To the Editors:

Thank you for the opportunity to respond to the feedback of the reviewer. Here we address the points raised by the reviewer regarding the manuscript’s framing, introduction, program descriptions and figures.

Framing

1) There is a strong, growing voice in maternal health making clear the fact that promotion of facility-based birth without ensuring good quality of care is futile or even harmful in some
cases where the facility-based care is very bad. This conversation overlaps with but is broader than the movement towards addressing D&A. The authors' work is framed as helping to facilitate facility births, which is fine, but it's also geared at improving quality, which is worth engaging with more explicitly. It may seem obvious, but it seems important to frame the work clearly within the realm of the move towards a focus on quality in maternal healthcare (with addressing D&A being a part of quality improvement).

We very much agree with this reviewer’s comments. In fact, we struggled while drafting the manuscript with how much of the overall quality improvement aspect to include, as this is a response to another article’s call for models for respectful maternity care. We have explicitly addressed how respectful maternity care and quality are intertwined in a new two-paragraph section entitled “Uniting Respectful Maternity Care and Quality of Care” (lines 306-336).

2) The piece is framed in the title and introduction primarily as an intervention to reduce D&A, however in reality the program is a lot more than that (addresses financial and transport barriers too, for example, and has a hypothesized impact on provider burnout/job satisfaction); further, primary goal of the program is (I think) to increase referrals and receipt of hospital-based care for obstetric emergencies. The piece (including perhaps even the title?) could use minor reframing to make this broader focus on improvement of multiple aspects of patient/provider experience, and the primary goal of facilitating referrals for emergency obstetric care, clear from the beginning.

As described above, we have included minor reframing of the introduction and a new section before the conclusion that touches on some of the other benefits provided by the care navigator model. We have also revised the title of the manuscript to reflect the inclusions of these larger themes (adding “and overcome barriers to safe motherhood”).

3) While the potential contribution of obstetric care navigation to reduction in maternal mortality is certainly of utmost importance, I urge the authors to also frame the importance of their work in terms of human rights as respectful care is important in and of itself.

We have made the linkage between disrespectful and abusive maternity care and human rights more explicit in the revised Introduction (lines 78-82) and formally cited the United Nations definition of human rights to bolster this link (reference 9).
Introduction

4) Lines 72-73: in my opinion, the authors can use stronger language than "emerging evidence" to make the point that there is an impact of dissatisfaction with care on care seeking behavior (they are bolstered by a review of many studies, which to me is more than emerging evidence).

The revised manuscript corrects this misclassification of the strength of the data supporting the negative impact of disrespectful and abuse care’s impact on mother’s willingness to accept facility-based delivery.

Program Description

5) Justification of the decision to incentivize care navigators by tying payment to number of referrals is justified as readers may have concerns with the potential (unintended) negative impacts of pay for performance

The primary motivation to integrate pay-for-performance into the care navigator program was to ensure that donor funds intended to benefit mothers and their families were responsibly and efficiently used. In addition, it facilitates adjusting referral volume to budget capacity. We have attempted to clarify this in the revised manuscript and tie it in to other revisions that tie disrespectful care to quality improvement.

6) The claim that the approach "empowers communities to generate their own solutions to disrespectful obstetric care" is unclear - in what way were community members involved in designing the care navigation program? If this is going to remain in the abstract and body of the commentary, clarification of this statement and how the community was involved in designing the program is needed.

Traditional midwives are important members of the communities served by the project. Yet they are often left out of government efforts to reduce maternal mortality. The group of 45 collaborating midwives voted 2 representatives to participate in project planning and ongoing quality improvement efforts, including biweekly in person team meetings. Similarly, care navigators are themselves drawn from the Maya communities served by the program and represent this perspective during biweekly team meetings. These points have been added to the Program Description (lines 222-224).
Figures

6) Figure 1 - perhaps improving intention to return to hospital for future births is another intended outcome of the project?

This goal is indeed included in this project and has been included in the revised version of Figure 1.

7) Figure 2 is unclear and needs work- the title conveys that it is displaying provider and patient perspectives, but it was difficult for me to discern how the figure does this. What does "provider rationalization" mean? This figure needs to be redesigned to make the point more clearly, perhaps in table format? The arrows and columns as it is are confusing.

We have taken the reviewer’s recommendation and presented with information in Figure 2 in table format. In addition, we removed the “provider rationalization” and favor of “Propagating Factors” which are meant to identify the “systems-level drivers of this [disrespectful and abusive] care” as is now explained in the figure label.

8) The types of abuse in Figure 2 should ideally match published typologies of D&A in maternity care and this should be explicitly stated (in text or figure footnote); if none of existing typologies suit the needs for this Figure, it should alternatively be made clear how the types of abuse were identified for this purpose

The source from which the eight types of disrespectful and abusive care were derived is now explicitly cited as the categorization used in the field’s preeminent systematic review.