Tool for Promoting

Culturally SAFE childbirth

Basic Manual

PAHO

Pan American Health Organization

World Health Organization

Americas

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Introduction

In order to achieve the goal of universal health, the Member States of the Pan American Health Organization (PAHO) have prioritized action to ensure that all people and communities have access, without any discrimination whatsoever, to comprehensive, appropriate, and timely quality health services (*1*).

The Region of the Americas is multiethnic and multicultural in nature, inhabited by indigenous peoples and other ethnic groups. In the field of health, this means acknowledging their different realities and needs. Indigenous populations and other ethnic minorities often face multiple forms of discrimination and exclusion, which are reflected in high levels of multidimensional poverty and a range of inequalities compared to other groups. Indigenous women in particular often face at least dual discrimination: for being women and for being indigenous.

Different standards are in place to protect indigenous peoples' rights, including: 1) the right to access and use their traditional medicines and maintain their health practices; 2) the right to the elimination of all forms of discrimination and to guaranteed access to health; and 3) the right to receive medical care without distinction of origin or ethnicity. In this regard, PAHO's Policy on Ethnicity and Health (2) focuses on adopting the measures necessary to guarantee an intercultural approach to health care access and health services, while taking into account the social determinants of health from the standpoint of equality and mutual respect between different cultures and health-related sectors, as well as the cultural practices, lifestyles, social organization, value systems, traditions, and worldviews of the Region's ethnic groups.

The intercultural approach promotes equality among different cultures; considers health a basic right, and assumes an implicit ability of health professionals to integrate their own knowledge with traditional beliefs and practices, not only in regard to the treatment of disease, but health promotion and end-of-life care (2). Thus, the Policy on Ethnicity and Health proposes the following five priority lines of action: 1) production of evidence; 2) promotion of policy action; 3) social participation and strategic partnerships; 4) recognition of ancestral knowledge and traditional and complementary medicine; and 5) capacity development at all levels.

Promoting an intercultural approach in the health services can contribute, among other things, to the elimination of access barriers to health services and improved health outcomes for indigenous peoples, Afro-descendants, Roma, and the members of other ethnic groups, considering, as appropriate, the national contexts, priorities, and norms specific to these populations (*2*).

The 2019 report of the High-level Commission, entitled Universal Health in the 21st Century: 40 Years of Alma-Ata (*3*), underscores the need to develop people- and community-centered models of care based on primary health care, taking into account human diversity, interculturalism, and ethnicity.

Recognizing the different realities of women (including their values and cultural traditions) is a good starting point for promoting joint efforts among relevant actors to develop health policies that are inclusive, geared to user satisfaction, and based on appropriate and compassionate quality care. Only then can maternal health outcomes, particularly those associated with maternal mortality, be improved without any discrimination. It is therefore necessary for health workers who care for indigenous women during the reproductive process to be able to address their different situations and specific health problems (associated in part with cultural differences) and provide timely, adequate responses. This will help reduce the inequalities in women's health care, promote an intercultural approach to models of childbirth care, increase culturally safe childbirth care in health facilities, promote strategies that support women's decision-making, and increase access to health services.

In line with all this, PAHO has developed an Excel tool for the promotion of culturally safe childbirth, which is available for download along with this manual at: https://doi.org/10.37774/9789275325698

This tool is based on respect and knowledge sharing (through knowledge dialogues) (4); is built mainly on consensus around good maternal and neonatal practices, as well as quality of care criteria for health service delivery; and uses PAHO's modular tool for assessing essential conditions as one of its main inputs (5). Its purpose is to determine whether maternal health services have adopted an intercultural approach to care in pregnancy, childbirth, and the postpartum period for indigenous women; however, it can be tailored to Afro-descendant women or women of any other ethnicity and used in the different settings where they receive care during pregnancy, labor, delivery, and the postpartum period.

The tool was validated through technical missions conducted in different settings in different countries of the Region: Argentina, Bolivia (Plurinational State of), Colombia, Ecuador, Guatemala, Honduras, Paraguay, and Peru. Since it presents different dimensions of culturally appropriate humanized childbirth, it can be validated and adapted from the cultural standpoint for other indigenous, Afro-descendant, or other populations.

Any health institution, with support from indigenous organizations (or the ethnic group involved), can use the tool. However, it should be clear that it does not evaluate either the functions or the performance of health workers in a particular health facility.

1

Objectives of the tool

1.1. General objective

The general objective is to improve the quality of care in maternal and perinatal health services by introducing an intercultural approach in reproductive care[1] (with emphasis on delivery and the postpartum period).

1.2. Specific objectives

1. Promote women's empowerment, autonomy, and decision-making on any issue related to their sexual and reproductive health (with an emphasis on childbirth care).
2. Determine the degree of participation by the community and other relevant actors in the cultural adaptation of the childbirth care provided by health facilities.
3. Identify health workers' skills and competencies in the delivery of culturally appropriate childbirth care.
4. Determine the state of the health service infrastructure for cultural adaptation of childbirth care and the postpartum period.
5. Learn about communication and the treatment of indigenous pregnant women in health services.

[1] From pregnancy to the postpartum period, including delivery.

2

Design and use of the tool

2.1. Structure and components

This easy-to-use tool evaluates three types of perceptions of childbirth care: 1) perception of health service providers (health workers); 2) perception of indigenous women; and 3) perception of outside observers (see figure on the next page).

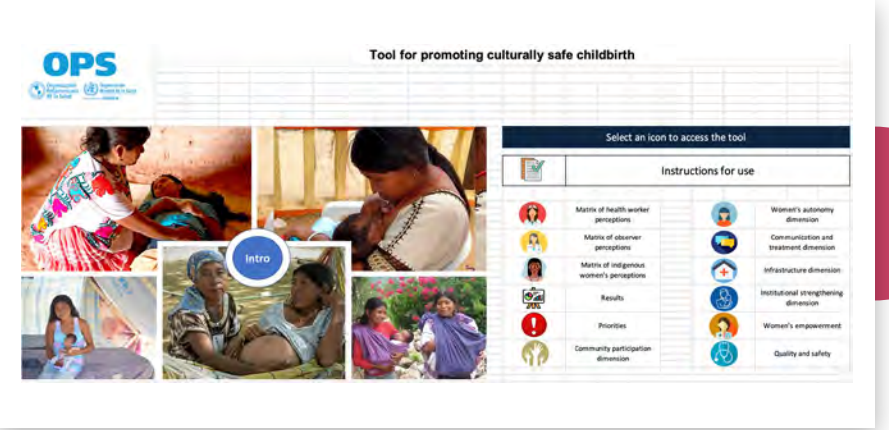
For each one, a specific matrix is used, assessing five dimensions:

1. Autonomy of indigenous women.
2. Communication and treatment.
3. Community participation.
4. Health service infrastructure (including culturally appropriate maternity homes).[2]
5. Institutional strengthening.

Each dimension is composed of a specific number of good practices and indicators (standard quality conditions) that are rated as perceived by the health worker, indigenous woman, or outside observer, to determine the extent to which they are applied.

[2] Maternity homes for pregnant women at high risk are low-complexity facilities where these women are monitored by qualified personnel prior to their due date, and where they are guaranteed specialized prenatal care, as well as speedy transfer to a hospital or facility at another level of complexity, as appropriate, when they go into labor.

Figure 1. **Introduction worksheet of the Tool for Promoting Culturally Safe Childbirth**



2.2. Using the tool: techniques and other general considerations

This tool can be administered through direct interview, observation, or self-application.

1. Direct interviews

a. The interviewer uses the tool (each of its matrices) individually with each respondent (health workers, indigenous women, or members of other ethnic groups).

b. The interview can be conducted at a first-level health facility or hospital; however, priority will be given to facilities where prenatal, delivery, and postpartum care is provided with an intercultural approach.

2. Observation

Observers answer the questions based on their own observations. This modality requires them to receive specialized training in advance so that they can record all the information and data necessary to complete the tool matrices.

3. Self-administration

Health workers complete the respective matrices without the intermediation of an external interviewer.

The basic requirements for administering the tool are:

- Selection of the health facility and identification of the locations where the health workers and indigenous women will be interviewed.
- Staff training for acquisition of the skills and knowledge necessary to complete the matrices.
- Availability of a camera with good resolution (a requirement for the outside observer).
- Participation of authorities from the health facility and indigenous communities or organizations (or from the ethnic group involved).
- Preparation of a report on the administration of the tool, and development of a plan that includes the priority aspects that could be improved (identified through the use of the tool).

2.3. Periodicity

It is recommended that the tool be administered once a year. Records should be kept of each use so that progress can be monitored from a base year onward.

Every year, the tool should be administered to at least 10 users (indigenous women) and 10 health workers in each health facility.

2.4. Description of each dimension and its practices and indicators

Each dimension covers particular aspects, practices, and indicators described below.

Dimension 1: Autonomy of indigenous women

- This refers to the power of indigenous women to freely decide about the care they receive in pregnancy, childbirth, and the puerperium. It consists of **17 practices and indicators** and addresses various aspects, including: accompaniment, choice of the health care provider, manner of dressing, food and beverages the woman wishes to consume, choice of position in which to give birth, use of medicinal plants, what to do with the placenta, management of the umbilical cord, possession of symbolic articles, route of delivery, pregnant woman's choice of how to bathe, counseling on contraceptive methods, and discharge with a modern contraceptive method.

Dimension 2: Communication and treatment

- Consisting of **eight practices and indicators**, this dimension reveals how the health services communicate with and treat indigenous pregnant women. It investigates whether: the patient is addressed by name; health workers introduce themselves to the patient by name; mechanisms are in place to interact with the population in the local language, including educational materials; the facility has culturally appropriate signage; culturally appropriate information is provided on warning signs, diagnostics, treatments, etc.; informed consent is obtained before any procedure is performed; confidentiality is guaranteed, and respect is shown for local social norms, ideas, and beliefs about care, reproduction, health, eating, and childbirth.

Dimension 3: Community engagement

- This dimension, comprised of **three practices and indicators**, focuses on learning about community participation in the promotion of culturally safe childbirth for indigenous women. It covers the following aspects: ensuring a continuous knowledge dialogue with the local population to discover women's needs; joint involvement of governments and the local population in the introduction of gradual, consensus-based changes that could affect services that provide culturally appropriate childbirth care; and reaching agreement with the community on the hours services are open for the care of all women.

Dimension 4: Health service infrastructure (including culturally appropriate maternity homes)

- This dimension is aimed at evaluating and disclosing the state of the local health service infrastructure. It consists of **three practices and indicators**, all of them related to the physical environment of the health service that serves indigenous pregnant women. It covers aspects such as: the existence of physical spaces that protect privacy, the availability of culturally appropriate maternity shelters or maternity homes, and access to culturally appropriate bathrooms.

Dimension 5: Institutional strengthening

- This dimension, comprised of **12 practices and indicators**, seeks to determine the policy and regulatory framework of health facilities (including small physician's offices) where care is provided to pregnant women. It considers the following aspects: the existence of an appropriate policy framework; standards and guidelines for safe childbirth care and obstetric emergencies (such as code red for hemorrhaging during labor); the critical path; the availability of blood and other supplies;[3] training for health workers; certification processes related to intercultural relevance; education and training strategies in the services on safe childbirth; the existence of manuals, standards, indicators, and instruments for measuring and periodically monitoring the implementation of culturally appropriate safe childbirth; a culturally appropriate community outpatient care program for indigenous women and their families; use of a systematic methodology that introduces culturally appropriate improvements in the quality of childbirth care; an administrative catalogue of the inputs and human resources necessary for applying the intercultural approach, and the promotion of spaces for knowledge dialogue.

[3] See: Vélez-Álvarez GA, Agudelo-Jaramillo B, Gómez-Dávila JG, Zuleta-Tobón JJ. Código rojo: guía para el manejo de la hemorragia obstétrica. Revista Colombiana de Obstetricia y Ginecología 2009;60(1):34–48. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0034-74342009000100006

Taken together, the good practices and indicators in each dimension are structured according to the perceptions of health service providers, indigenous women, and outside observers. That is, the tool includes a total of 43 good practices and indicators that serve as evaluation criteria and are assessed based on the type of perception: 40 good practices and indicators are assessed based on the perceptions of health workers; 30, on the perceptions of indigenous women; and 43, on the perceptions of outside observers (Table 1).

Table 1. Number of practices and indicators, by dimension and evaluator's perception

Dimension	Number of indicators	Health workers	Indigenous women	Outside observers
1. Autonomy of indigenous women	17	17	17	17
2. Communication and treatment	8	5	8	8
3. Community participation	3	3	2	3
4. Health service infrastructure	3	3	3	3
5. Institutional strengthening	12	12	0	12
Total	**43**	**40**	**30**	**43**

2.5. Assessment of practices and indicators and their respective dimensions

The rating for a given practice or indicator depends on the critical evaluation at the time it is made. The evaluation should identify opportunities for improvement and sensitive factors that could become health service access barriers for pregnant women.

As stated, each practice or indicator (in each of the five dimensions) is rated on a numerical scale of 1 to 5.

Each value on the scale is associated with the extent to which a practice or indicator is applied, using it as a quality standard. The general scale is descriptive and is customized for the dimension in question (Table 2).

Table 2. **Scale for assessing practices and indicators and their application level in terms of quality standards, by dimension**

	APPLICATION OF THE STANDARD				
	LOW		MEDIUM		HIGH
DIMENSIONS	1	2	3	4	5
General	**Does not meet the conditions or include the elements of the standard.**	**Meets some of the conditions and includes some of the elements of the standard. Only some application is observed in certain areas and services.**	**Includes several elements and meets several conditions of the standard. Its application is observed in several areas and services.**	**Includes most of the elements and meets most of the conditions of the standard. Its application is observed in the majority of areas and services.**	**Meets all the conditions and includes all the elements of the standard. Exceeds the evaluation's expectations. Is observed in all services and areas. Is a sustainable undertaking.**
Autonomy of Indigenous women	Does not meet the conditions of the standard; the levels of care provided in the physical environment and infrastructure are very low.	Includes some elements of the standard; their application is observed in some services, areas, or facilities. The findings are not consistent.	Includes several elements of the standard, and this can be observed in several areas or services. Adequate conditions are observed as a result of institutional management.	Includes the vast majority of the elements of the standard, and their application is observed in the majority of areas and services. Favorable trends in conditions are observed.	Includes all elements of the standard and exceeds expectations. The conditions are observed in all institutional services and areas.
Communication and treatment	Does not meet the conditions of the standard; staffing or the provision of resources in the different areas and services is not guaranteed.	Includes some elements of the standard; staffing conditions and resources are limited, making it hard to provide the service.	Includes several elements of the standard, and this can be observed in several areas or services. Staffing and the provision of resources are guaranteed most of the time.	Includes most elements of the standard, and its application is observed in the majority of areas and services. Favorable trends in conditions are observed.	Includes all elements of the standard and exceeds expectations. The conditions are observed in all institutional services and areas.

(continues) ↓

	APPLICATION OF THE STANDARD				
	LOW		MEDIUM		HIGH
DIMENSIONS	1	2	3	4	5
Community participation	Does not meet the conditions of the standard; the conditions for human resources are not guaranteed.	Includes some elements of the standard, but marked deficiencies in human resources are observed.	Includes several elements of the standard, and this can be observed in several areas and services. The presence of sufficient human resources is observed.	Includes most elements of the standard, and its application is observed in most areas and services. Favorable trends in conditions are observed.	Includes all elements of the standard and exceeds expectations. The conditions are observed in all institutional services and areas.
Health service infrastructure	Does not meet the conditions of the standard; the condition of clinical histories and medical records is not guaranteed. There is no evidence of process-based organizational development.	Includes some elements of the standard; process conditions are observed in some services.	Includes several elements and meets several conditions of the standard. Process-based development and consistency in the condition of medical records and clinical histories are observed.	Includes most elements and meets most conditions of the standard. Its application is observed in the majority of areas and services. Process-based development is mature and consistent. The information system is mature and consistent.	Includes all the elements and exceeds expectations. The conditions are observed in all institutional services and areas.
Institutional strengthening	Does not include any element or meet any condition.	Includes several elements or meets several conditions of the standard. Its application is observed in some areas and services. No sustainable progress is observed in terms of quality.	Includes several elements and meets several conditions of the standard. Its application and development are observed in several areas and services. The application and results of a quality improvement program are observed.	Includes most elements and meets most conditions of the standard. Sustainable progress in quality is observed. The conditions for the focus, implementation and dissemination of processes are observed.	Includes all elements and meets all conditions of the standard. The conditions for the focus, implementation, dissemination, outcome measurement, outcome improvement, and comparison with best practices are observed.

The tool also has a rating scale with equivalencies based on the different possible responses when a practice or indicator is evaluated in each dimension (Table 3).

Table 3. Rating scale of 1 to 5 and equivalencies based on the possible responses

1	2	3	4	5
Never	Sometimes	Normally	Nearly always	Always
Nowhere	In some places	In many places	In the vast majority of places	Everywhere
Very low	Low	Medium	High	Very high
Very little/not at all	Inadequate	Acceptable	Meets expectations	Meets and exceeds expectations

Aggregate ratings of practices and indicators yield numerical results corresponding to a four-color (traffic light) rating system: red indicates less than 40% application of the standard; orange, 40%–60%; yellow, 60%–80%; and green, more than 80%.

2.6. Results

The tool is not intended to make value judgments or determine whether something is good or bad, but rather to identify the extent to which good practices are applied and standard conditions met in the dimensions considered fundamental for ensuring the adaptation of care to provide safe childbirth for indigenous women and helping to identify strengths and opportunities for improvement. This tool makes it possible to obtain results through different types of analysis:

1. General analysis of the health facility.
2. Analysis based on a comparison of the perceptions of health workers, outside observers, and indigenous women.
3. Analysis of priorities, which will be used for the preparation of the basic improvement plan.[4]
4. Analysis of each dimension.
5. Analysis of practices and indicators.
6. Analysis of women's empowerment, evaluating the extent to which the health service respects and values the principles and beliefs held by women concerning ancestral medicine. This is a mechanism for strengthening empowerment and timely decision-making.
7. Analysis of quality criteria in three categories: quality and patient safety, management and leadership, and infrastructure/physical environment.

Analysis of the results for points 6 and 7, above, can be obtained from prior assessment of a series of selected practices and indicators (from the five matrices or main dimensions of the tool); that is, a purposeful set of pre-evaluated indicators and practices.

[4] Priorities are the practices and indicators assessed at having a low level of application (red, according to the tool's traffic light system) once the three levels of perception have been considered. See the "Priorities" tab in the tool's Excel file.

References

References

1. Pan American Health Organization. Strategy and Plan of Action on Ethnicity and Health 2019-2025. 57th Directing Council; 2019 September 30-October 4 [Internet]. Washington, D.C.: PAHO; 2019 [cited 2021 October 20]. 32 p.
Available from: https://iris.paho.org/bitstream/handle/10665.2/51744/PAHOEGC19002_eng.pdf?sequence=1&isAllowed=y

2. Pan American Health Organization. Policy on Ethnicity and Health. 160th Session of the Executive Committee; 2017 June 26-30 [Internet]. Washington, D.C.: PAHO; 2017 [cited 2021 October 20]. 27 p.
Available from: https://iris.paho.org/bitstream/handle/10665.2/34242/CE160-r11-e.pdf?sequence=1&isAllowed=y

3. Pan American Health Organization. Universal Health in the 21st Century: 40 Years of Alma-Ata. Report of the High-Level Commission [Internet]. Washington, D.C.: PAHO; 2019 [cited 2021 April 30]. 126 p.
Available from: https://www.paho.org/en/documents/universal-health-21st-century-40-years-alma-ata-report-high-level-commission-revised

4. Pan American Health Organization. The Knowledge Dialogues Methodology [Internet]. Washington, D.C.: PAHO; 2021.
Available from: https://iris.paho.org/handle/10665.2/55863

5. Pan American Health Organization. Essential condition assessment. Modular tool. [Internet]. Washington, D.C.: PAHO; 2020 [cited 2021 April 30]. 15 p.
Available from: https://hsvce.paho.org/users/sign_in

This tool for promoting culturally safe childbirth is grounded in respect and knowledge sharing. It was developed through a consensus on good maternal and neonatal practices, and on criteria for quality childbirth care in health services. Its main purpose is to determine whether an intercultural approach to pregnancy, childbirth, and postpartum care is being integrated into maternal health services for women of different ethnicities.

The tool focuses on indigenous women but can be tailored to Afro-descendant women or women from other ethnic groups. It also targets three different groups –health service providers, indigenous women, and outside observers– to evaluate their different perceptions of care.

The purpose of the tool is not to make value judgments but to determine the extent to which good practices and standard conditions are applied in the dimensions essential to guaranteeing safe childbirth for indigenous women, and to identify strengths and opportunities for improvement.

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