Learning Paper

Closing the Gap
Between Community and Formal Health Systems

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Content

Overview

Every pregnant woman deserves the right to be treated with respect and dignity when visiting a health facility. Unfortunately, this is still not the case in many countries around the world. This creates an environment in which women decline antenatal care in facilities and/or prefer home births to giving birth in the attendance of skilled birth attendants. The possibility of complications during their pregnancy increases, which can put both the mother and child in danger and can even cause maternal mortality. To contribute to the elimination of preventable maternal deaths, the fully Amref sponsored Zambian program Closing the Gap Between Community and Formal Health Systems has been implemented and tackled a few factors associated with maternal mortality. The programs aim was to strengthen the relation between formal health systems and communities, but the novel and unique aspect of the program was the implementation of Respectful Maternity Care (RMC) and Customer Care (CC) (also informally known as the Smile Campaign). This could be understood as the root of the program, which had far reached influence on Maternal, Newborn and Child Health (MNCH) and its supporting system. This learning paper has examined the program and creates a RMC model, which shows the system in which all actors play its part, whereby providing knowledge and practice of RMC is seen as foundation and driving force. The aim is to have an optimized model, in which maternal mortality is diminished, by providing respectful care in a safe environment, and whereby formal and informal health systems work closely together.

Introduction

Reducing maternal mortality contributes to achieving the Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages. The first target of SDG 3 is to reduce the global maternal mortality ratio[1] (MMR) to less than 70 per 100,000 live births, by 2030. In 2017, the global MMR was estimated at 211/100,000 (UNICEF, 2021). According to the UN data, the maternal mortality rate in Zambia was 213 maternal deaths per 100,000 live births in 2017. For reference, the data shows South-Sudan as highest mortality rate, with 1,150 maternal deaths per 100,000 live births (UNICEF, 2021). In 2000, the maternal mortality ratio of Zambia was estimated to be 528. Between 2000 and 2017, Zambia has reduced its MMR with almost 60%, which can be seen as a big achievement, whereby currently, the UN has even labelled Zambia's MMR as 'low' (UNICEF, 2021). However, various data show different ratio's, showing the pressing issue of valid data collection and reporting, with high uncertainty intervals ("Maternal Health," 2022; Bill & Melinda Gates Foundation, 2021). Reducing maternal mortality contributes to quality of life and promotes human rights for women, whereby measures such as setting SDG 3.1 and implementing Universal Health Care contribute to this reduction. Even though Zambia's MMR was close to the global average in 2017, it is far from reaching SDG 3.1 goal by 2030 ("Maternal Health," 2022). Therefore, Amref Health Africa has set out the program of Closing the Gap in the Copperbelt province and to fight maternal mortality.

[1] Maternal mortality is understood as "The annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100,000 live births, for a specified time period." (UNICEF, 2021).

Closing the Gap Between Community and Formal Health Systems programs' main goal was to eliminate preventable maternal deaths. The program was implemented from June 2017 until December 2021 in the Copperbelt Province, Ndola and Kitwe district. Brenda Mubita, a registered nurses and midwife, holding a BSc in Social Work and a Master's in Public Health, led the program.

She explains that very few NGOs supported maternal health in the Copperbelt Province at the time when Closing the Gap commenced. The Copperbelt province was often left behind since the Lusaka region has a greater population and has therefore been the point of interest of many NGO's and donors, together with highly remote areas of the country. However, as Brenda explains, the Copperbelt Province experience health challenges too and health facilities need improvement. Both districts are chosen because the population combined counts for more than fifty percent of the province. In addition, both districts are equipped with third level hospitals, which are absent in the other eight districts of the province. A third level hospital adds value as highly specialized staff and technical equipment is present, whereby more services and resources are present than in first or second level hospitals, such as teaching activities (McCord et al., 2015). Therefore, complicated cases from all over the province are referred to either Ndola or Kitwe hospitals. Brenda explains that whenever these regions will improve, the whole province will benefit from Amref's interventions.

The "project aimed to achieve 80% skilled birth attendance by bridging the gap between communities and formal health systems through improved health promotional activities, increased demand for quality health care services and strengthened linkages between community and formal health systems in the two districts of Copperbelt Province"[2]. This had many aspects, whereby a collaboration between Amref Health Africa in Zambia and the Ministry of Health Zambia (MoH) was pursued. Hereby, the Copperbelt Provincial Health Management Team (PHMT) and the Ndola and Kitwe District Health Management Teams (DHMT) played an important role, with both its Community Health Workers (CHWs), as well as health facility staff as key figures. In addition, the development and design of the program was a collaboration between the Ministry of Health Zambia and Amref, whereby the need of the community was the driving force behind Closing the Gap. The full program, however, was funded by Amref solely.

Closing the Gap can be considered as novel model, due to its focus on Respectful Maternity Care (RMC). Respectful Maternity Care for Closing the Gap was measured by seven indicators on abuse and disrespect: namely: physical abuse, non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific attributes, abandonment or denial of care and detention in health facilities[3]. Improving pregnancy outcomes is undeniably intertwined with improving abuse and disrespect during antenatal visits (Mulenga et al., 2020). Experienced abuse and disrespect have far reaching consequences, such as but not limited to, normalizing abuse and absence of care, reinforcing systematic gender inequality, difficulties during labor (Solnes Miltenburg et al., 2018) and postpartum depression (Silveira et al. 2019). RMC is a public health and human right issue and as the World Health Organization (2015) states:

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the

[2] ETE Closing the Gap, page 15.
[3] ETE Closing the Gap.

right to be free from violence and discrimination. Abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles.

RMC is both experienced from service providers side, as well as from the patient side. The WHO framework of 2015 shows five indicators for prevention on abuse and disrespect during facility-based childbirth[4]. Service providers, such as CHWs and health facility staff are responsible for knowledge, practice and adoption of RMC, whereas patients experience the quality of RMC, but should also know their rights. The lack of RMC decreases the possibility for women to deliver in a health facility, as well as decreases their confidence in the health system in general (Kujawski et al., 2015). Attaining soft skills contributes to achieving RMC, however the focus on RMC is still lacking in Zambian health care education and within the health facilities. The focus within these institutions is both on hard and soft skills, such as technical/procedural skills, and communication and organizing skills (HealthPro Research & Consultancy Inc., 2021). However, as Brenda Mubita explained, at school or within the facility, knowledge and practice on Respectful Maternity Care and its importance is limited.

Respectful Maternity Care should be understood as overarching theme, which influences many aspects within the Closing the Gap program. Respectful Maternity Care is not limited to nurses and midwives but should be known among the whole health facility staff, since pregnant women in Zambia are exposed to various personnel when visiting a health facility, as well as on a community level. Providing Respectful Maternity Care increases the probability that pregnant women visit a health facility during and after pregnancy, and therefore reduces risk factors, such as homebirths and preventable pregnancy complications, which contribute to maternal mortality (Mulenga et al., 2020). It is therefore of great importance to provide Respectful Maternity Care in health facilities and to educate communities, in order to reduce maternal mortality, and present a safe environment for Zambian women. Amref was involved in providing RMC and Customer Care trainings to health facility staff and CHWs, as well as supervising the mentorship program. As Viviane Sakanga, Head of Country Program Amref Zambia, says: "Amref was the only organization implementing Respectful Maternity Care in Zambia. We were the pioneers. So that was our flagship program and we're trying to establish ourselves as leaders with Respectful Maternity Care."

For this learning paper, a Respectful Maternity Model is created, which includes the Zambian Mentorship Model of the program, as well as other aspects. This model is the foundation of the paper and its multifaceted character will be explained and explored. The paper will map the essential aspects of the RMC model, as well as review the effectiveness, sustainability, and scalability of the RMC model by critically looking at documentation and evidence of its implementation. The model will be strengthened by desk review, aiming for continuously learning from our past and current comparative programs. Furthermore, this learning paper

[4] These are: 1. Greater support from governments and development partners for research and action on disrespect and abuse; 2. Initiate, support and sustain programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care; 3. Emphasizing the rights of women to dignified, respectful health care throughout pregnancy and childbirth; 4. Generating data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support are required; 5. Involve all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices.

should be considered as ongoing research, as its subject is ever evolving and hopefully, improving.

Firstly, the method of the paper will be discussed. As mentioned above, a desk review is implemented. In addition, four interviews have taken place with Amref Health Africa colleagues, for in-depth insights within the program. This created more understanding from experiences in the field. The result section will combine the literature with the results of the interviews and will explain the RMC model in-depth. It will provide an optimized RMC model, deduced from Closing the Gap, and Amref its influence on RMC and CC trainings. In the discussion, challenges and opportunities of the RMC model will be explored and lessons learned from Closing the Gap. The paper will finish with a conclusion and recommendations for a learning agenda and future programmes.

Method

Desk research: this learning paper uses Amref documents as primarily resource. This will include unpublished reports and proposals, base-, mid- and endline evaluations from past and current Amref Health Africa (AHA) programmes and published papers from Amref Health Africa on Closing the Gap. The End Term Evaluation (ETE) of the program was conducted by independent consultants from the University of Zambia and the Copperbelt University in 2022. This learning paper extracted information from this document and researched unclear or surprising results from this ETE. In addition, comments of and correspondence between colleagues on Closing the Gap reports will be included in the paper. Furthermore, the interviews with AHA colleagues will be used as foundation for the paper. Lastly, this learning paper will make use of literature from the international scientific community on the subjects. Scientific resources will ground theory and foundation on the two aforementioned resources, which results in a throughout examination of the RMC model.

Interviews: within the time frame of a month, in June and July 2022, four interviews were conducted with key Amref Health Africa colleagues who were instrumental in proposal development or project implementation. These formal in-depth, semi-structured interviews were recorded and transcribed via Microsoft Teams. The interview questions included both open questions, such as asking positive, unexpected outcomes, as well as, for example, questions more specific on the Theory of Change. The main aim of the interviews is to create a deeper understanding of working within the program, its strengths, its unexpected outcomes and overall experience. Therefore, the interviews serve as supportive data, along with the desk research. The interviewees had different roles in relation to the Closing the Gap, respectively Head of Programmes and M&E Amref Malawi, Head of Country Program Amref Zambia, Lead of Program Closing the Gap and HQ Technical Support Officer on RMNCH.

Results

Closing the Gap has a foundation within certain theoretical frameworks. These frameworks are both analyzed with academic literature, as well as reports within the Amref community. This section is not depending mainly on literature, but also incorporates the interviews held with specific Amref Health Africa colleagues. During desk research, the goal was to review the RMC model by critically looking at the program and literature. The RMC model aims to eliminate preventable maternal deaths, originating from community and facility-based health problems.

Figure 1 is visualizing the Respectful Maternity Care model. This model is deduced from the interviews and from the evaluations and reports from Closing the Gap. In yellow, the involved actors are stated, which shows the integrated approach of the model on different levels of the health system. In blue, the activities/aspects are shown.
The model in figure 1 brings the Amref Mentorship Model Zambia, which was implemented during Closing the Gap, together with implemented activities such as the education on RMC (community), referral system and Customer Care, as well as future aspects such as the education on RMC (Health Facility) and reporting mechanism. Therefore, it can be understood as an optimized model, that includes implemented as well as future aspects within Respectful Maternity Care, which is developed for this paper. Figure 2 clarifies the role of Amref on implemented RMC and Customer Care trainings within the model.

The interviews with Amref Health Africa staff showed the importance of providing Respectful Maternity Care, as this influences all aspects and actors within the model. Hereby, all aspects are aimed to be monitored and institutionalized in the participating actors' activities.

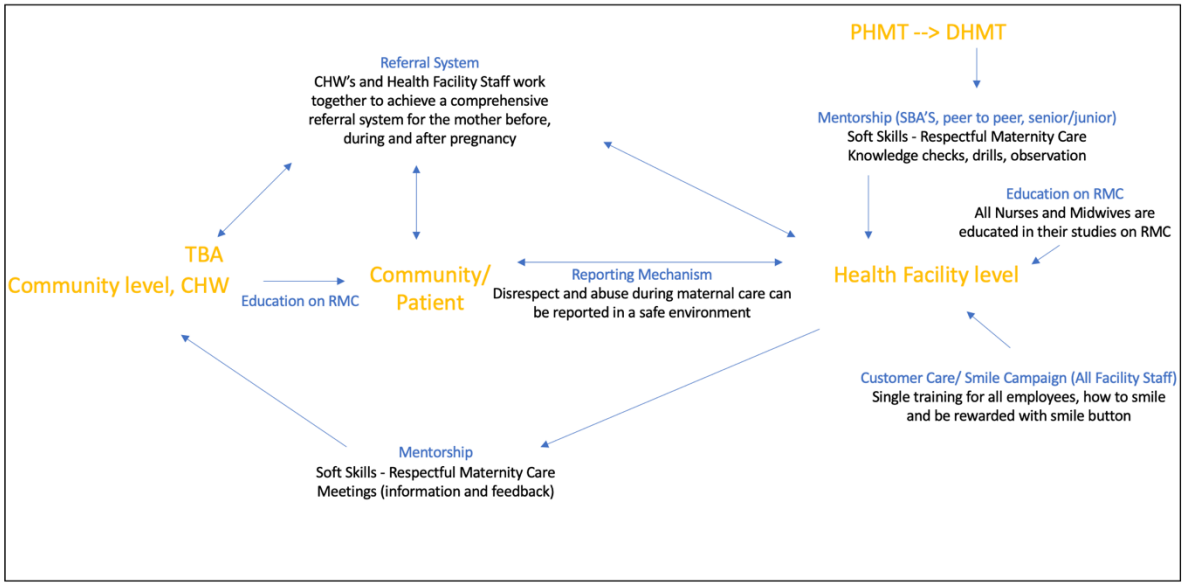

Figure 1. Optimized Respectful Maternity Care Model.

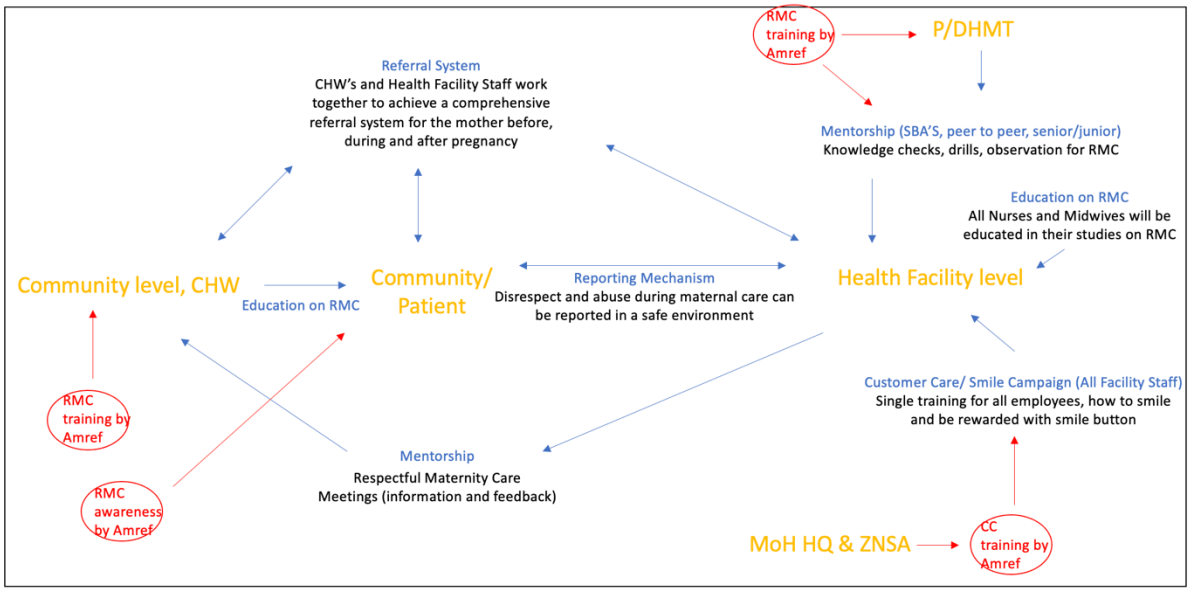

Figure 2. Respectful Maternity Care Model and Amref's engagement on RMC and CC trainings.

Respectful Maternity Care

As discussed above, Respectful Maternity Care and its lack of, affects all aspects of the model. Therefore, it is important that on all levels, knowledge and practice of RMC is experienced. While the quality of EmONC (Emergency Obstetric and Newborn Care) services can significantly reduce MMR, the lack of RMC knowledge and practice should not be a barrier for these services (Adegoke & Van den Broek, 2009; Paxton et al., 2005). Amref provided trainings on RMC to P/DHMT, nurses, midwives, other paramedics and CHWs. Such trainings included topics such as contributing factors of MMR, definitions of key actions such as 'disrespect', 'abuse' etc, but also taught and discussed health facility management and professional ethics and responsibility regarding RMC. Amref also provided RMC knowledge and practice on mentorship and supported supervision on the aforementioned parties. Lastly, within the communities, Amref contributed to more awareness on RMC, rights of childbearing and access to maternal health information. This was done, in addition to mentorship, with posters, t-shirts and aprons with clear RMC message, and also holding meetings with key figures within the community, such as church representatives, police officers and other community members.

Health Facility - Mentorship

In the initial Zambian MNCH MoH mentorship tools had no provision on RMC. RMC was therefore offered as a training before the mentorship and integrated into the program. In order to improve and monitor RMC, this was added to the mentorship aspect of the program. The mentorship aspect of the Closing the Gap program is highly valued, due to its multifaceted character and its integrated approach on several (non)institutional levels. Mentorship was provided from PHMT to DHMT, from DHMT to health facility staff and peer to peer (within and outside same facility), mainly to mentor new staff. RMC at the health facility was taught during quarterly emergency response drills, from year 2 until 4 of the program, and knowledge checks. During the emergency drills, staff was trained to provide RMC in a stressful, emergency situation. In addition, mentorship was provided on real clients and with observation skills.

The endline evaluation shows that knowledge on maternal rights increased and behavior attitude changed positively towards maternal health after RMC trainings[5]. As Kok (2015) states, mistrust towards the formal health sector often originates from disrespect of health facility staff towards the community and CHWs. With these trainings and mentorship, a significant behavioral and mental change is made, which positively influences many other aspects within the health system. The importance of these trainings and mentorship should be emphasized, as it is often not recognized for preventing maternal mortality; quality care and skilled birth attendant should not only attain hard skills and soft skills such as communication but should go beyond this and add RMC to it (Adegoke & Van den Broek, 2009). In order to create a safe environment within the facility, all staff, especially nurses and midwives, are ought to have sufficient hard and soft skills. Attaining knowledge on Respectful Maternity Care is rather the exception than the rule for both skilled birth attendants as well as other facility staff (Adegoke & Van den Broek, 2009). A skilled birth attendant should operate in an 'enabling environment'[6], whereby health facility staff should provide adequate care and take many factors into account. As mentioned in the introduction, the RMC model will not include hard skills specifically, since Respectful Maternity Care is considered as a soft skill. However, since hard and soft skills are complementary, the relevance and connection of both within this context is explained below (HealthPro Research & Research Consultancy Inc., 2021).

Viviane Sakanga and Brenda Mubita explained the cost effectiveness and sustainability factor of the mentorship program. Viviane Sakanga: "For example, the project was a targeting to only train 100 healthcare workers. But with the mentorship program, we managed to reach 670 healthcare workers." This shows both the cost effectiveness of the mentorship program, since many health care workers were reached beyond the initial intention.

Hard Skills

The learning paper will not bring too much attention to the hard skills. Attaining hard skills are necessary for health facility staff, as well as for CHWs. However, for the RMC model, the focus will be on the soft skills part of mentorship, trainings and campaigns; this is the novel and most valuable part of the model. Often, soft skills are not researched or focused on in various projects, whereby hard skills are seen as indicator. However, it is worth mentioning that during the interview with Brenda, she explained the importance of having up to date hard skills. The overarching aspect of the RMC model is the achievement to deliver respectful maternity care, which can be unsuccessful when a health care professional lacks certain hard skill. A bad attitude, demonstrated with (but not limited to) stressed, rude, insecure personnel,

[5] The 'Mentorship Model Zambia' discusses: "Findings from the project end-line evaluation indicate that the projects trainings, mentorships, and sensitization activities on respectful maternity care helped substantially in increasing the knowledge on RMC among community health workers and service providers. There was a substantial increase in knowledge on the rights of childbearing women among service providers in health facilities and there was evidence to show that there was a difference in the behavior/attitude/skills/performance of service providers and CHWs. Findings also show that the mentorship model was substantial in sensitizing the community on respectful maternity care and importance of access as well as utilization of health care services."

[6] "The term skilled birth attendance has been defined as the process by which a woman is provided with adequate care during labour, delivery and the early postpartum period. This requires skilled personnel to attend the delivery and an 'enabling environment', which was initially defined as including adequate supplies and equipment, transport and effective communication systems. It has also been suggested that the enabling environment should not be limited to just these factors but be seen more broadly to include the political will, policy and, sociocultural influences as well as other factors such as the education and training of skilled attendants at pre-service and in-service levels, and following that supervision and deployment" (Adegoke & Van den Broek, 2009).

can emerge due to a lack of hard skills, such as failing to manage labour well or vacuum extraction. Therefore, it is important that hard skills stay up to date with training and mentorship, to limit this underlying factor and improve respectful maternity care.

Community Health Workers
Community Health Workers have a unique position with connecting the formal health system to communities in low- and middle-income countries. CHWs play an important role in improving health in rural and poor communities, when given the right and available resources and trainings (Kok, 2015). During Closing the Gap, CHWs received health education training (on SRHR, MNCH) to be able to educate and sensitize communities and were able to interact more with HWs by means of mentorship. This mentorship was received from the corresponding health facility. Within the mentorship program, CHWs and health facility staff held meetings together, to transfer knowledge on RMC, as well as on patients and could serve as providing feedback about the quality of care in the health facility. As Kok (2015) has researched, CHWs feel supported when they receive regular and visible supervision. CHWs also received RMC trainings from Amref. The mentorship and RMC trainings resulted in more transparency between the health facilities and communities, gaining trust and providing accurate health care information to the community. In addition, on a more personal level, CHWs felt more included and respected, which resulted in a strengthened relation between community and formal health facilities. As CHWs are in close contact with the community, their knowledge and experience are valued, and therefore CHWs are in the position of making communities aware on the importance of RMC. To increase motivation and performance of CHWs, the relationship between the CHWs and its community and health facility needs to be strong (Kok, 2015). This can have a positive influence on the referral and reporting system, whereby the CHW can serve as a trustworthy professional. They can make the community aware that services in health facilities are more friendly and respected, due to the incorporation of RMC, thus creating demand at the community level for RMC. The position of the CHW is therefore unique in the model and serves as an indispensable link between communities and the formal health system. When RMC cannot be offered or lived up to significant standards, the model cannot be optimized as the position of the CHW is weakened.

The mentorship was, as with formal health workers, cost effective and has a big reach of transmitting information and skills, as around 200 CHWs were targeted but Amref managed to reach over 400.[7]

<u>Smile Campaign/Customer Care</u>

The Customer Care training, which was also called the Smile Campaign, was a single training for everyone working in the health facility from health staff to cleaners of the facility. The training was taught by the Zambia National Speakers Association and Ministry of Health HQ to provincial master trainers and Amref staff. These master trainers provided and rolled out training on Customer Care to supported health facilities. This training was a more general training regarding customer care but covered some RMC aspects. The exact content of the training is not available. The training focused mostly on open attitude and smiling to patients. Everyone who finished the training received a smile badge. Together with the RMC mentorship training, the Smile Campaign was a unique approach for Amref programs. It made all employees conscious about how to treat patients, especially pregnant women who

[7] ETE Closing the Gap page 33.

enter a facility. Being rewarded with a badge reinforces behavioral changes, since it can function as a constant reminder to smile and have a positive attitude. Also on the customer side, it established trust, whereby the patient know it is a safe and welcoming zone, and the staff received training.

Referral System

A referral system between Community Health Workers and the health facility staff contributes to strengthening the relationship between both parties, whereby communication and information is exchanged, as well as mutual respect and understanding is established. At a community level, CHWs are often the first contact with the health sector for patients and therefore they are of great importance for community health. Rieger et al. (2019) have shown the effective contribution of a community driven approach in reducing maternal mortality, whereby CHWs are essential. A referral system can be seen as the link between the patient, the CHWs and the health facility. In rural areas, this link can be weak or difficult to access due to issues such as transport and distance. The ETE of Closing the Gap explains as following: "However, despite the improvement, the quality of care experienced by women during childbirth in facilities needs to be established and strengthened. Lack of Respectful Maternal Care (RMC) by health facility staff negatively affects the quality of care and demand for health services by women of childbearing age." [8] The importance of a functioning referral system is explained below.

A decrease of health-related issues, such as maternal mortality can be achieved with timely referrals to health facilities (Kok, 2015). Giving birth assisted by a skilled health care professional, in an enabling environment is key in improving maternal health and an evidence-based intervention identified by WHO that reduces maternal mortality and morbidity (Adegoke & Van den Broek, 2009). Adegoke and Van den Broek (2009) and Paxton et al. (2005) show evidence that with an increased access to skilled health professionals, maternal mortality can significantly be reduced. In addition, a functioning referral system contributes to increasing prenatal screening tests, especially in the first trimester, which can detect and prevent pregnancy complications (Mulenga et al., 2020). Therefore, a functional referral system between CHWs and health facilities is of great importance. This is in line with the goal of the World Health Organization (WHO; Department of Making Pregnancy Safer) goal to strengthen health systems with skilled birth attendants and timely referrals, which not only contributes to improved maternal and neonatal health, but also has a positive effect on other health services (Kongnyuy et al., 2008).

In addition, Amref Health Africa staff emphasized the fact that whenever this referral system is functioning well, CHWs feel more respected and listened to and more equal to health facility staff, since the health facility staff value their knowledge and information. Give et al. (2019) identified various barriers for a functioning referral system, which one being the lack of feedback between the CHW and the health facility. The exchange of knowledge and validation of the CHW will happen with the present mentorship aspect of the RMC model, which is discussed later.

Furthermore, Adegoke and Van den Broek (2009) discuss that training Traditional Birth Attendants (TBA) within the community, does not have any positive relation to reducing maternal mortality. At a communal level, traditional birth attendants (TBA's) often do not

[8] ETE Closing the Gap page 14.

have the skills to safely deliver children. As Madalitso Tolani, Head of Programmes and M&E Amref Malawi, explained, TBA's receive money or gifts for these births, which reinforces them to continue with unsafe deliveries in the communities. Within the RMC model, these TBA's can be given another task, which will still give them a sense of purpose, but will leave out the responsibility of delivering children. The TBA's can be incentivized in a way to refer a woman to a health facility, and to be part of this referral system. On the other hand however, TBAs can be retrained to CHWs. Amref programs in Kenya have assimilated TBAs as community health workers and they are encouraged to be birth companions as well. The health system should be aware of a possible friction between CHWs and TBA's, since TBA's are often well respected within their communities, and CHWs can be positioned between TBA's and health facilities (Kok, 2015).

Reporting Mechanism

Whereas the referral system, the mentorship and Smile Campaign are aspects of the RMC model which happen before or during the experience of the health facility, but an important part too is when these systems fail and how to report this. To optimize the RMC model, a fair, trustworthy reporting mechanism should be in place, to report abuse and disrespect, in the health facility. In the endline evaluation, a reporting mechanism is recommended, and seen as strengthening management when build into the program. The possibility is present that abuse and disrespect do occur in the health facilities, or possibly at a communal level, and the government/facilities should provide a mechanism whereby women can report this abuse. Currently, boxes and posters are present in some facilities, but its reach and usability is limited. Boxes are present as goal to report violations and write down contact information and the situation. Viviane Sakanga explained that posters indicate the rights for women in the hospital and specifically in labor, and what their entitled to, but that information to that regard is limited. Also, it is possible that the boxes and posters are in a language women cannot read, or more general, illiterate women do not understand the use of boxes or message of the posters. When these rights are violated, women still do not know how to report such a situation or know their rights. She stressed the added value of having a reporting system, which will not only report violations, but will also give feedback on the health workers for their professional growth grow to improve their performance. This is a more proactive way of reporting, as well as verbal, which can be more useful for illiterate women.

Discussed by Madalitso Tolani, such a reporting mechanism should also provide feedback on satisfaction, in addition to possible issues. A better reporting mechanism will also make Amref work more efficient and comprehensive, since data can be monitored more efficiently. As Dr. Shiphrah Kuria stresses in our interview, an important part of monitoring and improving our work is to have feedback from patients, not merely at facilities, but also in communities. Brenda Mubita explained the importance of a functioning, and especially quick process after a complaint is made. Some facilities have a suggestion box, or somewhere they can put feedback in, but Brenda vouches for random sampled exit interviews, whereby feedback is provided. In both cases, the complaints should be handled with care and urgency, and not handled two months later by management. Brenda explained that they had some exit interviews randomly in big hospitals, and that the women did not fear the outcomes of these conversations. However, it should be stressed that anonymity and a safe environment are always priority for the women in question and what this is something the health facility, as well as Amref can safeguard.

Discussion

Amref ownership on RMC and Smile Campaign

Respectful Maternity Care was provided by Amref and taught both to health facility members as well as to CHWs. This was a training which was provided before the mentorship and monitored and improved during, in addition to emergency drills and observing skills. The ETE shows that from self-assessment that all service providers (100%) had substantial knowledge on all seven RMC indicators; the rights childbearing women including the right to non-abuse (96.7%), right to consented care (100%), right to confidential care (100%), right to dignified care (100%), right to non-discrimination based on specific attributes (100%), right to non-abandonment or denial of care (100%) and right to non-detention in facilities (100%).[9] On the practice side, in general, behavior towards pregnant women improved, but the ETE shows that still 40% did not introduced themselves to the patients, and 2/3 did not explain to clients what was being done. [10] These activities fall under 'Rights to Consented Care', and should be improved in the future when providing care, which is also in line with the 2015 WHO framework.

On the side of the women's experience on RMC, the numbers are more nuanced. Even though the general satisfaction of women on health care in the facility increased in both the household survey (84.5% to 87.3%) as well as during the exit interviews (86% to 91.2%), various indicators did not show a significant improvement from base- to endline. Such indicators, but not limited to, are: Provider respond to your questions with promptness, politeness (72.1% - 73.2%); Provider obtain consent or permission prior to any procedure (68.5% - 59.7%); Provider insult, intimidate, threaten or coerce you and/ your companion (10.4% - 10.7%); Provider left you alone or unattended to (30.8% - 28.4%).[11] Most indicators saw a slight increase or decrease, which is interesting, since the health providers knowledge and overall activities on RMC were close to 100% at the end of the program. Thus, this shows a difference in perspective between patients' experience and health care providers' (self) reflection. Here, we can conclude that patients' satisfaction and health workers self-assessment are not yet in line with each other, and more improvement can be shown.

Lessons learned: Overall satisfaction on patient side and perceived knowledge and experience on health worker side does not indicate significant changes in behavior and experienced RMC from the health facility. Even though changes have been made and steps have been taken, knowledge is increased at the community level and health facility level on RMC, it takes time to implement knowledge and see significant changes. It is also possible that due to an increase in knowledge on RMC in the community, people might be more critical of health workers attitude, which can influence satisfaction. Amref should take ownership in these outcomes and research on how to align community and health facilities better

The Smile Campaign/Customer Care trainings were not conducted and designed by Amref. The Zambia National Speakers Association (ZNSA) and Ministry of Health HQ provided the initial training to staff and Amref, who rolled out this program further. Health facility staff received this training from Amref, CHWs did not receive this training. The curriculum and timeline of the training is not available. The ETE does not show much data on Customer Care

[9] ETE Closing the Gap page 7.
[10] ETE Closing the Gap page 36.
[11] ETE Closing the Gap page 42&43, household survey.

trainings, even though all international colleagues stressed the importance and great impact of these trainings.

Lessons learned: When looking into the scalability of Closing the Gap, Amref should gain more knowledge on the curriculum of the Customer Care trainings, as well as the timeline. Amref should increase ownership of the trainings and investigate creating its own curriculum to accomplish sustainability and scalability of RMC model. In addition, Amref can also investigate the possibilities of a partnership with the ZNSA or other similar organizations in countries. Since the Smile Campaign hold such valuable contribution to the program, the importance of exploring sustainable partnerships is as lesson learned.

CHWs are Key within the System

As the model shows, CHWs are key within the system. With a leading position between the community and the formal health system, CHWs can transfer knowledge and be part of the referral and feedback mechanism. An increase (93.3% to 97.9%) has been measured in the number of pregnant women who visited someone for antenatal care during their current pregnancy from midline to endline in the household survey; first antenatal visits in the first trimester (47.6% to 51.1%) and preference of facility delivery (92.6% to 99%). These number could be explained with CHWs impact on the communities during the program, but could also be seen as an outcome of substantial implemented sensitization activities within the community, by CHWs and/or Amref. Further research on which interventions contributed to the increase in the utilization of preventive maternal care by mothers is recommended.

An interesting outcome of the ETE shows a great decrease of CHWs referring women to a health facility and thus that the referral system did not function as expected. The ETE shows that from base- to endline, the percentage of CHWs who correctly refer their patients to the nearest facility decreased by 36%[12] and CHW referral to the facility from baseline to endline decreased from 71% to 27.6%[13]. In addition, the household survey which was distributed among women who visited health facilities in the two districts, showed that an increase of 43.4% was experienced of not having correctly beings referred to the closest health facility[14]. However, this household survey showed a slight increase of 'yes' as answer of "Service provider ever referred you to a Community Health worker"[15], but this is negligible since the exit interviews did not see any significant change to this regard[16]. These are interesting results, since in the conversations with Amref Health Africa colleagues', as well as literature shows, an increase should be shown in referrals back and forth between CHWs and the health facility. Interestingly, when asking Brenda about this, she gave two reasons for this. One of it be COVID-19, which influenced the referral system to a great extent, due to limitations of movement and other COVID-19 related lockdown and restrictions. Secondly, she mentioned that the number of self-referrals increased, due to education and information on RMC from the CHWs to the community. The trends in ANC and institutional delivery seem to confirm this, but more evidence is needed.

Lesson learned: A behavioral change within the communities has been documented. More women visited health facilities during their pregnancy and women preferred facilities

[12] ETE Closing the Gap page 33.
[13] ETE Closing the Gap page 45.
[14] ETE Closing the Gap page 46.
[15] ETE Closing the Gap page 46.
[16] ETE Closing the Gap page 47.

deliveries to home deliveries. Learned from this is that women understood the importance of monitoring and safety of the facility. Furthermore, external factors have contributed to a disappointing number of referrals from CHWs to the facility. Literature shows the importance of this, but it was also expected from the ToR and project design. In the future, external factors, such as a possible increase in self-referrals and communities' disruptions should be taken into account whereby the model can be adjusted for unexpected positive/negative factors.

As mentioned above, the position of the CHW is of great value and the satisfaction among women on offered maternal health is high (endline 95.9%). If, indeed, the amount of self-referrals in communities increased because of education and information, provided by CHWs, its position is strengthened and supported. In addition, the community health workers can play a key role in the feedback mechanism on abuse and disrespect. Women in communities should know their rights, and even though the program provided sensitization tools such as posters and t-shirts to the community, CHWs can play a more active role in this too. As for the sustainability of the program, Amref is no longer able to provide such tools, and therefore, CHWs can step in. In addition, feedback on the health facility, whether it be on disrespect or general experience, could also be documented within the community, and not merely within the health facility. This could be done during health dialogues, organized by CHWs between health facility staff and the community. Also, CHWs can play a part in this and give feedback to the facilities during the mentorship meetings. Community members could feel safer telling stories to their CHW, than to health facility staff. Including them in the feedback mechanism, will improve the health facility. However, the health facility should take this feedback system seriously and should deal with complaints thoroughly and swiftly, as mentioned in the ETE recommendations.

Lesson learned: Community Health Workers can take a greater active role in safeguarding RMC in health facilities by means of participating in the feedback mechanism. Hereby, the formal health system and CHWs will strengthen their relation, not only by attending meetings and mentorship, but also as serving as confidant for women.

TBA's

Lastly, the ETE does not give any information on Traditional Birth Attendants. TBA's can alter their activities to safeguard the aim at women delivering and paying antenatal visits at a health facility. For example, in Mexico, a project of WHO has implemented a respectful childbirth model too and "promotes alternative practices to the traditional model of care". (Juárez-Ramírez et al., 2020). In this project, traditional midwives are accompanying women to and in the facility when giving birth. Thereby, they guard RMC from the patient's perspective. It would be recommended to for CHWs and health facility staff to discuss with TBA's their renewing role within the RMC model, as they can fulfill a different, valuable task or retrain them to CHWs.

Lesson learned: TBAs should not be excluded in the RMC model and renewing health system. Redefined roles of TBAs should be explored. Amref should look into other country programs (Malawi, Kenya) to see how this is implemented.

Tools

Dr. Shiphrah Kuria emphasized the fact that the lack of proper equipment for CHWs limits their position and motivation. She explained that tools need to be facilitated to report and track patients, and for communication among CHWs and between CHWs and health

facilities. These tools, such as mobile phones, tables, proper work equipment but also sufficient data, should be funded by the government, which is seen difficult to achieve. Currently, it can be the case that the provided tools are facilitated by the CHWs themselves and not compensated. Kok (2015) found that a lack of supplies can cause confusion and/or disappointing feelings and stress among CHWs.

RMC Included in both Education and MoH Mentorship Tools

RMC
Respectful Maternity Care is taught and executed during this program by means of training and mentorship. However, Amref Health Africa colleagues did stress the limitation of the mentorship program and RMC trainings. Attrition and replacement made it difficult to continue with equal and continuous mentorship throughout the program. During the interviews, it became clear that health facility staff often are trained, and leave the facility or even workforce, making the RMC trainings and mentorship unprofitable. If knowledge is not optimized and passed on, the gap on RMC will persist. Therefore, there is an urgent need for an integrated approach with various actors and whereby Provincial and District Health Management Teams should provide not only RMC mentorship but should also offer leadership possibilities and provide an enabling environment. As mentioned before, an enabling environment is needed for a skilled health care worker, whereby the environment provides possibilities to execute Respectful Maternity Care. In addition to leadership skills to transfer knowledge and safeguarding RMC within facilities, an enabling environment can also entail the inclusion of an RMC policy/code of conduct in the facility.

Education
To ensure an equal level of RMC knowledge and practice, as recommended in the ETE, RMC should be included within the educational programs of nurses and midwives. To ensure an equal level of RMC knowledge and practice, as recommended in the ETE, RMC should be included within the educational programs of nurses and midwives. Even though soft skills, such as communication and empathy, are taught at university, classes on knowledge and practice of RMC and its influence on maternal health are lacking. All skilled birth attendants should have a foundation of RMC in their education, whereby the possibility of knowledge gaps within the facilities will diminish and communities will be aware of this knowledge and practice within the facilities. The system as a whole will benefit from this, while attrition and replacements of skilled birth attendants won't cause a gap in RMC knowledge and practice. Currently, skilled birth attendants are taught RMC through trainings and mentorship, limited to some selected health facilities in the Copperbelt Province . The Nursing and Midwife Council Zambia has already committed to incorporated RMC (incl. refreshers and mentorship) in their future educational program.

In addition to creating an enabling environment to provide RMC and a foundation of RMC during education, the mentorship aspect of the model should also be strengthened. Mentorship has various positive aspects, also regarding replacement of health staff. Knowledge and experienced gained in one facility when leaving is never wasted, since a spillover effect can appear whereby other facilities and colleagues are informally taught about RMC. However, this effect and its sustainability should be further examined. This could create impact, especially when leadership skills are taught, as posed above, whereby staff member have the skills to provide such knowledge transfer. Therefore, MoH should include RMC within the mentorship tools nationwide.

Lesson learned: To make sure that Respectful Maternity Care is sustained, the foundation of health workers in both the community as well as health facility level should include knowledge and practice on RMC. With this approach, P/DHMT should provide more than just mentorship. With mentorship alone on monitoring and improving RMC, the program cannot guarantee sustained quality of RMC. Respectful Maternity Care should be institutionalized in the MoH mentorship tools, education, on health facility and P/DMHT level. This counteracts the gaps that would appear with attrition and replacement om RMC knowledge and practice, as a foundation and institutionalization of RMC will be in place.

Conclusion

This learning paper had explored many facets of the Respectful Maternity Care Model. This model was created with existing models, literature, experiences from the field, and the program design regarding respectful care on Closing the Gap and MNCH. The model includes various actors on different levels, such as the Provincial and District Health Management Team, the Health Facility level, Community Level with CHWs and TBAs, and Community level regarding the patient. Actors act with each other with different practices. The result section discussed such practices, which are key part of the RMC model. First, the result section explained Respectful Maternity Care more thoroughly, by means of the Mentorship and the role of Community Health Workers. Thereafter, the Smile Campaign/Customer Care was explained, and the importance of a Referral System and Reporting Mechanism. This shows the complexity and multifaceted character of the RMC model, and the importance of providing RMC, as well as communication between the community and health facility, as well as education of the communities. The discussion had three major subjects; Amref ownership on RMC and Smile Campaign, CHWs are Key within the System and RMC Included in both Education and MoH Mentorship Tools. This explained the importance of RMC and Amrefs' role, and the importance of partnerships with this subject. Furthermore, CHWs were explored more, and especially the importance of retraining Traditional Birth Attendants. Lastly, the paper discussed the importance of educating health workers on the subject of RMC and the inclusion of RMC in the mentorship tools of the MoH.

This learning paper had showed how Respectful Maternity Care is intertwined into many aspects of the health system in Zambia, and how the connection between various health care levels can be strengthened or weakened by the presence or absence of Respectful Maternity Care. Working within a system whereby disrespect and abuse on pregnant women is eliminated should be the goal, since every woman deserves to bear a child with dignity and respect. The aim is to implement such a model for future programmes and learn from past experiences to improve Maternal, Newborn and Child Health to reduce maternal mortality.

Recommendations and Challenges

The paper has seen various aspects for recommendations and seen challenges on the topic. Additionally, the End Term Evaluation, there are more relevant recommendations on the program.

- Internal communication and learning about Respectful Maternity Care for Amref colleagues and staff. Not only to communities and health workers can learn from a such a paper, but also Amref staff can learn from this. How do we look at RMC and what do we do to safeguard RMC as Amref, apart from implementing such a program? Think about when organizing the Africa Classic or work visits, how do we enter health facilities and safeguard respectful maternity care?
- Amref should update and research the RMC model regularly. In order to stay relevant and add future experiences, this model is not static. It is already discussed to present this model to Research CoP to further research RMC. Thereby, it stays a relevant topic.
- Talking to Viviane Sakanga, we noted the importance of incorporating this Smile Campaign within the RMC model, and especially within the RMC mentorship training. However, the focus for this campaign should still lay on the whole facility staff, and not reduced to only maternal health staff. In addition, this campaign in Closing the Gap was not done on a regular basis, thus, new staff did not receive the training. Even though a spillover effect within the facilities by means of peer-to-peer support and mentorship could have taken new staff members along, this is unsure to say and not monitored.
- CHWs did not receive any Customer Care training. A timely framework of giving the Smile Campaign to all new staff should be in place to make sure everyone working in a health facility has received this training, including CHWs. This was also something mentioned by Madalitso Tolani. He suggested to look into this campaign more and to scale it up and implement it in other Amref programs on MNCH.
- A reporting mechanism on abuse and disrespect has not been implemented completely with Closing the Gap. According to Viviane, it is “still a work in progress”. The importance of a functioning reporting mechanism should not be taking lightly and implemented further.

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