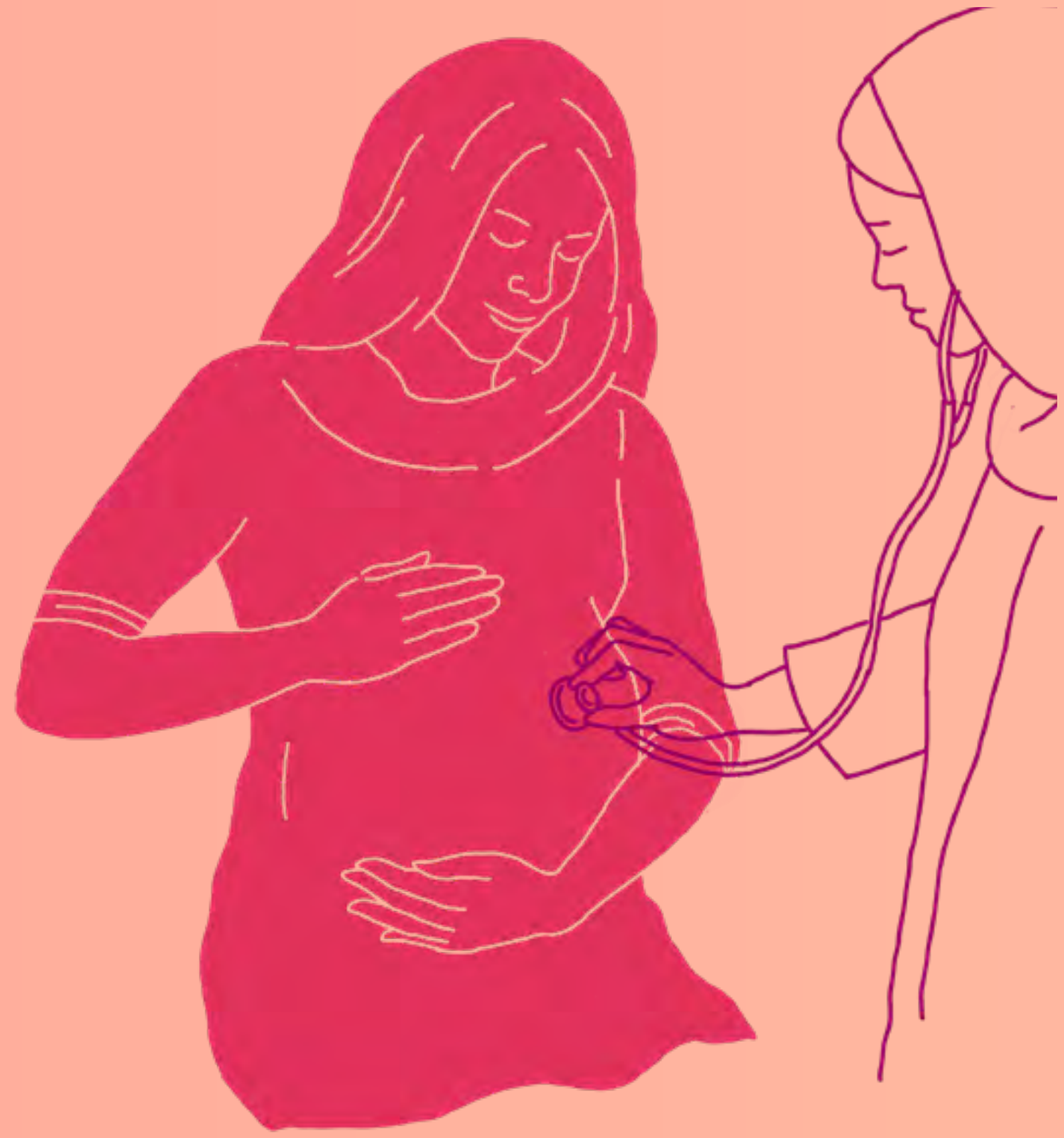
5

Measuring mistreatment and respectful newborn care



Purpose measuring respectful maternal and newborn care

Measurement is crucial for identifying and addressing mistreatment and respectful maternal and newborn care throughout the antenatal, intrapartum and postnatal periods. Most evidence on the quality of health services comes from research rather than routine programme monitoring, particularly for women's and parents' experiences of care during childbirth and the immediate postnatal period.

Understanding different approaches to measuring mistreatment and respectful care is essential for selecting suitable methods for monitoring, evaluation and research. Even if programme managers are not directly involved in evaluations or research, this knowledge is valuable when commissioning or reviewing studies and reports.

Lubaba Tilahun and her child Elham Mohammed at a postnatal follow-up in Ethiopia. Photo: ©UNICEF/ Mulugeta Ayene

Robust measurement of mistreatment and respectful care serves several important purposes, including:

- **improving the understanding of the context** of mistreatment and respectful care in specific settings (see Section 4); when data are lacking and resources allow, additional assessments can identify areas of need and guide the setting of priorities related to the manifestations and drivers of mistreatment/respectful care, as well as planning and resource allocation;
- **appraising the implementation and effective ness of programmes or interventions** aimed at improving the quality of care, which can then strengthen respectful care and end mistreatment;
- **tracking changes over time** in care experiences and health outcomes through routine data collection and review, informing service redesign and policy decisions;
- **informing advocacy efforts** by highlighting key problems, needs and achievements, including the impact of advocacy efforts;
- **improving accountability** to stakeholders, including health workers, women, parents and families, by sharing data on progress.

Data collection approaches

The purposes of measurement and a programme's specific needs guide the choice of data collection approaches. Both qualitative and quantitative methods (or mixed methods) can deepen the understanding of mistreatment and respectful care in different contexts.

Qualitative approaches gather non-numerical data to explore individuals' experiences, opinions and attitudes about mistreatment and respectful care. Common methods include in-depth interviews, focus group discussions, unstructured or semi-structured observations and arts-based techniques (e.g. photo-elicitation and body mapping).

Quantitative approaches use numerical data to measure the prevalence and frequency of experi-ences, assess the burden of mistreatment and track respectful maternal and newborn care over time. These can include community-based, facility exit or online surveys, and structured observations during labour, childbirth or antenatal and postnatal contacts.

In Annex 4, Table 1 outlines qualitative approaches and their methodological considerations while Table 2 addresses quantitative approaches. Together, these tables highlight examples and key factors to consid-er when selecting data collection methods for measuring mistreatment and respectful maternal and newborn care.

Data can be collected from multiple sources using similar or different methods, a process known as triangulation. This approach offsets the limitations of individual methods, enhancing the validity and reliability of findings.

The approach to and frequency of data collection should align with its purpose, the needs of target audiences and the available resources. Collected data should inform decision-making and adaptive programme management to refine strategies and drive improvement

Data analysis

Annex 4 provides an overview of data analysis approaches for qualitative, quantitative and mixed-methods research. It is not an exhaustive guide but offers options and tips to help pro-gramme managers select an appropriate ap-proach. When using qualitative or quantitative methods, it is helpful to partner with an experi-enced research team, such as those from local universities, public health departments or non-governmental organizations.

As part of data analysis, it is important to examine disaggregated data to ensure that the needs of diverse population groups are being met. Data that is disaggregated by key stratifiers (age, location, etc.) helps highlight subpopulations that may face disproportionate mistreatment or, conversely, higher levels of respectful care (see Annex 4 for more information). If disaggregated data is not yet available, efforts should focus on integrating it into health management systems over time.

Validated measurement tools for assessing mistreatment and respectful maternal and newborn care

Numerous tools are available for measuring mistreatment and respectful maternal and newborn care. Annex 4 provides a list of tools that have been validated in at least one low- or middle-income setting, ensuring that they accurately measure what is intended and are contextually relevant and reliable.

Users of the compendium are encouraged to review Annex 4 and select the tools that best meet their needs. These tools can assist in assessing progress, guiding activity selection and improving communication with key stakeholders. However, any measurement tool must be adapted for a specific context. Stakeholders should review and pilot the questions – even those from validated tools – with a small group of target participants in relevant local languages. This pretesting helps ensure that the question(s) are understood as intended before wider use. Furthermore, since sensitive topics are being discussed with women and health workers, ethical considerations should be built into the measurement process (see "Ethical considerations for measurement" later in this section).

Tools for measuring women's experiences

In the past decade there have been rapid advances in measuring women's experiences* of maternity care. A 2020 scoping review identified 171 studies and 157 unique tools assessing experiences of facility-based childbirth care, with the majority focusing on the intrapartum period. Of these, 16 tools have been validated in low- and middle-income countries, primarily examining women's experiences during childbirth. Six of these tools specifically measure respectful maternity care or mistreatment (see Annex 4), while the remaining 10 measure related concepts such as satisfaction, communication and support.

Only two of the six tools – the "How women are treated during facility-based childbirth" tool *(1)* (see Box 8) and the "Person-centred Maternity Care (PCMC)" tool *(2)* (see Box 9) – have been validated in more than one low- or middle-income country setting and in different languages and contexts. They are discussed in detail here because they offer robust and reliable measurement of women's experiences. The also build on previous measurement work and the validated tools outlined in Annex 4.

* The majority of evidence on measurement tools has focused on women's experiences, highlighting the need for further understanding on the perspectives of gender-diverse individuals in maternal and newborn care.

Box 8. Measurement tool: **How women are treated during facility-based childbirth**

What does it measure?
The tool includes two elements: a community-based survey for postpartum women; and observations of women throughout labour, birth and the early postpartum periods.
It measures the mistreatment of women during childbirth, focusing on the following manifestations:

- physical abuse
- verbal abuse
- stigma and discrimination
- informed consent and confidentiality
- informed consent around vaginal examinations and interventions
- pain relief
- neglect and abandonment
- supportive care (labour companion ship, mobilization, birth position)
- health system conditions and constraints.

There is a long-form version of both elements *(3)* which allows for a comprehensive set of measures for all aspects of mistreatment during childbirth. These versions are useful in settings where teams seek to fully understand and explore mistreatment. Alternatively, two shortened scales *(4, 5)* offer a more practical option for routine monitoring and evaluation, using a subset of questions from the long-form versions of the scales that measure the most common forms of mistreatment.

Where has it been validated?
The tool has been used in over 30 countries across different regions and has been formally validated in Ghana, Guinea, Myanmar and Nigeria.

What are the data collection methods?
For the community-based survey, teams can take one of the following approaches:

- Recruit women at the time of birth or discharge for follow-up in the community during the post partum period (e.g. 6–8 weeks after birth). This allows time for reflection on the birth experience and enables the research or programme team to link the results with care provided at a specific facility.
- Recruit women from the community (e.g. those who gave birth in the past 6–12 months). This allows time for a woman to reflect on her birth experience, but may not enable the research or programme team to link responses to a specific facility unless a question about the facility is included. The time since childbirth may also introduce recall bias.

Labour observation uses a one-to-one approach, with a single observer monitoring one woman from admission for childbirth until two hours after birth.

What are the strengths and limitations of the tool?
The tool's development was informed by a systematic review of qualitative and quantitative experiences and measures of mistreatment *(6)*. It has been validated in four low- and middle-income country settings and provides robust and reliable measures of mistreatment.

The tool is specifically designed to measure mistreatment during childbirth in health facilities and does not directly measure respectful maternity care (recognizing that the absence of mistreatment does not necessarily mean that respectful care was provided). The tool is best suited for identifying and exploring the key manifestations of mistreatment that aim to be addressed. Due to the resources required for community surveys and birth observations, this tool is more feasible for planning and periodic evaluation than for routine monitoring in settings with resource constraints.

Where can the tool be accessed?
It is available in eight languages (English, French, Malinke, Poular, Sousou, Twi, Burmese and Yoruba) at: https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-018-0603-x.

Where can more information about the tool and results be found?
These publications describe:

- the main results from the WHO measurement study in Ghana, Guinea, Myanmar and Nigeria *(1)*;
- the main results from the measurement study in the occupied Palestinian territory *(7)*;
- the development of face validity and content validity of the tools *(3)*;
- the psychometric validation of the community survey tool *(8)*;
- the psychometric validation of the labour observation tool *(9)*; and
- the comparison between the two tools *(10)*.

Box 9. Measurement tool: **PCMC**

What does it measure?
The person-centred maternity care (PCMC) tool measures maternity care that is responsive to and respectful of people's preferences, needs and values, focusing on three broad domains during childbirth:

- dignity and respect, which includes perceived respect, privacy, confidentiality and the absence of verbal and physical abuse;
- communication and autonomy, which includes information provision, consent and birth position;
- supportive care, which includes labour and birth companionship, the absence of neglect, pain relief, and the health facility environment.

The full PCMC scale includes 30 items *(11, 12)*, with a shorter version consisting of a subset of 13 of the items *(13)*.

Where has it been validated?
The PCMC scale was initially developed and validated in India and Kenya. It has also been validated in Cambodia, China, Ghana, Sri Lanka, Türkiye and the USA. It has been used successfully in other countries, including the Dominican Republic, Ethiopia, Iran (Islamic Republic of), Madagascar, Malawi, Nigeria, Pakistan and the United Republic of Tanzania.

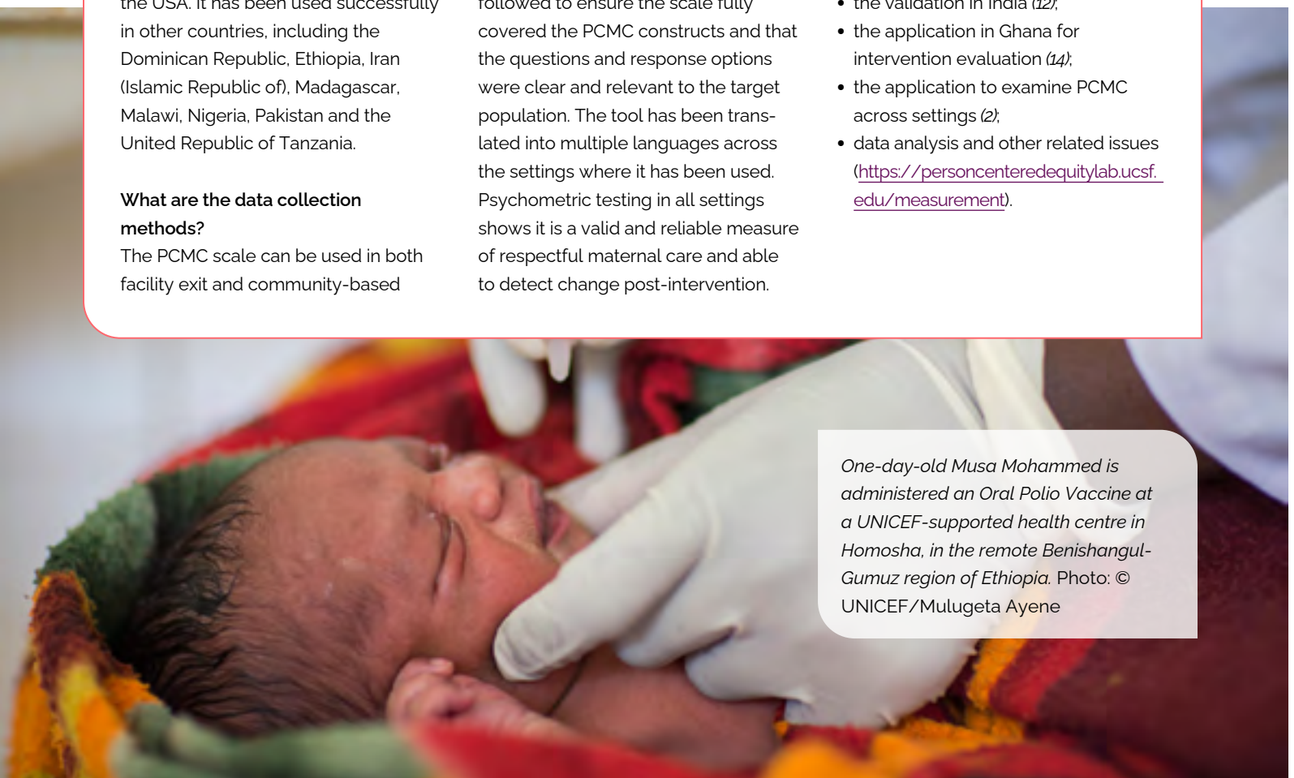
What are the data collection methods?
The PCMC scale can be used in both facility exit and community-based surveys. It can be administered through one-on-one interviews or self-administered. Exit surveys can be conducted after discharge from the facility or during postnatal care visits. For community surveys, women can be recruited from either the community or at a health facility and followed up at home or in another location for the interview. The scale is ideally administered to women within 12 weeks postpartum, though it has also been used up to one year after birth.

What are the strengths and limitations of the tool?
The PCMC scale is a comprehensive measure of women's experiences during childbirth across all domains of respectful maternity care. It captures a continuum – from the negative (mistreatment) to the positive (respectful care). Developed through a rigorous validation process, it began with an extensive literature review on person-centred care constructs, including respectful care and mistreatment. Expert reviews and interviews followed to ensure the scale fully covered the PCMC constructs and that the questions and response options were clear and relevant to the target population. The tool has been translated into multiple languages across the settings where it has been used. Psychometric testing in all settings shows it is a valid and reliable measure of respectful maternal care and able to detect change post-intervention. One limitation is the tool's length, but this has been addressed by the creation of a shorter version. In addition, like any composite indicator, the PCMC score by itself will not determine the specific point at which a problem is occurring or why. Examining the subscale scores and responses to individual items will, however, provide guidance on where the main gaps are, to help inform planning and monitoring of quality improvement interventions.

Where can the tool be accessed?
The tool is openly available in English in the original publication *(11)* and on the person-centred equity lab website (https://personcenteredequitylab.ucsf.edu/measurement). Translations in other languages, including Swahili and Hindi, which have been validated, are available from the authors and will be accessible on the website in the future.

Where can more information about the tool and results be found?
These publications describe:

- the original validation in Kenya *(11)*;
- the validation in India *(12)*;
- the application in Ghana for intervention evaluation *(14)*;
- the application to examine PCMC across settings *(2)*;
- data analysis and other related issues (https://personcenteredequitylab.ucsf.edu/measurement).



One-day-old Musa Mohammed is administered an Oral Polio Vaccine at a UNICEF-supported health centre in Homosha, in the remote Benishangul-Gumuz region of Ethiopia. Photo: © UNICEF/Mulugeta Ayene

Tools for measuring newborn experiences

A 2023 scoping study investigated tools for measuring various aspects of newborn care experiences and satisfaction using an adapted version of the WHO small and sick newborn care standards. The review revealed the absence of a specific conceptual framework or typology for respectful newborn care. It found 72 papers using 76 unique measurement instruments or indicators, 34 of which had undergone some validation *(15)*. Many of these tools focused on specific aspects of care, such as parental involvement, pain management, continuity of care and quality of parent–health worker communication. These tools are highlighted in Annex 4.

More evidence-based measures are needed to track parent and newborn care experiences *(16)*. Two studies directly measured respectful newborn care or mistreatment in the first two hours after birth in Ghana, Guinea, Nigeria *(17)* and Nepal *(18)*. Both used the "How women are treated during facility-based childbirth" tool, which primarily measures mistreatment of the woman, but also includes some aspects of newborn mistreatment from birth until two hours after birth, though these components were not specifically validated. The tool covers neonatal dimensions such as physical or verbal abuse, skin-to-skin contact, use of evidence-based medical interventions, breastfeeding within one hour of birth, separation of the mother and baby, the presence of a health worker, and the level of communication and counselling for parents *(17, 18)*.

A qualitative situation analysis is a potential starting point for better understanding the context of respectful newborn care. For example, two studies in Kenya explored manifestations of newborn mistreatment through in-depth interviews with health workers and parents of newborns, along with observations of activities and interactions in newborn units, nurseries and postnatal wards across five hospitals *(19, 20)*. The findings were shared and discussed with health workers, parents and policy-makers to collaboratively identify interventions for ensuring respectful newborn care.

Currently, no validated quantitative instrument exists specifically to measure respectful newborn care. However, different tools are available to identify and address common manifestations of mistreatment of newborns during the intrapartum and immediate postnatal periods, such as separation from mothers, neglect, abandonment and physical abuse. These can be measured through exit or community surveys, labour observations and health-worker interviews or peer reflections.

Global efforts are underway to extend the lessons learned from respectful maternal care to respectful newborn care, by developing a conceptual definition and standardized measures to assess core features. The compendium will also be updated as new evidence emerges.

Monitoring – types of indicators

Section 4 introduced a planning template for identifying interventions and output and outcome indicators to track the reduction of verbal abuse experienced by women. Various types of indicators can help programme managers, implementers, service users and other stakeholders monitor the impact of activities, including the following.

INPUT INDICATORS

measure the availability of resources and prerequisites necessary for implementing respectful care programmes, such as training materials, funding or health-worker participation.

PROCESS INDICATORS

measure the implementation of activities and how they are carried out, such as the number of communication training sessions or supervisory visits that have been conducted, or adherence to respectful care guidelines.

OUTPUT INDICATORS

measure whether the activities are implemented as intended, such as delivery of communication training sessions, and if they produce immediate effects, such as improved communication skills among health workers.

OUTCOME INDICATORS

assess reported experiences of specific manifestations of mistreatment and respectful maternal and newborn care; they serve as the primary outcomes for programmes aimed at ending mistreatment and achieving respectful care.

For indicators being monitored, it is essential to define their parameters clearly, including:

- numerator and denominator (if applicable)
- measurement method
- frequency of measurement
- responsible individuals or teams for data collection and analysis.

In general, it is best to include only a few carefully selected indicators to reduce the measurement burden and focus on the most meaningful data. Monitoring a few impactful indicators well is far better than trying to measure too many indicators poorly. Respectful maternal and newborn care is complex, and it is neither possible nor desirable to measure everything.

Where possible, it is preferable to use existing indicators from the routine health information system. However, quantitative data on the experiences of women, gender-diverse people, newborns and families across the antenatal, intrapartum and postnatal periods is not often routinely collected. As programmes and health facilities gain practical experience with local approaches for regularly measuring care experiences, there will be opportunities to integrate service-user-reported experience indicators into existing systems.

Where existing indicators do not exist, additional costed data collection might be required, which will require the identification of potential funding sources.

Table 12 gives examples of different types of indicators and details of how to monitor the presence of a labour companion, which is a component of emotional support.

Masudio Schoviah, a midwife activity manager, checks the vital signs of a patient who recently gave birth to twins at Gambella hospital, Ethiopia. Photo: © MSF/Zacharias Abubeker

Table 12. Example of indicators and related components for measuring emotional support, particularly the presence of a labour companion

Indicator	Indicator definition	Numerator	Denominator	Measurement method	Frequency	Responsible person(s)	Additional cost to measure (if applicable) (e.g. for 12 months)
● ***Input*** Availability of training materials on labour companionship in facilities	Proportion of target facilities with all required training materials for labour companions	Number of target facilities with all required training materials available	Total number of target facilities	Facility inventory checklist	Annually	Facility managers and district health information officers	US$ 150 annually (US$ 30 per inventory review in five facilities)
● ***Process*** Health workers who completed labour companion training	The proportion of health workers in target facilities who completed training on labour companionship	Number of health workers who completed training	Total number of health workers in the target facilities	Training attendance records	Quarterly	Facility health information officers	US$ 180 (US$ 30 per survey in five facilities x six surveys per year)
● ***Outcome*** Women and gender-diverse people who felt supported during labour and birth	Proportion of women and gender-diverse people who felt supported during labour and birth	Number of women and gender-diverse people surveyed who reported feeling supported during labour and birth	Total number of women and gender-diverse people surveyed	Survey of women and gender-diverse people	Every two months	District and facility health information officers in five facilities	US$ 180 (US$ 30 per survey in five facilities x six surveys per year)
● ***Output*** Labour companion/ pre-discharge postnatal care	Proportion of women reporting a labour companion	Number of women surveyed who report a labour companion	Number of women surveyed after delivery	Survey of women and gender-diverse people (could be collected using PCMC scale item)	Every two months	Community member and facility health information officer	US$ 180 (US$ 30 per survey x six surveys per year)
● ***Output*** Monthly community workshops discussing women's experiences of care	Number of community workshops convened	Number of community workshops convened	Not applicable	Respectful maternal and newborn care activity logbook	Monthly	District supervisor	No additional cost for data collection
● ***Output*** Monthly community workshops discussing women's experiences of care	Proportion of district facility quality improvement teams plotting and publicly displaying results of monthly client survey	Number of facility quality improvement teams publicly displaying results of client (or parent of newborn) survey	Number of facility quality improvement teams participating in district "Respectful maternal and newborn care quality improvement" initiative	Direct visualization during supervision visits	Monthly; if supervision missed one month, it is documented at the next visit	District supervisor	No additional cost for data collection

Evaluation

Section 4 outlined steps for establishing a strategic vision for respectful maternal and newborn care, and planning implementation cycles that incorporate monitoring, documentation and learning. When resources allow, programme managers and stakeholders may choose to conduct more rigorous evaluations across one or more implementation cycles or at the conclusion of a strategic planning period. These valuations help assess progress, inform next steps and support advocacy for additional resources to expand activities.

To evaluate the impact of programmes or interventions aimed at ending mistreatment and achieving respectful maternal and newborn care, two distinct but complementary approaches can be used: impact evaluation and process evaluation.

Impact evaluation

Impact evaluation focuses on assessing the effectiveness of a programme, project or intervention by measuring whether it achieved its intended outcomes.

Key components include the following.

- **Baseline prevalence assessment:** This provides a clear picture of the context of respectful maternal and newborn care before interventions are introduced. Ideally this assessment occurs prior to the rollout of interventions and may coincide with a situation analysis (see Section 4).
- **Endline prevalence assessment**: Conducted towards the end of a programme, this assessment measures the overall impact of activities. Comparing baseline and endline data on specific manifestations of mistreatment and respectful maternal and newborn care can helps determine the effectiveness of the interventions.

Process evaluation

Process evaluation helps determine what did and did not work and why.

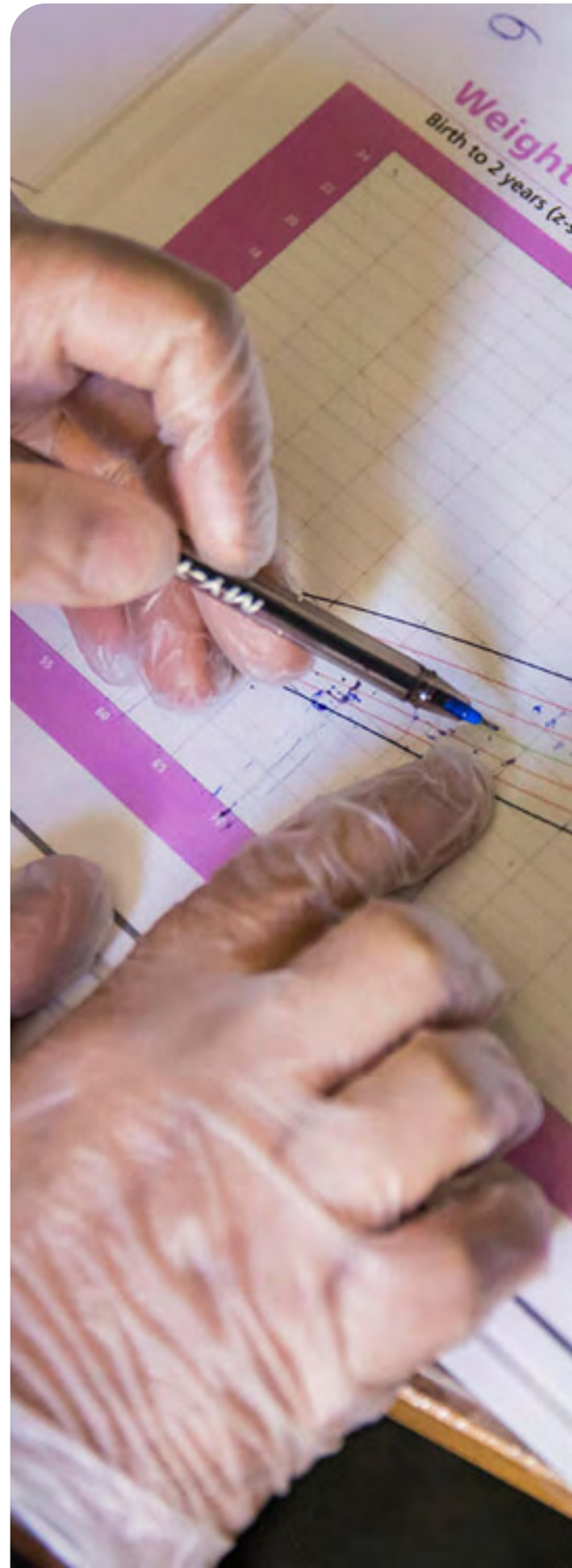
This evaluation typically includes:

- assessing acceptability, feasibility, fidelity, sustainability and scalability *(21)*
- gathering qualitative insights from women, gender-diverse people, their partners and health workers through in-depth interviews or focus group discussions
- understanding barriers, enablers, challenges and contextual factors that shaped the programme's implementation.

In a longer or more complex project with multiple activities, it may be useful to collect data at different intervals. For example, in a five-year implementation project, annual prevalence measurements can reveal trends over time. If activities are introduced in stages – such as two activities in year two and three in year three – measuring prevalence a few months after implementation can help evaluate the impact of specific activities and assess the benefits of any changes or improvements.

This approach invites all individuals who gave birth at a specific facility over a two-week period to participate in exit interviews or community surveys, rather than surveying everyone over an entire year. Focusing on this shorter time frame helps reduce recall bias, as experiences are fresh, and minimizes recruitment bias, ensuring no group is over- or under-represented. It also addresses practical challenges by making data collection more feasible, as it avoids the need to gather information from every birth, which would be resource-intensive and logistically difficult.

A framework can help structure the evaluation of a programme, project or intervention. One that is commonly used is RE-AIM (Reach, Effectiveness, Adoption, Implementation and Maintenance).
It is designed to guide the planning, implementation and evaluation of health programmes and interventions. The framework's domains can be adapted to fit the specific context, in this case respectful maternal and newborn care. Box 10 provides an overview of the framework integrating equity with key questions relevant for respectful maternal and newborn care.



In Raparin Children's Hospital, Erbil, Iraq, Doctor Diyar Jeff shows some data about children growth and development.
Photo: © UNICEF/Ilvy Njiokiktjien

Box 10. Overview of RE-AIM framework with key questions for respectful maternal and newborn care

RE-AIM domain	Definition	Key questions for a programme on respectful maternal and newborn care
Reach	Proportion of the target population that participates in the programme	How well does the programme reach the intended audience? What percentage of the target population participates?
Effectiveness	Positive and negative outcomes of the programme; involves assessing the completion of implementation cycle(s) or evaluating the strategic vision	What is the impact of the programme on the manifestations of respectful care? How effective is it in achieving the desired outcomes?
Adoption	Proportion and representativeness of facilities, organizations or health workers and managers willing to initiate the interventions	To what extent are different facilities, organizations, health workers or health managers willing to adopt and implement the programme or interventions?
Implementation	Extent to which a programme is delivered as intended	How well is the programme executed in real-world settings? Are the programme components delivered consistently and as planned?
Maintenance	Long-term effects of a programme at system levels (national, subnational, facility, community)	What is the sustainability of the programme effects over time? To what extent are the changes in behaviour or outcomes maintained?
Equity	Fairness and justice in the distribution of resources, rights, outcomes and opportunities	Do different population groups have different outcomes or experiences? Is impact distributed equitably, including across marginalized groups?

Source: adapted from Glasgow, Vogt and Boles *(22)*.

Mother with newborn in Kenya.
Photo: © DFID/Russell Watkins

Ethical considerations for measurement

Ethical considerations are critical in research, but also when monitoring and evaluating the impact of interventions to end mistreatment and achieve respectful care. Adhering to standards – such as confidentiality, informed consent, fair participation and minimizing risks – protects the rights and well-being of participants, such as women, parents and health workers, while building trust in the data and processes. Box 11 outlines ways to integrate these ethical considerations into monitoring, evaluation and research. To ensure ethical integrity, the benefits must outweigh the risks.

For routine monitoring activities (e.g. monthly or quarterly reviews), ethics approval from a review committee or institutional review board is generally not required. However, if results will be published or presented externally, or if the monitoring is part of an implementation research project, ethics approval may be necessary. Ethics review committees or institutional review boards may offer exemptions or expedited approvals for public health work. If there is uncertainty about whether ethics approval is needed, consult the relevant ethics committee before starting data collection, as retrospective approval is typically not allowed.

Sheuly Akhter is playing with her child at Mirpur-13, Dhaka, Bangladesh. Photo: © UNICEF/Chak

Box 11. Ethical considerations for measurement

For all participants

Confidentiality: Ensure participants' personal information is accessible only to authorized personnel (e.g. evaluation, monitoring and research staff) and is securely maintained. Protect all identifying details (e.g. names, addresses). Women may worry that health workers will learn what they said, and health workers may fear that managers will find out. Such concerns can deter participation and compromise safety.

Anonymity: Whenever possible, use anonymized data by removing identifying details from forms, such as contact information, or specifics about a baby's birth date or location. For example, when collecting information about childbirth experiences, assign unique identification codes to each participant to ensure that responses cannot be traced back to individual mothers or newborns.

Respect: Treat all participants with fairness, dignity and respect. This includes providing clear and accessible information about the purpose, procedures and potential impacts of participation. All interactions should be sensitive to participants' values and preferences.

Justice and equity: Ensure that any burdens, such as time spent away from a baby, and benefits, such as opportunities to share personal perspectives, are fairly distributed among participants. For example, when gathering information from new mothers, avoid repeatedly asking the same group to attend extra sessions or share overly personal details so as not to unfairly target or exploit any particular group.

Protection: Safeguard participants from physical, psychological, social and economic harm, ensuring benefits outweigh risks. Provide psychological and emotional support for those reporting mistreatment. Avoid interviewing individuals who are particularly vulnerable, such as women or parents who have recently experienced the loss of a baby, and take extra care in engaging adolescent mothers. Ensure that participation is voluntary, support is available, and the approach is sensitive to their specific social and emotional needs.

Informed consent: Clearly explain the purpose, procedures, risks and benefits in simple language. Ensure that participants voluntarily agree to take part, without any coercion, and that they can withdraw their participation and data at any time. Reassure them that their care will not be affected by their decision to participate or by the responses, especially since the interviews or surveys may be conducted at the facility where they receive care.

For data collection and analysis teams

Support mechanisms: Establish regular debriefing sessions to address emotional impacts and ethical challenges and the potentially distressing nature of discussions about mistreatment. Create a safe environment for open discussion and reflection to help the team process these experiences, refine procedures and provide mutual support.

For pregnant/postpartum women, parents and caregivers

Timing of participation: Schedule interviews and surveys at times when participants are not overwhelmed or rushed, such as avoiding periods immediately after birth.

Location: Conduct interviews and surveys in a discreet setting at health facilities to safeguard participants' privacy and help them feel comfortable sharing. Be aware that some women may be hesitant to disclose their experiences of mistreatment on-site. Online interviews are also increasingly common in some contexts.

Clarify implications for care: Assure participants that their care will not be affected by their participation or responses, and that they agree without any coercion. Emphasize that the data collection aims to better understand their experiences – both positive and negative – to improve the quality of care for all families.

For health workers

Private interview locations: Conduct interviews in confidential spaces, where no colleagues or supervisors are present to protect privacy.

Employment: Clearly communicate that participation will not affect current or future employment and that the purpose is to understand experiences and beliefs to enhance care quality for all.

Recap and what's next

This section provided practical strategies for programme managers to address measurement gaps in respectful maternal and newborn care. It covered data collection methods, validated assessment tools and guidance on selecting appropriate monitoring indicators. The next section looks ahead to the future of respectful maternal and newborn care and highlights the actions needed to drive ongoing improvements and ensure dignity and respect for all mothers and newborns..

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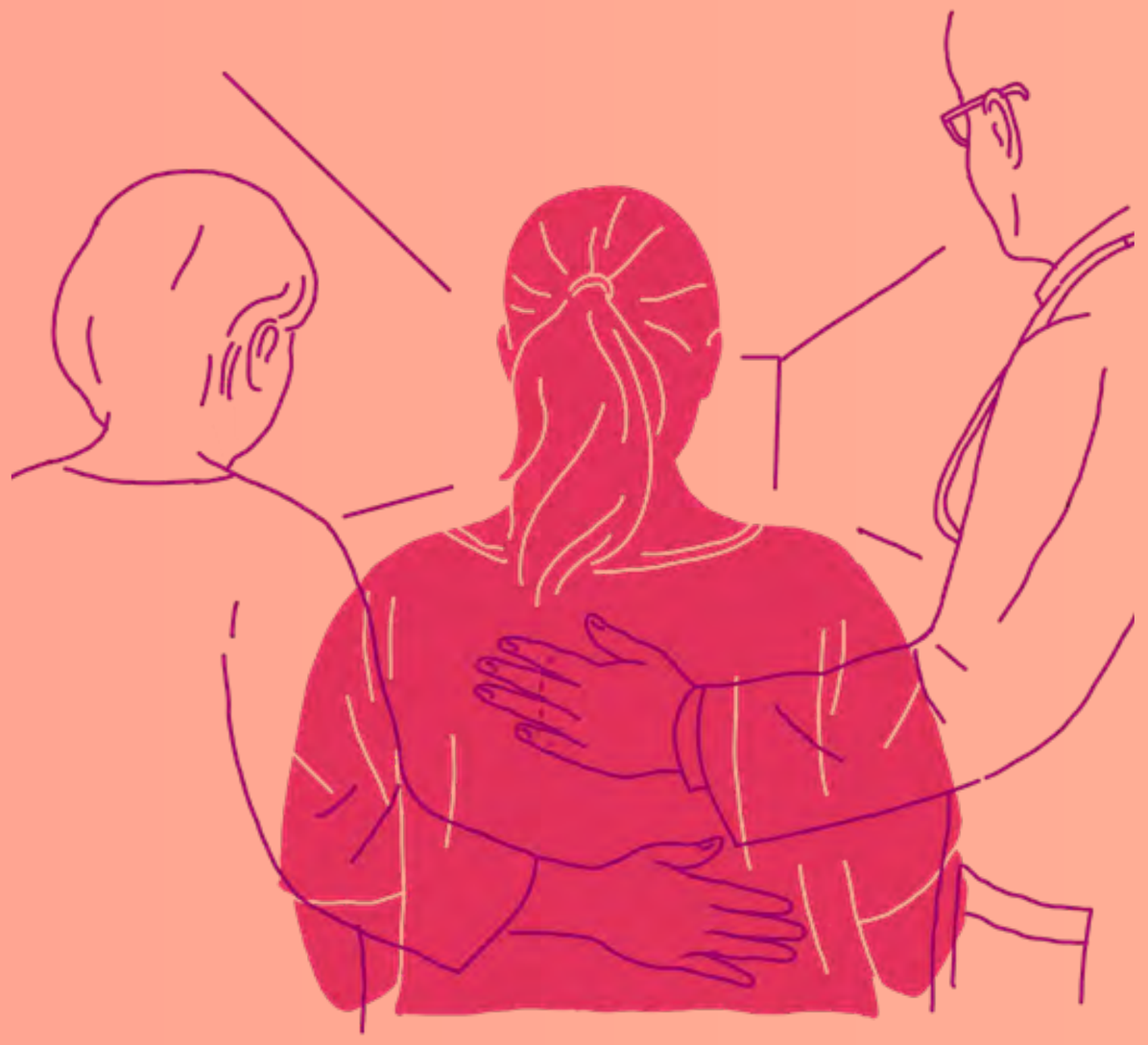
22 Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. 1999;89(9):1322-1327 (https://doi.org/10.2105/ajph.89.9.1322).

6

Charting a path to respectful maternal and newborn care



Providing respectful care to all women, gender-diverse people, and newborns is an urgent global health priority, recommended in WHO guidelines and documents. Over the past decade respectful care has gained increased attention, especially as quality of care plays a crucial role in shaping experiences and outcomes for these groups. Despite notable progress in understanding and measuring respectful maternal and newborn care, it remains a challenge to implement and scale-up promising interventions.

This compendium is designed to support these efforts, particularly in light of the 10th anniversary of the 2014 WHO statement on the prevention and elimination of disrespect and abuse during facility-based childbirth *(1)*.

Health systems vary in their progress towards achieving respectful maternal and newborn care, with some countries having well-established programmes and others just beginning. Regardless of a country's progress, the compendium offers important context and foundational knowledge for ending mistreatment and achieving respectful care, and provides current evidence, tools and resources to support implementation across diverse settings.

Midwife home visit in Nepal. Photo: © USAiD/Thomas Cristofoletti

Users of the compendium can gain valuable insights in the following key areas.

Concepts and principles

The compendium serves as a timely resource by outlining the evolution of global thinking on respectful maternal and newborn care. Understanding key concepts and terminology is important for designing and implementing programmes to end mistreatment and achieve respectful care.

Manifestations and drivers

Achieving respectful maternal and newborn care requires addressing mistreatment while promoting dignity, autonomy and compassion throughout the care experience. This involves understanding the manifestations of mistreatment, such as stigma or lack of pain relief, as well as those of respectful care, such as privacy and confidentiality. The drivers of these manifestations – whether policy-related, sociocultural, organizational or individual – must be identified and understood, as they can either contribute to mistreatment or enable respectful care, when the right conditions are in place.
By addressing these drivers as part of an implementation plan, it becomes possible to target the root causes of mistreatment and develop strategies to strengthen respectful, person-centred care.

Areas of intervention

Promising interventions have been identified to address these drivers of mistreatment and respectful care, offering valuable insights for planning and implementing activities. Multicomponent strategies tailored to specific contexts – combining approaches across levels of the health system and addressing an array of drivers – are effective in strengthening respectful care. However, gaps in the evidence and knowledge base persist, underscoring the need for evaluating these interventions, along with ongoing documentation and learning to refine and sustain efforts.

Implementation in practice

As programme managers engage with the compendium, they are encouraged to draw upon the information and resources it offers to collaboratively develop and implement tailored plans that address the priority drivers and manifestations of mistreatment/respectful care, aligning with existing plans, structures and programmes. A phased approach to implementation is key, starting with stakeholder engagement and strategic planning, identifying manifestations, drivers and interventions, and then progressing through cycles of implementation, monitoring, learning and adaptation.

Engagement of key stakeholders

Collaborating with stakeholders, including women, gender-diverse people, parents, families and health workers, from the outset and throughout all phases, is critical to ensuring local ownership and oversight. Their lived experiences provide valuable insights into the social, structural and systemic factors at play. Skilled facilitation is essential for navigating sensitive discussions. Only by embracing diverse perspectives and bringing together multidisciplinary and multisectoral stakeholders can teams effectively address the complex factors that perpetuate mistreatment.

Data to improve implementation

Monitoring and documentation are essential for tracking progress, identifying gaps and improving implementation. Users of the compendium are encouraged to use the data collection methods, validated tools and key indicators to monitor and evaluate impact. Adaptive management is an approach that supports programme managers to regularly review data and meet frequently with implementation teams and stakeholders to assess progress, address challenges and adapt activities as needed. Documenting what is learned will be invaluable for others.

Advancing respectful care

There is still more to be done to advance the critical agenda of ending mistreatment and achieving respectful care. Additional steps to drive transformation include the following.

Prioritize respectful maternal and newborn care as an objective within national plans, quality-of-care efforts and monitoring frameworks
A major challenge is that respectful maternal and newborn care is rarely seen as a priority in national goals and monitoring frameworks. Without explicit inclusion, it can be easily overlooked, making progress difficult to track. Recognizing respectful maternal and newborn care as both a core component of care quality and as a right for all women and newborns can drive resource allocation and ensure its inclusion in plans aimed at improving the care experiences of women, gender-diverse people, newborns and families.

Ensure integration into curricula and clinical guidance
Embedding efforts to end mistreatment and achieve respectful care into the health system rather than treating them as stand-alone initiatives, is critical to making these goals a core aspect of maternal and newborn health services. Integrating respectful care into pre-service education, in-service training, clinical guidelines and routine practices will ensure it becomes a fundamental part of maternal and newborn care.

Improve the sharing of documentation and lessons learned for scale-up and to support implementation in other settings
A collective effort is needed to build the knowledge base on what does and does not work when implementing respectful maternal and newborn care. When country programmes can draw on available evidence and share challenges and solutions, they foster a culture of collaboration and continuous improvement. This exchange of knowledge enables country programmes to learn from each other's experiences and adapt effective interventions to their own contexts.

Prioritize resource mobilization
Advocates for respectful care, including policy- and decision-makers, can actively promote the allocation of resources to address health system readiness. This involves securing funding, essential physical resources and a competent, motivated workforce.

Start to apply respectful care across all areas of sexual, reproductive, maternal, newborn, child and adolescent health
While the compendium primarily focuses on ending mistreatment and achieving respectful care during labour, childbirth and the immediate postnatal period, programme managers and stakeholders can extend the principles across all areas of sexual, reproductive, maternal, newborn, child and adolescent health. The aim is to ensure zero tolerance for any form of disrespect and abuse throughout the entire health-care system (see Box 12).

Box 12. Broaden respectful maternal and newborn care for person-centred care across the life course

The compendium underscores the urgent need to end mistreatment and achieve respectful maternal and newborn care during labour, childbirth and the immediate postnatal period. This focus is vital, as it represents a uniquely vulnerable time – when the absence of respectful care can severely impact the health and well-being of women, gender-diverse people and newborns. A substantial body of evidence supports this focus. However, for lasting improvements in maternal and newborn outcomes, respectful, person-centred care must extend throughout the entire life course.

The principles and approaches in the compendium can be applied to improving person-centred care across all stages of life. Expanding respectful care beyond childbirth ensures that people of all ages – newborns, children, adolescents, adults and older people – receive health care that is respectful, compassionate and responsive to their individual and family needs. This commitment to person-centred care emphasizes the importance of treating each stage of life with dignity and empathy.

Health systems can benefit from integrating the principles of respectful maternal and newborn care into all services, including sexual and reproductive health, HIV and AIDS care, and gender-based violence counselling. This approach fosters continuity of respectful, person-centred care at every health interaction. Because the same health workers may provide multiple services throughout the lives of women and gender-diverse people, and for their children, interventions can be implemented across various life stages simultaneously. By embracing this integrated approach, the concepts in the compendium can be applied to benefit people throughout the life course.

Summary

Ending mistreatment and achieving respectful maternal and newborn care requires both immediate action and sustained commitment. Programme managers and stakeholders can use the compendium to design strategies that centre respect as a core dimension of quality care. These efforts will not only improve maternal and newborn care experiences but also strengthen health systems and service quality more broadly.

The compendium offers an evidence-based road map to transform respectful care at multiple levels, supporting well-being and fostering trust during a pivotal life stage for women, gender-diverse people, and newborns. Quality of care is essential – not only for maternal and newborn health but as a cornerstone of equitable, dignified health systems across the life course.

References: *Section 6*

1 The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/134588).

Annexes

Annex 1: Methodology to develop the compendium

Co-creation and compendium development

The compendium was developed through a structured, collaborative process, beginning with the formation of a technical working group composed of global and programme experts (see Annex 2). This group played a key role in co-designing and refining the content, providing both technical and strategic input to ensure alignment with best practices and real-world implementation needs.

To ensure the integration of diverse perspectives, implementation science and human-/user-centred design methodologies were used to iteratively engage potential users throughout the development process *(1)*. This also enabled us to better understand the context of respectful care implementation to-date. This approach was guided by a well-established conceptual framework *(2)* structured around three key stages: **(i)** understanding context, **(ii)** developing and refining content and **(iii)** user engagement.

Global stakeholder meetings were convened in Ghana (March 2023), South Africa (May 2023) and France (July 2023) to gather insights, validate key concepts and ensure the compendium's relevance across different contexts. Following these meetings, content development meetings were held at WHO headquarters in September 2023 and April 2024 with members of the technical working group and WHO secretariat. This was followed by two rounds of peer review by an expert review group in February and March 2024 and September and October 2024) (see Annex 2).

Additionally, structured discussions with six programme managers took place in two rounds (March 2024 and October 2024) to gather direct user input. There were also online consultations and structured discussions, including user insight interviews, which further supported refinement of the content. This helped ensure that the compendium would be aligned with both implementation goals and user expectations.

Literature identification and search

Relevant WHO standards, recommendations and technical guidance documents on maternal and newborn care and quality formed the basis of the compendium's content. This included WHO recommendations on intrapartum care for a positive childbirth experience, and specifically the recommendations on respectful maternity care, effective communication and companion of choice during labour and childbirth *(3)*. Additionally, it included WHO recommendations on care for preterm and low-birth-weight babies, which emphasized family involvement in newborn care *(4)*.

Seven systematic and scoping reviews, including those informing the WHO intrapartum care guideline and a 2021 supplement on mistreatment of women during childbirth, provided further insights *(5)*. WHO also commissioned a series of reviews on strategies to reduce the mistreatment of women and improve respectful maternity care *(6)*. Together, these sources formed a robust foundation for the global evidence on drivers of mistreatment and interventions for respectful care.

Global stakeholder meetings in South Africa and Ghana in 2023 helped identify additional literature to support the compendium's evidence base. This included systematic, scoping and landscape reviews on social accountability mechanisms, the health workforce and structural factors affecting maternity care. A supplementary literature search in 2023 in Medical Literature Analysis and Retrieval System Online (MEDLINE) and Cumulative Index to Nursing and Allied Health Literature (CINAHL) also identified an additional four review articles relevant to the drivers and interventions for mistreatment.

Synthesis and extraction of drivers and interventions

The areas of intervention were based on the theory of change and a seminal landscape review of interventions to promote respectful maternal care *(7)*. To systematically map out the drivers of mistreatment and respectful care, they were categorized into policy, sociocultural, organizational and individual drivers. A matrix-based approach was used to collate and synthesize information from the literature, organizing drivers and corresponding interventions into a structured framework. This process was conducted in a spreadsheet format, allowing for systematic analysis and organization of interventions at national, subnational, facility and community levels.

Limitations and considerations

While the areas for intervention are based on systematic, scoping and landscape reviews as well as primary research, several limitations remain, therefore interventions were referred to as "promising" rather than "evidence-based" or "effective".

First, the global scope of systematic reviews may have missed studies from low-resource settings or technical organizations not published in peer-reviewed journals. While some interventions align with WHO and UN recommendations, others are based on small, uncontrolled studies with unclear effectiveness. These studies often lacked control groups, limiting the ability to isolate intervention effects, such as the implementation of another policy, and many were conducted over short timescales, making long-term impact unclear. However, evidence from Bangladesh, Ghana, the United Republic of Tanzania, India and Kenya supports the effectiveness of multicomponent interventions in strengthening respectful maternal and newborn care. Lastly, a comprehensive electronic search using pre-determined inclusion criteria was not conducted potentially leaving regional or language gaps. Nonetheless, supplementary searches suggest that most relevant literature was captured.

Future updates to the compendium

The compendium is a living document that will be continuously updated based on user feedback and new evidence. It is envisioned that future iterations will include additional examples from the antenatal and postnatal periods, as well as areas beyond maternal and newborn health, such as family planning, responses to gender-based violence, child and adolescent health, and aged care.

Annex 2: Contributors to the compendium

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Annex 3: Respectful care recommendations from WHO guidelines

WHO recommendations on intrapartum care for a positive childbirth experience, related to respectful maternal and newborn care. *Source: WHO (1).*

Care option	*Recommendation*
First stage of labour	
Perineal/pubic shaving	Routine perineal/pubic shaving prior to giving vaginal birth is not recommended.
Enema on admission	Administration of enema for reducing the use of labour augmentation is not recommended.
Epidural analgesia for pain relief	Parenteral opioids, such as fentanyl, diamorphine and pethidine, are recommended options for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.
Opioid analgesia for pain relief	Relaxation techniques, including progressive muscle relaxation, breathing, music, mindfulness and other techniques, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.
Manual techniques for pain management	Manual techniques, such as massage or application of warm packs, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.
Oral fluid and food	For women at low risk, oral fluid and food intake during labour is recommended.
Maternal mobility and position	Encouraging the adoption of mobility and an upright position during labour in women at low risk is recommended.
Second stage of labour	
Birth position (for women without epidural analgesia)	For women without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.
Birth position (for women with epidural analgesia)	For women with epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended.
Episiotomy policy	Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth.
Fundal pressure	Application of manual fundal pressure to facilitate childbirth during the second stage of labour is not recommended.

Care of the newborn	
Routine nasal or oral suction	In neonates born through clear amniotic fluid who start breathing on their own after birth, suctioning of the mouth and nose should not be performed.
Skin-to-skin contact	Newborns without complications should be kept in skin-to-skin contact with their mothers during the first hour after birth to prevent hypothermia and promote breastfeeding.
Breastfeeding	All newborns, including low-birth-weight babies who are able to breastfeed, should be put to the breast as soon as possible after birth when they are clinically stable, and the mother and baby are ready.
Bathing and other immediate postnatal care of the newborn	Bathing should be delayed until 24 hours after birth. If this is not possible due to cultural reasons, bathing should be delayed for at least six hours. Appropriate clothing of the baby for ambient temperature is recommended. This means one or two more layers of clothes than adults have on, and use of hats/caps. The mother and baby should not be separated and should stay in the same room 24 hours a day.

WHO recommendations on maternal and newborn care for a positive postnatal experience. *Source: WHO (2).*

Oral non-steroidal anti-inflammatory drugs (NSAIDs); oral analgesia for perineal pain relief	Oral paracetamol is recommended as the first-line choice when oral analgesia is required for the relief of postpartum perineal pain; it is also recommended for pharmacological relief of pain due to uterine cramping/involution.
Pharmacological relief of pain due to uterine cramping/involution	NSAIDs can be used when analgesia is required for the relief of postpartum pain due to uterine cramping after childbirth, based on a woman's preferences, the clinician's experience with analgesics and availability.

WHO recommendations for care of the preterm or low-birth-weight infant. *Source: WHO (3).*

Family involvement	Family involvement in the routine care of preterm or low-birth-weight infants in health-care facilities.

WHO recommendations on health promotion interventions for maternal and newborn health. *Source: WHO (4).*

Companion of choice at birth	Continuous companionship during labour and birth is recommended for improving labour outcomes. Continuous companionship during labour and birth is recommended for improving women's satisfaction with services.
Community participation in quality improvement processes	Community participation in quality improvement processes for maternity care services is recommended to improve quality of care from the perspectives of women, communities and health workers. Communities should be involved in jointly defining and assessing quality. Mechanisms that ensure women's voices are meaningfully included are also recommended.
Community participation in programme planning and implementation	Community participation in programme planning, implementation and monitoring is recommended to improve use of skilled care during pregnancy, childbirth and the postnatal period for women and newborns, increase the timely use of facility care for obstetric and newborn complications and improve maternal and newborn health. Mechanisms that ensure women's voices are meaningfully included are also recommended.

Annex 4: Tools and approaches to plan and measure respectful maternal and newborn care

Tools for maternal indicators

Authors	Title	Type of tool	Languages available	Validated in a low- or middle-income country?	Number of countries validated in	Manifestations of mistreatment or respectful maternal and newborn care measured
Bohren 2019 *(1)*	How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys	Community survey (women) Observations of labour	Burmese, English, French, Malinke, Poular, Soussou, Twi, Yoruba	Yes – Ghana, Guinea, Myanmar, Nigeria	4	Physical abuse, verbal abuse, stigma or discrimination, informed consent, confidentiality, communication, autonomy, vaginal examinations, pain relief, neglect and abandonment, labour companionship, health system constraints, privacy
Afulani 2017 *(2)*	Development of a tool to measure person-centered maternity care in developing settings: validation in a rural and urban Kenyan population	Facility exit and community surveys (women)	Chinese, English, French, Hindi, Kinyarwanda, Luo, Spanish, Swahili, Turkish	Yes – Kenya, India, Ghana, Türkiye, Sri Lanka, USA, Cambodia, China, Iran (Islamic Republic of)	9	Dignity and respect: perceived respect, friendliness, privacy, confidentiality, verbal and physical abuse Communication and autonomy: information provision, consenting, shared decision-making, language, birth position choice Supportive care: timeliness, labour and birth companionship, neglect, pain relief, safety, trust, the health facility environment
Kujawski 2015 *(3)*	Association between disrespect and abuse during childbirth and women's confidence in health facilities in the United Republic of Tanzania	Facility exit survey (women)	Swahili	Yes – the United Republic of Tanzania	1	Verbal abuse, bribes, privacy, ignoring or abandoning, non-consent, physical abuse, sexual abuse, detention for failure to pay
Abuya 2015 *(4)*	Exploring the prevalence of disrespect and abuse during childbirth in Kenya	Facility exit survey (women)		Yes – Kenya	1	Humiliation or disrespect, non-confidential care, neglect or abandonment, non-consented care, physical abuse, inappropriate demand for payment
Asefa 2015 *(5)*	Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centres in Addis Ababa, Ethiopia	Facility exit survey (women)	Amharic	Yes – Ethiopia	1	Not protected from physical harm or ill-treatment, right to information or informed consent or choice, confidentiality, privacy, dignity or respect, equitable care, left without care, detained or confined
Sheferaw 2016 *(6)*	Development of a tool to measure women's perception of respectful maternity care in public health facilities	Mix of facility exit survey and community survey (women)	Amharic	Yes – Ethiopia	1	Friendly care, abuse-free care, timely care, discrimination-free care

Tools for newborn indicators

Authors	Title	Validated in a low- or middle-income country?	Number of countries	Measures of respectful newborn care or mistreatment
Sacks E et al. 2021 *(7)*	The first 2 hours after birth: prevalence and factors associated with neonatal care practices from a multicountry, facility-based, observational study	Yes	4	Mistreatment of the newborn: delayed cord clamping, skin-to-skin contact, separation of the mother and neonate
Warren et al. 2023 *(8)*	Lessons from a behavior change intervention to improve provider-parent partnerships and care for hospitalized newborns and young children in Kenya	Yes	1	No: experiences of parent of newborn with communication, empowerment and responsiveness
Atkins, et al. 2022 *(9)*	Is care of stillborn babies and their parents respectful? Results from an international online survey	Yes	multiple	Experiences of parent: respectful care and bereavement
Nakphong, et al. 2021 *(10)*	Separating newborns from mothers and maternal consent for newborn care and the association with health-care satisfaction, use and breastfeeding: findings from a longitudinal survey in Kenya	Yes	1	Experience of parent: separation

Midwife Saida Ahmed Jama holds Maryama, a newborn baby, at Gambool Health Centre in Garowe, Puntland, Somalia.
Photo: © UNICEF / Ismail Taxta

Overview data analysis

This appendix briefly describes data analysis approaches for qualitative and quantitative research, and triangulation between qualitative and quantitative research. It is not intended to be an exhaustive training on how to conduct data analysis; rather, it is designed to give an overview of options and tips for data analysis and help health managers and implementers to choose an appropriate approach.

If you are implementing qualitative or quantitative research methods in your setting, you will need to collaborate with a research team that has experience in these methodologies. For example, this may mean collaborating with a local university public health department, or a nongovernmental organization working in public health or maternal health.

Qualitative data analysis approaches

Qualitative data provides rich insights into people's perceptions, experiences and social norms and how and why things occur. Data analysis is often considered one of the most difficult or complex parts of qualitative research, particularly when there is a perception that there is "too much data". The main goal of qualitative data analysis is therefore to use rigorous methods to transform the data into summaries, explanations, understandings and interpretations of the people and situations under exploration (e.g. respectful maternal and newborn care and mistreatment). Throughout the qualitative analysis process, the analysis team will be seeking to ask and answer questions such as:

- What common patterns or themes do participants reflect on?
- How do these patterns or themes help to answer the broader research questions?
- Are there any "deviations" from these patterns, and if so, what factors might explain them?

Qualitative data collection and analysis can be resource-intensive and require specialized training. Therefore, collaborating with a local research institution or university (e.g. department of health promotion, public health, anthropology or sociology) may help to ensure that a robust and rigorous approach is used.

There are different approaches to qualitative data analysis and choosing the right one will depend on the purpose of the research and how the data will be used in decision-making or programme planning.

Thematic analysis and reflexive thematic analysis

Thematic analysis identifies patterns or themes within qualitative data *(11)*. Reflexive thematic analysis *(12)* is a thematic analysis approach that involves reflexive (examining own feelings, reactions, motives, positionality) and recursive (moving back and forth through different phases) engagement with the dataset. Broadly speaking, both approaches follow six key phases to analysis – and note that moving between each step is typical and expected:

- familiarizing yourself with the dataset
- coding
- generating initial themes
- developing and reviewing themes
- refining, defining and naming themes
- writing up.

Qualitative content analysis

Qualitative content analysis is an analytic approach to systematically identify and classify qualitative data using groupings of words, codes and concepts within the data, and can be conducted either inductively or deductively *(13)*. In contrast to thematic analysis, content analysis typically focuses on identifying the recurrence of concepts or words and is typically done at a more surface level of analysis.

Framework analysis

Framework analysis is a structured approach to qualitative analysis that focuses on developing a matrix of rows (participants or groups), columns (codes) and cells (summarized data) *(14)*. This framework provides a clearly defined structure for the research team to systematically reduce the data into analysis by case and by code, in order to identify recurring patterns and deviant cases *(15)*.

The framework thus provides a clear and transparent approach to chart and analyse qualitative data. However, framework analysis also comes with the trade-off that it can be viewed as a way to "quantify" qualitative data and limits reflexive engagement with the data.

Choosing the best approach

When selecting the most appropriate qualitative analysis approach, consideration should be given to:

- what the data are being used for and the purpose of the analysis
- available time and resources
- existing qualitative analysis expertise
- whether analysis will be conducted by hand or using software (e.g. NVivo, Atlas.ti, Excel).

Quantitative data analysis approaches

Quantitative data provides an estimate of how frequently the different manifestations of mistreatment or respectful maternal and newborn care occur in a given setting. After collecting quantitative survey and/or observational data, quantitative analysis will begin with descriptive analysis, which is the approach to understanding the frequency and burden of each item of interest. In the context of programme monitoring, specific data items (indicators) may be measured over time (e.g. quarterly, monthly) to monitor the evolution of specific indicators and guide implementation of activities and communication with key stakeholders (see Section 5 of the compendium).

Cross-sectional research designs often use descriptive quantitative analyses to answer critical and proximal questions related to:

- prevalence of mistreatment or respectful care, and differences across population groups
- distribution over geographical areas or health facilities
- changes over time throughout a project (baseline/endline) or during continuous monitoring and evaluation.

The first step in conducting a descriptive analysis is to generate summative means or percentages for each item/question of interest (e.g. percentage of women who were slapped during labour, or newborns slapped to breathe). Once the percentage or mean score has been created, it can be aggregated and disaggregated to any level. For example, it is recommended that for each item/question of interest, data are disaggregated based on relevant stratifiers, which may include equity, obstetric history, health system, and newborn stratifiers.

Equity stratifiers are variables chosen to reflect perceived inequalities (also known as "dimensions of inequality") and are useful for understanding potential health inequalities between population groups. These equity stratifiers are often categorical variables used to facilitate comparisons of aggregate data among different groups of people. The most commonly used equity stratifiers are called PROGRESS-PLUS *(16)* and refer to:

- age (both adolescents and older women)
- marital or relationship status
- place of residence
- race or ethnicity
- occupation
- gender or sex
- religion
- education
- socioeconomic status
- social capital
- personal characteristics or identities associated with discrimination (e.g. disability), time-dependent relationships (e.g. discharge from a health facility following birth, time periods where people may temporarily be at a disadvantage) or migration status.

Obstetric stratifiers are variables chosen to reflect the woman's or birthing person's obstetric history and are useful for understanding potential differences in outcomes and experiences based on this history. Some commonly used obstetric stratifiers are:

- mode of birth (unassisted vaginal, assisted vaginal, caesarean)
- parity or gravidity
- maternal complications (pre-eclampsia/eclampsia, postpartum haemorrhage) or interventions (blood transfusion, etc.).

Newborn stratifiers are variables chosen to reflect the newborns' health and are useful for understanding potential differences in outcomes and experiences based on their current health status. Some commonly used newborn stratifiers include:

- gestational age at birth
- small and sick newborns
- birth weight
- preterm birth/prematurity
- baby survival status
- newborn complications
- Apgar score
- admission to special care or neonatal intensive care unit.

Health system stratifiers are variables chosen to reflect health system challenges that might result in varied outcomes, such as:

- time of birth (daytime or night-time)
- day of birth (weekday or weekend)
- referral status or (perceived) delay in arriving at the health facility where birth occurred
- type of birth health worker
- antenatal care attendance.

Disaggregating each item/question of interest based on the most relevant equity and obstetric stratifiers in a given context has the power to shed light on subpopulations of women or babies who may be experiencing a disproportionate burden of mistreatment or receiving more respectful care. Understanding these potential differences across population groups can help to identify which groups may need additional support, or how to design a programme or service to meet the needs of a group experiencing disadvantage.

The next step is to aggregate the data to different levels of interest such as facility, subdistrict, district or region. For example, it may be relevant to conduct analysis to identify:

- the proportion of women in X who experienced any type of mistreatment
- the proportion of women in X who scored more than 90 on the person-centred maternity care scale
- the proportion of newborns in X experiencing skin-to-skin contact in the first hours after birth
- the proportion of newborns in X separated from their mother during the stay in the health facility.

In addition to descriptive and bivariate analysis to stratify, more advanced analytic approaches may shed light on different areas of interest. These often require someone with more advanced skills and are not discussed here *(17)*.

Table A4.1. Overview and examples of **qualitative** approaches and methodological considerations

Potential participants	Data collection methods	Data collection tips	How to use the data	Benefits and drawbacks
• **Women and gender-diverse people** (pregnant or recently gave birth) and their partners (fathers of newborn) • **Family** (mothers, sisters), community members or leaders (traditional birth attendants, local authorities, community health workers) • **Health workers** and managers (midwives, nurses, doctors) • **Ancillary staff** (e.g. security officers) • **Policy-makers or other stakeholders**	• **In-depth interviews** with individuals or couples using open-ended or semi-structured questions • **Focus group discussions**, or small group discussions with 5–8 people using open-ended or semi-structured questions; requires a facilitator and a notetaker • **Unstructured or semi-structured observations** of the birthing environment at a health facility (antenatal room, labour and birth wards, postnatal wards, nurseries or newborn units) • **Arts-based methods**, such as photo-elicitation, values ranking exercises, body mapping; can be used alongside other qualitative methods to promote creativity and innovation	• **Consider who is conducting the interview.** For example, for interviews with women and gender-diverse people or community members, it may be more appropriate to have a non-clinical person who does not work at the health facility as interviewer, and who is the same gender and a similar age as the participant. • **Ensure that data collectors are trained in responding** if the participant becomes distressed or needs referral to psychological or other support services. • **Ensure that data collectors are trained on how to probe effectively** (e.g. ask follow-up questions when the response is not fully understood, or is vague, or more specific information is desired). This includes asking follow-up questions such as: *why do you think that is? What could be done to achieve that? When have you done something like this before? Tell me more,* and *What else?* • **To help build rapport with the participant (woman, family, community), it may be helpful to start with 'easy' questions** such as *tell me about your birth* before asking specific questions about mistreatment and respectful maternal and newborn care. This approach allows the participant to warm up and express the important aspects of the birth and their care without prompting, and may help them to give rich and detailed responses. • **If conducting facility exit interviews within a few hours or days after a woman or gender-diverse person has given birth, consider: (i)** a private location in the health facility where the interview is conducted to reduce social desirability bias; **(ii)** whether the time from birth to facility discharge is sufficiently long to reasonably ask someone to participate in an interview (e.g. may be less appropriate if discharge is < 24 hours after birth); **(iii)** ensure it is clear to the interviewee that their responses will be confidential and not affect their or their baby's care; and **(iv)** if there has been a stillbirth or neonatal death, consider the most appropriate timing to conduct an interview so as not to exclude these parents, nor cause additional harm.	**Planning** Understand the current issues that need to be addressed **Periodic monitoring** To inform future programme strategies **Evaluation** Understand what components of a programme or intervention worked or did not work and why	**Benefits:** Rich and detailed descriptions of individual experiences, motivations, values, meanings and social norms. Participants can engage with each other to shape and express ideas. Qualitative results can be used together with quantitative results to show a full picture of challenges and opportunities. **Drawbacks:** Can be time-intensive to organize and for data collection and analysis. Often expertise is required to administer specific qualitative methods and analyse results. Findings may not be transferrable to other settings.

Table A4.2. Overview and examples of **quantitative** approaches and methodological considerations

Potential participants	Data collection methods	Data collection tips	How to use the data	Benefits and drawbacks
• **Women/gender-diverse people (pregnant or recently gave birth)** • **Partners/fathers/family members of newborn** • **Health workers (midwives, nurses, doctors)**	• **Community-based surveys** conducted with women and gender-diverse people who recently gave birth in a health facility, and their families; can recruit from either the health facility or community depending on the research question • **Facility-based surveys or exit interviews** conducted with women and gender-diverse people who recently gave birth in a health facility, and their families; can recruit from the labour or postnatal wards, or at postnatal care check-ups or infant vaccination clinics • **Observations of labour, birth** and antenatal and postnatal contacts using a structured observation guide to record interactions between the woman/gender-diverse person and health worker; newborn and health worker; birth environment, etc. • **Facility-based health worker surveys** conducted with health workers and managers about their self-report or peer-report of respectful maternal and newborn care, and/ or their well-being and experiences • **Routine health information systems:** Health systems can also routinely collect data from both users and health workers to measure the extent of mistreatment and respectful care and interventions being implemented	• **Consider how the survey is administered.** Survey data can be obtained through self-administered surveys in literate populations. In populations where many people are not literate, the surveys may need to be interviewer-administered. Audio-Computer Assisted Self-Interview may help to reduce social desirability bias. • **If interviewer-administered, consider who is administering** – a non-clinician and/or person who does not work at the health facility may be most appropriate. • **Consider timing of data collection** to allow time for women and gender-diverse people to recover after birth, and process and reflect on what happened during their birth experience. For example, courtesy and social desirability biases can make women under-report negative experiences about their care or their newborn's care when asked in the setting in which they received the care, particularly if facility staff are involved in data collection. If data collection takes place too long after the birth or facility discharge, then the woman, gender-diverse person or family may have recall bias (forgetting or inaccurately remembering different aspects of the birth or care experience). • **Consider how you plan to use the data** to design recruitment and sampling strategies for research or programme monitoring purposes. If looking to understand prevalence in a community context, identifying women and gender-diverse people who are pregnant/recently gave birth regardless of where may be appropriate. If looking to understand prevalence in a health facility, you may need to either recruit women and gender-diverse people at the time of antenatal care or birth, or engage with community health workers to know who gave birth where. If aiming to measure the experience of care as part of a programme monitoring strategy, then you will need to decide on a feasible and affordable data collection method and sampling strategy in the programme context (e.g. monthly interview of 20 women/parents). • **Make it clear to participants that participating in the survey will have no impact on the care** they or their babies have received or will receive postnatally. • **Facility exit surveys:** Consider the context of when women and gender-diverse people are discharged after birth and whether it is appropriate to conduct surveys at facility exit. Or it might be more appropriate to recruit women as they leave the facility and ask to speak to them in a few weeks in person or on the phone. For example, in settings where they are discharged < 24 hours after birth, consider how usable this data would be and ethical considerations of asking them to participate in research at this time. Also consider where in the facility to conduct data collection. Outside of the maternity ward (e.g. a separate tent or building) may help to reduce social desirability bias (under-reporting). • **Community-based surveys:** Consider where in the home or community is appropriate to conduct data collection to protect the woman's privacy and confidentiality. • **Facility-based health-worker surveys:** Consider who is conducting the survey. Ideally this should not be another health worker in the same facility and should not be a supervisor. Self-administered surveys may be more feasible with health workers. Take steps to ensure confidentiality and assure health workers that responses will not impact their jobs. Consider time of data collection to not interrupt workflow.	**Planning:** Understand the current issues that need to be addressed **Monitoring:** Track and inform implementation of programme activities **Evaluation:** Measure the impact of a programme or intervention on experiences of mistreatment **Comparisons or benchmarking:** Across programmes, health facilities or countries	**Benefits:** Community-based surveys may have less social desirability bias (under-reporting) compared to facility-based data collection, as it allows time for women to process and reflect on their birth experiences. Facility-based surveys may be more feasible and sustainable for programme monitoring. Provider surveys, especially of peer behaviour, are a quick way to assess facility culture; well-being questions help assess potential drivers and indicate to health workers that their needs are being accounted for. **Drawbacks:** There may be logistical challenges around recruitment and resources needed to identify potential participants and collect data. There may be ethical considerations and data quality issues around asking women and gender-diverse people to complete a survey too close to the time of birth (e.g. limited time for reflection and processing of the birth experience) or too long after birth (recall bias). Labour observations are time- and resource-intensive and may not be well-suited for all settings. Provider surveys are prone to social desirability bias, especially where confidentiality is not assured, and trust is not earned.

Learning-driven planning templates for manifestations of mistreatment and respectful maternal and newborn care

Section 4 of the compendium provides learning-driven planning templates with illustrative drivers, interventions and indicators and a vision for eliminating verbal and physical abuse, which is a common manifestation of mistreatment in many settings. The following planning templates present common drivers, promising interventions from the literature and indicators for three additional manifestations: stigma and discrimination (a common manifestation of mistreatment); and effective communication and supportive care (important manifestations of respectful maternal and newborn care).

Programme managers are encouraged to use these planning templates and the example of verbal and physical abuse in Section 4 of the compendium as tools to systematically address mistreatment and strengthen respectful maternal and newborn care. These templates can help identify local drivers and interventions, and relevant indicators, to adapt to the unique context of each programme. Drawing on studies of respectful maternal and newborn care from diverse contexts, the examples provide a resource for considering which interventions may be feasible based on the readiness of different health systems to tackle mistreatment.

As contexts vary, programme managers can critically assess which drivers and interventions are applicable to their specific setting.

Table A4.3. Learning-driven planning template: **effective communication**

Manifestation of respectful care: effective communication

Drivers	Interventions	Indicators to monitor outcomes and programme outputs	Strategic vision
– Health-worker communication skills – Communication provided in language understood by women and carers of newborns (translation services available as needed)	*Community level:* – Develop and implement participatory approaches that include women, partners or newborns' parents/families in the design of strategies to address factors that affect interpersonal communication and shared decision-making (e.g. health literacy challenges or language preferences) – Build the capacity of health workers and carers to recognize newborn behaviour, cues and ways of communicating, and to respond with appropriate care *Facility level:* – Train and mentor health workers on effective communication with women, newborns and carers of newborns, including active listening to women's and families' concerns and recognizing and respecting newborn behaviours and cues – Distribute locally adapted communication and decision-support tools – Identify and implement mechanisms to ensure communication is provided in a language that is understood by women, carers of newborns, and families (e.g. trained local translators, mobile translation services)s *National/sub-national:* – Incorporate communication competencies and skills into existing pre-service training curricula for health-worker cadres that care for women and newborns – Incorporate effective communication guidelines into existing national policies	*Outcomes:* – % women reporting that health workers explained exams, procedures – % women who felt able to ask questions *Programme outputs* – % facilities with 24/7 accessibility of local translation services – % district supervision or mentoring visits that reinforce effective communication skills (e.g. via simulated practice, peer to peer practice, etc.)	All women, gender-diverse people, newborns, parents and families receive communication that fulfils their information needs, enables their full participation in decision-making and is provided in a language that they understand

Table A4.4. Learning-driven planning template: **emotional support**

Manifestation of respectful care: emotional support

Drivers	Interventions	Indicators to monitor outcomes and programme outputs	Strategic vision
Facilitators of emotional support – Enabling institutional structures and processes – Enabling health system policies and structures – Pre- and in-service training on respectful maternal and newborn care *Barriers to supportive care* – Resource scarcity – Moral judgements about women – Limited accountability – Stressful work environments	*Community level:* – Plan and implement participatory workshops for women and families on their rights related to childbirth, including supportive care with a labour companion *Facility level:* – Revise facility protocols to include labour companionship, non-separation of the mother and baby, ambulation and fluids, birth position of choice and pain management options – Implement open maternity days in which pregnant women and family members visit the maternity ward, learn about it and interact informally with health workers – Train and mentor local change champions on supportive care (e.g. midwives, nurses, doulas, doctors) – Modify the maternity environment to enable supportive care (e.g. chairs, privacy curtains) – Mentor/support facility quality improvement teams, inclusive of community members, to improve supportive care	*Outcomes (disaggregated by marginalized group)* – % women who report feeling supported during labour/birth – % women who report a labour companion – % women who are offered a labour companion *Programme outputs* – % facilities with a written policy and standard operating procedures mandating key elements of supportive care – % facilities implementing a monthly open maternity day for pregnant women and family members – % facility quality improvement teams that update and publicly display at least two supportive care outcome indicators on a quarterly basis	All women, gender-diverse people and newborns receive emotional support during labour, birth and after birth including a labour companion if desired
	Regional/ district level: – Update district/regional policy to include key dimensions of supportive care including labour companionship – Plan and implement region/district-wide quality improvement initiatives (e.g. improvement collaborative) to improve supportive care for women and newborns across facilities *National level:* – Develop standards and benchmarks for respectful maternal and newborn care with recommendations for implementation and indicators for monitoring – Incorporate respectful maternal and newborn care, including supportive care components, into national and subnational policies, strategies and guidelines – Incorporate respectful maternal and newborn care awareness and skills, including for supportive care, into pre- and in-service training and mentoring curricula for health-worker cadres that care for pregnant women, babies, parents and families		All women, gender-diverse people and newborns receive emotional support during labour, birth and after birth including a labour companion if desired

Table A4.5. Learning-driven planning template: **stigma and discrimination**

Manifestation of respectful care: stigma and discrimination

Drivers	Interventions	Indicators to monitor outcomes and programme outputs	Strategic vision
– Power inequalities – Marginalizing people or groups who are perceived as different or as behaving outside of accepted norms – Stigma and bias against medical conditions (birth defects, prematurity) – Maintenance of hierarchies (e.g. social, economic) – Intersecting inequalities (e.g. gender, economic, social)	*Community level:* – Implement community-driven empowerment approaches with communities that are experiencing discrimination – Implement a participatory approach involving stigmatized groups in the development of interventions to reduce stigma *Facility level:* – Build skills of health workers to increase knowledge of discrimination and awareness of their own biases, and improve their competencies to work with stigmatized populations – Address discrimination against co-workers at the facility level *Regional/district level:* – Implement periodic client surveys to assess experiences of discrimination directed at women, newborns and families *National level:* – Policy reform (including removal of discriminatory policies)	*Outcomes (disaggregated by marginalized group)* – % women, parents, families surveyed reporting experience of discrimination and stigma during care in maternity (including newborn unit) *Programme outputs* – Proportion of health workers in district who have participated in respectful maternal and newborn care and bias training within X time period – Proportion of facilities that implement a client survey at least quarterly and publicly display results	All women, gender-diverse people and newborns, parents and families receive equitable and non-discriminatory care around childbirth

Annex 5: Reflections from the field – understanding and implementing respectful maternal and newborn care

Learning activities

This section explores the most common drivers of mistreatment and respectful care, along with intervention areas across different levels of the health system. At this stage, compendium users can reflect on this information and apply their learning to various situations. The following scenarios encourage users to consider different experiences of mistreatment, their underlying drivers and potential interventions in response.

Clockwise starting up left: *Kokobe Ashebir with her two month old baby in Ethiopia.* Photo: © UNICEF/Mulugeta Ayene.
Parents Kankay Suma and Amara Turay in Sierra Leone, Photo: © UNICEF/Michael Duff
Vida T. receives with her 6 months old daughter in Ghana. Photo: © WHO/Francis Kokoroko
A health worker examines Selamawit Teklu who recently gave birth to a baby girl in Ethiopia. Photo: © UNICEF/Nahom Tesfaye

Note: The women depicted in Annex 5 are not associated with the experiences described in the learning activities.

Kokobe Ashebir, 20 with her two month old baby attending a routine check-up at Kolabe Bale Health Post in Sire, Ethiopia. Photo: © UNICEF/ Mulugeta Ayene

Learning activity 1: **Adolescents' experiences of mistreatment during childbirth**

Experience of mistreatment

Compared to adult women, adolescents and young women may not receive adequate health care and support during labour and childbirth in facilities. Adolescents are more likely to encounter mistreatment, including physical and verbal abuse, and those with limited education are especially vulnerable. This mistreatment worsens the health and social burdens young women already face. For many, pregnancy may be the result of an abusive relationship, adding to feelings of shame and isolation. The mistreatment experienced by adolescent girls can have long-lasting effects, influencing their future interactions with the health system and their trust in health workers.

The following quote, reflecting the experiences of many adolescent girls, is presented in the voice of Miriam, a fictional 15-year-old girl from Accra, Ghana:

"Teenage mothers like me often don't get the support we need because we are judged and looked down upon by health workers. Some health workers believe we should know better than becoming pregnant when unmarried or at such a young age and make us feel bad. My experience of maternity care was difficult.
I think that I was treated badly during the birth of my child because I was a young mother and the way staff spoke and behaved with me made the birth much harder. Because of their own beliefs, health workers yelled at me and were rude and harsh.
The negative experience I had really affected me and made me think about whether I would go to the health facility for maternity and childbirth care in the future."

Drivers of mistreatment

Mistreatment of adolescents during labour and childbirth is driven by multiple factors. Adolescents frequently face stigma and judgement from health workers who may hold prejudiced views about adolescent pregnancy. Cultural biases and pervasive biases can result in punitive or patronizing attitudes that alienate young mothers. Health workers may also lack training in adolescent-friendly care, leading to unintentional gaps in person-centred care. This lack of tailored care and communication can leave adolescents feeling disrespected, fearful and unsupported during a vulnerable time in their lives. Finally inadequate resources and poorly equipped facilities often fail to meet adolescents' unique needs, such as providing privacy and specialized counselling.

Reflection prompt:
Reflecting on your context, what factors might contribute to the mistreatment of adolescents during labour and childbirth? Are there particular gaps in training or resources that could be addressed to support better care?

Intervention options

National/subnational level

- Develop and implement policies and guidelines that prioritize access and high-quality care for adolescents, including allocating resources to ensure policies translate into practice modifications.
- Eliminate any law or policy that denies adolescents consented care, restricts their ability to make decisions about their care, or results in care being withheld based on age.

Facility level

- Support health workers to recognize the unique needs of adolescents and how these intersect with social stigma and prejudice around adolescent sexual behaviour *(1)*.
- Provide training to tackle discrimination and moral judgements among health workers and equip them with knowledge and skills to counteract stigma and its impact *(2)*.
- Create an adolescent-friendly environment that promotes autonomy and respect. This can include the use of adolescent champions to guide facilities towards being more adolescent-friendly *(3)* and the use of partitioning and curtains for privacy *(1)*.

Community level

- Involve adolescents in community workshops that teach them about their rights to sexual and reproductive health care and respectful care.
- Develop client service charters with community members that emphasize the need for adolescent-friendly care.

Reflection prompts:
If you were to implement changes in your facility or community, what specific interventions would help create a more adolescent-friendly environment? What role could community engagement play in ensuring that adolescents' needs are addressed, both in terms of care quality and respect? How could adolescents themselves contribute to these efforts?

Source: Irinyenikan et al. *(1)*.

Learning activity 2:
Mistreatment during vaginal examinations

Experience of mistreatment

Vaginal examinations during the first stage of labour are part of routine assessments, but they can be sensitive and invasive. Many women find them painful, uncomfortable and disrespectful and they are often performed without informed consent. These practices fail to meet quality-of-care standards and violate women's rights.

The following quote, reflecting the experiences of many women and adolescent girls, is presented in the voice of Tamaana, a fictional 18-year-old girl from Conakry, Guinea:

"As I went through labour, every moment was very intense and full of pain. It was my first birth, and I had lots of anticipation. But what made it harder was the number of vaginal exams I had. There were no curtains at the health facility, and this made me feel exposed. I felt like everyone could see me. It made me feel embarrassed and uncomfortable. In my country, it's common for women to go through these exams without being asked for permission, but it made me feel like I had no say in what was happening to my body. And when the health care providers didn't communicate with me, it made me more confused and fearful."

Community Health Worker Mbalu Turay meets with parents Kankay Suma and Amara Turay in Masiaka Community, Kambia District, Sierra Leone, to provide basic mental health and psychosocial support services. Photo: © UNICEF/ Michael Duff

Drivers of mistreatment

Entrenched social and gender norms can normalize disrespectful practices, such as performing vaginal examinations without consent. Systemic factors, including inadequate staffing and high birth volumes, can increase stress among health workers, leading to rushed and impersonal care. A lack of curtains or screens in labour wards further compromises women's dignity and comfort during procedures. Insufficient training on respectful care and the absence of refresher courses on informed consent also contribute to poor communication, increasing the risk of insensitive or non-consensual practices.

Reflection prompt: *Consider the factors contributing to mistreatment. What strategies could be implemented in your community or facility to address similar or other challenges and promote a more respectful maternity care environment?*

Intervention options

National/subnational level

- Create enabling environments that support health workers, including through appropriate continuing education or training, supervision and supportive policies to promote respectful care *(4)*.

Facility level

- IImplement privacy measures, such as the availability of curtains, which are important for women's rights to privacy and confidentiality *(5)*.
- Structure and organize maternity wards to support and respect women and health workers *(6)*.
- Provide communication training for health workers to improve informed consent and trauma-informed approaches *(7,8)*.
- Ensure availability of a standard informed consent form.

Community level

To help women prepare for childbirth, provide education and counselling on vaginal examinations as part of routine antenatal care, covering why they are conducted, what they feel like, how often they may occur and the associated risks *(9)*.

Reflection prompts:
How do the experiences shared in this example resonate with your understanding of respectful care in maternity settings? What similarities or differences can you identify based on your context?
What specific barriers do you see in your context that might hinder the implementation of these or other interventions to address mistreatment during vaginal examinations? Conversely, what opportunities exist that could facilitate their success?

Source: Adu-Bonsaffoh et al. *(9)*.

A health worker examines Selamawit Teklu who recently gave birth to a baby girl in Ethiopia.
Photo: © UNICEF/Nahom Tesfaye

"When I held my baby for the first time, I felt a rush of love, but they quickly took my baby away from me. They said it was because of hospital rules and worries about space and sickness and because I had a caesarean section. Being apart from my baby was painful. I wanted to hold her close, to feed her, keep her warm and bond with her. But they wouldn't let me. I felt lost and alone without her by my side. I missed my baby so much and I received little information from the health workers.
Even when I was eventually able to visit her in the newborn unit I was only able to hold her and feed her at specific times. I wished we could be together all the time, but it felt like we were kept apart by rules that didn't make sense to me.
My baby's father also missed out on seeing her in the first week or so of her life. He was unable to visit during the strict visiting hours due to his job and the distance he had to travel."

Learning activity 3:
Mistreatment through separation of the mother and newborn at birth

Experience of mistreatment

Separation of mothers and their newborns hinders bonding and attachment. This separation can induce stress and trigger physiological changes that adversely affect a baby's developmental trajectory and potentially have long-term consequences for the mother–baby relationship. It also prevents the initiation of early breastfeeding and the practice of skin-to-skin care, both of which are critical for stimulating bonding and regulating a newborn's body temperature. This separation also reduces satisfaction with the overall experience of care.

The following quote, reflecting the experiences of many women, is presented in the voice of Maria, a fictional 26-year-old from Kiambu, Kenya:

Drivers of mistreatment

The mistreatment of newborns, specifically the unnecessary separation from their mothers, stems from issues such as overcrowded and under-resourced facilities that prioritize efficiency over individualized care. In these environments, the absence of guidelines and policies supporting family involvement in newborn care exacerbates the problem. Despite contrary evidence, cultural practices, outdated hospital norms, and policies implemented during the COVID-19 pandemic may have perpetuated the misconception that separating mothers and babies is beneficial. Inadequate training among health workers on essential newborn care practices, such as breastfeeding support and skin-to-skin contact, also increases the likelihood of separation, undermining the well-being of both mother and baby.

Reflection prompt:
Consider the drivers of mistreatment of newborns. How does the separation of mothers and newborns during critical early moments influence their emotional well-being and the mother–baby relationship? What specific barriers do you observe in your context that may prevent keeping a mother and baby together?

Intervention options

National/subnational level

- Support facilities to adopt the updated *Baby Friendly Hospital Initiative* (BFHI) requirements, and support health workers and managers to have the relevant knowledge, competency, skills and attitudes for effective implementation.
- Support facilities to implement *Kangaroo Mother Care*, which involves nursing small and sick babies on their mother or caregiver immediately after birth, to promote bonding, skin-to-skin care, early and frequent breastfeeding and minimal separation *(10)*.

Facility level

- Review facility policies on childbirth and new born practices to allow 24/7 rooming-in.
- Provide health workers with mentoring, training and job aids to promote family involvement in newborn care.
- Develop plans to introduce or strengthen BFHI, *Kangaroo Mother Care*, family involvement and other processes that promote respectful care. This includes avoiding unnecessary separation and involving another caregiver if the mother is unwell or has had a caesarean section.
- Facilitate effective communication between health workers and parents to build confidence, encourage bonding and promote mothers' involvement in newborn care *(11)*.

Community level

- Educate and counsel women on the importance of keeping the mother–baby dyad together.
- Inform women and seek their consent for any newborn procedures or transfers to the newborn or neonatal intensive care unit. Involving women in these decisions means they are more likely to be satisfied with the care and return for follow-up visits for themselves and their babies *(11)*.

Reflection prompts:
How can health workers be better supported to prioritize family involvement in newborn care? What specific training or resources do you think would empower them to implement practices that minimize separation and promote bonding? Reflect on your own role in this issue. What actions can you take within your sphere of influence to promote a culture of respectful care that prioritizes the mother–baby relationship? How can you encourage others to understand the importance of keeping mothers and newborns together during and after childbirth?

Source: Nakphong, Sacks, Opot and Sudhinaraset *(12)*; Sacks et al. *(13)*.

Learning activity 4: **Mistreatment due to health-worker burnout**

Experience of mistreatment

Women often experience mistreatment during childbirth due to health-worker burnout and power imbalances. In understaffed and high-stress environments, exhaustion can compromise health workers' ability to provide empathetic care, leading to rushed, impersonal or even abusive interactions. Bias among health workers can also result in differential treatment based on factors such as socioeconomic status, ethnicity and age. These conditions leave women feeling disrespected, unsupported and fearful, ultimately undermining the overall quality of care.

The following quote, reflecting the experiences of many health workers, is presented in the voice of Migori, a fictional health worker from Kenya.

"... previously, we [the providers] never had time to laugh, but after the training, and when we were going on with our refresher training, we would vent our stress and share your experience, and you [would] feel good about your work. At least nowadays, you will find that after we have gone through the shift report, people ... spare ten to 15 minutes to vent out and share how the shift was ... it's kind of a debrief."

Vida T. receives a records book for her 6 months old daughter in the Breman Amanfopong community, Ghana. Photo: © WHO/Francis Kokoroko *learning activity.*

Drivers of mistreatment

Health-worker burnet and bias are two primary drivers of mistreatment. Burnout – characterized by physical, mental and emotional exhaustion – is a critical predictor of negative experiences for both service users and health workers. It often leads to negativity, cynicism and poor attitudes towards patients, resulting in substandard care. Burnout stems from prolonged exposure to stressors beyond an individual's control. In low-resource settings, these include heavy workloads, insufficient resources, unsupportive work environments, limited skills to manage obstetric and newborn emergencies, and repeated trauma from patient complications or death.

Bias, whether unconscious or intentional, can create disparities in quality of care. For instance, service users from lower socioeconomic backgrounds may receive less time and attention from health workers, reinforcing distrust, reducing adherence to treatment and ultimately worsening health disparities. Stressed health workers are also more likely to exhibit biased behaviours.

Reflection prompts:
Consider the factors contributing to health-worker burnout in your context. What steps could be taken to alleviate stress for health workers, and how might these changes improve care during childbirth? Think about ways bias might occur in your own interactions, either as a health worker or as a service user. How can awareness of these biases lead to more equitable care for all service users?

Intervention options

The *Caring for Providers to Improve Patient Experience Initiative (14)* integrates multiple strategies across different levels of the health system to improve the experiences of health workers and reduce the effects of implicit and explicit bias. Key interventions include the following.

National/subnational level

- Engage national leaders to advise on interventions and to identify and implement gender-transform ative solutions that aim to reduce stressors and address systemic gaps that contribute to health-worker stress and gender bias.

Facility level

- Promote group peer support to discuss challenges and to brainstorm solutions and support health workers.
- Establish mentorship programmes to foster mentor–mentee relationships, coaching junior health workers on professional development, work–life balance, clinical skills, career advancement and other relevant topics.
- Appoint champions to serve as role models within health facilities and to lead peer support groups and refresher trainings.
- Offer presentations and interactive sessions for health workers that include refreshers covering, for example, person-centred care, stress management, gender-sensitive and trauma-informed care, mindfulness, bias awareness, values clarification and attitudes transformation, teamwork and effective communication.

Reflection prompts:
How can you advocate for policies or practices that prioritize the well-being of health workers while ensuring that the quality of care remains at the forefront? Consider your own experiences in health care. What insights do you have about supporting colleagues in managing stress and preventing burnout?

Source: Afulani et al. *(15)*; Afulani et al. *(16)*.

An implementation story from Zomba District, Malawi

Box 1. Implementation story from Zomba District, Malawi – part one: stakeholder engagement and situation analysis for mistreatment and respectful maternal and newborn care

In Zomba District, Ms Rose, the District Maternal and Newborn Health Manager, recognized the need to address the low level of use of facility childbirth services and frequent complaints about poor-quality care in health centres and the district hospital. Rather than immediately suggesting refresher training or reviewing service-user complaints with already overworked maternity health workers, she chose a more systematic process to understand the underlying reasons for these issues.

With a limited budget, Ms Rose enlisted two colleagues to help identify articles or reports on women's and families' experiences with facility childbirth care in Zomba or other districts. They found five articles and two reports from neighbouring districts, three of which included assessments childbirth and postnatal care experiences. After reviewing these materials, Ms. Rose convened a group stakeholder – including women/community group representatives, district administrators and maternity care health workers – to participate in a process to better understand the factors (drivers) for positive and negative childbirth experiences among women, newborns and families, and to identify actions for improvement.

During their discussions, many stakeholders were surprised to hear about instances of verbal abuse, poor facility conditions (e.g. no access to a clean bathroom) and discrimination reported by women and families. They agreed on the need to collaborate and take concrete steps to address these manifestations and make childbirth services more respectful and supportive.

Drawing on their knowledge of the local context, they identified simple, immediate actions and scheduled a follow-up meeting to set a strategic vision and prioritize manifestations to address in a first phase.

The Zomba District implementation story introduced in Box 1 is continued in Box 2 to illustrate how stakeholders can select the drivers and manifestations of mistreatment/respectful care that will be addressed in an implementation cycle.

Box 2. Case study from Zomba District, Malawi – part two: working with stakeholders to select manifestations and drivers of mistreatment and respectful maternal and newborn care

A literature review and stakeholder discussions sparked conversations at the community and facility levels and generated enthusiasm to address key issues. Stakeholders held two meetings, facilitated by a trusted community leader, to select the manifestations that they would address in the first implementation cycle, and to analyse the drivers of these phenomena. They reviewed reports and recent publications on women's experiences of care in other districts, and invited a university researcher to share recent findings about the perspectives of women, families and health workers in relation to care. They also worked in small groups to contribute insights from their own knowledge and experiences as women, community members, health workers, managers and representatives from civil society organizations and professional associations.

They agreed to address three manifestations of mistreatment/respectful care in the first implementation cycle: verbal abuse, emotional support and effective communication. To identify the likely drivers, they reviewed published literature (see Section 3 of the compendium, Table 5), local reports and research, and discussed their own experiences. This process helped pinpoint the specific drivers of the three manifestations in their setting.

Drivers of verbal and physical abuse

- Power asymmetries between health workers and service users who are afraid to get on the "bad side" of health workers
- Health-worker stress and burnout due to provider shortages, frequent on-call shifts and stock-outs of essential supplies, leading to fatigue and feelings of frustration, and powerlessness
- Health-worker fears of a bad outcome if they do not yell at patients, amplified by recent legal cases against health workers and publicized findings of death audits in the local press.

Drivers of effective communication

- Maternal and newborn care health workers have practical communication skills and confidence
- National maternal and newborn care policy includes explicit standards for effective communication.

Drivers of emotional support

- The national policy on maternal and newborn health care specifies that a woman must be offered a labour companion
- The midwifery pre-service curriculum emphasizes the importance of knowledge and skills for providing emotional support to women, gender-diverse persons and newborns.

After analysing drivers, Ms. Rose and the stakeholders planned a one-day meeting to identify the most promising interventions and select indicators and measurement methods to monitor progress. They emphasized the importance of including community stakeholders, especially women, in the meeting, and agreed to invite the District Health Information Officer and a local university professor to get their input on indicators and measurement.

Box 3 continues the Zomba implementation story by providing a practical example of identifying local assets and resources. It focuses on selecting interventions, indicators and measurement methods based on the manifestations and drivers identified in the second part of the implementation story described in Box 2.

Box 3. Implementation story from Zomba District, Malawi – part three: selecting interventions and indicators based on identified drivers and local assets

Ms. Rose and her team met with stakeholders to review the drivers they had identified of verbal abuse, emotional support and effective communication. Acknowledging their limited resources, they focused on leveraging existing assets, including the following.

- A national maternal and newborn health policy with clear standards for respectful childbirth and postnatal care
- An existing district Maternal and Newborn Health Technical Working Group comprised of Ministry of Health managers and partners
- A midwifery training curriculum with practical, interactive exercises to build skills for supportive care and effective communication
- Two existing women's community groups
- Quality improvement teams in health centres
- A midwifery professional association committed to improving working conditions for midwives.

Considering these assets and the identified drivers, they prioritized the following interventions.

- Establish or strengthen quality improvement teams which include community members, to iteratively test changes aimed at reducing verbal and physical abuse (supported by the district Maternal and Newborn Health Technical Working Group, district Quality Focal Point and Maternal and Newborn Health Manager, and a women's community group).
- Ensure that all Zomba District facilities allow for and encourage the presence of a labour companion (see the example in Table 12 in Section 5 of the Compendium).
- Provide practical training on and supervision of communication and supportive care skills using a midwifery training curriculum, with practical exercises and role-plays, led by trainers from the midwifery professional association.
- Introduce interventions that support health workers, such as ensuring that tea and biscuits are available for breaks and overnight shifts, with the backing of community members, facility management committees and the District Health Management Team.

After selecting interventions, the team discussed the need to identify key indicators to monitor implementation and assess improvements in the experiences of care for women, gender-diverse people, newborns and health workers. They reviewed indicators and measurement methods from Section 5 of the Compendium and Annex 4 and discussed both qualitative and quantitative data collection approaches. Given staff workloads and their limited experience with qualitative methods, they agreed to focus on quantitative methods for the first implementation cycle. After this review, they selected the following five indicators and associated measurement methods to help guide and track their progress:

- Percentage of women, gender-diverse people and families who report experiencing verbal or physical abuse, or that of their newborns, measured by a bi-monthly exit survey, disaggregated for adolescents
- Percentage of women and gender-diverse people who report having a labour companion, measured by a monthly exit survey, disaggregated for adolescents
- Percentage of facility quality improvement teams that update and publicly display at least two service-user-reported respectful maternal and newborn care indicators on a quarterly basis, measured during district managers' quarterly supervision visits to facilities
- Percentage of maternity care health workers trained and mentored in effective communication, measured using a district training record.

The team set a timeline for reviewing and sharing the data (i.e. indicator results) with health workers, community members and key stakeholders.

They planned to develop an operational plan at their next meeting, outlining an activity timeline and methods to monitor the indicators.

They also agreed to invite the District Health Team Financial Manager to help estimate the costs and identify funding sources. Ms. Rose and the stakeholders left the meeting confident in their plan to implement the agreed activities and monitor the progress in reducing verbal abuse and improving supportive care and communication.

Box 4 elaborates on the Zomba implementation story with a practical example of the process of developing a costed operational plan. This includes selected intervention-specific activities, and processes for monitoring and learning and stakeholder oversight and communications.

Box 4. Implementation story from Zomba District, Malawi – part four: developing a costed operational plan to implement and monitor activities and indicators

Three weeks after their last meeting, Ms. Rose met with the stakeholder group to develop a costed plan using the template in Table 11 of this Web Annex.

They outlined specific activities in four categories: interventions, monitoring, coordination and oversight, and communication. They decided to create a 12-month operational plan to implement interventions addressing the three manifestations of mistreatment/respectful care selected in the first implementation cycle. The activities would begin in 15 health facilities that provide maternity services across Zomba District (the district hospital, and seven large and seven smaller health centres).

For each activity they designated between one and three focal points, estimated costs and funding sources, and scheduled the quarter in which the activity would be implemented. They also aligned these activities with the remaining six months of the Zomba District's annual health operational plan and agreed to incorporate select activities directly into the District's operational plan in the next implementation cycle.

They debated who should serve as focal points for each activity and assigned established roles, such as district and facility health information officers for monitoring, and district quality focal point for quality improvement. For some activities, they designated two or three people to share responsibilities and ensure there would be input from a diverse group of stakeholders. For example, they agreed that biannual stakeholder meetings would be jointly led by a representative of the Zomba Women's Community Group, the local chapter of the Midwifery Professional Association and Ms. Rose, the Zomba District Maternal and Newborn Health Manager.

They also struggled with estimating costs and identifying a funding source for activities outside of existing plans or roles. Fortunately, the Zomba District Health Financial Focal Point was present to help with cost estimates and suggest potential funding sources within and beyond the budgets of the District and health facilities. For activities outside the District's annual plan, they scheduled a follow-up meeting with community and faith leaders to explore additional fundraising options.

They encouraged each other to make the activities as concrete as possible for the selected interventions. With limited financial and human resources, they focused on how to leverage the existing assets identified in Box 9 to implement these activities.

Table A5.1. Example of costed operational plan in Zomba District

Activity	Responsible actor(s)	Estimated cost & funding source	Quarter 1 (e.g Jan–Mar)	Quarter 2	Quarter 3	Quarter 4
Intervention-specific activities						
Support the creation of multi-cadre quality improvement teams with community membership in 15 health facilities in Zomba District	Maternal and newborn health (MNH) manager and quality focal point on the Zomba District Health Management Team (DHMT)	No cost (part of existing role)	X	X	X	X
Provide monthly coaching of facility quality improvement teams (virtual and in person)	MNH manager and quality focal point on Zomba DHMT	Grant to Professional Association by local donor (US$ 2800 for 12 months)	X			
Place privacy curtains around every bed in the labour and delivery rooms	Maternity in-charge	US$ 300 (Maternity fund)				
Educate women, families and health workers about benefits and rights to a companion of choice	Facility quality improvement team (providers and community members)	No cost (part of existing care processes)				
Update facility protocols to state that every person should be offered and supported to have a labour companion	District MNH manager; facility managers; maternity in-charge	No cost (part of existing role)				
One-day on-site training in communication skills for all providers of maternity care, using role-plays and exercises from recently updated midwifery training curriculum	Professional Association of Midwives	US$ 1000 (District MNH programme fund)				
Institute weekly peer-to-peer patient communication and counselling practice sessions	Maternity in-charge	No cost (part of existing tasks)				
Create a fund to supply daily tea and biscuits for providers of maternity care	Facility manager, maternity in-charge, community representative	US$ 60 per month (facility fund + additional funding to be identified)				
Rotate responsibility for purchasing and setting up daily tea and biscuits	Maternity in-charge and designees	No cost (part of established tasks)				
Monitoring and learning						
Monthly calculation, visualization and analysis of selected indicators (outcome and output)	District and facility health information officers	No cost (part of established tasks)	X	X	X	X
	District MNH manager, district information officer and district quality improvement focal point	District MNH and quality improvement programme fund	X	X	X	X
Stakeholder group regularly reviews results (indicators, qualitative data) and supports adaptive management activities (e.g. after-action review; "pause and reflect") (see subsection "Document and learn")	District and facility health information officers	No cost (part of established tasks)	X	X	X	X
Coordination of activities and stakeholder oversight						
Respectful maternal and newborn care subgroup of district MNH Technical Working Group meets at least quarterly and monitors activities and indicator results	District MNH manager	District programme fund	X	X	X	X
Community groups with particular interest in respectful maternal and newborn care hold regular internal meetings to monitor activities	Women's community group	Community fund	X	X	X	X
Stakeholders meet at least twice per year to review progress	District MNH manager and representative of midwifery professional association and community women's group	US$ 200 per one-day meeting (following immediately after district management meeting to reduce local transport costs); district health management	X		X	
Communication						
Quarterly meetings with community representatives to share results Annual presentation to broad group of stakeholders	District MNH manager and maternity in-charters	To be decided	X	X	X	X

Box 5. Case study from Zomba District, Malawi – part five: implementing a costed operational plan and monitoring

Six months after completing their operational plan, Ms. Rose met with the stakeholder group to review progress. Each person responsible for a planned activity updated the group about their successes and challenges, and they brainstormed solutions together. They reviewed the results for the six indicators (see Table 2) and were encouraged by improvements, notably a decline in reports of verbal and physical abuse among women. However, young people continued to report higher rates of abuse and lower rates of having a companion of their choice than older age groups. As a result, the group decided to partner with a local university to conduct focus groups separately with young people and with health workers to explore these issues.

Representatives of the local Midwifery Association highlighted the challenges of securing transport for mentoring visits. The group proposed alternating phone check-ins with on-site mentoring visits and initiating peer counselling among health workers. Ms Rose also committed to providing monthly transport for mentoring visits at each health centre for six months.

Ms. Rose also announced the availability of reserve funding for convening a one-day workshop with community members, health facility representatives and members of the District Health Management Team to review activities and results, share learnings and strengthen or adapt existing activities. She also suggested inviting participants from neighbouring districts to encourage broader improvements in respectful maternal and newborn care. Finally, a quality improvement team from a participating health facility recommended a quarterly meeting with community members to share results and gather feedback, which the group agreed to implement.

Table A5.2. Percentage of women who reported on selected indicators in Zomba District

Indicator	June	July	Aug	Sept	Oct	Nov
% women who report verbal or physical abuse (all ages)	22	23	19	17	17	14
% girls age 18 or younger who report verbal or physical abuse	31	29	26	24	24	22
% women who report having a companion of choice (all ages)	65	72	79	82	84	84
% youth who report having a companion of choice (all ages)	46	49	52	58	63	65
% facility quality improvement teams that publicly display results for at least two (regularly updated) reproductive, maternal, newborn and child health indicator results in their clinic	None	10	14	20	40	65
% of maternity health workers trained and mentored on effective communication (initial training and at least monthly mentoring for six months)	45	54	62	75	69	73

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