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Promoting Respectful Maternity Care: A training guide for facility-based workshops—Participant's guide

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PARTICIPANT'S GUIDE

PROMOTING RESPECTFUL MATERNITY CARE

A TRAINING GUIDE FOR FACILITY-BASED WORKSHOPS

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Note: This publication is part of the “Promoting Respectful Maternity Care” Resource Package. This document is intended to support facilitators in leading RMC workshops at the facility level.

The Resource Package includes the following:

- ✓ Facilitator's guide (Facility-based workshops)
- ✓ Participant's manual

- ✓ Facilitator's guide (Community-based workshops)
- ✓ Community flipchart

- ✓ Tools
- ✓ Program briefs

For more information or clarification on any of the above materials, please contact the Population Council at publications@popcouncil.org.

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Abbreviations and acronyms

AAAQ	Available, Accessible, Acceptable and of Good Quality
ADR	Alternative Dispute Resolution
ANC	Antenatal Care
CHEWs	Community Health Extension Workers
CHWS	Community Health Workers
CPD	Continuous Professional Development
CQI	Continuous Quality Improvement
D&A	Disrespect and Abuse
FIDA	Kenya Federation of Women Lawyers
FIGO:	The International Federation of Gynecology and Obstetrics
HFMC/B	Health Facility Management Committees or Boards
HMIS	Health Management Information System
IDI	In Depth Interview
ICM	International Confederation of Midwives
ICN	International Council of Nurses
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
NNAK	National Nurses Association of Kenya
PNC	Postnatal care
PPT	PowerPoint
RMC	Respectful Maternity Care
SBA	Skilled Birth Attendance
SRH	Sexual and Reproductive Health
TOTs	Trainers of Trainers
TRAction	Translating Research into Action
USAID	United States Agency for International Development
VCAT	Values Clarification and Attitude Transformation
VE	Vaginal Examination
WRA	White Ribbon Alliance

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Introduction

Pregnancy, childbirth, and their consequences are still the leading causes of death, disease, and disability among women of reproductive age in developing countries. Nearly 275,000 maternal deaths due to treatable conditions during pregnancy and childbirth occurred globally in 2011. Almost all of these took place in developing countries.¹ Maternal mortality is highest in sub-Saharan Africa, where the maternal mortality ratio (MMR) is 100 times greater than in developed regions. A key strategy to address high maternal and newborn morbidity and mortality is to increase the proportion of births attended by skilled birth attendants (SBAs), a target of the maternal health Millennium Development Goal (MDG 5).

Progress toward achieving MDG 5 has been slow because improvements require overcoming financial and geographical barriers to accessing skilled care, as well as the poor quality of care in maternity units. A little understood component of the poor quality of care experienced by women during facility-based childbirth is the disrespectful and abusive (D&A) behavior of health care providers and other facility staff. Acknowledgment of these behaviors by policymakers, program staff, civil society groups, and community members indicates the problem is widespread.

In a landscape analysis conducted in 2010, these behaviors were categorized into seven manifestations:

- Physical abuse
- Non-consented care
- Non-confidential care
- Non-dignified care
- Discrimination
- Abandonment of care
- Detention in facilities²

Numerous factors contribute to this experience, which are grouped into:

- Individual and community-level factors
- Normalizing D&A
- Lack of legal and ethical foundations to address D&A
- Lack of leadership in this area
- Lack of standards and accountability
- Provider prejudice due to lack of training and resources

Respectful maternity care (RMC)

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. Because disrespectful and abusive behaviors and environments degrade the quality of maternity care, identifying and addressing D&A is an important component of cultivating RMC in health facilities. The Resource Package is designed to support health facility managers, health care providers, and communities to confront disrespect and abuse during facility-based childbirth and to promote respectful maternity care.

¹ Lozano R, Wang H, Foreman KJ, et al. 2011. "Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: An updated systematic analysis." *Lancet* 378: 1139-1165.

² Bowser L. and Hill K. 2010. "Exploring evidence for disrespect and abuse in facility-based childbirth: Report of a landscape analysis." Washington, DC: USAID.

Why focus on preventing disrespect and abuse during childbirth?

The baseline survey in Kenya revealed several facts that emphasize that disrespect and abuse is a pressing problem in Kenyan facilities, including:

- One out of five postpartum women leaving the postnatal ward reported feeling humiliated at some point during their most recent delivery in one of the 13 participating health facilities
- Nine out of ten health care providers said they had heard of or witnessed colleagues treating women inhumanely
- The majority of facilities do have most of the essential equipment and supplies needed to support women in childbirth
- The poorest women were not physically abused or asked for a bribe, but they were more likely to be abandoned
- Women under 19 years of age were more likely to experience non-confidential care compared to those between 20 and 29 years of age
- Women of higher parity (with one to three children) were more likely to be detained for nonpayment or bribes compared to those who had just given birth to their first child
- Married clients were less likely to be detained for nonpayment or bribes, but more likely to be neglected
- Clients with support from a partner or companion during delivery were less likely to experience inappropriate demands or detention for nonpayment

These facts all reveal an unacceptably high degree of D&A occurring in a variety of ways in Kenyan facilities.

About this training

This training includes activities and materials that advance a specific agenda: to promote increased support, advocacy, and provision of high-quality, woman-centered maternity care. These changes are not likely to occur immediately after one workshop; they may be incremental. It takes a hands-on approach to empower service providers, communities, and policymakers with the knowledge and skills to tackle disrespect and abuse during childbirth.

OVERALL WORKSHOP OBJECTIVES

By the end of the workshop, the participants will be able to:

- Outline the current status of maternal and neonatal health in relation to respectful care
- Discuss key RMC concepts, terminology, legal and rights-based approaches related to respectful maternity care and the RMC Resource Package
- Demonstrate knowledge and use of VCAT theory and practice
- Discuss selected evidence-based strategies that reduce disrespect and abuse
- Discuss the participants' role in promoting RMC
- Develop action plans to support the implementation of RMC interventions at various levels of health (e.g., policy, program, regional/county, subcounty, facility, and community levels)

SESSION 1

Icebreaker and introduction to the workshop

Learning objectives

Participants will articulate their hopes and concerns about the workshop and about the topic of disrespect and abuse.

Participants will write:

- My expectation for this workshop is ...
- During the workshop, I hope that I will be able to...
- By the end of this workshop, I hope that I ...

Required learning

By the end of this session the participants will:

- Have been introduced to each other
- Be able to articulate their hopes and concerns about the workshop

SESSION 2

Overview of maternal health and disrespect and abuse during facility-based childbirth

The goal of this session is to provide participants with an overview of concepts related to maternal health and the causes, consequences, and characteristics of maternal mortality and morbidity.

Learning objectives

Participants will:

1. Outline the current status of maternal and newborn health globally, regionally, and locally.
2. Discuss factors contributing to maternity mortality and morbidity.
3. Explain the meaning of “respectful,” “dignified,” “disrespect,” and “abuse.”
4. Discuss factors leading to disrespect and abuse.
5. Discuss the categories and evidence for D&A during facility-based childbirth in relation to maternal health care.

Required learning

By the end of this session participants will have learned about the concept of respectful maternity care, current global and context-specific maternal health status. They will also have learned about the determinants of skilled birth attendants and contributing factors to maternal morbidity and mortality.

Overview of maternal health

Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. While motherhood is often a positive, fulfilling experience, far too many women associate it with suffering, ill health, and even death.³

Major, direct causes of maternal morbidity and mortality

The major causes of maternal morbidity and mortality include hemorrhage, infection/sepsis, pre-eclampsia /eclampsia, unsafe abortion, and obstructed labor/ruptured uterus.⁴

Some 215 million women who would prefer to delay or avoid pregnancy lack access to safe and effective contraception. It is estimated that satisfying the unmet need for family planning alone could cut the number of maternal deaths by almost a third. Up to 287,000 women die globally each year during pregnancy and childbirth. Most die from not having access to skilled, routine,

³ WHO, UNICEF, UNFPA, and The World Bank. (2012) Trends in maternal mortality: 1990 to 2010. Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland

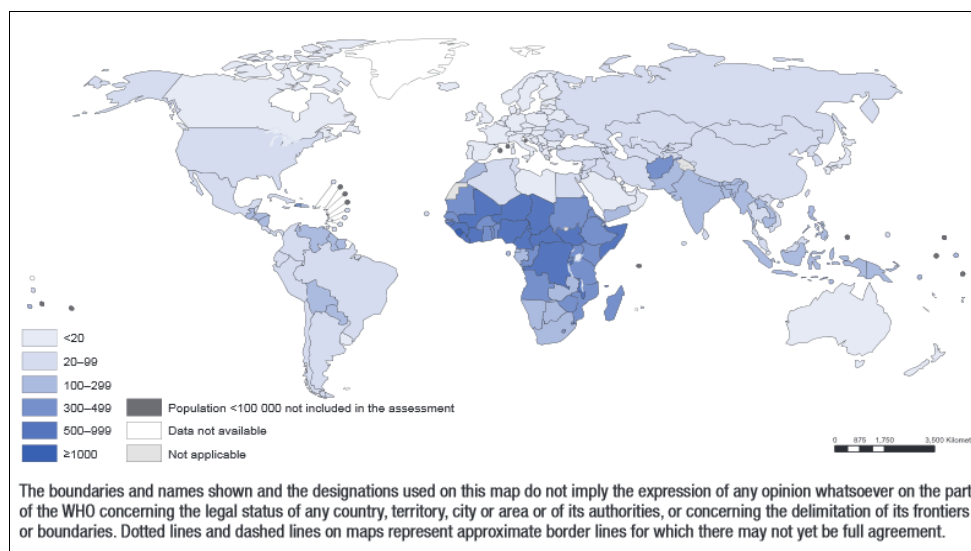
⁴ Say Lale, Doris Chou, Alison Gemill, et al 2014. Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health*, Volume 2 Issue 6.

and emergency obstetric care. Since 1990, however, some countries in Asia and Northern Africa have reduced maternal mortality.⁵

The maternal mortality ratio in developing countries is 240 per 100,000 live births versus 16 per 100,000 live births in developed countries. A few countries have extremely high maternal mortality ratios with 1000 or more deaths per 100 000 live births. There are large disparities between and within countries, between people with high and low income, and between people living in rural and urban areas.⁶

About 800 women die from preventable pregnancy- or childbirth-related complications around the world every day. Almost all maternal deaths (99%) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa (SSA) and approximately one-third occur in South Asia.⁷ Figure 1 below shows where maternal mortality is high. It is clear that maternal mortality rates are unacceptably high in Africa.

Figure 1: Map with countries by category according to their maternal mortality ratio (MMR, death per 100,000 live births), 2013⁸



Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. All women need access to quality antenatal care, skilled care during childbirth, care and support in the weeks after childbirth, and access to fully functioning emergency obstetric care. It is critical that all births be attended by skilled health professionals who provide competent life-saving interventions. Interventions need to focus on improving quality of care during facility-based childbirth.

⁵ WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division. 2014. *Trends in Maternal Mortality: 1990 to 2013 estimates by WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division.*

⁶ Ibid.

⁷ Ibid.

⁸ WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division 2014 op. cit.

Financial and nonfinancial barriers to accessing or receiving quality maternal health care

Financial barriers

- Inadequate provision of the absolute minimum of obstetric care
- Poor facility infrastructure, e.g., water, electricity, equipment, drugs and supplies
- Cost of services
- Poor access to facilities due to weak road network and other communication network
- Lack of available emergency transportation

Nonfinancial barriers

- Perceived or real negative provider attitudes
- Poor quality of care reported in facilities during childbirth, including disrespectful and abusive treatment by health providers and facility staff
- Low levels of provider competency and skills, and lack of supportive supervision
- Cultural beliefs, stigma, and the perception of both clients and providers on various health conditions and services
- Gender and the decision-making process
- Lack of awareness and recognition of signs and symptoms of obstetric danger
- Lack of awareness of availability of services

Context: Disrespect and abuse (D&A) globally and regionally

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.⁹

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 during childbirth.

⁹ Respectful Maternity Care Advisory Council, White Ribbon Alliance for Safe Motherhood. (2011). *Respectful maternity care: the universal rights of childbearing women*. Washington, DC: WRA. Retrieved [18th March 2013].

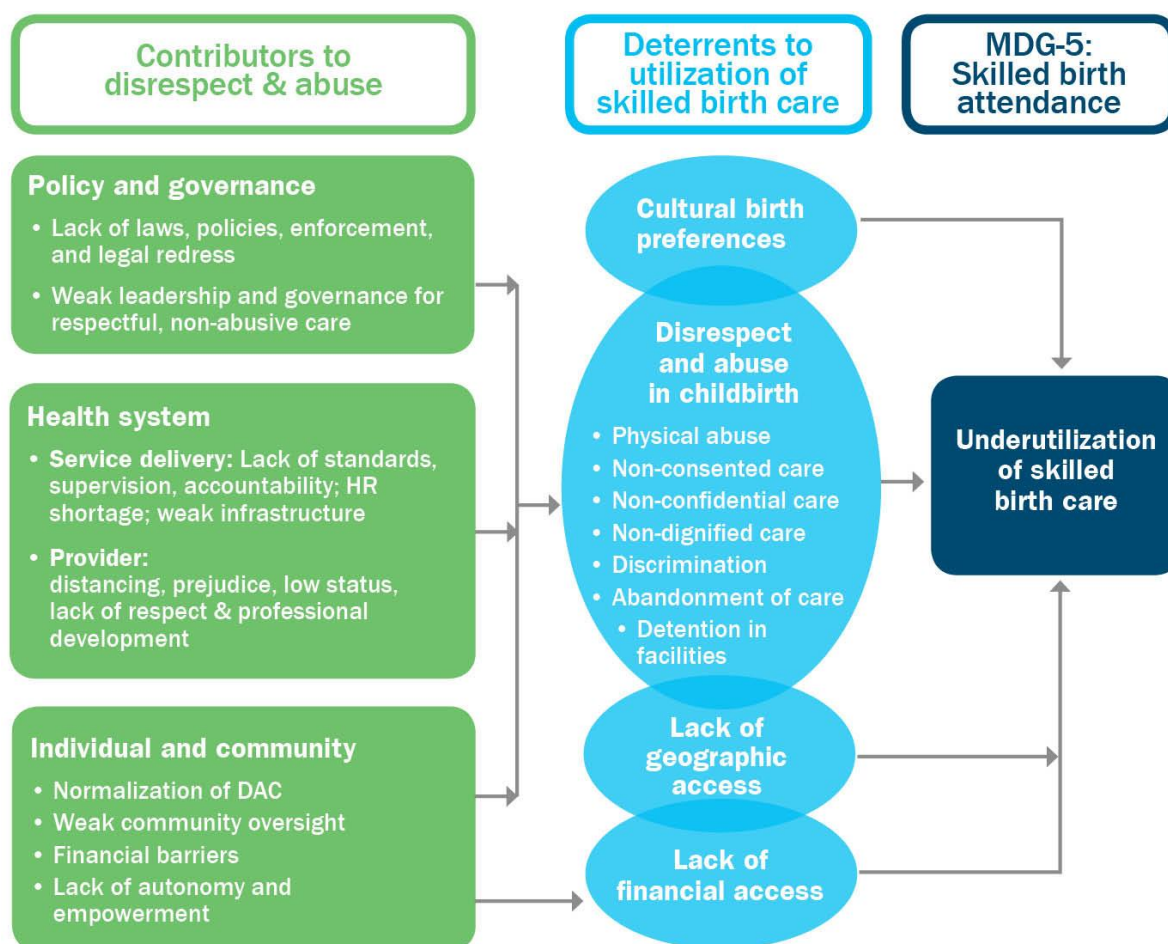
Definitions of terms

1. “Dignified” is an adjective from the word dignity; it means being tasteful in appearance or behavior or style, especially formality or stateliness in bearing or appearance.
2. “Respect” can be a specific feeling of regard for the actual qualities of the one respected (e.g., “I have great respect for her judgment”).
3. “Undignified” is lacking dignity or value for someone.
4. “Disrespect” is rude conduct and usually considered to indicate a lack of respect.

Disrespect and abuse in childbirth

Based on a comprehensive review of research conducted by Bowser and Hill in 2010,¹⁰ seven categories of disrespect and abuse in childbirth have been identified, and exist in medical facilities around the world. Manifestations of disrespect and abuse often fall into more than one category, so the categories are not intended to be mutually exclusive, rather they should be seen to overlap one another along a continuum.

Figure 2: Landscape analysis of disrespect and abuse (Bowser and Hill 2010).



¹⁰ Bowser, D., and K. Hill. 2010. Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth: Report of a Landscape Analysis. Bethesda, MD: USAID-TRAction Project, University Research Corporation, LLC, and Harvard School of Public Health.

Disrespect and abuse as barriers to receiving quality maternal health care

In addition to geographic, financial, and cultural barriers to quality maternal health care, the disrespect and abuse that women sometimes experience at health facilities is an additional barrier to their seeking care. Seven categories of disrespect and abuse have been identified: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities or demand for payment.¹¹

A study conducted in Kenya¹² to determine the prevalence of disrespect and abuse during childbirth showed that one in five women interviewed as they left the postnatal ward (n=644) reported feeling humiliated at some point during the labor and delivery experience across 13 Kenyan health facilities. The study also showed that 18% of these women experienced non-dignified care, 14% neglect/abandonment, 9% non-confidential care, 8% detention, and 4% physical abuse, and 1% were asked for bribes during labor and the immediate postnatal period. Nine out of ten health care providers said they had heard of or witnessed colleagues treating women inhumanely. Figure 3 identifies potential drivers of D&A.

Figure 3: Drivers of disrespect and abuse

WHAT DRIVES DISRESPECT AND ABUSE?		
<p>At policy and governance levels:</p> <ul style="list-style-type: none"> • No knowledge of international conventions • Complacency of policymakers • Insufficient funding for maternal health care 	<p>At health facility and provider levels:</p> <ul style="list-style-type: none"> • Lack of understanding of clients' rights • Inadequate infrastructure leading to poor working environment • Staff shortages leading to high stress • Poor supervision • Lack of professional support • Weak implementation of standards and quality of care guidelines 	<p>At the community level:</p> <ul style="list-style-type: none"> • Imbalanced power dynamics • Difficult for victims to seek justice • Lack of understanding of women's health rights

Although a lack of equipment and supplies is sometimes described as a driver of D&A, the data found that facilities do in fact have most of the essential equipment and supplies needed to support women in childbirth; with a mean score of 31 out of 35 essential pieces of equipment and supplies available for normal maternity services.

GROUP ACTIVITY: HAVE YOU SEEN OR HEARD ABOUT POOR QUALITY OF CARE OR HUMILIATING TREATMENT?

If a woman wants to squat during childbirth, what should you do?

What happens to a woman's placenta in your facility?

¹¹ Bowser, D and Hill, L., 2010 Exploring evidence for disrespect and abuse in facility based childbirth: Report of a Landscape Analysis, Bethesda, MD: USAID TRAction Project, University Research Corporation, LLC, and Harvard School of Public Health

¹² Population Council. 2014. Confronting Disrespect and Abuse during Childbirth in Kenya--The Heshima Project: Project Brief January www.popcouncil.org.

SESSION 3

Human and childbearing rights

The goal of this session is to educate participants on the global context of human rights, to enable them to practically link these rights to the rights of childbearing women, and to explore the definitions and characteristics of disrespect and abuse during childbearing.

Learning objectives

Participants will:

1. Define and discuss the characteristics of human rights.
2. Discuss a human rights-based approach to reproductive health.
3. Discuss the universal rights of childbearing women.
4. State the legal definition of the categories of D&A; the corresponding Universal Rights of Childbearing Women; list examples and standards of care.

Required learning

By the end of this session participants will have learned the meaning of human rights, the origin and characteristics of human rights as well as their limitations. They will also learn the definition of reproductive health, reproductive rights and child bearing rights and demonstrate the use of a human rights approach to provide maternity care services. Finally, the participants will learn the categories of D&A, their legal definition and the corresponding Universal Rights of Childbearing Women.

Overview of Human Rights

Definition of Human Rights: Human rights are those rights that every human being possesses and is entitled to enjoy simply by virtue of being a human being (*United Nations General Assembly 1948*).

Origin and Characteristics of Human Rights: Human rights are founded on religious, philosophical and legal principles. Most religions promote the concept of equal and fair treatment of all human beings. The principle of equality, dignity, and nondiscrimination form the philosophical basis of human rights (*United Nations General Assembly in 1948*).

The following are characteristics of human rights:

- Internationally guaranteed
- Legally protected
- Focus on the dignity of human beings
- Obligations of state and non-state actors

Examples of Human Rights

The legal concept of human rights is a powerful tool for promoting social justice and dignity. Some of the human rights guaranteed in the main international human rights treaties include the right to:

- Nondiscrimination
- Life
- Bodily integrity
- Privacy
- Freedom of thought
- Liberty and security
- Freedom of expression
- Choose to marry and have a family
- Enjoy the highest standard of physical and mental health
- Choose when, whether, and how many children to have
- Prohibition of arbitrary arrest, detention, and exile
- Effective remedy for violations
- Due process in criminal trials
- Self-determination
- Enjoy one's sexuality
- Education
- Information

Limitations of Human Rights

Rights are not absolute. Under certain conditions limitations can be imposed by the state on the exercise and realization of certain rights. This ensures respect for the rights of others and to meet the just requirements of public order, health, morals, and national security. For example, an individual's right to freedom of assembly and expression are subject to national security concerns and a requirement for public order.

Human Rights and Reproductive Health¹³

Definition of reproductive health:

Complete physical, mental, and social well-being in all matters related to the reproductive system including a satisfying and safe sex life, capacity to have children, and freedom to decide if, when, and how often to do so.

Definition of reproductive rights:

The rights of couples and individuals to decide freely and responsibly the number and spacing of their children; to have the information, education, and means to do so; to attain the highest standards of sexual and reproductive health; and to make decisions about reproduction free of discrimination, coercion, and violence.

A rights-based approach to reproductive health

The general principle of a human rights-based approach includes accountability, participation, transparency, empowerment, and nondiscrimination, and identifies entitlements as the core of human rights.^{14,15}

¹³ Adapted from definitions of SRHR in the ICPD and Beijing Platforms of Actions 2005.

¹⁴ Sexual Rights Initiative. 2012. Application of a Human Rights-based Approach to Sexual and Reproductive Health, Paper submitted to the thematic consultation on Health in the Post-2015 Development Agenda by the Sexual Rights Initiative.

¹⁵ Insight Share A Rights-Based Approach to Participatory Video: toolkit. Orientation to a Rights-Based Approach. [www/http/insights.share.org](http://insights.share.org). accessed on 6 May 2014

More specifically, to align the concepts of international human rights laws and the disrespect and abuse of women seeking maternity care, in 2011 the White Ribbon Alliance (WRA) and its partners developed the Charter on the Universal Rights of Childbearing Women (see Appendix 4). Universal human rights are unalienable and thus also apply during the reproductive and childbearing periods.

The Charter on the Universal Rights of Childbearing Women directly ties the problem of disrespect and abuse during childbirth to human rights, and The Charter identifies seven universal childbearing rights:

- Every woman has the right to be free from harm and ill treatment.
- Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care
- Every woman has the right to privacy and confidentiality
- Every woman has the right to be treated with dignity and respect
- Every woman has the right to equality, freedom from discrimination, and equitable care
- Every woman has the right to health care and to the highest attainable level of health
- Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion

Table 1 describes categories or manifestations of D&A, the corresponding legal definitions, and observable elements of the universal childbearing rights. It also lists examples of infringements to women's rights that result in D&A and the standards of quality of care. Health care providers are duty-bound to offer quality maternity care services that reflect universal childbearing rights and that adhere to the standards of maternity care.

Table 1: Categories of D&A, their legal definition, and the corresponding Universal Rights of Childbearing Women; their examples and standard of care adapted from WRA 2011 Charter

Construct map for D&A				
Type of abuse	Legal definition (where it exists)	Observable element/child-bearing rights	Examples	Standards of care
Physical abuse	Physical or mental mistreatment of a person resulting in mental/physical/emotional/sexual injury.	Every woman has the right to be free from harm and ill treatment.	<ul style="list-style-type: none"> - Pinching, slapping, pushing, and beating - Stitching episiotomy without anesthesia - FGM during labor or re-stitching FGM scar - Rape or inappropriate touching during examination (genitals/thighs) 	Staff conduct procedures devoid of physical harm. Clients are protected from emotional, physical, and sexual injury.
Non-consented care	Medical procedures that are performed without a client's consent to and full knowledge of the risks involved. This may constitute an actionable tort of "trespass" to the client's body.	Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care. A woman's right to information is respected.	No explanation of medical procedures, e.g., tubal ligation and hysterectomy.	<p>Staff takes time to explain: procedures, diagnosis, progress, results, and options.</p> <p>Information is given in an open and friendly manner.</p> <p>Clients are encouraged to ask questions.</p>
Non-dignified care	To subject person to a demeaning, inhuman and degrading treatment with an intention of hurting their feelings and emotions as human beings.	Every woman has the right to privacy and confidentiality. A woman's right to dignity is respected. A woman's right to information is respected.	<ul style="list-style-type: none"> - Use of non-dignified language or speaking rudely - Threats, e.g., <i>"if you don't cooperate I will take you to the theater"</i> - Failure to provide services due to personal values - No explanation of services offered - Failure to explain nature of procedure or examination - No choice of gender of provider - Body exposed unnecessarily. - Unhygienic conditions: Bed sharing/no change of linen/babies sharing incubators /women asked to clean delivery couches/dirty toilets and bathroom 	<p>Staff is polite and use appropriate language, gestures in communicating with clients.</p> <p>Curtains and screens used and clients covered with linen when examined.</p> <p>Every health care provider reduces the risk of infection by washing hands before and after every procedure.</p> <p>Staff implements infection prevention measures.</p>

Construct map for D&A				
Type of abuse	Legal definition (where it exists)	Observable element/child-bearing rights	Examples	Standards of care
Discrimination	Differential treatment based on sex, tribe, age, dress, nationality, religion/medical status.	Every woman has the right to equality, freedom from discrimination, and equitable care.	<ul style="list-style-type: none"> - Mothers' record clearly marked HIV positive - Failure to provide medical procedures to HIV clients, e.g., limit VE exam done for HIV clients - Denial of services due to lack of money, poverty 	Staff provides all the required services to all clients equally.
Abandonment/neglect	The act of refusing to render medical or surgical treatment /the act of rendering medical or surgical treatment "in a manner so hash or negligent as to endanger human life or to be likely to cause harm /injury/death.	"Every woman has the right to health care and to the highest attainable level of health. <i>Every woman has access to skilled attendance during delivery.</i> "	<ul style="list-style-type: none"> - Delay in receiving care after a decision has been made, e.g., to perform a C-section - Failure to stitch episiotomy in time, taking too long before being attended - Failure to provide supplies, even if available - Failure to offer service even when staffing is adequate - Failure to examine clients according to the national guidelines even when the resources are available - Neglect post-delivery 	<p>On arrival at facility every pregnant woman in labor is attended by skilled person within 30 minutes of arrival.</p> <p>Every woman with obstructed labor, is observed, delivered or referred within the guidelines upon the diagnosis.</p>
Detention	The act of holding a person in custody, confinement, or compulsory delay in a medical facility for reasons of failure to settle medical bills.	Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion.	<ul style="list-style-type: none"> - Retaining a mother in the facility when she is unable to pay - Retaining the mother in the facility if her baby is sick while her welfare is not taken care of 	Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.
Non-confidential care	The act of sharing a patient's health and other personal information without the patient's consent.	A woman's right to privacy and confidentiality is respected.	<ul style="list-style-type: none"> - Asking for or providing clients with information in presence of others - Keeping client's information in such a way that it can be assessed by others for reasons other than provision of care 	<p>History taking and examination done in as much privacy as possible.</p> <p>Women are never exposed unnecessarily.</p> <p>Staff actively protects women's privacy and confidentiality.</p> <p>Women are examined or attended to behind screens.</p> <p>Staff does not discuss or disclose client information to non-health care staff.</p>

SESSION 3 Role Play 1: Communicating a woman's right to dignified childbirth

Directions: The trainer will select three participants to perform the following roles in a role play: a skilled provider, a woman seeking information about the services available at the health center, and the woman's mother. The three participants in the role play should take a few minutes to read the background information provided below and to prepare. The observers should also read the background information so that they can participate in the small group discussions afterward.

The purpose of the role play is to provide an opportunity for participants to appreciate the importance of good communication when providing information to women about available health care and their sexual and reproductive rights.

Participant Roles:

Provider: The provider is an experienced community midwife at a primary health care center and who has good communication skills.

Jane: Jane is a 28-year-old woman; she has four living children and is now 4 months pregnant; she had one baby who die shortly after birth. Her sister died in childbirth last year.

Jane's mother: Jane's mother is 52 years old. She has eight living children; she had two stillbirths and one child died at 1 month old. One of her daughters died in childbirth last year.

Situation: Jane has come to the health center with her mother. Jane's mother and grandmother helped her to deliver each of her babies at home. Jane has been to the health center once before: she brought her 5-year-old son there when he had pneumonia last year. The women are interested in learning more about the care available at the health center because a relative delivered her baby there 6 months ago. Jane is nervous about her current pregnancy because her sister died in childbirth last year.

Focus of the Role Play: The focus of the role play is the interaction between the midwife, Jane, and Jane's mother as they discuss Jane's desires as an expectant mother, keeping in mind her rights as a human being. The midwife should:

- Be friendly and reassuring
- Discuss safe motherhood principles and a woman's right to expect safe, respectful health care
- Assess Jane's knowledge about the role of the midwife and the services available for women
- Describe the role of the midwife to the women
- Briefly explain what services are available and how Jane can be involved in the decisions about her care
- Discuss Jane's human rights as a childbearing woman, generally (such as her right to be free from ill treatment and to be assured privacy and confidentiality) and specifically (such as her to have a companion during doctor's visits during her pregnancy and during childbirth)
- Encourage the women to ask questions and, address the questions they ask

Jane and her mother should ask questions and express their concerns until the midwife has provided them with enough information about the role of the midwife, their rights, and the care available at the health center.

Discussion Questions: The trainer/ facilitator should use the following questions to facilitate discussion after the role play:

1. How did the midwife approach Jane and her mother?
2. Did the midwife give Jane and her mother enough information about the role of the midwife? About the health center? About her right to safe motherhood? About her right to have a birth companion?
3. How did Jane and her mother respond to the midwife?
4. What did the midwife do to demonstrate emotional support and reassurance?
5. Were midwife's explanations and reassurance effective? Why? or Why not?

SESSION 4

Values clarification and attitude transformation (VCAT)

The goal of this session is to enable providers to examine their own values, to transform their attitudes to enable them to provide better care and to increase awareness of respectful maternity care and accountability.

Learning objectives

Participants will:

1. Discuss the values clarification and attitude transformation theoretical framework.
2. Explain the meaning of the terms “values,” “values clarifications,” and “attitude transformation.”
3. Identify the values that inform their current beliefs and attitudes about childbirth and midwifery practice.
4. Discuss the assumptions, myths, and cultural beliefs surrounding facility-based childbirth,
5. Discuss ethical issues surrounding childbirth.
6. Demonstrate separation of participants’ personal beliefs from professional roles and responsibilities in advocating for respectful maternity care.
7. Discuss participants’ intentions to change their behavior in order to provide respectful care during childbirth which is consistent with their chosen, affirmed values.

Required learning

By the end of this session participants will have learned to use the VCAT process to examine their values and attitudes and how it might affect their work. They will use the knowledge gained to transform their attitudes to offer or support dignified and respectful care during facility-based childbirth. They will also learn how to use VCAT tools and the self-concept model in behavior and attitude transformation.

What is values clarification?

Values clarification is the process of assessing the effect of personal values on decision-making. It determines the outcome of an action. This means that a person's personality can be determined by looking at what he or she does.¹⁶ Given the central role that values play in our lives, it is important to understand how values form and how they affect our decision-making and behavior. “Valuing occurs when the head and heart ... unite in the direction of action.”¹⁷

Attitudes and beliefs

An **attitude** is a favorable or unfavorable evaluation of a person, place, thing, or event. A **belief** is a thought we hold and deeply trust about something. Beliefs tend to be buried deep within the subconscious with the result that they trigger automatic reactions and behaviors. We seldom question beliefs; we hold them to be truths.¹⁸

¹⁶ Theory of Valuation, International Encyclopedia of Unified Science Vol II No. 4 Chicago University <https://archive.org/stream/theory-of-valuation>

¹⁷ Dewey, 1939 in Turner, Katherine L. and Kimberly Chapman 2008 *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC, Ipas

¹⁸ Fishbein M, Raven B: The AB scales: An operational definition of belief and attitude. *Human Relat* 1962, 15(1)

- Our beliefs shape our attitudes, or the way we think about and act toward particular people and ideas. They are so ingrained that we may be unaware of them until we are confronted with a situation that challenges them.
- Everyone has a right to her or his own beliefs. However, health care providers have a professional obligation to provide care in a respectful and nonjudgmental manner. Being aware of your personal beliefs and how they affect others – both positively and negatively – will help you do just that.
- Childbirth brings up many emotional, private, and sensitive issues in most cultures around the world. However, specific issues and concerns differ from place to place.

How we communicate our beliefs and attitudes (both verbally and nonverbally) is an important aspect of our interactions with clients. Every interaction between health care providers and a pregnant woman, from the moment she enters the maternity unit until she or her relatives leave, affects her and her family by having an impact on:

- Choice of facility-based childbirth or future fertility intentions
- Willingness to trust and to share personal information and concerns
- Ability to listen to and retain important information
- Capacity to make decisions that accurately reflect her situation, needs, and concerns
- Commitment to adopting new health-related behaviors
- Future health-seeking behavior

To attain the highest standard of sexual and reproductive health, individuals need to be able to:

- Decide if, when, and how they will have sex, and have children and seek skilled care during childbirth with freedom to act on their decisions
- Make informed decisions about fundamental expression of their sexual and reproductive rights surrounding pregnancy and childbirth
- Ensure informed and voluntary decision-making

Motivation to Change: Values clarification begins with an individual's desire to change their current behavior or the current norm. One must begin by gaining knowledge, deepening understanding of existing or new knowledge, experiencing empathy, acknowledging current values, considering alternative values, recognizing barriers to change, and remaining open to change. Through this process, it is possible to understand the range of our experiences and influences which have brought us to hold our values, and consciously accept what our values are which may have previously been subconscious. For this process, some questions to consider include:

- How did you arrive at having this value?
- Did anyone suggest this value to you, or did you develop this value on your own?
- What will the results of holding this value be?
- What assumptions are you making?
- What are the alternatives values?

Process of values clarification

Values clarification is the process of becoming aware of, considering, and affirming or rejecting our own values around a particular topic, in this case around issues related to maternal health. The process of values clarification typically involves three steps:

- 1) Choosing, 2) Prizing, and 3) Acting.¹⁹

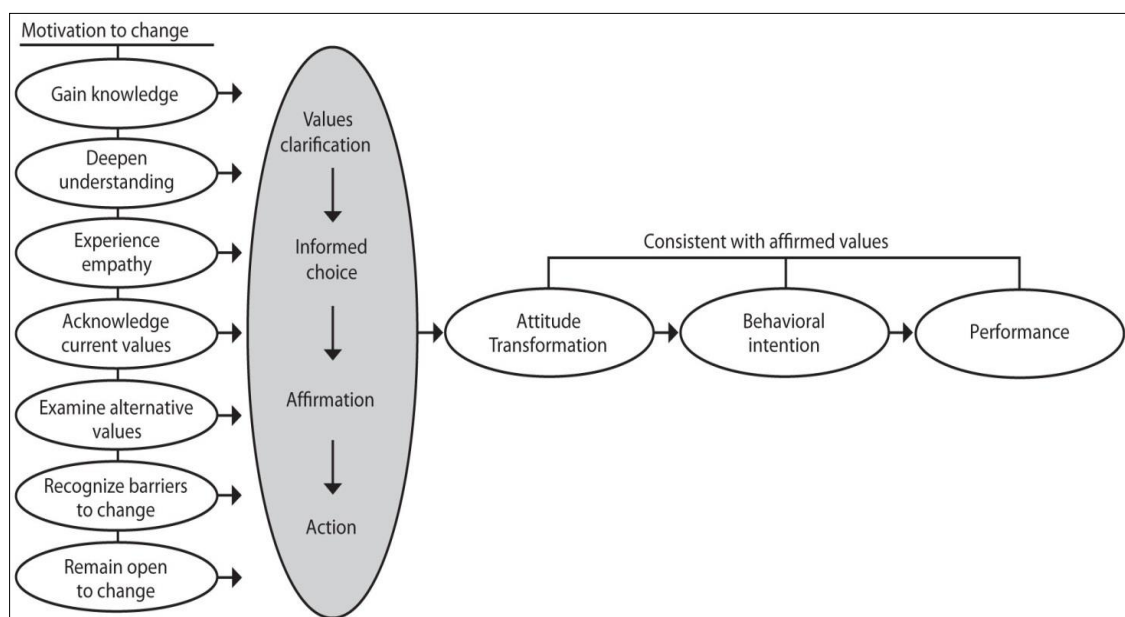
¹⁹ Adapted from *Values and Teaching* (2nd ed.), by L. Raths, M. Harmin, and S. Shore, 1978 pp. 63–65, Columbus, OH: Merrill.

- 1) **Choosing:** A value must be chosen freely from alternatives with an understanding of both positive and negative consequences of that choice. Once values have been clarified, an informed choice can be made about which values we truly and consciously want to uphold.
- 2) **Prizing:** A chosen value must be associated with some level of satisfaction and affirmation, as well as confidence in the value. Some questions to consider:
 - How do you feel about your choice? How satisfied are you with your decision?
 - Is this something that is really important to you?
 - Would you be prepared to stand up and announce your choice in public?
 - Are you willing to put it in writing?
- 3) **Acting:** A freely chosen, affirmed value must translate into action. Ideally, the action will lead to some positive outcome and be done repeatedly. Some questions to consider:
 - What are the first steps you will take or have taken to make this choice a reality?
 - Have you made definite plans to act on this value?
 - Is your decision definite or tentative?
 - Is this something you have done or will do regularly?
 - Have you been consistent in your actions?

The process of **values clarification** relies on a skilled facilitator who can create a safe, comfortable space and assist participants to:

- Use rational thinking and emotional awareness to examine personal belief systems and behavior patterns;
- Identify and analyze issues for which their values may conflict through thoughtful reflection and honest self-examination;
- Specify how they can act in a manner consistent with their clarified value(s);
- Experience new or reframed information or knowledge designed to be accessible and relevant (personally, socially and politically)

Figure 4: Values clarification for RMC attitude transformation theoretical framework²⁰



²⁰ Adapted from Turner, Katherine L. and Kimberly Chapman 2008. *Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences*. Chapel Hill, NC, Ipas.

Activity 3: The self-concept model as a tool for understanding one's own behavior

Content

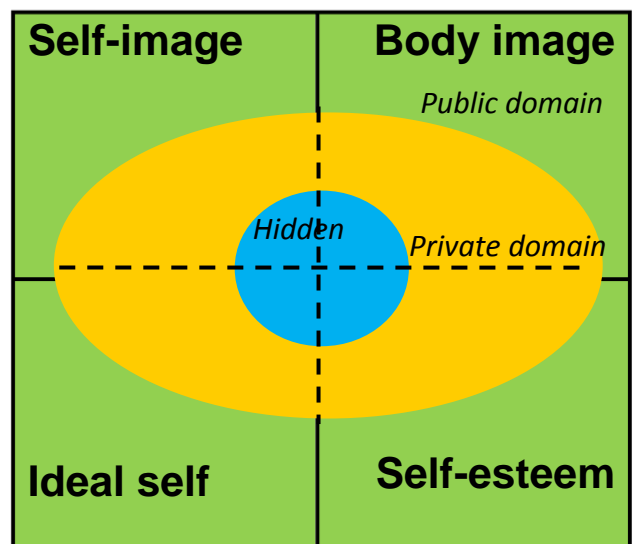
The family and social groups in which we grew up often play an important role in shaping the core values that inform our beliefs. Social groups may include immediate and extended family, racial, ethnic, or cultural groups, heritage, and socioeconomic groups. The role that these external influences may play is often subconscious and operates in the background of our beliefs and interactions. At different points in our lives and for different reasons, we may challenge these beliefs and underlying values. Reflecting on the source and influence of these core values on our present beliefs about midwifery or childbirth and how this has changed over time helps us respond to new knowledge and practice.

Understanding our behavior: The self-concept model in offering care during childbirth

The self-concept model is one that providers may use to understand themselves;

- Providing care during childbirth is complex and requires communication as a main tool of work as they deal with many people.
- Providers are first of all people and secondly they are midwives/doctors. We all have our own weaknesses, strengths, fears, anxieties, doubts, and uncertainties. All these can either hinder or facilitate providers' work with clients
- Providers must therefore continuously engage in self-exploration to be aware of their weakness, how others affect them, and the effect they have on others

The self-concept model is divided into four equal and interrelated parts: self-image, ideal self, body image, and self-esteem. The four parts of the self-concept have three intrinsic circles superimposed on them: the public, the private, and the hidden domains.^{21, 22}



²¹ Luft J and Ingham H. (1955). The Johari Window: a graphic model for interpersonal relations, University of California Western Training Lab. <http://www.au.af.mil/au/awc/awcgate/sgitc/read5.htm>

²² Understanding the Johari Window model. A Johari window a psychological tool created by Joseph Luft and Harry Ingham in 1955. <http://www.chimaeraconsulting.com/johari.htm>

Public domain: All of the information here is public or can easily be seen or known by the person or others. The information includes sex, age, race, color, tribe, residence, and occupation. The person here has little control over that information.

Private domain: Information here is confidential. The individual has control over what to tell other and discloses this information to only a chosen few. It includes secrets or intimate thoughts such as, "I am a loser, a failure, successful, in love with ..., hate...."

Hidden domain: Information here is hidden from the person's own awareness. It is information that may be buried in early childhood memories, or which may be painful, embarrassing, or humiliating to remember, so the person has learned to repress it deeply in the unconscious. An example of this may be experience of sexual abuse in childhood. This person may need professional help to deal with it.

The three domains (public, private, and hidden) affect how we behave and deal with our professional practice /life situations as they affect our image and self-esteem. The domains are super imposed by our ideas about our self that are divided into four imaginary parts:

- Self-image
- Body image
- Ideal self
- Self-esteem

Self-image: Self-image is how you perceive yourself. It is a number of self-impressions that have built up over time: What are your hopes and dreams? What do you think and feel? What have you done throughout your life and what did you want to do? These self-images can be very positive, giving a person confidence in their thoughts and actions; or negative, making a person doubtful of their capabilities and ideas. Your self-image can be different from how the world sees you.²³

Body image: Body image is our perception of our physical self – including feelings of attractiveness or unattractiveness.²⁴ How we think our body looks may not always be acceptable to us. Some people are not happy with their body weight or size or shape, perceiving their bodies to be undesirable, no matter how they may actually appear to others. They may not like the fact that they are short, tall, dark, big, or thin.

Ideal self: The ideal self is the person we wish we could be (i.e., "how I would like to see myself"). This includes the way we wish we could look, behave, feel, and think. In many cases, when a person's self-esteem is low, the way a person sees his or herself and the way they would like to be does not quite match up.²⁵

Self-esteem: After knowing ourselves, it is a reflexive next step to decide what we like about who or what we are. Self-esteem is a term used in psychology to reflect a person's overall evaluation or appraisal of his or her own worth.²⁶ This is our total worth or our pride, values, enjoyment, or

²³ Positive Self Image and Self Esteem. Mountain State Centers for Independent Living
<http://www.mtstcil.org/skills/image-1.html>

²⁴ [idshealth.org/teen/your mind/body image/body_image.html](http://idshealth.org/teen/your%20mind/body%20image/body_image.html)

²⁵ Bridging the Gap Between Self-Concept (Have) and Ideal Self-Concept (Want) Mashayekhi, Shima Bridging. The Gap Between Self-Concept (Have) and Ideal Self-Concept (Want). *Journal of edupres*, 1 . pp. 29-34.

²⁶ Baumeister, R. F. (1998). The self. In D. Gilbert, S. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (pp. 680–740). New York: Random House.

respect about ourselves. If both our self-image and our body image correspond with our ideal self, then our self-esteem is reasonably high. If our public domain and private domain are not much different, meaning that we are open and have nothing much to hide from people, then our self-esteem is also high.

The impact of self-esteem on interactions with other people

The interactions between our self-image, body image, and ideal-self combine to affect our self-esteem. Consequently, our self-esteem (i.e., feeling good or bad about ourselves) impacts how we treat people around us. High self-esteem may result in positive, optimistic interactions with other people, while low self-esteem can result in negative, unhappy interactions with people in our social and professional lives.

Negative behaviors can include behaving in a way that is harsh, aggressive, impatient, and domineering. Consistently engaging in negative behaviors can be destructive to the self and others by enabling and reinforcing negative environments. When negative environments make it difficult for providers to focus on providing quality care, this can negatively impact maternal health outcomes. Positive behaviors include being calm, patient, reasoning or understanding, kind-hearted, and caring among others. Positive behaviors result in acceptable social and professional norms, which in turn can reinforce providing quality care which can improve maternal health outcomes.

Behavior transformation

Behavior transformation is a self-directed process that starts with:

- Aspiring to change as a result of self-critique and desired improvements
- Understanding what the change means in your life, including life purpose and goals
- Taking personal responsibility by cultivating the ability to accept personal, social, and professional responsibility
- Self-behavior coaching through affirmations as a mechanism for bringing about behavior change. An affirmation is a short statement made up of words charged with power, conviction, and faith that an individual can repeat several times a day for reinforcement while undertaking a task or procedure
- Group coaching or mentoring, psychological debriefing through peer groups and counseling
- Attitude talk for positive internal dialogue. This is a way to override past negative actions and thoughts by erasing or replacing it with a conscious, positive internal voice that helps you face new directions

Behavior transformation requires us to identify the positive relationships in our lives, i.e., “who do I need to help me change my behavior and how will they support me?” People with whom we have positive, affirmative relationships can help us be positive and affirmative people ourselves. Furthermore, supportive professional and social environments also play an important role in serving as an enabling environment for our positive behavior.

SESSION 5

Psychological debriefing of health care providers

The goal of this activity is to discuss psychological debriefing or “Caring for the carers” as an option to support providers in dealing with negative behavior and work-related stress.

Learning objectives

Participants will:

1. Explain how work-related stress can be a driver of D&A during facility-based childbirth.
2. Examine the impact of difficult or traumatic work experiences on providers.
3. Discuss psychological debriefing sessions for health care providers as strategy to reduce work-related stress.
4. Explain the steps in conducting psychological debriefing sessions for health care providers.

Required learning

By the end of this session participants will have learned about the impact of work-related traumatic events or stress that they may have experienced. The session will draw their thoughts to how these experiences affected their emotions and behavior perhaps resulting in disrespectful behavior. Participants will discuss the impact of work related stress on providers and how psychological debriefing sessions can be used to reduce the stress thus minimizing D&A.

Work-related stress

Work-related stress is the adverse reaction people have to excessive pressures or other types of demand placed on them at work.²⁷ Some of the symptoms of work-related stress include:

Physical symptoms: fatigue, muscular tension, headaches etc.

Psychological symptoms: anxiety, irritability, pessimism (won't make it and can't happen), feelings of being overwhelmed and unable to cope and reduced ability to concentrate or make decisions.

Behavioral symptoms: an increase in sick days or absenteeism, aggression, diminished creativity and initiative, a drop in work performance, problems with interpersonal relationships, mood swings and irritability, lower tolerance of frustration and impatience. Whether a person experiences work-related stress depends on the job, the person's psychological make-up, and other factors (such as personal life and general health). These three types of symptoms may trigger health care workers to be disrespectful and abusive in the course of their work.

²⁷ Van der Klink JJ, Blonk RW, Schene AH, van Dijk FJ. The benefits of interventions for work-related stress. *American Journal of Public Health* 2001;91(2):270-276. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446543/>

The impact of difficult or traumatic work experiences on providers

Events around labor and delivery may overwhelm a person's coping skills, and this distress or trauma can result in negative behavior on the part of the provider.²⁸ Maternal health care providers often experience traumatic events such as maternal death, fetal death, or caring for a terminally ill patient which can cause them much sadness and grief.

There are other critical incidents that are not as serious as loss of life, but are morally draining and can disturb the sense of peace and purpose of health providers. These may include high workload and lack of professional support for staff, and poor governance and leadership. Because humans have a tendency to externalize internal stress by lashing out at those around them, these issues have been identified as potential drivers of D&A during facility-based childbirth.

The incidents described could be perceived as "lower-level" critical incidents, but if they occur consistently over time, the accumulated emotional burden can contribute to staff stress, burnout and emotional exhaustion which ultimately detracts from their providing quality care to patients.

It is therefore important that health providers be given opportunities to release through psychological support their emotional distress following any trauma or critical incidents they may encounter during their work.

Conducting psychological debriefing sessions for providers: "caring for the carers"

"Caring for the carers" refers to the provision of supportive services for health care providers as a way to relieve anxiety and distress arising from work situations. One such service includes psychological debriefing sessions. This is an approach that enables groups and individuals to deal with work-related stress.²⁹ Group psychological debriefing occurs when a group of providers meet to discuss their experiences, impressions, and thoughts of an event with the goal of emotionally dealing with challenging or upsetting work events in a safe, productive way.

The facilitator can be a counselor or professional peer (facility staff) who helps the group process the information being shared. This may include nurse/midwives, hospital chaplains, or psychologists. The facilitator should have the professional and interpersonal skills to guide the established process that will help group members recover from their distress. The facilitator will assess the need for individuals who might benefit from further individual counseling, and will make recommendations for individual follow-up.

The debriefing sessions follows seven phases:

1. Introduction phase
2. Expectations/narrative/facts phase
3. Impressions and thought phase
4. Emotional reaction phase
5. Normalization/education phase
6. Future planning
7. Coping/disengagement phase

For details on these debriefing session phases, see Appendix 6.

²⁸ Neil Schneiderman, Gail Ironson and Scott D. Siegel. STRESS AND HEALTH: Psychological, Behavioral, and Biological Determinants Stress and Health: Psychological, Behavioral, and Biological Determinants. Annual Review of Clinical Psychology, Apr 1, 2005

²⁹ Murphy LR. Occupational stress management: a review and appraisal. J Occup Psychol. 1984; 57:1-15.

SESSION 6

Professional ethics

The goal of this session is to provide participants with insight into the way that personal and professional ethics can conflict with one another when providing medical care.

Learning objectives

Participants will:

1. Define health care ethics, code of conduct, courtesy, scope of practice, professional associations.
2. Discuss the principles of ethics.
3. Explain the themes of ethics that promote RMC.
4. Describe the role and responsibilities of regulatory bodies in promoting RMC.
5. Describe the roles and responsibilities of professional associations in promoting RMC.

Learning required

By the end of this session participants will have learned about professional ethics and the courtesy required in provision of maternity care. Participants will also gain insight on what is ethical or not ethical in the way they provide services in maternity units as well as what to do when faced with an ethical dilemma. They will also learn the role of regulatory and professional bodies in supporting health care providers in adhering to their professional ethical practice.

Professional Ethics

Definition of Ethics: Ethics involve a systematic examination of moral life and seek to provide sound justification for the moral decisions and actions of people. The word ethics can also refer to philosophical inquiry in examining "right" from "wrong" and "good" from "bad."

Codes of Ethics: A code of ethics makes public the professional values of health care providers and indicates the values central to professional education and practice. Each health care provider has a personal value system influenced by his or her upbringing, culture, religious and political beliefs, education, and life experiences. Ethical decision-making understands that the values of other individuals are equally important as one's own.

Professional values are made explicit in a code of ethics, a code of conduct, and other formal statements that establish and make public the standards of a professional group.

Examples are:

- The International Council of Nurses (ICN) Code of Ethics³⁰ and The International Confederation of Midwives (ICM) Code of Ethics³¹: These reflect professional values inherent

³⁰ The ICN Code of Ethics for Nurses, International Council of Nurses; revised 2012; <http://www.icn.ch/icn/code-of-ethics-for-nurses/>

³¹ International Code of Ethics for Midwives. 2008. <http://www.internationalmidwives.org>

in nursing and midwifery and center on respect for human rights, including right to life, to dignity, and to be treated with respect.

- FIGO code of Ethics³²: This states that the relationship between a doctor and patient is based on confidentiality, honesty, and trust. The doctor must act as an advocate for the patient and make all decisions based on her benefit. If there is no established doctor–patient relationship, the doctor may refuse to provide care (except in emergencies).

These codes of ethics have been adapted for country-specific needs and service providers and are entrenched in the context of specific laws governing the different cadres of professionals.

Scope of practice: The scope of practice defines the responsibilities of the provider and legal boundaries of practice. It spells out what health professionals can be held accountable for in the course of providing care. This differs from one profession to another and stipulates the practice boundaries and linkages between them. Providers need to be competent in and enabled to fulfill their scope of practice.

Courtesy: Courtesy refers to polite and civil mannerisms and behavior that people display when interacting with one another. Use of courtesy generally conveys respect for one's self and the other individual. In a professional setting, courtesy can refer to a code of ethical behavior regarding the professional practice, or to the interactions between members of a profession or their clients. Professional courtesy can have several different appearances. For example:

- An employer could show courtesy to employees by respectfully acknowledging the work stress they are under, and offering small comforts such as serving hot tea and short breaks away from the work environment.
- A health care provider could display courtesy to a colleague by ensuring that shared supplies are cleaned and neatly put away after they use them.
- A provider could display courtesy to a laboring woman by offering her companion a chair to sit in, or by speaking quietly when discussing her medical information with her.

Ethical principles

Ethical principles guide moral decision-making and moral action, and are the foundation of making moral professional judgments.

Ethical principles are important to medical practice which represent obligations on the part of the provider include:

- In providing medical care, to do "good" and "avoid doing deliberate harm"
- To treat all individuals equally and equitably without regard to a patient's background or ethnicity. Only differ the amount of care provided based on the severity of the medical condition (i.e., provide more intensive care to patients in critical need)
- Patients are free and autonomous, and once they have been given full information about their condition and the medical choices they have, they can choose to opt in or out of a medical procedure. Very occasionally, when the benefits are far greater than the risks, a provider can override a patient's desires

³² Women's Sexual and Reproductive Rights: Rights-Based Code of Ethics, 2003; <http://www.figo.org/Code-of-ethics>

- Some themes found in codes of ethics include the health care workers relations with co-workers, and their responsibility to report breaches of professional behavior. Service providers need to use their knowledge of ethics and ethical reasoning to make ethical decisions while using their knowledge of the law to determine the legal parameters of their professional practice³³ (see ICM code Appendix 7)

1: Professional issues

- Practice competence and relations with co-workers
- Conditions of employment
- Purpose of nursing profession and personal conduct
- Incompetence of other health workers
- Role and accountability - holding self-responsibility for your own actions and acting as the women's advocate

2: Patient issues

- Respect life and dignity of the patient
- Uphold patient confidentiality
- Nondiscrimination against persons

3: Social issues

- Addressing and improving the health/social needs of the community
- Health care providers' relation to the state and obeying laws of the country

The roles and responsibilities of regulatory bodies

A **regulatory body** is a legally designated public authority or government agency that is responsible for regulating or supervising a designated activity in an autonomous, unbiased capacity. Each professional discipline has a regulatory body (usually referred to as boards or councils) whose functions include safeguarding the public by ensuring licensed professionals have a certain level of skill, supporting professionals by regulating continual professional development, and playing a disciplinary role in the event of professional misconduct.

Role of health professional associations

A **health professional association** exists to represent a particular profession, promote excellence in practice, and therefore protect the good standing of the professionals. It is not a profitmaking entity. Professional associations represent the interests of a profession; serve as the public voice of the profession; protect the profession by guiding terms and conditions of employment; maintain and enforce training and practice standards and ethical approaches in professional practice; and influence local, regional, and national policy. They can also act as a labor or trade union for organizations and health care workers that choose to conduct collective bargaining.

³³ ICM, International Code of Ethics for Midwives. Adopted at Glasgow International Council meeting, 2008

SESSION 7

Promoting mutual accountability:

Rights and responsibilities of health providers and clients during childbirth

The goal of this session is to familiarize participants with tools and interventions to promote mutual accountability including the use of a charter and holding Maternity Open Days.

Learning objectives

Participants will:

1. Define the concept of a charter as a tool for ensuring a rights-based approach to maternal health care.
2. Briefly discuss the core functions and responsibilities of ministries of health.
3. State the responsibilities of health service providers in a service charter.
4. Discuss the responsibilities of patients/clients in the service charter.
5. Discuss Maternity Open Days as an approach for improving mutual understanding, accountability, and respect between community members and service providers.

Required learning

Participants will learn about "mutual accountability," a "charter," a "service charter," and a "health service charter". The session will also equip the participants with knowledge on how to use the service charter as tool to ensure mutual accountability, to improve clients' and providers' rights and obligations.

Mutual accountability

What is mutual accountability? Mutual accountability refers to two individuals or groups adhering to an understanding of responsibility to maintain the commitments or obligations they have to one another, and to maintain transparency in their actions. Mutual accountability is critical to improving the quality of health care and effectiveness in achieving better results. The partners involved in health service delivery usually include governments, implementing partners, health managers, providers, clients, and the community.³⁴

What is a charter? A charter is a formal document that outlines the standards, core functions, and organizational rules of conduct and governance. A charter grants certain rights, power, and functions to an organization but also includes obligations and rights to the customers.

What is a service charter? A service charter is a simple public document which briefly and clearly states the standard and quality of service that any customer can expect from an organization within the context of its services. It is guided by a vision, mission, values, culture and ethical policies.

³⁴ Mutual Accountability for Development Results, background study for DCF and AusAID Background brief on mutual accountability. <http://www.un.org/en/ecosoc>.

What is a health service charter? A health service charter is a statement of intent to clients and customers, which defines an institution's (such as a health ministry or health facility) core functions, services offered, commitments, obligations, customer's rights and obligations, mechanisms for complaint, and redress for any dissatisfied customers. A health service charter is guided by the health sector's vision, mission, and mandate.

Core functions of ministries of health include:³⁵

- Formulation of standards, implementation, and regulation of health policy, sanitation policy, and health service delivery
- Registration of doctors and paramedics
- Administration of medical research institutes, medical training colleges, the hospital insurance fund, medical supplies agencies, and government chemists
- Manage clinics, dispensaries, health centers, and hospitals
- Provide health education, health inspection, and other health services including food safety

Ministry of Health responsibilities/commitments

Ministries of health are expected to achieve the following types of goals for delivering services to clients:

- Equitable distribution of health services
- Timely provision of health care services
- Provision of quality services
- Customers' rights to information
- Courtesy and respect to customers
- Nondiscrimination to customers
- Confidentiality of a client's information
- Privacy of customer care and treatment
- Avoiding any corrupt practices and preferential treatment of clients
- Establishing customer care centers in all facilities
- Conducting regular customer surveys and publishing reports

Responsibilities of health service providers

Examples of health service providers' responsibilities include:

- Promotion of healthy lifestyles
- Prevention of diseases
- Protection of the public against harm
- Coordination and provision of health services
- Prompt response to enquiries
- Provision of accessible and timely services to all

³⁵ Ministry of Health Service Charter, 2007. A flyer is developed by Health Rights Advocacy Forum (HERAF), with support from European Union (EU).

Client rights

All clients have the right to:

- Optimum care by qualified health providers
- Accurate information
- Timely service
- Choice of health provider and service
- Protection from harm or injury within health care facility
- Privacy and confidentiality
- Courteous and dignified treatment
- Continuity of care
- Personal/own opinion and to be heard
- Emergency treatment in any facility of choice
- Dignified death, preservation and disposal
- Participate in the planning and management of health care services

Client Responsibilities

Health care clients are obligated to:

- Engage in a healthy lifestyle
- Seek treatment promptly
- Seek information on illness and treatment
- Comply with treatment and medical instructions
- Be courteous and respectful to health providers
- Help to combat corruption (report any corrupt practices and refrain from seeking preferential treatment)
- Enquire about the related costs of treatment and/or rehabilitation and to agree on the mode of payment
- Care for health records in his or her possession
- Respect the rights of other patients and health care providers
- Provide health care providers with relevant and accurate information for diagnosis, treatment, rehabilitation, or counseling purposes
- Be respectful of health facilities (e.g., do not intentionally cause damage)
- Participate in the management of health care services;
- Foster partnership in service delivery

Activity 1: Maternity Open Days

What are Maternity Open Days?

A maternity open day is an event in which a health care facility opens its doors to the community and provides a specific opportunity for pregnant women and their families to interact with health care providers and visit the maternity unit. This can help promote transparency, familiarity, and increased client knowledge of what to expect. It is also an avenue for ensuring accountability of the facility to society, enabling community members to confirm that the facility upholds the service charter's rights and obligations. Furthermore, it provides an opportunity for facilities and communities to work together to find solutions to problems. For example, if a facility has an inadequate supply of water, the community may offer to support the facility by harvesting rain water.

Summary of how to hold a Maternity Open day (see brief in toolkit)

- Agree on a date for the open day with health facility managers and community leaders
- Send invitations through the existing community information systems
- Invite pregnant and interested women and their families to visit the maternity unit
- Arrange simple refreshments to be made available (if possible)
- Before the maternity unit tour, explain about care and procedures during labor and delivery including the layout of the maternity unit. Describe the quality of care that clients can expect. Allow for discussion to dispel any misconceptions/rumors
- Explain the rights that maternity clients have, and their obligations to the provider and facility
- Allow groups of 5–8 community members to tour at time to avoid congestion **Note: you must not disrupt care of any women currently attending the maternity unit**
- Maintain privacy and confidentiality for mothers in labor
- After the tour, midwives and other health providers engage the community members with a question-and-answer session on:
 - Were their expectations met during the tour?
 - Clarify any other queries they may have
 - Ask community members for recommendations, i.e., what contributions can the community members make toward improving the maternity unit for both the providers and the clients?
- Encourage facility-based childbirth and male involvement/birth companions during pregnancy labor and delivery. Remind pregnant women about birth and complication readiness plans

Other curative or preventive health services may be integrated into the day's activities, e.g., minor treatment of childhood illnesses, screening for cancer of the cervix or prostate.

SESSION 8

Health facility management

The goal of this session is to help participants understand the mechanisms of health facility management and to find opportunities for promoting RMC at a management level.

Learning objectives

Participants will:

1. Discuss the composition of the health facility management committees/boards.
2. Discuss the role of the committee in promoting RMC.
3. Discuss the powers of the health facility management committees/boards.
4. Review the criteria for selecting HFMC/B members by facility management.

Required learning

By the end of this session participants will have learned the composition, role and responsibilities of HFMC/Bs, reviewed the current performance of the HFMC/B and the linkages between the community and the health facility including community involvement in the facility management. Learners will also be able to identify the role of the HFMC/B in promoting respectful maternity care. *(Note: Refer to your country's national, region and facilities' standard operating procedures or guidelines if available)*

Health Facility Management

Health Facility Management Committees (HFMCs) or Health Facility Management Boards (HFMBs) are established through national or regional governments. Community representatives in the committees or boards should represent public/community interest in the management of health facilities. The community members' representatives should enjoy equal rights in decision making in the committees or boards as the technical and health management representatives.

Role of the HFMC/B in promoting respectful maternity care

It is the HFMC/B's role to perform the following duties:

1. To advise the community on matters related to the promotion of health services.
2. To oversee the general operations and management of the health facility.
3. To represent community interests on matters pertaining to health in local development forums.
4. To facilitate the feedback process to the community regarding health facility operations and management.
5. To implement community decisions pertaining to their own health.
6. To mobilize community resources toward the development of health services within the area
7. To oversee continuous quality improvement (CQI) at the facility level. This includes risk management functions (including mortality and morbidity reviews and the review of adverse events)

and near misses), as well as continuous quality improvement activities to improve care processes at all levels of service delivery.^{36, 37}

Powers of the HFMC

1. The committee shall have the authority to raise funds from within, the community, or from donors and other well-wishers for the purpose of financing the operations and maintenance of the facility.
2. The committee shall have authority to hire and fire subordinate staff employed by itself in the health facility.
3. The committee shall oversee the development and expansion and maintenance of the physical facilities within their respective area.

³⁶ World Health Organization. 2006. "Quality of Care. A process for making strategic choices in health systems."

³⁷ Family Care International. "The enabling environment for skilled care: a health systems approach." Technical Brief. June 2005.

SESSION 9

Mediation as an alternative dispute resolution mechanism

The goal of this session is to equip participants with the knowledge and basic skills to lead and participate in mediation for resolution of any disputes.

Learning objectives

Participants will:

1. Define alternative dispute resolution (ADR) mechanisms.
2. Describe examples of ADR mechanisms available in the local context.
3. Discuss mediation as an ADR mechanism in dealing with D&A incidents.
4. Define characteristics of a mediator.
5. Describe a mediator's role.
6. Explain the ADR or mediation process.
7. Discuss advantages and disadvantages of ADR mechanisms.
8. Demonstrate the use of ADR mechanisms in resolving disrespect and abuse cases.

Required learning

Participants will learn how to improve accountability by holding individuals responsible for acts of disrespect and abuse. This session equips participants with knowledge and skills of how to use the alternative dispute resolution mechanism through mediation to resolve or seek redress for acts of D&A. The participants are also expected to adapt ADR to compliment other mechanisms used to demand accountability among health workers within the health care setting.

Alternative dispute resolution (ADR) mechanism

ADR is a process of resolving disputes by using methods other than conventional litigation (i.e., by utilizing traditional or community justice systems).³⁸ It is the act or process of mediating between parties, to effect an agreement or reconciliation.³⁹ ADR is often used as a means to avoiding the often cumbersome, slow, and expensive nature of many conventional legal systems.⁴⁰ It is used strictly on a voluntary basis – no party should be coerced into it. The ADR mechanism has been found to work effectively in resolving conflicts resulting from D&A.

Definition of mediation, a mediator, and the mediator's role

Mediation: Mediation is a process whereby an independent and impartial third party facilitates the negotiation process between disputing parties. The third party, the mediator, is not a decision maker-like a judge or a magistrate. Decisions are made by the parties themselves with facilitation from the mediator. Mediators need to be specially trained.

³⁸ Christopher Moore, *The Mediation Process: Practical Strategies for Resolving Conflict* (Jossey-Bass Publishers, San Francisco, 1996), p. 14-33

³⁹ Random House Kernerman Webster's College Dictionary, 2010. K Dictionaries Ltd. Copyright 2005, 1997, 1991 by Random House, Inc

⁴⁰ Kariuki Muigua 2013. "Heralding a New Dawn: Achieving Justice through effective application of Alternative Dispute Resolution Mechanisms (ADR) in Kenya" a Paper Presented at The Chartered Institute of Arbitrators (Kenya Branch) Annual Regional Conference held on 25-26 July, 2013 in Nairobi.

A mediator: A mediator is a convener, an educator, a guardian of the mediation process, and an independent and impartial intervener.

The role of the mediator is to:

- Assess the degree of conflict
- Expand access to relevant resources that enable the parties to make informed decisions
- Test the reality of each party's assumptions and engage the parties to gain new perspective on their own positions
- Serve as a neutral facilitator for negotiation and enhance communication between disputing parties
- Educate the parties on the negotiation process and ensure that the process is upheld and not abused

Mediation process in promoting respectful and dignified care during childbirth

Childbirth is a stressful yet joyous moment for the mother, family, and the service provider. However, sometimes the mother, partner or relatives may feel that some of the events occurring around the labor and delivery process are not well handled. Incidents of D&A should be discussed and the responsible parties held accountable in order to resolve the issue and prevent it from happening again. Mediation is a recommended method to address incidents of D&A. The mediation process is voluntary and may be terminated at any time by any party or the mediator.

The advantages of mediation for patients/relatives include that mediation is:

- Faster than a court process
- Less confrontational or adversarial
- Encourages creativity for solutions
- Improves communication between parties
- Results in more durable solutions
- Less costly
- Flexible
- Less formal
- Party-controlled/driven
- Confidential
- Satisfying to the parties

Mediation can follow the following structure:

Stage 1 – Introduction and opening statement (setting the climate)

Stage 2 – Narration or presentation by the parties (storytelling)

Stage 3 – Determining interests

Stage 4 – Setting out issues

Stage 5 – Brainstorming options

Stage 6 – Selecting durable solution

Stage 7 – Closure

The seven stages each involve unique steps:

Stage One – Introduction

- Introduction of mediator and parties
- Disclosure of mediator's qualifications
- Congratulating parties for choosing mediation
- Establishing and maintain trust and confidence
- Explanation of the mediation process/ground rules
- Disclaimer of bias and neutrality of mediator
- Signing confidentiality agreement (see Appendix 8)

Stage Two – Presentation by the parties

- Parties provide perspective of dispute without interruption:
 - Gives parties opportunity to vent or express their anger and emotions
 - Helps mediator to understand the parties and their interests
 - Helps mediator to identify obstacles to resolutions
 - Opportunity for parties to hear each other directly and get the other's perspective
- The mediator acts as an active listener and asks questions for clarification

Stage Three – Determining interests

- Mediator summarizes, clarifies, and confirms the interests of the disputants
- Parties confirm the accuracy of the mediator's understanding of the disputants
- Mediator may encourage parties to address each other directly, ask and answer questions, clarify misunderstandings, and offer acknowledgments

Stage Four – Setting out issues

- Mediator helps disputants develop a list of issues:
 - Objective is to help disputants focus on the specific items that must be resolved
 - All issues that need to be resolved must be identified
- Mediator frames issues in a manner that promotes problem-solving:
 - Exemplifies use of neutral language

Stage Five – Brainstorming options

- Mediator encourages the disputants to generate options
- Mediator encourages disputants to select familiar and creative options
- Mediator and parties explore and discuss the pros and cons of each option
- Mediator guides parties to focus on the problems and not on each other or the past:
 - Mediator should only make suggestions of options if there is certainty that he or she has no personal bias in the situation
- Ideally, a workable option should originate from the parties themselves

Stage Six – Selecting Durable Options and Closure

- Mediator facilitates negotiations between the parties
- Mediator helps the parties pick realistic and viable options for resolution
- The mediation will hopefully result in agreement
- If no agreement, the mediator acknowledges progress and explores alternative solutions

Disadvantages and challenges of mediation

Disadvantages:

- Nonbinding unless parties consent
- Proceedings have the potential to go on indefinitely
- Goodwill is necessary
- Unsuitable when parties need urgent protection (e.g., sexual assault)
- Unsuitable where there is inequality of bargaining power (e.g., a manager and supervisee)
- No precedents are created (a precedent is a rule established in a previous legal case that is either binding on or persuasive). This implies that in mediation the way a case is resolved cannot be used as a basis for resolving another case

Challenges of mediation

- Lack of trust among participants and poor communication
- The meeting of parties involved in mediation may be difficult or uncomfortable
- Parties may believe that there is a better way of resolving their disputes
- Parties who come into the mediation with a set definition of their problem

Applying the mediation process to situations of disrespect during childbirth

Once a case is identified through a complaint and the parties involved chose to resolve it through mediation the following should be done to begin the process:

- Verify the facts from reports and listening to parties involved. Such parties may include community strategy focal persons, members of community watch-dog groups, CHWs, or service providers
- Identify the mediators through whom the case can be heard and with whom disputants must feel comfortable
- Mediators may include:
 - Members of facility management committee
 - Society/community leaders
 - Quality improvement committee members
 - Representatives of professional association bodies
 - Health management teams members (regional, county, facility etc.)
 - Hospital management teams.
- Identify a suitable venue, date and time
- Inform all interested parties and selected mediators and confirm their availability
- Once the parties and mediator(s) convene at the venue the mediator employs the mediation process as describe above

Role Play 1: Using mediation to resolve an incident of physical abuse

Directions:

The facilitator selects three participants to perform the following roles: a skilled provider, a woman seeking redress for physical abuse during childbirth at a health facility, and the mediator identified to handle the incident. The three participants should take a few minutes to read the background information provided below and prepare for the role play. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play. The purpose of the role play is to provide an opportunity for learners to appreciate the role of mediation and the mediation process as an alternative dispute resolution mechanism in dealing with D&A incidents and promoting accountability in reproductive rights.

Participant Roles

- Provider:** The provider is a midwife at the local health center who is accused of slapping a woman during childbirth in her facility.
- Mrs XY:** Mrs. XY, 21 years old, is a first-time mother who gave birth at KaKoi hospital two months ago. She is accompanied by her husband, a sister, and her mother-in-law to seek redress for being slapped during the birth of her baby in the health facility.
- The mediator:** The mediator is a 50-year-old respected elder who is trained in mediation and is also the chairperson of the health facility management committee. The facility management asked him to assist in resolving the issue.

Situation: Mrs. XY is 21 years old, a first-time mother who came to the hospital for maternity care services. During the second stage of labor she was asked to "bear down" or push, but she was "uncooperative" and the health provider slapped her. Mrs. XY thinks she was mishandled during childbirth and reported the incident to the head of the maternity unit. But she informed Mrs. XY that she should just forget about the issue. Mrs. XY was unsatisfied with the response and was aware that she has a right to seek redress. She sought help from the community legal aid officer to resolve the incident. The legal aid officer advised Mrs. XY of an alternative dispute resolution mechanism (mediation) and also assisted her in informing the facility management of her desire to seek redress through mediation. The facility management verified the facts of the incident and informed the provider involved in the incident of Mrs. XY's wishes. The provider agreed to a mediator and the date for mediation. The provider, Mrs. XY, and her relatives came for the mediation session.

Focus of the role play: The focus of the role play is the interaction between the midwife, Mrs. XY, her relatives, and the mediator.

The mediator should follow the mediation stages described above to perform the session;
(See the Protocol on Alternative Dispute Resolution in RMC Resource Package www.popcouncil.org)

- Stage 1** – Introduction and the mediator's opening statement (setting the climate)
- Stage 2** – Narration or presentation by the parties (storytelling)
- Stage 3** – Determining interests
- Stage 4** – Setting out issues
- Stage 5** – Brainstorming options
- Stage 6** – Selecting sustainable solutions
- Stage 7** - Closure

Discussion questions

1. How did the mediator approach Mrs. XY, her relatives, and the provider?
2. Did the mediator give the parties enough information about the role of a mediator? About the process of mediation? About maintaining confidentiality? About their right to be heard equally?
3. How did the provider and Mrs. XY respond to the mediator?
4. How did the mediator demonstrate objectivity, noncoercion, control of the discussions during interactions between Mrs. XY and the provider? And during the interactions with Mrs. XY's relatives?
5. Were the mediator's explanations and communication effective in resolving the incident?

Role Play 2: Using mediation to resolve an incident of non-dignified care, discrimination, or detention in facility-based childbirth (*suitable for managers*)

Directions:

The facilitator will select three participants to perform the following roles: a facility manager, a woman seeking redress for disrespect and abuse during childbirth at a health facility, and the mediator identified to handle the incident. The three individuals participating in the role play should take a few minutes to read the background information below and prepare for the role play. The observers in the group should also read the background information so that they can participate in a small group discussion following the role play. The purpose is to provide an opportunity for learners to appreciate the role of the mediator and the mediation process as an alternative dispute resolution mechanism to deal with D&A incidents and to be accountable for reproductive rights.

Participant Roles

- Facility Manager:** The manager is the sole owner of a private maternity nursing home who is being accused of discrimination, offering services in a non-dignified manner, and for the detention of Christina's baby.
- Christina:** Christina is a single mother of three children who had planned to give birth in the public facility where maternity services are free, but she gave birth in a nearby private health facility and was unable to acquire the maternity fees. Her baby was detained while she looked for money. She feels that her rights were infringed upon and wants redress through mediation.
- The mediator:** The mediator is a respected midwife and is a leader of the local branch of the midwives professional association with experience in championing both the providers' rights and women's reproductive rights and is also trained in mediation.
- Situation:** Christina had planned to give birth in a public facility where maternity services are free. Her labor started late in the evening and, due lack of transportation to the public health facility, she was carried by handcart to a nearby private health facility where she gave birth to a baby girl. However, she is unable to raise the maternity fees.

The facility management decided to allow her to go home to raise the money, but detained her newborn baby. Her family managed to raise the fees seven days later, paid the maternity fees and Christina's baby was discharged. Christina approaches the facility management committee with the complaint of being discriminated against, treated in a non-dignified manner, and with the detention of her baby.

She wants the responsible person held accountable for denying her reproductive health rights. The facility management and the mother agree that her rights were denied and to reach a consensus to resolve the case through mediation. The facility manager represents the facility in the mediation session. Christina and her relatives arrive for the mediation session.

Focus of the role play: The focus of this role play is the interactions between the manager, Christina, her relatives, and the mediator.

The mediator should follow the following stages (refer to the alternative dispute resolution protocol tool) while conducting the session;

- **Stage 1** – Introduction and the mediator's opening statement (setting the climate)
- **Stage 2** – Narration or presentation by the parties (storytelling)
- **Stage 3** – Determining interests
- **Stage 4** – Setting out issues
- **Stage 5** – Brainstorming options
- **Stage 6** – Selecting durable solutions
- **Stage 7** – Closure

Discussion Questions: The facilitator should use the following questions to facilitate discussion after the role play:

- How did the mediator approach Christina, her relatives, and the manager?
- Did the mediator give Christina and the manager enough information about the role of a mediator? About the mediation process? About maintaining confidentiality? About their rights to be heard equally?
- How did Christina and the manager respond to the mediator?
- How did the mediator demonstrate objectivity, noncoercion, and control of the discussion during his/her interactions with Christina and the manager? And during interactions with Christina's relatives?
- Were the mediator's explanations and communication effective in resolving the incident?

SESSION 10

Community's role in promoting respectful maternity care in facilities

The goal of this session is to empower participants to connect with the community so that the community can also be advocates of RMC.

Learning objectives

Participants will:

1. Outline community members' roles in promoting respectful maternity care.
2. State community structures available for dealing with incidents of D&A.
3. Demonstrate techniques for strengthening community–facility links and methods to deal with incidents of D&A at the community level.

Required learning

By the end of this session participants will learn how to strengthen the existing community structures to respond to reports on D&A incidents effectively. The participants will also learn how to strengthen community–facility linkages to deal with D&A.

The community's role in promoting respectful maternity care

Community members' role in promoting respectful maternity care includes identifying the barriers that prevent women from receiving respectful care during childbirth in health facilities.

Barriers include:

- Inadequate knowledge of labor and delivery procedures
- Failure to fulfill obligations or demand rights
- Cultural beliefs and practices
- Myths and misconceptions
- Financial barriers

Community members should:

- Recognize their right to quality care during childbirth in health facilities and proactively pursue information on good health practices including childbirth
- Respectfully demand good customer care during all services provided in health facilities including childbirth
- Encourage women who have experienced disrespect and abuse during childbirth to speak out and seek redress through mediation, counseling, or other available avenues
- Offer emotional support to women and their birth partners/families that experienced disrespect and abuse during childbirth
- Establish or strengthen a clear linkage connecting the community and facilities to address disrespect and abuse
- Mobilize community resources (money, materials, and people) to support initiatives promoting respectful maternity care, such as legal and maternal health advocates,

community watchdogs, health facility management committees, community members/volunteers to work as mediators, etc.

Community-level structures for dealing with D&A

Community members should be made aware of the existing structures through which to claim their rights by reporting the incidence of D&A. These include:

- **Community Health Workers:** Volunteers trained by the Ministry of Health to offer basic health care and refer community members to formal health care services as appropriate.
- **Health Facility Management Committees (HFMCs):** Established through an act of parliament, they include representatives from communities and health facility management. Community members represent the community interests and have authority to make the HFMC accountable for good-quality health services.
- **Legal aid officers and community watchdog representatives:** Trained by civil society on the community's legal rights and mandated to educate the community about their civil rights and assist them in obtaining redress when their rights are infringed.
- **Local administration:** Chiefs and village and society leaders who are charged with the responsibility of linking their community to other formal governments in dealing with social issues including health and community welfare.

SESSION 11

Strengthening continuous quality improvement (CQI)

The goal of this session is to reinforce providers' training on continuous quality improvement (CQI) and encourage them to apply these concepts to strengthening RMC during childbearing and engaging more effectively with the maternity units to ensure that quality is continually reinforced.

Learning objectives

Participants will:

1. Describe the term continuous quality improvement (CQI).
2. Discuss CQI in relation to respectful maternity care.
3. Explain the membership of CQI teams.
4. Determine the roles of CQI teams in promoting respectful maternity care.
5. Discuss ways to strengthen CQI teams so that they involve maternity units.

Required learning

The participants will learn how to strengthen existing continuous quality improvement teams (QITs). They will also learn how to use the continuous QITs in order to support individual providers, maternity or facility teams as well as community members to implement and monitor interventions aimed at promoting respectful maternity care.

Continuous quality improvement (CQI)

CQI refers to the combined and ongoing efforts of everyone—health care professionals, patients and their families, researchers, planners, and educators—to make changes leading to better patient health outcomes and care, better professional development, and improved access to care.⁴¹

Quality of care includes the following elements;

- **Availability:** a sufficient quantity of functioning public health and health care facilities, goods, services, and programs
- **Accessibility:** non-discrimination, physical accessibility, affordability, information accessibility
- **Acceptability:** respectful of medical ethics and culturally appropriate, sensitive to age and gender
- **Quality:** scientifically and medically effective

Health care services (including care during childbirth) must be available, accessible, acceptable, appropriate, and of good quality. This combination of terms is known as AAAQ. Respectful Maternity Care is thus one of the components addressed by the AAAQ framework.⁴²

⁴¹ World Health Organization 2005, Preparing a Health Care Workforce for the 21st Century: The Challenge of Chronic Conditions, WHO, Geneva

⁴² WHO, 2010. Using Human Rights for sexual and reproductive health: Improving legal and regulatory frameworks. Bulletin of the World Health Organization, Geneva

Introduction to CQI in childbirth: In labor and childbirth, CQI includes woman-centered care, which refers to health care that respects the values, culture, choices, and preferences of a woman and her family, within the context of promoting optimal health outcomes. Woman-centeredness is designed to promote satisfaction with the maternity-care experience and improve well-being for women, newborns, their families and health care professionals. Woman-centered care is an essential component of health care quality improvement.

Woman-centered care:

1. Accepts each woman's knowledge and feelings of her own being and respects her ability to identify her own needs and those of her baby.
2. Recognizes the importance of ensuring optimal maternal and newborn health outcomes.
3. Is 'holistic' in terms of addressing the needs engendered by a woman's physiology, psychology, ethnicity, socioeconomic circumstances, sexual orientation, culture, religion, and level of education.
4. Recognizes women as predominant caregivers and strives to support them in managing the challenges they face in accessing health care.
5. Facilitates links to childbirth information and education, enabling women to ask questions and make informed choices about who provides care, where it is given, and what form it takes.
6. Recognizes women's rights to self-determination in terms of choice of caregiver and birth support, including decisions about the role family members or significant others will play during pregnancy, labor, birth, and postnatal periods.
7. Offers continuity of care so women are able to form trusting relationships with the providers who support them, and promotes collaboration with care providers to ensure smooth transitions from one level of care to another.
8. Focuses on women's unique needs, expectations, and aspirations rather than the needs of institutions or professions involved.
9. Ensures women are equal partners in the planning and delivery of maternity care.

CQI teams are one strategy that should be used in maternity care units to ensure women-centered care and promote respectful maternity care. Managers and providers need to devise ways to ensure CQI teams exist and function with a specific remit for maternity units.

Forming or strengthening CQI care teams

Components

- Review the current policy of CQI teams
- Review the current membership
- Ensure that the team includes people who have an interest in the issues, those directly affected by the issues and those who can act on them
- Include maternity unit staff
- Include community members from the facility management committee
- Set goals, objectives, and tasks to be achieved by the team

Steps to developing a new CQI team (or strengthening an existing CQI team)

1. Identify team members

Teams should have 3-4 members who will plan, implement, and evaluate their work. If a facility already has a team, make sure it includes appropriate members promoting respectful maternity care. Suggested members are: a midwife, a nursing officer in charge, a hospital administrator and a medical officer in charge. Staff will select members for the CQI team.

Note: Facilities with large maternity units may have a maternity unit CQI team but they should be linked to the overall facility CQI team.

2. Identify a time and place for short weekly meetings (no more than 30 minutes) The CQI team does not have to meet at the same time and place each week. Meetings can be more or less frequent as needed. *Note:* Post meeting schedules in a place accessible to all team members. Team notes should be taken in the following format:

Date	Main points for discussion	Next steps	Person responsible	Due by

3. Set goals. A goal is a clear statement of the intended improvement and how it is to be carried out and then measured. Team members will use their goal statement to stay focused and to establish boundaries for what is and what is not included in the team’s scope of work, and to define their successes. The goals will be posted at every team meeting.

Write a goal to improve quality. A goal:

- Should answer the question, “What do we want to accomplish?”
- Should be measurable
- **Should be short** so that everyone can remember it
- Does *not* include *how* you will achieve it
- May include a beginning and an end date

4. Clarify the role of CQI in promoting respectful maternity care. CQI teams will gather data and information on providers' and clients' perspectives of respectful maternity care by using the following tools:

- a. *Maternity Care Providers Interview Guide (Appendix 9):* A guide for soliciting providers’ perspectives on caring behaviors and the feasibility of performing them. The CQI team can use this to track progress on individual and facility work plans to support efforts to promote a good working environment that enhances caring behaviors.
- b. *Maternity Client Exit Interview Guide (Appendix 10):* An interview guide for exploring clients’ perspectives on provider caring behaviors and recent birth experiences.

SESSION 12

Monitoring and data management

The goal of this session is to improve participants' abilities to keep good records and use this as a tool for improving maternity care.

Learning objectives

Participants will:

1. Explain the terms recordkeeping, reports, monitoring, and data management.
2. List different types of records and reports in facility childbirth.
3. Outline the use of the various records and reports.
4. Discuss the purpose of recordkeeping and reports.
5. Describe management issues relevant to recordkeeping.
6. Demonstrate the ability to complete and maintain records in relation to RMC.
7. Briefly discuss the monitoring and evaluation for RMC.

Required learning

Participants will learn about the types of records used for maternity care services; the importance of record keeping and data management as well as the various tools that could be adapted for use in supervision and monitoring respectful care in childbirth.

Definitions

Recordkeeping: involves physically recording and retaining information with the purpose of facilitate future planning or reference needs.

Reports: Involves filling out and compiling specific information and data for use at different levels of planning.

Monitoring: is a continuous data collection and analysis process to assess a project or program and compare it with the expected performance. It provides regular information on how things are working.

Evaluation: provides a snapshot against some benchmarks or targets at a point in time of programs that may or may not be continuing.

Types of recordkeeping tools in relation to childbirth

Admission registers: retain data on admission history, reason for visiting/medical complaints, HIV counseling and testing, next of kin, etc.

Maternity/delivery registers: keep data on child delivery, time, mode, status of the baby, sex, blood loss, etc.

Nursing notes/Kardex record the midwifery care given to the mother/baby.

Partographs: record progress of labor and condition of mothers and babies.

Stock keeping records e.g., *bin cards*: record the drugs and supplies in the ward or the facility or service delivery points.

<i>Reports:</i>	submitted to different levels of management, e.g., daily/ shift reports, monthly reports, incident reports (maternal death, loss of baby); continuous professional development reports (CPD).
<i>Postnatal registers:</i>	record the care received by the mother and baby after delivery up to 6 months.
<i>Mother–baby booklet</i>	records ANC, PNC services, and care received by mothers and babies for up to five years.
<i>Death reviews/reports:</i>	includes maternal and perinatal death review forms, verbal autopsies, and community report forms/booklets.
<i>Other:</i>	linen book/register, ward and bathroom cleaning log sheets, diet order sheets /books, CPD log books, etc.

Importance of recordkeeping and reporting in promoting RMC

- Good recordkeeping and reporting practices are key planning tools in providing adequate and high-quality care at the ward/health facility level
- Information collected and kept can be used for decision making in management and supervision activities during childbirth. This enables providers to continually benefit from not only their own previous case experiences but also those of the entire ward or facility
- Maintaining accurate, clear, complete, and relevant information for client records can help ensure that clients receive full and appropriate care given their medical history and condition status

Importance and purpose of medical records

Medical records serve many purposes. First and foremost they document the history of examination, diagnosis, and treatment of a patient. This information is vital for all providers involved in a patient’s care and for any subsequent new provider who assumes responsibility for the patient.

- In disciplinary or peer review matters, medical records can justify (or refute) the need for a particular treatment
- Medical records improve accountability
- In reimbursement and utilization disputes, medical records document what services were rendered and whether they were medically necessary. Medical records are the single most important evidence for a provider during a malpractice claim or other inquiry concerning patient care
- In today’s health care environment that features multi-specialty care within ever-changing health care networks, consumers transfer to different providers, thus the need for comprehensive, accurate medical records cannot be overemphasized
- Medical records should contain sufficient, legible information that clearly demonstrates why a course of treatment was undertaken or why an indicated course of treatment was not
- Records must contain sufficient information to identify a patient, support their diagnosis, justify their treatment, and accurately document the course and result of their treatment
- Records must include: patient histories; subjective complaints; examination results; test results, x-rays; objective assessments; treatment plans; reports of consultations and hospitalizations; record of prescription drugs dispensed or administered; actual treatment rendered; and copies of records or other documents obtained from other providers

- Certain patient information such as billing records or test results should be part of the patient's medical records

Some means of verifying recordkeeping information include: exit interviews, supervision reports, periodic surveys, and monthly monitoring data reports. These include the following Monthly Monitoring Data Forms:

Health facility: Facility in charge (Appendix 11)

Maternity in charge (Appendix 12)

Community health workers (CHW) tool (Appendix 13)

Activity 1: Use of monitoring tools

Samples of monitoring tools are found in the appendix

Support supervision for promoting respectful childbirth

Support supervision is aimed at motivating staff and strengthening implementation of the activities at different levels of health care. The supervisors oversee the activities and support staff to carry out tasks correctly and without mistakes.⁴³ The RMC supervision guide below could be incorporated into existing maternal and neonatal health supervision structures.

Interventions	Services	Comment
What support structures exist to strengthen dignified and respectful care?	Continuous professional development targeted for RMC Orientation of new staff in the RMC concept Supervision and mentoring including role models/RMC champions	
Does the facility support the Caring for the carers?	Debriefing sessions Number of staff in attendance	
Does the facility have Maternity Open Days?	Number of maternity of days conducted Number of providers in attendance Number of managers in attendance Total number of community members in attendance Number of men in attendance Number of women in attendance	
Follow-up system on reported cases of disrespect and abuse	Available and functional: <ul style="list-style-type: none"> • Suggestion boxes • Continuous quality improvement team that includes maternity unit/staff 	
Community involvement in dealing with D&A	Incidents reported/referred by the community member to the facility management Number of D&A incidents resolved by mediation.	
Managers' support and commitment in: <ul style="list-style-type: none"> • Resolving D&A incidents; • Improving working conditions for maternity staff; and • Improving clients', companions', and relatives' comfort. 	Number of the above D&A incidents discussed for accountability Availability/minimum supplies and commodities for maternity units Availability of water, hot showers, drinks/meals, linen, clean labor room Clients allowed to bring in partners/companions during labor and delivery	
Check for availability and use of the RMC guidelines program briefs, tools, and posters	Brochures on RMC Service charter	
<ul style="list-style-type: none"> • What health messages are shared with your clients? • What health messages are shared with your providers? 	RMC concept Disrespect and abuse Values clarification and attitude transformation in promoting RMC Others.....	

⁴³ USAID. 2010. Uganda Ministry of Health and USAID Deliver Project – Encourage Supportive Supervision, USAID.

SESSION 13

Clinical experience

The goal of Session 13 is to give participants the opportunity to observe maternity services and identify acts that can promote RMC or, conversely, that are disrespectful and/or abusive. All seven categories of D&A may be observed: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities.

Learning objectives

Participants will attempt to identify acts of inclusion or negligence that result in D&A or to identify acts of inclusion that promote RMC as they observe the following:

1. History-taking of admitted mothers.
2. Physical examinations at any stage of labor or postnatally.
3. Proper infection prevention practices.
4. Effective use of delivery registers and other data management tools.
5. The level of cleanliness of the ward/unit/facility.
6. An example of the public display of a service charter and general information.
7. An optimal state/condition of ward areas, e.g., is there privacy and confidentiality.
8. Positive, professional provider working relationships with colleagues, patients, relatives, and/or community members.

Required learning

Participants will observe any acts of omissions and commission resulting in D&A during the site visit. They will use the experience to reflect on the way they work and identify areas that need to be strengthened in order to promote respectful maternity care.

NOTE: participants must seek consent from the clients and the providers before observing them.

SESSION 14

Translating evidence into action

The goal of this session is for each participant to use the skills they have learned throughout the workshop to develop an action plan. Skills include dealing with D&A at a personal level; ward, unit, or facility level; and health management level.

Learning objectives

Participants will develop action plans that include:

1. Initiating or strengthening the tested interventions discussed during the RMC workshop.
2. Orienting/updating other service providers in the participants' respective work stations through mentorship and support supervision.

Required learning

Participants will reflect on what they have learnt throughout the whole orientation and develop and individual work plan.

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Appendix 1: Three-day training schedule for providers

Day 1	Day 2	Day 3
Climate setting Participants Expectations/norms Pretest Workshop objectives RMC concept and RMC Resource package Workshop logistics	Recap Psychological debriefing: “Caring for the carers” Professional ethics and code of conduct Role of professional association and regulatory bodies in RMC	Recap Monitoring and data management for RMC <ul style="list-style-type: none"> • RMC indicators – discussion on data • monitoring tools
Overview maternal and neonatal health Human and childbearing rights Understanding disrespect and abuse	Rights and responsibilities of clients and providers for mutual accountability Group work <ul style="list-style-type: none"> • Where are we with the health service charter? 	Clinical practice <ul style="list-style-type: none"> • Introduce clinical objectives
Tea/Coffee Break	Tea/Coffee Break	Tea/Coffee Break
<ul style="list-style-type: none"> • Role play on women’s rights 	Maternity open day	Clinical practice
Introduction to values clarification and attitude transformation (VCAT) in RMC	Health facility management committee	Clinical practice
	Alternative dispute resolution mechanism – mediation in RMC <ul style="list-style-type: none"> • Demonstration on conducting mediation 	Clinical practice
Lunch	Lunch	Lunch
Group work VCAT exercises <ul style="list-style-type: none"> • Crossing the line Thinking about my values <ul style="list-style-type: none"> • Thinking about my worksheet 	<ul style="list-style-type: none"> • Role plays on mediation Community’s role in promoting RMC Group work <ul style="list-style-type: none"> • Community’s role in RMC 	Post test Review of clinical experience Workshop evaluation and closure
Tea/Coffee Break	Tea/Coffee Break	Tea/Coffee Break
Understanding self-concept	Continuous quality improvement group work <ul style="list-style-type: none"> • CQI teams and RMC • 	

Appendix 2: Community members' TOT training schedule

Time	Activity	Facilitator
08.30	<ul style="list-style-type: none"> • Participant registration • Welcome and Introductions • Logistics 	Community/project staff
08.45	<ul style="list-style-type: none"> • Expectations and norms • Workshop objectives 	
9.00	<ul style="list-style-type: none"> • Overview of maternal health • Categories of disrespect and abuse during childbirth • overview of gender, human rights, and law 	
10.30	Tea/Coffee Break	
11.00	<p>Dealing with disrespect and abuse</p> <ul style="list-style-type: none"> • Customer's rights and obligations • Responsibilities of health service providers • Responding to clients'/providers' rights – Maternity Open Days • Health facility management committees/boards (HFMC/B) • Continuous quality improvement (CQI) teams – Community participation • Community's role promoting in respect and dignified childbirth 	
01.00	Lunch	
02.00	<ul style="list-style-type: none"> • Mediation as alternative dispute resolution <ul style="list-style-type: none"> ○ Role play demonstration on conducting mediation • Community monitoring and data management in RMC • RMC- Action Plans • Workshop evaluation and way forward 	
04.30	Departure	

Appendix 3: Template for organizing the RMC workshop

LOGISTICS (SHOULD BE AT LEAST 1–2 months prior to workshop)				
Task	Person assigned	Date due	Done	Comments
Ensure that the training venue has been appropriately selected (classroom and clinical) and is adequate to create a positive learning climate, conduct the planned activities, and meet the course objectives				
Confirm clinical training sites: Location Capacity for training				
Meet with clinical staff and management				
Ensure that client scheduling is arranged with clinic staff or management as needed				
Prepare clinical staff if additional preceptors are needed				
Ensure participants have been invited (include information on travel reimbursement, per diem, lodging facilities, etc.)				
Ensure any consultants needed (<i>WHERE APPROPRIATE</i>) are arranged for (scope of work and contracts, etc.)				
Ensure logistics are being managed: included dietary needs, travel and transportation, lodging, and per diem				
Ensure transportation to clinic site is arranged (if needed)				
MATERIALS				
Ensure that the necessary training materials are prepared in time Trainers materials Participants materials Training supplies Reference documents				
Ensure the day before that all the necessary models, instruments and supplies are in good condition and will be available				
Ensure needed supplies are in place for projection of AV materials (extension cords, power supply, surge protector)				
Ensure that participant certificates of qualification or participation are drafted, finalized, and printed				
SHORTLY BEFORE				
Review any training needs assessment or learning needs assessment information				
Review course materials and adapt if needed				
Review pre- and post- assessments for accuracy, practice skills				
Reconfirm clinical training site arrangements				
Reconfirm role of consultants				
Meet with trainers to coordinate roles and responsibilities				
Ensure training manuals/reference resource materials are there				
Prepare certificates for statements of qualification or participation				
Visit classroom and arrange it, check supplies and equipment				

Adapted from Jhpiego, Sullivan, R., et al. 2009 *Clinical Training Course (CTS) for health care providers*. Jhpiego Baltimore

Appendix 4: The WRA charter (Session 3)

In seeking and receiving maternity care before, during and after childbirth:

1 EVERY WOMAN HAS THE RIGHT TO
BE FREE FROM HARM AND ILL TREATMENT
NO ONE CAN PHYSICALLY ABUSE YOU

2 EVERY WOMAN HAS THE RIGHT TO
INFORMATION, INFORMED CONSENT AND REFUSAL, AND RESPECT FOR HER CHOICES AND PREFERENCES, INCLUDING COMPANIONSHIP DURING MATERNITY CARE
NO ONE CAN FORCE YOU OR DO THINGS TO YOU WITHOUT YOUR KNOWLEDGE AND CONSENT

3 EVERY WOMAN HAS THE RIGHT TO
PRIVACY AND CONFIDENTIALITY
NO ONE CAN EXPOSE YOU OR YOUR PERSONAL INFORMATION

4 EVERY WOMAN HAS THE RIGHT TO
BE TREATED WITH DIGNITY AND RESPECT
NO ONE CAN HUMILIATE OR VERBALLY ABUSE YOU

All rights are grounded in established international human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women.

Safe Motherhood is more than the prevention of death and disability...It is respect for every woman's humanity, feelings, choices, and preferences.

RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN



5 EVERY WOMAN HAS THE RIGHT TO
EQUALITY, FREEDOM FROM DISCRIMINATION, AND EQUITABLE CARE
NO ONE CAN DISCRIMINATE BECAUSE OF SOMETHING THEY DO NOT LIKE ABOUT YOU

6 EVERY WOMAN HAS THE RIGHT TO
HEALTHCARE AND TO THE HIGHEST ATTAINABLE LEVEL OF HEALTH
NO ONE CAN PREVENT YOU FROM GETTING THE MATERNITY CARE YOU NEED

7 EVERY WOMAN HAS THE RIGHT TO
LIBERTY, AUTONOMY, SELF-DETERMINATION, AND FREEDOM FROM COERCION
NO ONE CAN DETAIN YOU OR YOUR BABY WITHOUT LEGAL AUTHORITY

Disrespect and abuse during maternity care are a violation of women's basic human rights.



For more information visit:
www.whiteribbonalliance.org/respectfulcare

Appendix 5: Thinking about my values worksheet (Session 4)

Instructions: Please think carefully about the following questions and answer honestly, according to your personal experiences.

Please keep your written responses brief. You will only be asked to share the responses you feel comfortable discussing with others.

Part A: Family and social groups

1. Did the family who raised you discuss specific beliefs or values regarding childbirth?

Yes

No

Please describe:-----

2. Did you experience any personal or family events that changed your beliefs or values about childbirth and maternity care services?

Yes

No

Please describe:-----

3. Describe similarities or differences between the values you presently hold about maternity care services and your family's values.

4. Do your family's values about maternity care services reflect the values commonly held by your family's racial or ethnic group, cultural heritage or nation?

Yes

No

Please describe:-----

5. Do you think the socioeconomic situation you were brought up in influences your values about maternity care services?

Yes

No

Please describe:-----

6. Is your present socioeconomic situation and/or level of professional education and practice different from that of the family who raised you?

Yes

No

Please describe on maternity care services:-----

7. Which one social group has had the greatest influence on your current values related to maternity care services?

Racial/Ethnic

Family who raised you

Professional colleague(s)

Religious/spiritual

Activist community

Lecturers/trainers who trained you

Friends

(Other describe: _____)

Part B: Religion and spirituality

1. Have you held the same spiritual/religious beliefs since childhood?

Yes

No

If yes, what are they?: _____

If no, describe how they have changed: _____

2. How do your personal spiritual/religious beliefs relate to your views on maternity care services?
Describe:.....

3. Do you consciously refer to your spiritual/religious beliefs when you are making an important life decision?

Always

Sometimes

Not Usually

Never

4. Describe a time when you felt challenged by a life event or circumstance that called for an action not supported by your religious/spiritual beliefs?
.....

5. How were you able to reconcile this action with your beliefs?
.....

6. Do your current values about any of the following topics conflict with your spiritual/religious beliefs in any way? Check all that apply:

Parity of the mother

Mother too young

Marriage/partnership relationship

Level of formal education

Mother too old

Mother physically or mentally challenged

Mother poor

Part C: Maternity care/midwifery practice and experience

1. Describe how your insights about maternity care have changed from when you were an adolescent; in your mid-20s; mid-30s; 40s and older:
.....

2. What specifically contributed to that change?
.....

3. How do you think your present age affects your perspective when offering maternity care services?
.....

Appendix 6: Psychological debriefing – Caring for the Carers (Session 5)

Directions

Counselors who will be identified to offer psychological debriefing sessions for the providers will use this as reference to prepare for the sessions.

Background

Events that overwhelm a person's coping skills can cause distress, sadness, and grief. Health care professionals often experience traumatic events (such as the death of a patient or caring for the terminally ill). Other critical, but less serious, incidents (perhaps an unusual event or unanticipated loss that negatively affects the staff) can be morally draining and can disturb the sense of peace and purpose of health care professionals. These lower-level critical incidents can accumulate and contribute to staff stress, burnout, and emotional exhaustion, all of which ultimately detracts from providing quality care. It is important that health care professionals be given an opportunity to release the emotional distress that follows such trauma or critical incidents through psychological debriefing.

What is psychological debriefing?

Psychological debriefing is a group meeting of survivors of a traumatic event or critical incident who meet to discuss their experiences, impressions, and thoughts of the event with a view toward preventing development of adverse reaction by reducing unnecessary psychological aftereffects. The facilitator can be a counselor or professional peer who helps the group process the information being shared. The facilitator should have the professional skills to guide the established process that will help group members recover from their distress. An important aspect of debriefing is that the facilitator will assess the needs of individuals who might benefit from further individual counseling and will make recommendations for individual follow-up.

Psychological debriefing improves individuals' cognitive understanding of what they have undergone, by making sense of the experience and the impact it has had on their lives now and in the future.

Objectives of psychological debriefing

- To mobilize resources within and outside the group to increase solidarity, group support, and cohesion
- To decrease the sense of uniqueness or abnormality of reactions in order to increase normalcy
- To promote cognitive organization through clear understanding of both events and reactions
- To promote ventilation of reactions and feelings
- To prepare the individuals for experiences related to the trauma or critical incident
- To identify avenues for further assistance if required, e.g., medication, legal redress, or counseling

Where can psychological debriefing be done?

It should be done in a safe place away from the stressor, by trained personnel if and where possible and as quickly as possible.

Structure of psychological debriefing

There are seven phases: 1) introduction phase, 2) expectations/narrative/facts phase, 3) impressions and thought phase, 4) emotional reaction phase, 5) normalization/education phase, 6) future planning/coping phase, and 7) disengagement phase.

The introduction phase

First sit the members in a circle, with the facilitator (team leader) and the housekeeper (co-facilitator) opposite each other. Make introductions, mentioning qualifications in the field of trauma, then outline the purpose of the meeting, and talk about psychological debriefing and its benefits. Help participants identify norms and rules and emphasize the leader's role; participants are not forced to say anything but they are encouraged to talk. Confidentiality is critical: note taking or any form of recording is not allowed and participants are not allowed to disclose to outsiders what they were told by other members of the group.

Emphasize that the meeting is not a forum for tactical evaluation and warn participants that during the meeting they may feel worse than before. Assure them this will reduce problems in the long run. The housekeeper keeps checking what people are going through and finally asks them if they have any questions.

Expectations/narrative/facts phase

The facilitators ask the members to give answers to the following questions:

- How did you learn about the event?
- How did you come into contact with the situation?
- What was your role during the event?

These questions are addressed to each member of the group. They bring out facts about the situation. Finally let the participants talk about their expectations after narrating the facts.

Impressions and thoughts phase

The leader focuses on the participants' thinking and decision making by asking this question:

What was your first thought upon encountering or learning about the event?

Encourage participants to talk about their experience. Encourage group members to show their impression in terms of sight, touch, and hearing. This produces inner images and thoughts in the period following the traumatic event thereafter. What they saw, heard, or smelled is specified.

Impressions are extremely important when it comes to developing a coping strategy. Recalling an impression is one of the best ways to prevent such memories from taking control over the individual (therefore provides catharsis). It also provides a good method of cognitively organizing the experience and working through triggering an emotional release. It enables the participants to confront the experience.

Emotional reaction phase

Ask the following question: What was the worst part of what happened to you?

This phase takes the longest part of debriefing because it is the time for relating to impression and emotional reaction. The participants realize that their emotions are similar. The facilitators take note of any participant who seems to be suffering the most or who is silent or showing extra ordinary symptoms. Such participants are gently approached after the meeting.

Normalization/education phase

The leader points out commonality in reaction using examples given as well as relating experience. The leader discusses the reactions and symptoms they should expect to develop over time e.g., post-traumatic stress disorder or acute stress. Teach about what is going on in them in terms of feelings reactions and behavior and assure them that this is normal to the traumatic event. Teach them what to expect so that they are best able to cope with the situation should it rise. Teach them stress management techniques and let them practice them in session.

Future planning and coping phase

Participants are once more active toward the end of the debriefing when future planning and coping are being discussed. Aspects relating to mobilization of support from family and friends are discussed. Allow members to show how they are planning to cope and to explain how they are coping so far.

Disengagement

At this stage any unattended areas are discussed and questions encouraged. Provide contacts and addresses of where participants can get further help. It is important to mention about the need for follow-up and provide your own contact.

Conclusion

Psychological debriefing accelerates the recovery of normal people experiencing normal reactions to abnormal events.

Appendix 7: International Code of Ethics for Midwives (Session 6)



PREAMBLE

The aim of the International Confederation of Midwives (ICM) is to improve the standard of care provided to women, babies, and families throughout the world through the development, education, and appropriate utilization of the professional midwife. In keeping with this aim, the ICM sets forth the following code to guide the education, practice, and research of the midwife. This code acknowledges women as persons with human rights, seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect and trust, and the dignity of all members of society.

The code addresses the midwife's ethical mandates in achieving the aims and objectives of the ICM concerned with how midwives relate to others, how they practice midwifery, how they uphold professional responsibilities and duties, and how they are to work to assure the integrity of the profession of midwifery.

THE CODE

I. Midwifery relationships

1. Midwives develop a partnership with women in which both share relevant information that leads to informed decision making, consent to a plan of care, and acceptance of responsibility for the outcomes of their choices.
2. Midwives support the right of women/families to participate actively in decisions about their care.
3. Midwives empower women/families to speak for themselves on issues affecting the health of women and families within their culture/society.
4. Midwives, together with women, work with policy and funding agencies to define women's needs for health services and to ensure that resources are fairly allocated considering priorities and availability.
5. Midwives support and sustain each other in their professional roles, and actively nurture their own and others' sense of self-worth.
6. Midwives respectfully work with other health professionals, consulting and referring as necessary when the woman's need for care exceeds the competencies of the midwife.
7. Midwives recognize the human interdependence within their field of practice and actively seek to resolve inherent conflicts.
8. Midwives have responsibilities to themselves as persons of moral worth, including duties of moral self-respect and the preservation of integrity.

II. Practice of midwifery

- a. Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures.
- b. Midwives encourage realistic expectations of childbirth by women within their own society, with the minimum expectation that no women should be harmed by conception or childbearing.
- c. Midwives use up-to-date, evidence-based professional knowledge to ensure safe birthing practices in all environments and cultures.
- d. Midwives respond to the psychological, physical, emotional, and spiritual needs of women seeking health care, whatever their circumstances.
- e. Midwives act as effective role models of health promotion for women throughout their life cycle, for families and for other health professionals.
- f. Midwives actively seek personal, intellectual, and professional growth throughout their midwifery career, integrating this growth into their practice.

III. The professional responsibilities of midwives

- a. Midwives hold in confidence client information in order to protect the right to privacy, and use judgment in sharing this information except when mandated by law.
- b. Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.
- c. Midwives may refuse to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.
- d. Midwives understand the adverse consequences that ethical and human rights violations have on the health of women and infants, and will work to eliminate these violations.
- e. Midwives participate in the development and implementation of health policies that promote the health of all women and childbearing families.

IV. Advancement of midwifery knowledge and practice

- a. Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.
- b. Midwives develop and share midwifery knowledge through a variety of processes, such as peer review and research.
- c. Midwives participate in the formal education of midwifery students and ongoing education of midwives.

International Code of Ethics for Midwives. 2008. <http://www.internationalmidwives.org>

Appendix 9: Maternity providers interview guide (Session 11)

The CQI team will track progress on individual and facility work plans in order to support efforts to promote a good working environment that enhances caring behaviors. The CQI team working with the facility or maternity unit management will set a date for the group discussions at least once a month.

The team will use this guide to seek providers' views, analyze the findings and write a report, and follow up and provide feedback on any gaps or strengths identified during the discussion.

1. In your own opinion how has the values clarification and attitude transformation (VCAT) training affected:
 - a. Provision of maternity care services; and
 - b. Health care providers in the maternity unit? Please explain your answers.

2. Each of the service providers developed their own individual work plan after the training (see Appendix 15).
 - a. Have the providers followed their plans? (Please ask for details).
 - b. What individual changes have taken place over the last month? (Ask for details).

3. In your own opinion what would you say about the following caring behaviors in this maternity unit/facility in the past month? *For each of the items please probe for the reason for the response given.*
 - a. Privacy
 - b. Confidentiality
 - c. Use of dignified tone/language
 - d. Obtaining consent for procedure during labor and delivery
 - e. Explain procedures about care and ward operations to clients and their relatives
 - f. Allowing birth companions during labor and delivery
 - g. Availability of hot showers, water, a clean environment, a warm labor room
 - h. Availability of meals and hot drinks for clients
 - i. Availability and adequacy of linen for use by clients and their newborns
 - j. Availability of commodities and supplies for labor delivery (lignocaine, oxytocin, ergometrine, sutures, gloves, chlorine 0.5%, gentamycin, crystalline penicillin, tetracycline eye ointment, etc.)
 - k. Timely response/action to clients' needs when required, e.g.,
 - going to theatre
 - pain relief or other medication
 - support with their babies
 - referral

4. In your own opinion, what would you say about service providers' working conditions in the last month? **Probe for what and how** regarding support from facility managers, professional associations–community members' involvement–Maternity Open Days, caring for the carers, teamwork, etc.
Probe for any challenges and success experienced in the maternity unit or facility in relation to childbirth.

5. Any other comments/observations
Thank the service providers

Appendix 10: Maternity client exit interview (Session 11)

Questionnaire Number

Date.....

Facility..... Mode of delivery.....

Condition of baby..... Condition of mother.....

Instructions

1. Introduce yourself to the client
2. Explain to the client the purpose of the interview
3. Reassure the client of confidentiality and privacy during the Interview

Introduction

My name is and I am going to ask you a few questions on the services you received in this facility. This interview is voluntary. Any information you provide will be treated with confidentiality, anything you say and your name will not appear in any report(s). Should you choose not to participate, provision of services to you in this or any other health care facility will not be affected. Please feel free to ask any questions or clarifications, and feel free to decline to participate in the interview.

	Questions and Filters	Yes	No	N/A	Comments
1.	Were you allowed to come with a birth companion who stayed with you during the birth of this baby?				
2.	Did the provider(s) explain to you all the procedures to be carried out for you during labor, delivery, and after the birth of this baby?				
3.	Did the service provider physically examine you a. immediately after delivery? b. within 6 hours in the ward?				
4.	Was privacy offered during examination and childbirth?				
5.	Did the service provider explain the results of the health examination?				
	Did any service provider tell you when you should return for another visit? Specify which services.				
6.	Do you feel you were offered adequate care a. on admission? b. during labor and delivery? c. after delivery?				
7.	Did you feel that the providers who attended to you used appropriate/friendly language?				
8.	Do you feel that the service providers responded in a timely way any time you called for help?				
9.	Did the service provider leave you alone when you felt you needed him/her for support/help during labor and delivery at any time?				
10.	On which day after delivery were you discharged? a) 1 st day (within 24 hours) b) 2 nd day c) 3 rd day and beyond				
11.	If the response is 3 rd day and beyond indicate why?				
12.	In summary would you say you were satisfied with the services you received in this facility? Would you recommend this facility to a friend?				
13.	Do you have any suggestions on areas that can be improved?				

I appreciate your time, participation, and insights during this interview

Appendix 11: Facility in charge monthly monitoring data form (Session 12)

Health facility management tool promoting RMC

Facility managerPhone number.....

Year ----- Month----- Facility-----

Activities for health facility management	No. of females	No. of males	Total numbers
1. Health facility management team support on RMC			
a. No. of health facility management members trained quarterly on promoting respectful childbirth.			
b. No. of health facility management members meetings conducted quarterly to promote respectful childbirth.			
c. No. of health facility management members actively involved during this quarter in community activities to deal with D&A.			
d. No. of D&A cases dealt with by the health facility management members during this quarter (e.g., maternity clients detention)			
e. No. of D&A cases reported to health facility management quarterly			
f. No. of D&A cases referred to the Health Facility Management members this quarter for counseling and mediation (specify.....)			
2. Health facility management committees (HFMC) support to facility improvement			Tick
a. No. of meetings held by HFMC during this month to discuss maternity supplies and commodities for promoting respectful childbirth			
I. Bed linen			
II. Drapers/mother gowns			
III. Curtains/partitions			
IV. Gloves			
V. Drugs – oxytocin, magnesium sulphate, vitamin K, iron, folate			
VI. Oxygen supplies			
VII. Infection prevention supplies (buckets, mops/rugs, gowns, masks, boots)			
VIII. Equipment – delivery sets, BP machine, thermometer, Uri sticks			
IX. Infrastructure – lighting, rooms, beds/cots repairs/ refurbishing			
b. No. of meetings held by HFMC during this quarter to discuss maternal health staff and human resource issues in maternity unit or facility			
c. No. of health facility management meetings discussing staff motivation to promote respectful maternity care this quarter.			
I. Staff housing			
II. Staff transportation – (Eg: at night or when working overtime)			
III. Transportation for referrals (staff escort client and means of transport)			

Any comments-----

Health facility management contact person-----Telephone -----

Signature----- Date-----

Appendix 12: Head of Maternity Unit monthly monitoring data form (Session 12)

Promoting dignified care to women during childbirth: In charge of maternity.....Phone

Year ----- Month----- Facility-----

Institutional mechanisms to promote respectful maternity care during childbirth	No. of females	No. of Males	Total No.
1. Attitude and values clarification and training			
a. No. of providers trained in VCAT during this month through /Continuing Professional Development sessions.			
b. No. of providers with individual work plans to deal with D&A cases during this month.			
c. No. of providers self-reporting progress on individual work plans to deal with D&A cases during this month.			
d. No. of facility group counseling sessions conducted for maternity unit staff during this month.			
e. No. of staff attending the counseling sessions conducted for maternity unit staff during this month.			
2. Facility's continuous quality improvement team's activities			
a. No. of CQI team meetings conducted to promote respectful childbirth during this month.			
i. No. of client exit interviews conducted involving community members.			
ii. No. of times suggestion boxes opened.			
iii. No. of cases of D&A discussed after opening suggestion boxes.			
b. No. of facility staff members actively participating in CQI team activities to promote respectful childbirth this month.			
c. No. of community members actively participating in CQI team activities to promote respectful childbirth in this month.			
d. No. of CQI team meetings advocating for staff motivation during this month:			
a. Provision of Staff/team meals.			
b. Staff/team recognition.			
e. No. of D&A cases audited by CQI teams during this month.			
f. No. of health staff held accountable by CQI teams during this month.			
g. No. of HMT members actively participating in forums conducted by CQI teams to discuss D&A drivers this month.			
h. No. of HMT members held accountable by QI teams for D&A drivers during this month.			
3. Mentorship approach for improving quality of care			
i. No. of mentors in this facility during this month.			
j. No. of mentors actively participating in mentoring activities to promote respectful childbirth during this month.			
k. No. of mentees ongoing during this month.			
l. No. of mentees completed mentoring sessions during this month.			
4. Management of resources at facility levels			
a. No. of days without adequate supply of magnesium sulfate in the maternity unit during this month.			
b. No. of days without adequate supply of oxytocin in the maternity unit during this month			
c. No. of days without adequate supply of ergometrine in the maternity unit during this month.			
d. No. of days without adequate supply of lignocaine in the maternity unit during this month.			
e. No. of days without adequate supply of antibiotic (crystalline penicillin and gentamycin) in the maternity unit during this month.			
f. No. of days without adequate supply of gloves in the maternity unit during this month.			
g. No. of days without adequate supply of chlorine for infection prevention in the maternity unit during this month.			
h. No. of days without adequate supply of tetracycline eye ointment in the maternity unit this month.			
5. Maternity Open Days			
a. No. of Maternity Open Days in the facility conducted this month.			
b. No. of women attending Maternity Open Days this month.			
c. No. of male partners attending Maternity Open Days this month.			
d. No. of youths attending Maternity Open Days this month.			

Facility contact person-----Signature----- Date-----

Telephone -----

Appendix 13: Monthly monitoring data form for community health workers (CHWs) and community health extension workers⁴⁴ (CHEWs) (Session 12)

Promoting dignified care to women during childbirth

Name of CHW/CHEW.....Phone number.....

Year ----- Month----- Facility-----Community unit-----

IINDICATORS FOR COMMUNITY LEVEL	No. of females	No. of males	Total number
1. COMMUNITY-MEMBERS' TRAINING			
a. No. of community dialogue days conducted to promote respectful childbirth this month.			
b. No. of community members trained on promoting respectful childbirth during community dialogue days this month.			
c. No. of community members actively involved in community activities to deal with D&A during this month (e.g., society leaders, community legal watchdogs).			
d. No. of D&A cases reported by community members to health facility management committees during this month.			
e. No. of D&A cases resolved through mediation by community members and facility management or staff participation during this month.			
f. No. of D&A cases referred for counseling and mediation during this month.			
g. No. of women referred or escorted from the community for facility-based childbirth during this month.			
2. MALE INVOLVEMENT IN BIRTH PLANNING			
a. No. of male forums conducted to promote respectful childbirth this month.			
b. No. of male partners trained on birth preparedness this month.			
c. No. of male partners willing and involved in birth planning this month.			
d. No. of male partners accompanying their partners/wives for ANC services this month.			
e. No. of male partners accompanying their partners/wives for delivery services this month.			
f. No. of male partners accompanying their partners/wives for postnatal cares services this month			
g. No. of men championing rights and obligations to respectful childbirth this month			
3. YOUTH INVOLVEMENT IN PROMOTING DIGNIFIED CHILDBIRTH			
h. No. of youth forums conducted this month to promote respectful childbirth.			
i. No. of youths sensitized on promoting respectful childbirth during this month.			
j. No. of youths willing and involved in promoting respectful childbirth during this month.			
4. WOMEN'S GROUP INVOLVEMENT IN PROMOTING DIGNIFIED CHILDBIRTH			
a. No. of women's group forums conducted to promote respectful childbirth this month			
b. No. of women sensitized on promoting respectful childbirth through women groups this month			
c. No. of women's groups championing rights to and obligations for respectful childbirth this month			

Any comments-----

.....

-----CHEWs contact -----

Telephone -----

Signature----- Date-----

⁴⁴ This form is used by CHWs to keep records of the community-level activities. The community health extension workers then sum up the reports from their respective community units and send to the district/subcounty community focal person.

**Appendix 14 Translating evidence into action: implementation action plans
(Session 14)**

County		Sub county/district	
Facility Facility Code/No.		Plan's facility/sub county/district supervisor: Telephone contact: Email address:	
Person(s) completing the plan			
Name	Designation	Position in facility/sub county/county	Telephone contact
Statement of goal and objectives			
Goal:			
Objectives:			

IMPLEMENTATION				EVALUATION	
What needs to be done?	By whom?	By when	What resources?	What evidence indicates progress?	How and when will evidence be gathered?