NATIONAL RESPECTFUL MATERNITY CARE
GUIDELINES

First Edition, January, 2020
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APPENDIX 1: LIST OF CONTRIBUTORS TO THE RMC GUIDELINES.................................20
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Respectful Maternity Care (RMC) is a universal human right for every childbearing woman in any health system. Women’s experiences with providers of maternity care can empower and comfort them or inflict lasting damage and emotional trauma. Zambia has policies and laws, which protect the rights of women and children. It is imperative therefore, that these policies and laws are enshrined in reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAHN) programmes and services so as to dignify maternity care and services at all levels of care.

Against this background, the Ministry of Health (MoH) partnered with the Midwives Association of Zambia (MAZ), United Nations Population Fund Agency (UNFPA), Clinton Health Access Initiative (CHAI), Jhpiego and John Snow Incorporate (JSI) to develop the First Edition National Respectful Maternity Care Guidelines, which will promote respect for every woman’s humanity, feelings, choices and preferences and uphold the reproductive rights of women and children in Zambia. The RMC Guidelines aim to end mistreatment and violence against women in reproductive health services and during childbirth in relation to violations, which occur in the wider context of inequalities, discrimination and patriarchy in Zambia.

The institutionalization of RMC in RMNCAHN programmes in Zambia has the potential to increase institutional deliveries by skilled attendants. This will no doubt promote safe motherhood and contribute to reduction of maternal and perinatal deaths in accordance with the Zambia National Health Strategic Plan (NHSP), 2017 – 2021. RMC will further contribute to the attainment of the MoH’s Legacy 1: Reducing maternal and childhood illnesses by 2030. The NHSP supports the National Vision 2030, which expresses the Government commitment to address the Zambian people’s aspiration to develop the country to a prosperous middle-income nation by 20 by 20 by 30. The NSHP and therefore, plan envisions a prosperous country where all Zambians have access to quality health services.

In light of the above, I would like to urge the midwives and other health workers in public, private and mission facilities and those working in the community, to embrace respect for women’s basic human rights, autonomy, dignity, feelings, choices, including companionship and preferences at every contact as desired. They should uphold RMC throughout the continuum of service provision to dignify maternity care and motivate women to deliver in health facilities.

Hon. Dr. Chitalu Chilufya, MP
Minister of Health
ACKNOWLEDGEMENTS

I am indebted to UNFPA for the financial support to develop the First Edition National Respectful Maternity Care Guidelines in Zambia. I am also grateful to the Consultant Dr. Peggy Chibuye, for facilitating the development and writing of the National RMC Guidelines. The health of women and children is key to the wellbeing of the nation and economic development.

I commend the staff in the Department of Nursing in MoH and the National Executive of the Midwives Association of Zambia (MAZ) for their commitment and hard work to develop the RMC Guidelines as scheduled. The participation of the partners Jhpiego, UNFPA, JSI and CHAI attests to the successes in reproductive, maternal, neonatal and child health (RMNCH), which we have achieved together with cooperating partners and the communities. I have no doubt that strong partnership between the MoH and key stakeholders, including the community is imperative as we strive to attain Sustainable Development Goal 3 for women and children by 2030.

The MoH is further indebted to the members of MAZ who participated in the development of the Guidelines, for their contributions, commitment and hard work. The leadership they displayed during the development of the National RMC Guidelines is indicative that they will be key to ensuring that these are integrated in service delivery in order to provide dignified maternity care in public, private, mission health facilities and in the community throughout the country.

Dr. Kennedy Malama
Permanent Secretary – Technical Services
<table>
<thead>
<tr>
<th>ACRONYMS</th>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>CBD</td>
<td>Community Based Distributor</td>
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<tr>
<td>CBV</td>
<td>Community Based Volunteer</td>
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<td>CHA</td>
<td>Community Health Assistant</td>
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<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
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<td>CHAZ</td>
<td>Churches Health Association of Zambia</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>D&amp;A</td>
<td>Disrespect and Abuse</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>GNCZ</td>
<td>General Nursing Council of Zambia</td>
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<td>HPCZ</td>
<td>Health Professions Council of Zambia</td>
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<td>JSI</td>
<td>John Snow Incorporated</td>
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<td>MAZ</td>
<td>Midwives Association of Zambia</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NHC</td>
<td>Neighbourhood Health Committee</td>
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<td>NHSP</td>
<td>National Health Strategic Plan</td>
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<td>RMC</td>
<td>Respectful Maternity Care</td>
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<td>RMCNCH</td>
<td>Reproductive Maternal Neonatal and Child Health</td>
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<td>RMNCAHN</td>
<td>Reproductive, Maternal, Neonatal and Adolescent Health and Nutrition</td>
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<td>SMAG</td>
<td>Safe Motherhood Action Group</td>
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<td>PPIUD</td>
<td>Post-Partum Intra Uterine Device</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>VVF</td>
<td>Vesico-vaginal Fistula</td>
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<tr>
<td>ZAGO</td>
<td>Zambia Association of Gynecologists and Obstetricians</td>
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<td>ZUNO</td>
<td>Zambia Union of Nurses Organization</td>
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1. Introduction

Every woman around the world has a right to receive respectful maternity care (RMC)
. RMC has evolved and expanded over the past few decades to include diverse perspectives and frameworks
. It is a universal right due to every childbearing woman in every health system around the world
. Women’s experiences with maternity care givers can empower and comfort or inflict lasting damage and emotional trauma. Evidence suggests that the fear of disrespect and abuse (D&A) that women too often encounter in facility based maternity care is a more powerful deterrent to the use of skilled care than common recognised barriers such as cost or distance
.

Advancing respectful, dignified care is critical to increasing facility births and ensuring effective implementation of women’s rights-centered approaches in maternal health services
. In fact, efforts to increase the use of facility based maternity care services in low resource countries are unlikely to achieve desired gains without improving quality of care and focusing on women’s experience of care
.

Despite overall advances in maternity health care outcomes, ensuring women have skilled and respectful care during delivery remains a challenge
. In many countries, women are mistreated when delivering in health facilities and are unable to make choices or follow practices that put them in control of their own experience. In addition, health systems are under-equipped and health workers are overwhelmed due to inadequate pay, lack of infrastructure, or insufficient staff and supplies, staff may also not receive guidance or supportive supervision to uphold RMC in midwifery services.

The notion of safe motherhood must be expanded beyond the prevention of maternal morbidity or mortality to encompass respect for women’s basic human rights. This should include respect for women’s autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care. An encounter with providers during childbirth should be characterized by a caring attitude, empathy, support, trust, confidence, and empowerment, as well as gentle, respectful, and effective communication to enable informed decision-making. But this may not be the case for most women. Many women experience disrespect and abuse (D&A) during childbirth
.

In light of the above, MoH in collaboration with MAZ and financial support from UNFPA developed the First Edition National RMC Guidelines. The aim is to dignify maternity care for women and neonates in the community up to Third Level Hospitals in Zambia.

2. Background

The goal of RMC is to provide reproductive health services 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. Pregnancy and childbirth are momentous events in the lives of women and families and represent a time of intense vulnerability in every country and community worldwide
. Maternal health refers to the health of women during pregnancy, childbirth and postpartum
period and motherhood is often a positive and fulfilling experience. The concept of “safe motherhood” is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. As motherhood is specific to women, issues of gender equity and gender violence are also at the core of maternity care. Thus, the notion of safe motherhood must be expanded beyond the prevention of morbidity and mortality to encompass respect for women’s basic human rights, including respect for women’s autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care\textsuperscript{1,2,5,12}.

Zambia has not been spared in the issues of disrespectful, neglectful and abusive treatment of women during child birth. A study conducted in Ndola and Kitwe districts revealed that non-adherence to the rights of child bearing women are a barrier to achieving quality of care for child bearing women\textsuperscript{10}. Another study conducted in Lusaka urban revealed that disrespectful and abusive maternity care dissuaded some women from delivering at health facilities\textsuperscript{11}. Difference in beliefs and birthing practices between midwives and mothers suggest the need for open dialogue to co-design appropriate interventions to increase facility usage\textsuperscript{4,5}.

Financial barriers; such as Inadequate provision of obstetric care, poor facility infrastructure, for example, water, electricity, equipment, drugs and supplies, motivation of care providers, poor access to facilities due to poor road network and other communication network and minimal availability emergency transportation have a negative impact on RMC. Perceived non-financial barriers to RMC include negative provider attitudes, poor quality of care reported in health facilities during childbirth, including D&A treatment by health providers and other facility staff, low levels of provider competency and skills, and lack of supportive supervision. Others barriers include cultural beliefs, stigma, perception of both clients and providers on various health conditions and services, gender and decision-making process, lack of awareness and recognition of signs and symptoms of obstetric danger and lack of awareness of availability of services\textsuperscript{4}.

A report on exploring evidence for D&A in facility-based childbirth landscape analysis report, categorized these behaviors into seven manifestations:

- Physical abuse;
- Non-consented care;
- Non-confidential care;
- Non-dignified care;
- Discrimination;
- Abandonment of care;
- Detention in facilities\textsuperscript{12}.

An encounter with providers during childbirth should be characterized by a caring attitude, empathy, support, trust, confidence, empowerment, kindness, respectful, and effective communication to enable informed decision-making. But this may not be the case for most women. Many of them experience D&A during childbirth\textsuperscript{13}.
3. **Health Systems**

Zambia has a well-developed public and private health care system providing preventive, promotive, diagnostic, curative and rehabilitative care services. Ninety (90) percent of patients as well as pregnant women seek care in public facilities. The private sector in particular has earned the reputation as providers of good quality health care.

Health Systems in Zambia are classified into four levels. First Level comprises of 953 Health Posts, 1,839 Urban and Rural Health Centres and 99 District Hospitals. Second Level comprises of provincial and general hospitals, which provide curative care. Tertiary level comprises of Central Hospitals and the National University Teaching Hospitals which provide specialized care. The arrangement of health services is along the same administrative lines with the district as the hub for service delivery at community level while second and third levels provide tertiary care.

All third-level hospitals are Government owned. Twenty-six second level hospitals are Government-owned and eight are owned by the Churches Health Association of Zambia (CHAZ)\(^1\). Additionally, the General Nursing Council of Zambia (GNCZ) and the Health Professions Council of Zambia (HPCZ) regulate the education and training of health workers so as to maintain the standards of health care.

4. **Rationale**

RMC refers to the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and the period following childbirth. It respects her rights and choices through supportive communication, actions, and attitudes\(^1,12\). Because D&A behaviors and environments degrade the quality of maternity care, identifying and addressing them is an important component of cultivating RMC in health facilities and in the community\(^12\).

The National RMC Guidelines are designed to support health facility managers, midwives and other health care providers who attend to women, and communities to confront D&A during facility-based childbirth and to promote respectful maternity care in both facilities and in the community. RMC activities are significant events in the lives of women and families during pregnancy and childbirth. The National RMC Guidelines will therefore, be used by all health workers and support staff providing reproductive health services to women, men and their families. They have been designed in a way that no one will be left behind as it incorporates activities from the community level up to tertiary level.

The National RMC Guidelines will be implemented by health workers as they are the first contacts for women, companions and families. RMC has the potential to provide a lasting impression to women, companions and families. The community, traditional leaders, SMAGs, CHWs and other influential leaders are of paramount importance as they link the women to the health facilities for RMNCH services. D&A in health facilities are among the common barriers to women seeking maternal health services. It is apparent that a curtain of silence as evidenced by the non-availability of RMC Guidelines globally has obscured disrespect and abuse of women during pregnancy and childbirth. Equity of access to quality health care,
advocacy for strong health care system, conducive environment and policy change are cardinal to the successful implementation of the National RMC Guidelines.

It is therefore imperative for these National Guidelines to be used to raise awareness and generate demand for RMC, reinforce and hold accountable midwives and other health care providers, support staff, local leaders, civil society and communities to ensure that RMC rights are upheld at all levels of women care.

5. **Target Audience**

The key target group for the National RMC Guidelines are midwives and other health workers (Nurses, Obstetricians, general doctors, and Clinical Officers) who provide reproductive health services and maternity care to women in reproductive age group, adolescents and families. These groups of health workers are the face to the public on RMNCAHN services. Additionally, Midwifery and Nurse Educators, Students, Community Health Assistants (CHAs) and Community Based Volunteers (CBVs) comprising of SMAGs and CHWs, and NHCs play various roles from educating students on reproductive health and maternity care to enhancing RMC in the community. The other target audience include health facility in-charges and managers at district, provincial and national levels.

The target organisations for National RMC Guidelines include; Churches Health Association of Zambia (CHAZ), GNCZ, MAZ, HPCZ, Zambia Association of Gynaecologists and Obstetricians (ZAGO) and Zambia Union of Nurses Organisation (ZUNO). These institutions in concert share responsibilities to protect the rights of not only women but also health workers and families from education and training of health workers to upholding RMC in practice and through professional development activities. Cooperating partners, which support RMNCHAHN programmes will use the Guidelines to hold the organisations they fund accountable to uphold RMC in the districts where they provide support or work.

Additionally, CHAZ is a big player in service delivery in Zambia. It will hold accountable on RMC the varied providers and support staff in their institutions in all faith based or mission facilities. CHAZ is well placed to ensure that the National RMC guidelines are institutionalised in their education and training institutions and facilities.

Undoubtedly, institutionalising the National RMC Guidelines in education and clinical practice will transform the continuum of care by building and sustaining adaptation and resilience in reproductive health and maternity care and improve the quality of maternity care.

6. **Guidelines**

RMC is mandatory at every contact with a woman and her companion where applicable in reproductive health and maternity care service delivery points in the health system. It should become standard practice and not exceptional to the rule in order to provide dignified and quality maternity care for the benefits of women, neonates, men and their families. The National Guidelines are presented in two parts. The first part presents General Guidelines, which are applicable in all service areas, including in the community. The second part presents Guidelines, which are applicable to specific services areas.
6.1 General Guidelines

- Prepare yourself psychologically, emotionally and ensure that relevant equipment is ready to offer a reproductive health and maternal health service.

- Wear Identity Card at all times to build confidence and establish rapport with a woman and her companion when she comes for delivery.

- Maintain a clean, safe and conducive environment for providing reproductive health and maternity care services at all times.

- Welcome the woman, greet her and her companion as applicable. Introduce yourself and ask client for the name in order to establish rapport.

- Provide accurate information on client and provider rights and responsibilities according to Client’s Charter in Zambia.

- Treat all clients equally with dignity and respect regardless of colour, creed, socio-economic, marital status and political affiliation.

- Orient the client on the geography of the facility (Health Post, Health Centre, Department, Labour Ward) for her to be familiar with the environment. Orientation in labour ward should be done depending on the stage of labour on admission or condition of the client.

- Provide accurate Information to every client at every contact according to MoH Protocols (2015 Nursing and Midwifery Protocols).

- Uphold the privacy of women by use of screens, private room, curtains or linen and covering during physical examination at all times.

- Promote collaboration with other health care providers for smooth transitioning from one level of care to another.

- Maintain confidentiality for all women by not disclosing any information except with professional colleagues for treatment purposes with permission from the client. This is referred to as shared confidentiality.

- Explain the procedure to be conducted to the client to gain cooperation.

- Provide timely information to the client and companion where applicable, on the care to be provided or procedure to be performed and obtain informed consent.

- Dispel known myths and misconceptions about pregnancy, labour, delivery and postnatal in order to strengthen health seeking behaviour of women and families and reduce harmful practices.
• Triage clients as they come to the facility to help you to prioritise clients needing urgent care to be provided in a given service delivery point.

• Demonstrate competence in interactions with women and companions or family members for them to appreciate your work and the services you provide.

• Create a conducive environment for NHCs, SMAGs, CHWs, families, relatives, mothers and the community members to exercise their rights to information on RMNCAH when receiving maternity care.

• Communicate all procedures in the language the woman and her companion can understand to allay fear and anxiety in order to gain cooperation. If necessary use a translator for example, when working in an area where you are not familiar with the local language, including in humanitarian settings to enable the woman understand the procedure and make an informed decision on the services to be provided.

• Monitor RMC practices at your facility by holding monthly meetings to review and update the practices. No form of abuse (physical, verbal and emotional) should be condoned in the provision of maternity care.

• Health Centre/Post in Charges should support community structures to hold monthly meetings to review and update RMC practices in the communities.

• Uphold professionalism in service delivery to assure RMC in service provision.

• Display the MNCAH services offered at the facility in visible places for women and general public to know them for example, Family Planning and HIV services.

• Discourage harmful cultural practices in pregnancy and childbirth such as, use of traditional medicine to accelerate labour by discussing with women on disadvantages of such practices.

• Provide maternity care in a culturally sensitive and appropriate manner.

• Respect a woman’s harmless cultural beliefs at every contact with her and the family members. For example, you can ask the woman to identify the sex of the baby by touching and feeling the baby’s genitalia. You can also ask her for permission to show the baby to the companion.

• Collaborate with other health care team members in upholding RMC whenever in contact with a woman. The health team members include doctors, biomedical scientists, radiographers, physiotherapists, pharmacists and support staff.
• Obtain an informed verbal or written consent for every procedure to be done on clients in order to allow them exercise their rights and providers to offer legally accepted care.

• Allow the client to choose companion of her choice to support her throughout her maternity period to improve birth outcomes and the overall birth experience.

• Provide dignified care that is evidence based and shown to be beneficial to the client.

• Document accurately everything done on the client for continuity of care.

• Advocate for dignified maternity care at all levels.

• Collect the information from exit interviews, surveys and in suggestion boxes, analyse and provide feedback to staff and clients and use it for continuous improvement of maternity services.

• Campaign through local media such as radio, TV, newspaper, community social gatherings and Journalists to advocate for promotion of RMCs at all level.

• Empower communities to demand their right to RMC.

• Empower communities to hold health workers and local leaders accountable for raising awareness to generate demand for RMC rights.

• Sensitise clients on the importance of reporting any undignified treatment from staff to facility administrators to curb D&A treatment.

• Instill professionalism in student midwives and nurses through role modelling to uphold professional ethics especially in clinical areas.

• Allow the woman and her companion to ask questions on the care being provided.

• Utilise students on clinical attachment efficiently to practice in accordance with the level of training and uphold the women’s’ privacy.

• Uphold the rights of women by ensuring that they are attended to by a skilled birth attendant at all times (Antenatal, labour and delivery, postpartum and Family Planning services).

• Promote involvement of the mother in the care of a sick neonate by providing relevant information and answering all queries from the family to enhance support and cooperation.
6.2 Guidelines for Specific Services

6.2.1 Antenatal Care

- Schedule ANC appointments (specific time for client’s ANC visit) to enable efficiency.
- Triage ANC clients according to their needs and prioritise care and refer accordingly.
- Support every woman with or without a spouse to develop a Birth Preparedness Plan within their means. Discuss the Birth Preparedness Plan with individuals and advise them accordingly.
- Discuss delivery positions and pain relief with clients for informed choice in readiness for delivery.
- Uphold RMC when providing routine counselling and testing to women for HIV/STIs and commence treatment if positive. Support the woman to adhere to treatment.
- Refer women direct from Health Posts, Health Centres and District Hospitals to Central and Tertiary Hospitals as early as possible – Labour before 35 weeks gestation, previous or current coagulopathy, moderate to severe anaemia, pre-eclampsia or eclampsia, Sickle Cell Disease, Cardiac condition, hypertension, diabetes mellitus, hyperthyroidism, renal disease, RH negative, epilepsy and asthma (2018 MoH Maternal and Neonatal Referral Guidelines).
- Refer the women at booking or as soon as possible with health care provider from health posts/rural health Centres who have: Bad obstetric history, Pre-Eclampsia, Eclampsia or hypertensive disorder in previous pregnancy, history of myomectomy, history of ruptured uterus, history of previous prenatal death (still birth and neonatal death), previous cesarean section, bleeding in pregnancy, fibroids in pregnancy, intrauterine foetal death, intrauterine growth restriction, multiple pregnancy, premature rupture of membranes, (PROM), polyhydramnios/oligohydramnios, severe malaria, varicosity and any other condition deemed as urgent for referral.
- Refer the women at 34 weeks of gestation from Health Posts and Rural Health Centres: Under age (16 years or below), excessive vulva warts, grand multiparous, previous caesarian section, known contracted pelvis, previous ectopic pregnancy, mal-presentation, breech presentation, compound presentation, transverse/oblique lie.
- Always write detailed information on the referral form for every client you have referred for further management at the next level of.
- Always start family planning counseling during antenatal care. Discuss all the relevant methods (profiling), including Post-Partum Intra Uterine Device (PPIUD).
6.2.2 Essential Care for Labour and Birth

- Provide accurate information to the woman and companion on the progress of Labour to allay anxiety.
- Provide psychological care to the woman and allow her companion to be around if possible.
- Allow woman to have light meals and fluids of her choice.
- Provide privacy to all clients during physical examination by use of screens, and linen.
- Speak to the woman calmly and in a low tone to gain her confidence and make her feel cared for.
- Allow the client in labour to move around if condition allows to promote descent of the baby and prevent perception of being confined.
- Offer non-pharmacological pain relieving methods such as back rub, breathing technique and other diversional therapies.
- Administer pethidine and fentanyl to women in labour as needed in the active phase labour up to 6cm cervical dilatation.
- Allow client/woman to choose a birthing position of her choice to promote woman’s sense of control and reduce need for analgesia.
- Promote active engagement of a woman in the labour process in order to gain cooperation.
- Conduct a safe and clean delivery according to MoH Nursing and Midwifery protocols.
- Show the baby to the mother to identify the sex and verify the findings with the mother. Be patient if she refuses to see the baby.
- Put an identification tag on the baby and ask for permission to show the baby to the companion.
- Conduct active management of the third stage of labour skillfully and professionally in order to prevent post-partum haemorrhage (PPH). Inform the client when injecting oxytocin.
- Conduct post-delivery observations in accordance with the nursing and midwifery protocols to identify and act on any deviation from normal.
• Provide Family Planning counseling and options. Establish the method of choice the woman has opted for. If the woman settles for PPIUCD, counsel and proceed with the insertion procedure. Before insertion check that none of the following conditions are present:
  o Corioamnionitis (during labour)
  o More than 18 hours from rupture of membranes to delivery of baby;
  o Un resolved PPH.

• Refer women with the following conditions during Labour from Health Posts/Rural Health Centres: Puerperal sepsis, postpartum haemorrhage (PPH), wound dehiscence, postpartum psychosis, puerperal infections, vesico-vaginal fistula (VVF), and life threatening medical conditions\textsuperscript{16}.

• Always write detailed information on the referral form for every woman and neonate that has been referred for further management at the next level of care \textsuperscript{16}.

• Make the mother and baby comfortable. Continue monitoring the conditions of both mother and baby.

• Help the mother to initiate breastfeeding within one hour of delivery.

**Surgical Intervention**

• Provide accurate information and psychological care to the woman and her contact persons. Explain reasons for surgical intervention, obtain informed consent from the woman or relative(s) if the woman is under 18 years old or is unable to make own decision.

• Reassure client to allay anxiety by explaining the procedure to be done.

• Prepare client for the surgical intervention in accordance with MoH Nursing and Midwifery protocols\textsuperscript{16}.

• Escort the woman to theatre to maintain continuity of care.

• Provide regular and relevant updates to companions while the woman is in theatre and inform them once the woman is back from theatre to allay anxiety.

• When receiving the baby in theatre, identify the sex of the baby with the mother (if conscious) and the whole theatre team. Put an identity band on the baby with mother’s details, date and time of birth, sex and weight.

• The receiving midwife, together with the midwife giving hand over and the mother of the baby, should identify the baby and sex of the baby to prevent baby swapping during the handover.
• If client is planned for caesarian section and has been counselled and consented for PPIUCD, insert after delivery of the placenta. Rule out any contra indications.

• Conduct post-operative care that includes observations to identify and act on any deviations from normal.

• Administer prescribed pain relief drugs and antibiotics. Explain to the mother the outcome of the operation and show her the baby if possible once she wakes up. Encourage breast feeding and early ambulation.

• Make the mother and baby comfortable at all times by giving nursing and midwifery care. Promote mother baby bonding in the immediate postnatal period unless it’s not possible.

6.2.3 Postnatal Care

• Triage clients in the postnatal period according to their needs and identify and act on deviations from normal.

• Provide accurate information and psychological care to the client and their companion.

• Provide privacy during physical examination by use of screens and linen and speak calmly and in a low tone voice.

• Orient the client to the geography of the ward for her to be familiar with the environment.

• Inform client and companion on any procedures to be conducted to allay anxiety.

• Practice positive interactions between midwives and women and always express empathy and compassion for the women.

• Continue post-delivery observations and identify and act on any deviations from normal.

• Make the mother and baby comfortable to facilitate recovery.

• Promote skin to skin care between baby and mother in the postnatal period to promote bonding of the baby and mother.

• Counsel client for family planning and provide appropriate method of choice such as Implants and IUCD.

• Never detain a woman for failure to pay the financial obligations when they are due for discharge after delivery. This infringes on their rights to health care. Facilities can devise other means of collecting this money from clients.
• Counsel mothers that have suffered severe complications of pregnancy and childbirth.

• Counsel mothers and families who are grieving due to a loss of pregnancy, mother or neonate.

• Always work with the doctor to ensure that a detailed feedback has been given to the referring institution for follow up and provision of appropriate care for the woman and/or neonate at the facility\textsuperscript{16}.

\textbf{Discharge}

• Keep mothers for 48 hours before discharging them.

• Discuss the options for family planning to allow the mother to make an informed decision.

• Explain to the mother on her review/postnatal visits at six days and six weeks.

• Give information on breastfeeding, cord care, nutrition and immunisations including care during postnatal period.

• Discuss danger signs in postnatal period for both mother and baby and advise the importance of going to the facility when any of the danger signs are observed.

• Discuss importance of hygiene for both mother and baby to avoid infection.

• Maintain professional attitude at all times with women in order to create good rapport.

• Verify patient’s records in order to identify the mother, baby, sex of the baby and to prevent swapping.

• Conduct thorough examination of the mother and baby at discharge after 48 hours, at 6 days and 6 weeks to identify any deviation from normal and provide appropriate care. Thank the mother for coming to the health facility and encourage her to come for postnatal and family planning.

\textbf{Referred Clients (Antenatal, Intrapartum, Postpartum and Neonate)}

• The referring midwife, handover client to the receiving midwife, together with complete notes from the referring facility in a dignified and respectful manner in order to gain the client’s confidence and for accountability and continuum of care.

• The referring midwife, wait until the midwife receiving the woman or neonate has done an initial assessment. Both the referring and receiving midwife sign the Maternal/Neonatal Referral Form after the handover.
• Triage all referred women and neonates and act accordingly in order to save life.

• All referred women and neonates should be reviewed immediately by the senior health care provider (doctor, obstetrician, medical licentiate) on duty at each level of care.

• Upon receiving the woman/neonate, inform the obstetrician/neonatologist/pediatrician to examine the patient immediately.

• Provide feedback to referring facility on the patient’s wellbeing even before discharge.

• Provide detailed feedback on the patient to referring facility for continued care and management.

• Link the mother to relevant support groups in the community for continued support and care.

6.2.4 Community

• Train traditional and civic leaders, NHCs and CBVs on RMC. Professional health workers midwives and public health nurses should assume this responsibility.

• Educate community members on reproductive and child health rights in order for women and families to make informed decisions on RMNCAH and childbirth.

• Keeping in mind confidentiality of the client, provide relevant information to NHCs, CHAs and volunteers which include ICCM providers, SMAGs, families, relatives and the community members regarding the welfare of the mother and the baby.

• Emphasize importance of the Birth Preparedness Plan to enhance quality of care for pregnant women and families in facilities and community.

• Educate men on their role in supporting their partners to access reproductive health services to increase uptake of RMNCAH services.

• Educate pregnant women on their right to be with a companion during childbirth.

• Educate SMAGs, Community-Based Distributors (CBDs), traditional leaders and counsellors, CHWs on RMC to ensure that all pregnant and postnatal mothers are linked to a midwife at the facility and support groups in the community.

• Engage change champions on RMC in the community.
• Hold meetings with communities and the champions of RMC such as SMAGs, CBDs, families, CHAs and CBVs to get feedback on RMC activities and address any concerns.

• Ensure close supervision of the SMAGs, CBDs and the varied CHWs who attend to women in the community by NHCs to facilitate institutionalisation of RMC in the communities and families.

• Educate individuals, families, traditional leaders, religious leaders on the effects of gender-based violence (GBV) as a form of D&A against pregnant women who may end up with complications such as miscarriages and premature delivery.

• Sensitise families and community on importance of timely referral to access family planning, ANC, delivery and postnatal care services and use Mothers Shelters at local health facilities so that pregnant women are attended to by skilled birth attendants.

• Ensure that all women are supported by SMAGs during postnatal period to maintain good health outcome of the women and neonates.

• Discuss culturally appropriate maternity care interventions with SMAGs, traditional leaders and NHCs to reduce cultural practices that hinder respectful maternity care.

• Educate the mothers and families on human, women and children’s’ rights to promote understanding and prevent abuse of their rights in health facilities and in the community.

7. Conclusions

Respectful Maternity Care is the conduit to providing dignified care to women during pregnancy, Labour and delivery and postpartum periods. It accords them and their families the opportunity to know their reproductive and women’s’ rights as they relate to health care. It reinforces midwives’ and other health workers’ professionalism as they uphold reproductive and children’s’ rights and enhance the quality of care to reduce maternal and neonatal deaths in the country.
## APPENDIX 1

**LIST OF CONTRIBUTORS TO RESPECTFUL MATERNITY CARE GUIDELINES**

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>Sarah Ngoma</td>
<td>President</td>
<td>MAZ</td>
</tr>
<tr>
<td>3</td>
<td>Rhoda Amafumba</td>
<td>Vice President</td>
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<td>4</td>
<td>Idah Zulu</td>
<td>General Secretary</td>
<td>MAZ</td>
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<td>5</td>
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<td>6</td>
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<td>7</td>
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<td>44.</td>
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REFERENCES


9. Nyirenda HT¹, David Mulenga D¹, Nyirenda T², Choka N³, Agina P⁴, Mubita⁵, Chengo R⁴, Kuria S⁴, and Nyirenda HBC⁵, Status of Respectful Maternal Care in Ndola and Kitwe Districts of Zambia, Clinics in Mother and Child Health, 15:2 DOI:10.4172/2090-7214.1000297.


