# Promoting Respectful Maternity Care in Mozambique[1]

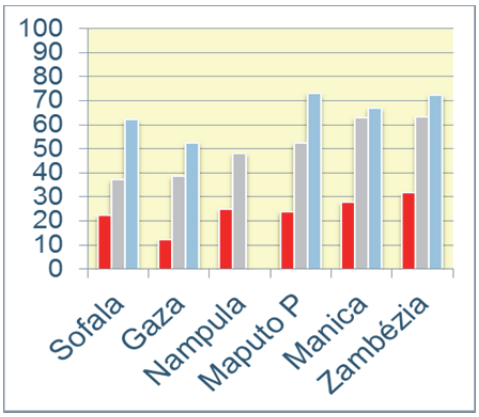

The objective of this document is to share the results of work undertaken in Mozambique to promote respectful health care, particularly in maternal and neonatal care. With its origins in "humanization of care" efforts in Latin America, this approach centers on the woman and her family and is grounded by principles of ethics and respect for human rights. The approach recognizes a client's cultural background, and views the client as a person with values and expectations that should be respected during the provision of health care.

Respectful maternity care (RMC) emphasizes the fundamental rights of the mother, newborn, and family, and recognizes that childbirth is a deeply personal experience for each woman and her family. In addition, RMC ensures that the client has timely access to health information, privacy, and evidence-based care. Promoting RMC can result in many benefits, including increased service utilization and better health outcomes. It is known that women refuse care from health providers who treat them poorly, even if these providers are capable of preventing or managing obstetric or newborn complications. In countries where a large proportion of births occur outside health facilities, RMC can contribute to increased uptake of maternal and newborn health (MNH) services.

In recent years, there has been a growing movement in Mozambique to promote the progressive implementation of a culture of respectful care within health care service delivery. Mozambique has a population of 23 million, with a life expectancy at birth of 52 years;[2] maternal mortality is 408 per 100,000 live births, and neonatal mortality is 30 per 1,000 live births.[3] The Ministry of Health (MOH), with the Maternal and Child Health Integrated Program (MCHIP), which is funded by the U.S. Agency for International Development (USAID), and other partners, has been incorporating the principles of RMC into national strategy documents—such as the Strategic Health Sector Plan, National Plan for the Development of Human Resources for Health, and the National Integrated Plan to Achieve the Millennium Development Goals (MDGs) 4 and 5—and in national technical guidelines.

[1] Developed by Veronica Reis (Jhpiego/MCHIP MNH and SRH Senior Technical Advisor), July 2012
[2] Population Reference Bureau. 2011. *World Population Data Sheet*
[3] Mozambique Demographic and Health Survey (DHS), 2011

The RMC movement began in 2007 when Mozambique's MOH grew increasingly concerned with the low institutional delivery rate—only 47% in 2003[4]—and the high maternal and neonatal mortality ratios. In response, they conducted a facility-level analysis that revealed compromised quality of care, including problems related to long waiting times, lack of welcoming reception, poor privacy, lack of confidentiality, mistreatment of clients, inadequate infrastructure and material resources, overworked and under-trained health providers, and substandard management of health services.[5] Following this analysis, the Minister of Health and other MOH leaders engaged a broad range of community representatives and other stakeholders to develop strategies to address these problems. Among the interventions proposed, the leaders gave special emphasis to the prevention of disrespect and abuse and the promotion of RMC.



Health facility performance systematic evaluation results: 2007-2008. Percent of performance standards achieved.
Red = baseline; gray = second evaluation; blue = third evaluation.

In this context, the MOH initiated the implementation of the National Plan to Improve the Quality of Reproductive Health and Child Health Services in 2007. This plan utilized a quality improvement methodology developed by Jhpiego called Standards-Based Management and Recognition (SBM-R), in which aspects of evidence-based care, including RMC, were incorporated into performance standards. These standards were then implemented and measured by health care providers and their supervisors in selected health facilities. The implementation of a quality improvement process that focused on respectful, evidence-based care in maternal and child health services was initiated in 18 health facilities (primary and secondary levels) in six provinces. As a result, by the end of 2008 these health facilities had doubled or tripled their performance and were operating at a higher quality level, adhering to established evidence-based standards.

In 2009, based on these experiences and lessons learned from the quality improvement processes put into place, the MOH, with USAID/MCHIP support, launched the national "Model Maternity Initiative" (MMI). Under this initiative the quality improvement process, using the SBM-R approach, was expanded to the 34 largest hospitals throughout the country. MMI is based on the principles of quality, including RMC, to create facilities that are not only models for quality maternity care, but that also serve as model clinical training sites.

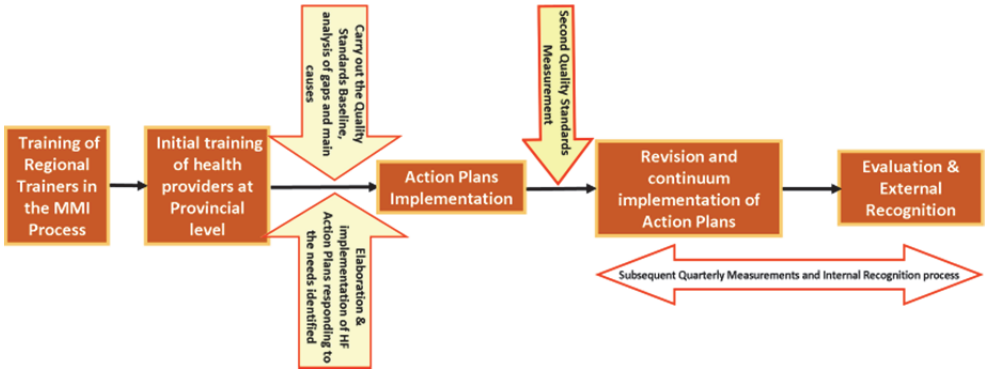
MMI promotes birthing practices that recognize women's preferences and needs. MMI also promotes the scaling-up of high-impact interventions. Specifically included are respect for beliefs, traditions, and culture; the right to information and privacy; choice of a companion; freedom of movement and position; skin-to-skin contact and early breastfeeding; appropriate use of technology and effective lifesaving interventions; and prevention of violence and disrespectful care. MMI promotes the implementation and monitoring and evaluation of quality standards in the nine areas shown in Table 1.

[4] DHS 2003
[5] Mozambique. Health Sector Strategic Plan 2007-2012. Ministry of Health. 2007.

**Table 1. MMI Selected Standards**

| AREAS | CONTENTS | NUMBER OF STANDARDS |
|---|---|---|
| 1. | Managment | 8 |
| 2. | Information, monitoring, and evaluation | 5 |
| 3. | Human and material resources | 4 |
| 4. | Health work conditions | 9 |
| 5. | Health education and community involvement | 4 |
| 6. | Antenatal and postnatal care | 14 |
| 7. | Labor, birth, and neonatal care | 23 |
| 8. | Basic emergency obstetric and newborn care | 9 |
| 9. | Training | 4 |
| **Total of Standards** | | **80** |

The following figure illustrates the implementation of the quality improvement process in the Model Maternities Initiative:




The implementation of MMI includes establishment of performance standards, provider training, baseline and systematic assessments in target facilities using the established standards, development and implementation of action plans, and recognition of progress. Health facilities in the MMI also track several key outcome indicators for MNH care. Graphics below show the results for some of these indicators. While there have been gradual improvements in all monitored indicators, the main challenge has been related to the implementation of some selected practices, such as allowing the presence of a companion during labor and birth, and the provision of care for birth in a more upright position.

Over time, the culture of promoting RMC has become more widespread in Mozambique, with increasing involvement of pre-service and in-service training institutions, professional associations (obstetrics/gynecology, pediatric, and nursing), and civil society. The MOH, with the support of MCHIP and other partners, is now working to scale up the MMI to include more than 122 health facilities by 2014.

## CONCLUSION, LESSONS LEARNED, AND SUCCESSFUL APPROACHES

The following are components essential to a successful program in promoting quality and respectful maternity care in Mozambique:

- Existing local ownership and involvement of high-level decision makers in the Ministry of Health
- Involving communities in this process from the beginning
- Establishing and implementing MNH performance standards, including specific standards related to respectful care, which improve quality of care and increase service utilization and client satisfaction
- Tracking MNH outcomes and process indicators to document effectiveness of approach
- Identifying champions at central and provincial levels for the smooth implementation of interventions
- Creating a pool of trainers who also act as supportive supervisors

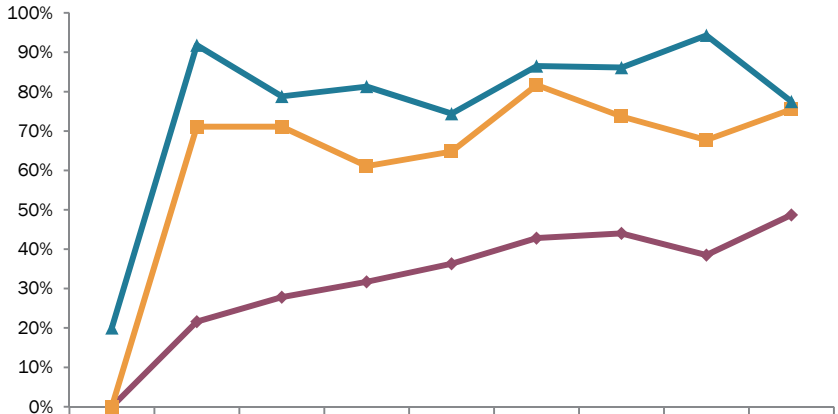
A Mozambican woman who had her first child under respectful care, accompanied by her partner, said, "This movement is so important. We women must speak up to fight for our rights."

- Encouraging supervision and investment in infrastructure and supplies
- Working together with pre-service training institutes, in-service trainers, and professional organizations for ensuring a more sustainable training process
- Providing support and clarification of critical managerial and technical issues (e.g., how to better organize labor and delivery rooms; how to correctly complete the partograph)

In conclusion, promoting quality and respectful maternity care is a complex and challenging process that requires contributions and a continuous investment from all involved, including the communities.

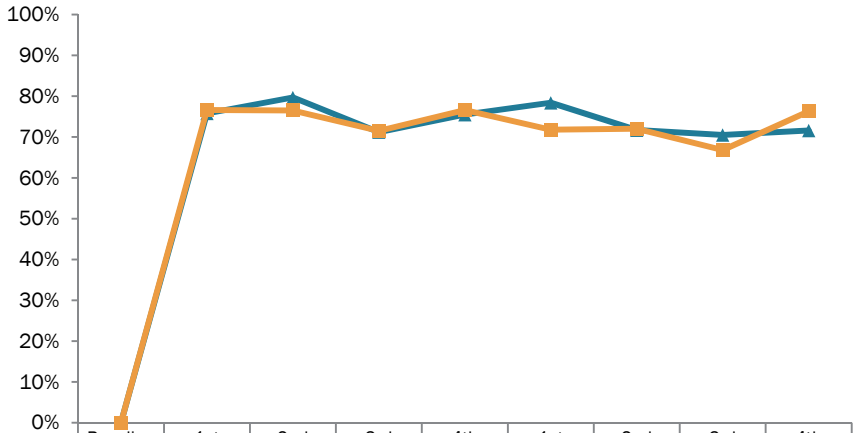
# ANNEX – EVOLUTION OF SELECTED MNH HUMANIZATION AND QUALITY INDICATORS TRACKED IN MMI – MOZAMBIQUE

**Figure 1: Evolution of coverage of partograph, use of magnesium sulphate, active management of the third stage of labor**



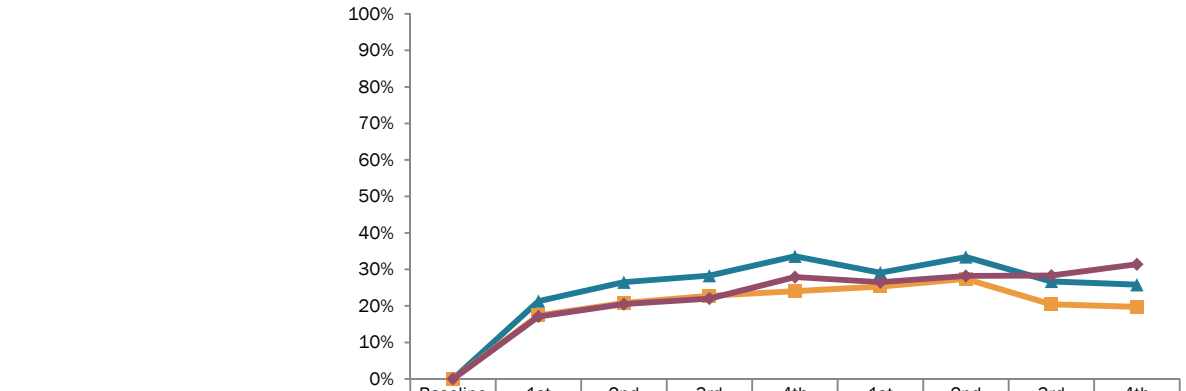

| | Baseline (Out-Dez 09) | 1st Trimester 2010 | 2nd Trimester 2010 | 3rd Trimester 2010 | 4th Trimester 2010 | 1st Trimester 2011 | 2nd Trimester 2011 | 3rd Trimester 2011 | 4th Trimester 2011 |
|---|---|---|---|---|---|---|---|---|---|
| Deliveries with Partograph Completed Filled in | 0.0% | 21.6% | 27.8% | 31.7% | 36.3% | 42.8% | 44.0% | 38.5% | 48.7% |
| Deliveries with Active Management of the 3rd Stage of Labor | 0.0% | 71.1% | 71.1% | 61.1% | 64.8% | 81.7% | 73.7% | 67.7% | 75.5% |
| Women with Eclampsia Treated with Magnesium Sulphate | 20.0% | 91.8% | 78.8% | 81.3% | 74.4% | 86.5% | 86.1% | 94.3% | 77.5% |

**Figure 2: Evolution of key newborn care outcome indicators (immediate skin-to-skin contact and immediate breastfeeding)**



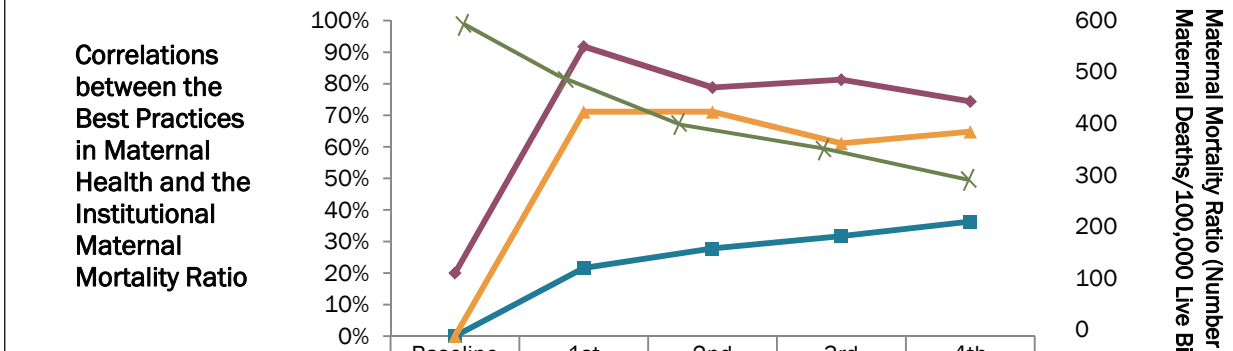

| | Baseline (Out-Dez 09) | 1st Trimester 2010 | 2nd Trimester 2010 | 3rd Trimester 2010 | 4th Trimester 2010 | 1st Trimester 2011 | 2nd Trimester 2011 | 3rd Trimester 2011 | 4th Trimester 2011 |
|---|---|---|---|---|---|---|---|---|---|
| Newborn: Immediate Skin-to-Skin Contact with the Mother | 0.0% | 75.8% | 79.7% | 71.2% | 75.5% | 78.4% | 71.7% | 70.5% | 71.6% |
| Newborn: Immediate Breastfeeding after Delivery | 0.0% | 76.6% | 76.5% | 71.5% | 76.6% | 71.8% | 72.0% | 66.8% | 76.3% |

**Figure 3: Evolution of coverage of key humanization of care indicators: presence of companion during labor and birth, delivery in a vertical or semi-vertical position**




| | Baseline (Out-Dez 09) | 1st Trimester 2010 | 2nd Trimester 2010 | 3rd Trimester 2010 | 4th Trimester 2010 | 1st Trimester 2011 | 2nd Trimester 2011 | 3rd Trimester 2011 | 4th Trimester 2011 |
|---|---|---|---|---|---|---|---|---|---|
| Women with Family Companion during the Labor Period | 0.0% | 21.3% | 26.5% | 28.3% | 33.6% | 29.1% | 33.4% | 26.7% | 25.8% |
| Women with Family Companion during the Delivery Period | 0.0% | 17.4% | 20.8% | 22.8% | 24.0% | 25.3% | 27.4% | 20.4% | 19.7% |
| Deliveries in Vertical and Semi-vertical Positions | 0.0% | 17.1% | 20.5% | 22.0% | 27.9% | 26.5% | 28.2% | 28.3% | 31.4% |

**Figure 4: Relation between the improvement of the selected indicators and the institutional maternal mortality ratio in MMI facilities**




| | Baseline (Out-Dez 09) | 1st Trimester 2010 | 2nd Trimester 2010 | 3rd Trimester 2010 | 4th Trimester 2010 |
|---|---|---|---|---|---|
| Deliveries with Partograph Completed Filled in | 0.0% | 21.6% | 27.8% | 31.7% | 36.3% |
| Deliveries with Active Management of the 3rd Stage of Labor | 0.0% | 71.1% | 71.1% | 61.1% | 64.8% |
| Women with Eclampsia Treated with Magnesium Sulphate | 20.0% | 91.8% | 78.8% | 81.3% | 74.4% |
| Institutional Maternal Mortality Ratio | 570 | 444 | 395 | 340 | 308 |