COUNTRY EXPERIENCE WITH IMPLEMENTATION RESEARCH ON DISRESPECTFUL CARE

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Background

• Prompted by a human rights report on incidents in Kenyan facilities

• USAID commissioned a study of the global evidence on disrespectful and abusive care:

• Population Council led consortium awarded project in March 2011
The Heshima* Project

- Specify types and prevalence of D&A
- Identify potential drivers of D&A
- Design, implement and evaluate interventions to reduce D&A

(* Dignity in Kiswahili)
Drivers of D&A

- Policy Perspectives
- Facility Perspectives
- Community Perspectives

Final Package of RMC Interventions

- Respectful Maternity Care
  - Policy Dialogue
  - Community Education & Male Involvement
  - Mediation Training for Society Leaders
  - Caring for the Carers
  - Provider Training
  - Maternity Open Days

Outputs

- Increased visibility of RMC as a rights-based approach
- RMC resource package developed for all levels of care
- RMC incorporated into Maternal Health Bill
- Advocacy for RMC through media and champions

Outcomes

- Improved RMC policy environment
- Reductions in D&A
- Community awareness on rights increased

Heshima Theory of Change
Policy Perspectives

- **Implementation gap** between MNH policy/guidelines and practice
- Inadequate **community participation** in policy process
- **Lack of awareness** of patient and provider rights (and obligations)
- Inadequate **funding** for MNH
- Lacking **synergy across sectors**
- Pre-service **curricula lack RMC focus**
- Limited regulatory authority (audits & redress mechanisms)
Drivers of D&A

Policy Perspectives

Facility Perspectives

Community Perspectives

Facility Perspectives

- Practice norms and shared attitudes limit ability to change
- Infrastructure, limited resources, staffing
- High case load/work-related stress
- Lack of awareness of rights and obligations in facilities
- Insufficient mentorship/supervision
- Inadequate compensation for overtime
- Inadequate reporting systems

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Community Perspectives
- Informal payments
- Inadequate linkages with facility
- Staffing and infrastructure constraints
- Poor provider skills and knowledge
- Power relationship skewed
- Inability to 'defend' or 'demand' rightful treatment

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Summary of implementation process

Project Launch
Baseline data collection
Dissemination of findings with stakeholders
Participatory intervention development
Phases 1 and 2 implementation
Supplemental data collection
Scale-up activities
Dissemination

Continuous consultation process over time

Promulgation of new Constitution (Aug 2010)
External Events influencing implementation
Free maternity care policy
Operationalization of devolution to county level
Respectful Maternity Care policy engagement in Kenya

- Advocacy for RMC research, interventions development and evidence use
- RMC Resource Package adapted and launched (2015-2016)
- Health Bill passed includes RMC
- Revised MNH strategies (2016 - 2018) includes RMC
- MNCH Bill passed: focus on rights including respectful care
- Scale up in about 17 out of the 47 counties and continues
- Kenya honored at World Health Assembly, May, 2017
Key messages

• RMC requires a health system that has strong commitment, is responsive, accountable to women’s rights, and inclusive of relevant stakeholders

• Weak accountability structures characterized by inadequate supplies and commodities management, demotivates overworked staff perpetuating D&A

• Strong facility and community links tend to improve responsiveness in seeking redress for D&A

• Success is evident where:
  • Frontline health workers and community members work together to achieve mutually beneficial outcomes and;
  • Hold health care managers accountable for RMC success
Implications for respectful newborn care

• Consider conceptually if RMC = respectful newborn care?
• Describe measures of respectful newborn care
• A need to further explore (if any) unique determinants of respectful newborn care
• Measure newborn outcomes against the implementation of a RM(N)C Resource Package
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