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Promoting Respectful Maternity Care: A training guide for facility-based workshops—Facilitator’s guide

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PROMOTING RESPECTFUL MATERNITY CARE

A TRAINING GUIDE FOR FACILITY-BASED WORKSHOPS
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Population Council
General Accident Insurance House
Ralph Bunche Road, PO Box 17643 - 00500
Nairobi, Kenya
Tel: +254 20 271 3480
Fax: +254 20 271 3479
email:info.nairobi@popcouncil.org


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

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

This Resource Package was developed by the Population Council in conjunction with the National Nurse Association of Kenya (NNAK) and the Kenya Federation of Women Lawyers (FIDA).

The Resource Package was developed and tested as part of an implementation research study conducted in Kenya by the Population Council as part of the TRAction project under USAID Cooperative Agreement No. GHS-A-00-09-00015-00. The research would not have been possible without invaluable support from the policymakers, health managers, service providers, and communities in five counties in Kenya. The authors wish to thank the Reproductive and Maternal Health Services Unit, and Nursing Services Unit, the Ministry of Health in Kenya, the Nursing Council of Kenya and the Heshima Project Steering Committee for their input. We are grateful for the support of USAID/Kenya, and would like to thank all of the Respectful Maternity Care champions at global and national levels for their support during the entire study period.
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. Nearly all of these took place in developing countries. 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 facilities

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

As part of the USAID Translating Research into Action (TRAction) project, the Heshima Project in Kenya was tasked to: determine the manifestations, types, and prevalence of D&A in childbirth; identify and explore the potential drivers of D&A; and design, implement, monitor, and evaluate the impact of interventions for reducing D&A including generating lessons for scale up. The interventions aimed to improve accountability of health providers at all levels of the health care system: policy, health program managers, facility or provider and community levels. This Resource Package is based on the most effective interventions, and provides practical, low cost, and easily adaptable strategies for facilities to improve respectful maternity care (RMC). RMC refers to the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and

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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.

**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 the Resource Package**

This set of resources is designed to be used by program managers, supervisors, trainers, technical advisors, and others who organize or facilitate RMC training workshops in the field of sexual and reproductive health, as well as skills updates in emergency obstetric and newborn care training. It provides experienced facilitators with the background information, materials, instructions, and tips necessary to effectively deliver a package of interventions to promote respectful care in the provision of reproductive, maternal, and newborn health services at both the facility and community levels.

This Resource Package 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.
How should respectful maternity care training be implemented?

Facilitators may offer a stand-alone Respectful Maternity Care Workshop at health facilities, or they may incorporate a selection of activities for ongoing training updates on maternal and newborn care. Trainers are encouraged to adapt the exercises or include other exercises helpful for promoting respectful maternity care. We suggest starting with stand-alone workshops. Then, once a core team of facilitators exists at the county/district/regional level, incorporate content into other meetings, workshops, or continuing professional development sessions. Be sure to allow sufficient time for discussion or role plays.

Workshops are designed to be offered as follows:

- **RMC orientation workshop (two days):** For policymakers, health managers, legal and health rights advocates, and media professionals (see schedule in Appendix 1). This workshop is intended to orient individuals about RMC who are not themselves medical service providers but who still influence the dynamic and quality of care that women receive. The workshop includes materials and intervention activities that highlight key practical points for promoting RMC. All sessions in the Facilitator’s Guide are covered, but in a much shorter version and level of detail than in the workshop for service providers. PowerPoint presentations, program briefs, and other instructional resources are available. (Note: a full two-day session allows for more discussion and reflection.)

- **Facility-based workshop for service providers (three days):** For maternity unit employees at health facilities. This workshop builds a team of individuals at a facility who understand the issues surrounding D&A and who can act as advocates of respectful maternity care. Those who are identified as good potential facilitators (e.g., of those who attend the orientation workshop; see selection criteria for facilitator on page 7) should also attend this workshop for more in-depth understanding of the issues. PowerPoint presentations for the three-day workshop and other instructional resources are available (see schedule Appendix 2).

- **Community-based workshop (one day):** for community health workers (CHWs) or volunteers, society leaders, and health and civil rights watch group representatives. The content can be delivered in a one-day workshop and includes information on the rights and obligations of women who give birth in facilities and of service providers (see schedule in Appendix 3). See Facilitator’s guide (for Community-based workshops) and the Community Flip Chart which supports the training of CHWs.
What is included in this Resource Package?

1. **Facilitator’s guide (for facility-based workshops):** This guide assists facilitators (who can be service providers, health managers, community health workers, legal professionals, etc.) in leading facility-based training workshops on improving respectful maternity care. The guide integrates Values Clarification and Attitude Transformation (VCAT) training into a set of interventions that promote respectful maternity care. VCAT training is designed to help participants explore, question, clarify, and affirm their values and beliefs about D&A during childbirth and related sexual and reproductive health (SRH) services to increase their awareness of and comfort in providing respectful care. The guide includes activities and materials (e.g., role plays and discussion questions) that promote the following values: increased support of childbearing women; advocacy for and provision of high-quality, woman-centered maternity care; and the rights of clients. PowerPoint presentations are available.

2. **Participant’s guide:** This guide is used by the participants as a reference tool; it includes participant learning activities and exercises.

3. **Facilitator’s guide (for community-based workshops):** This guide is designed to be used by facilitators to promote respectful maternity care at a community level. The manual can be adapted to educate a variety of stakeholders in community settings (i.e., Community Health Extension Workers, Community Health Workers, society leaders, legal aid officers, etc.). It highlights key practical points to enable participants to act as resource persons regarding the rights and obligations of childbearing women, and as advocates of respectful maternity care.

4. **Community flipchart:** This is a teaching aid for CHWs and other community-level resource persons to conduct community sensitization meetings or training workshops for general community members. The content and language used in the flipchart is simple and pictorial. Brochures are available for participants to take home as resources.

5. **Tools:** These offer guidance for conducting or organizing evidence-based interventions that promote respectful maternity care. These tools support:
   - **Maternity Open Days:** A day set aside by a health facility that permits community members to visit the maternity ward and interact with maternity staff in order to demystify myths and misconceptions surrounding facility-based childbirth.
   - **Alternative Dispute Resolution:** Mediation is a cost-effective conflict resolution mechanism that brings clients or relatives affected by D&A and the perpetrators together to discuss and resolve issues without the need for formal legal measures.
   - **“Caring for the Carers” counseling sessions:** Counseling sessions for service providers and other staff working in maternity units/wards, or the facility as whole, help them cope with work-related psychological stress or trauma, which is a major driver of D&A.

6. **Reference materials:**
   - **Research Briefs:** Describing evidence-based methods to reduce D&A at county/region, facility, and community levels.
   - **Links to other websites/resources:**
     - Universal Rights of Childbearing Women Charter, Respectful Maternity Care Brochure, Respectful Maternity Care: refer to the following webpage: [http://whiteribbonalliance.org/campaigns/respectful-maternity-care/](http://whiteribbonalliance.org/campaigns/respectful-maternity-care/)
     - Professional codes of ethics from FIGO, ICM, ICN
     - RMC on K4Health

All Resource Package materials are available on a CD-ROM or from the Population Council website at www.popcouncil.org.
Who should use this Resource Package?

This package can be adaptable for a variety of stakeholders in different settings that include: health care professionals, policymakers, legal professionals, lay community members, advocacy groups, and maternal health program implementers. Childbirth beliefs and behaviors tend to be context-specific and are founded on a myriad of social, cultural, professional and political factors. The activities in this Resource Package may be adapted to different social contexts.

Who should use the facilitator’s guide?

Reproductive health trainers, health care managers, supervisors, program managers or anyone responsible for training health care providers and community-level workers or volunteers can use the “Respectful Maternity Care Facilitator’s Guide.” Facilitators should be very familiar with all of the components of the Resource Package.

Tips for facilitators

This Resource Package is designed using a learner-centered, interactive training approach. Facilitators are encouraged to model the concepts and skills needed for effective training, including group facilitation, coaching, and nonjudgmental conduct. Take into consideration the following:

- Trainers and participants should understand the purpose of the training and workshop objectives
- Training methods should enable participants to achieve the objectives of the training
- Training should build on participants’ existing skills and experience
- Use open-ended questions that begin “how”, “what” “when”, and “why” to invite discussion
- New knowledge and skills should be presented in a meaningful and relative context
- Use a variety of training methods to meet the needs of different learning styles
- Create opportunities for participants to apply new knowledge and skills
- Provide constructive feedback to participants on their performance
- Ensure enough time for participants to meet the objectives of the training
- Solicit and accept feedback from participants and use the feedback to improve the training

REMEMBER: Effective training techniques keep participants engaged in the learning process, help trainers to assess how the training is being received, and help trainers adjust the training process as needed. For a checklist to organize workshops, see Appendix 4.
Facilitator’s guide
This guide includes sessions and activities that are designed to fully engage participants in a set of proven interventions and strategies that promote respectful maternity care and are founded on values clarification for attitude transformation (VCAT) training. The interventions are designed to move participants through a process of change that:

- Begins with individual willingness and motivation to change one’s behavior based on knowledge gained, deep self-understanding, and openness to change;
- Values clarification through self-critique, informed choice, affirmation, and taking action to change; and
- Transforms attitudes through a process of consistent affirmation and proactive adaptation of positive values, performance, and caregiving behaviors to promote respectful maternity care.

The intervention strategies are relatively simple and inexpensive to facilitate in low-resource settings. Nonetheless, supportive management, supervision, and follow-up of trainees at all levels of health service provision are required to ensure favorable results. The interventions are interconnected and include:

- Improving knowledge on health rights and laws
- Providing psychosocial support for work-related stress using caring for the carers activities
- Implementing Maternity Open Days
- Improving work environments through quality improvement and staff motivation initiatives
- Refocusing work ethics and strengthening professionalism
- Strengthening health facility management committees
- Improving (or developing) systems for reporting and documentation of rights violations
- Implementing conflict resolution mechanisms to deal with incidents of D&A
- Creating rights and legal campaigns at the national, regional and community levels

Facilitator selection
Criteria for facilitators include:

- Knowledge of VCAT theory and its application process
- Effective training skills
- Capacity to motivate and support others in the process to change attitudes and behaviors
- Experience in providing maternal health services
- Being a good role model and opinion leader
- Sensitivity and good listening skills

Participant selection
Facilitators are encouraged to carefully consider how participants’ backgrounds and characteristics will affect the experience and the effectiveness of the workshop. It is important for participants to feel safe and comfortable engaging in an honest examination and exploration of their beliefs, opinions and attitudes, and to remain open to change.

It is the responsibility of the facilitator to create and maintain an open learning environment. Different viewpoints about childbirth and the issue of D&A are valid, inevitable and will contribute to the richness of group discussion. There are benefits and risks to mixing participants with different personal and professional backgrounds, experiences of supporting women through labor and childbirth, and viewpoints about women’s rights and choice of where to give birth. In different circumstances, a more diverse group can increase the amount of facilitation needed.
The optimal facilitator-to-participant ratio is 1:5. Important workshop materials include:

- PPT presentations and projector
- Flipchart paper
- Markers
- Cards/sticky notes
- Masking tape
- Note books and pens
- Reference materials

**Teaching methods**

As with any training event, workshops should utilize adult learning principles. The following are commonly used teaching methods:

- Interactive presentations
- Large and small group discussions
- Individual and group work
- Hypothetical and real case studies
- Sensitivity and listening techniques
- Expressive activities (role play, songs, skits, artwork, games)
- Simulations
- Personal journals and interviews
- Self-analysis worksheets

**Additional background content**

We recommend background sessions on topics related to respectful and dignified maternity care. These may include:

- Data on maternal and newborn mortality and morbidity on regional, national, and global levels
- Context-specific data on the proportion of women who attend antenatal services, facility-based childbirth, and postnatal care services where available
- Overviews of international meetings, treaties, and agreements that support human rights and rights-based approaches to care
- Context-specific data on manifestation of disrespect and abuse (from DHS or other sources)
- Context-specific data on the drivers of disrespect and abuse from service provision surveys, WHO, or other relevant sources
- Relevant context-specific data on the magnitude and prevalence of disrespect and abuse (if available)

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**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
By the end of the session the participants will be able to:
1. Articulate their hopes and concerns about the workshop and about the topic of disrespect and abuse.

Training materials
- Index cards or paper
- Sticky note pads
- Pens or pencils
- Flipchart easel and paper

Session length:
15 Minutes
- 5 minutes for writing on cards/papers
- 5 minutes to discuss in pairs
- 5 minutes to discuss responses

Facilitator’s instructions

Advance preparation
Write the following statements on a flipchart:
- 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 ...

Ice breaker
1. Begin the workshop with a motivating, icebreaking activity that helps the participants to warm-up for the rest of the sessions. For example, you may use the “names and adjectives game” where participants are asked to think of an adjective that describes how they are feeling or that describes their personality. The adjective must start with the same letter as their name. For instance, “I’m Catherine and I’m confident.” Or, “I’m Ali and I’m amazing.” As they say this they can also mime an action that describes the adjective. You may choose to use another exercise, but be sure to consult a local person about local customs. For example, in some cultures it is not appropriate to have an activity in which men and women touch or shake hands.

Participants’ Expectations and Group Norms
This is an introductory activity that can be completed as an icebreaker at the beginning of a workshop or day’s sessions and then revisited at the end as a form of evaluation. This activity helps participants identify their expectations and/or concerns and discomforts regarding the workshop.

The same can be used at the end of the workshop to assess whether their expectations have been met as a result of the training they have undergone. The activity allows facilitators to identify additional expectations participants have and address any concerns about the workshop topic and contents.
2. Introduce the activity as an opportunity to discuss what people hope to gain from the workshop/day’s sessions and what concerns or discomforts they may have about the issues that will be discussed.

Introduction to the workshop

1. Give each participant an index card or paper. Post the flipchart with the statements. Ask them to take five minutes to silently read the statements and write their responses on their index card or paper.
2. Instruct participants to pair with the person sitting next to them and discuss the responses they feel comfortable sharing. Remind them that they do not have to discuss any responses they feel uncomfortable sharing.
3. Ask participants to share with the larger group their hopes during and after the workshop.
4. Record participants’ hopes on the flipchart under the headings “Expectations”, “Hopes” and “Hesitations.” As each person speaks, write their responses exactly as they are stated. Remind participants that they may decline to share a response if they feel uncomfortable. Remind participants to refrain from commenting on or evaluating anyone’s response.
5. After everyone who is willing has contributed, add your own expectations and hopes for the workshop that have NOT been mentioned by participants. Ask for one or two overall comments about the entire list of hopes (not any one person’s response).
6. Acknowledge that you will do your best to meet the group’s expectations. Explain which items meet certain expectations and those that may go beyond the scope of the workshop.
7. Record any items beyond the scope of the workshop under a ‘Parking Lot’ heading. Use a flipchart or writing board if appropriate. Assure participants that you will discuss how they might meet these expectations in other ways outside of the workshop.
8. Ask participants to keep their index cards as a reference until the end of the week/day as a way to check to see if the workshop addressed their hopes and expectations.
9. Solicit and discuss any outstanding questions, comments, or concerns with the participants.
10. End the session by asking the participants to decide what group norms or rules will guide the workshop dynamic. Write them on a flipchart and post the flipchart on the wall.

FACILITATOR’S TIP: The “Parking Lot”
The Parking Lot is a tool you can use to set aside ideas that participants raise which are important but not on topic at the moment. Write these ideas on a flipchart paper posted during the workshop.

It is crucial to revisit the “Parking Lot” at the end of each day and decide whether issues have been addressed and plan how you will discuss the pending issues during the remaining sessions or afterwards.

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
By the end of the session the participants will be able to:
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.

Training materials
- Flipchart paper, markers, masking tape, sheets of paper or cards
- PPT presentation
- Chart of the global status on maternal health
- Reference materials on country’s/region’s status on maternal health.

Session length: 30 Minutes

Facilitator’s instructions

Brainstorming activity
1. Introduce the session with a brainstorming activity.
2. Ask participants to define or explain the term “maternal health.” Write responses on the flipchart.
3. Summarize and correct as needed. Discuss additional content to fill knowledge gaps.
4. Ask participants about the current status of facility-based deliveries at their facilities and how the facility is performing, measured against current maternal health targets (ANC visits, SBA, PNC).
5. Ask participants to offer reasons why the targets remain generally low in their facilities.
   Use the PPT presentation to discuss the terms “respectful,” “dignified,” “disrespect,” and “abuse,” factors leading to disrespect and abuse, and the categories and evidence for disrespect and abuse during facility-based childbirth in relation to maternal health.
6. End by stating that among all the reasons mentioned, the workshop focuses on promoting respectful care during childbirth. If this is not mentioned among the reasons given for low SBA (which is highly unlikely), add it to the list.

Content

Definition 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.

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.5

Overview of maternal health
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, and emergency obstetric care. Since 1990, however, some countries in Asia and Northern Africa have reduced maternal mortality.6

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.7

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.8 Figure 2 below shows where maternal mortality is high. It is clear that maternal mortality rates are unacceptably high in Africa.

Figure 2: Map with countries by category according to their maternal mortality ratio (MMR, death per 100,000 live births), 20139

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7 Ibid.

8 Ibid.

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.

**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.10

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.

**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.

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Disrespect and abuse in childbirth

Based on a comprehensive review of research conducted by Bowser and Hill in 2010, 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. Categories are not intended to be mutually exclusive; they should be seen as overlapping one another along a continuum.

Figure 3: Landscape analysis of disrespect and abuse (Bowser and Hill 2010)

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. The seven categories of disrespect and abuse in childbirth are: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities or demand for payment.12

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A study conducted in Kenya\textsuperscript{13} 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 4 identifies potential drivers of D&A.

### Figure 4: Drivers of disrespect and abuse

<table>
<thead>
<tr>
<th>WHAT DRIVES DISRESPECT AND ABUSE?</th>
<th>At policy and governance levels:</th>
<th>At health facility and provider levels:</th>
<th>At the community level:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• No knowledge of international conventions</td>
<td>• Lack of understanding of clients’ rights</td>
<td>• Imbalanced power dynamics</td>
</tr>
<tr>
<td></td>
<td>• Complacency of policymakers</td>
<td>• Inadequate infrastructure leading to poor working environment</td>
<td>• Difficult for victims to seek justice</td>
</tr>
<tr>
<td></td>
<td>• Insufficient funding for maternal health care</td>
<td>• Staff shortages leading to high stress</td>
<td>• Lack of understanding of women’s health rights</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Poor supervision</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lack of professional support</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Weak implementation of standards and quality of care guidelines</td>
<td></td>
</tr>
</tbody>
</table>

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.

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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
By the end of the session the participants will be able to:
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.

### Training materials
- Flipchart paper, markers, masking tape, sheets of paper or cards
- PPT presentation
- Handout on international rights and laws
- Handout on landscape analysis of disrespect and abuse
- Handouts from White Ribbon Alliance universal rights of childbearing women
- WRA film maternal health

### Session length:
2 hours

### Facilitator’s instructions
1. Ask the participants to brainstorm the meaning of the concept of human rights. Allow several responses and provide the correct meaning as needed.
2. Discuss the origin and characteristics of human rights.
3. Use an interactive discussion to explore the legal background of a human rights approach.
4. Have a brainstorming session on the definition of reproductive health and reproductive rights. Write participants’ responses on a flipchart and discuss each. Use a PPT presentation to provide the correct meaning of the terms.
5. Discuss examples of human rights and limitation of approaches regarding reproductive health.
6. Conduct a role play on how to advocate for one’s reproductive health rights (see page 20).
7. Begin the section on disrespect and abuse during childbearing. Ask the participants to brainstorm on their perceptions of D&A; whether it is a common experience in other contexts, e.g., the transport industry, public offices, etc.
8. Invite participants to recount any personal experiences both in their social life and health care setting that they considered as disrespectful or inhumane. The facilitator may also offer his/her own personal experiences.
9. Ask the participants to identify at least two factors at a personal level that may lead to D&A during childbirth and conduct a brainstorming session on the feelings evoked by the experience and how that affected them/or continues to affect them.
10. Explain that D&A affects the individual at a personal level and their future behavior in terms of seeking services/recommending services to others.
Content for 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
- Cannot be waived/taken away
- Equal and interdependent
- Universal
- Protect individuals and groups

**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 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 health**\(^{14}\)

*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.\(^{15}\)\(^{16}\)

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 5). Universal human rights are inalienable 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.

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\(^{14}\) Adapted from definitions of SRHR in the ICPD and Beijing Platforms of Actions 2005.


\(^{16}\) Insight Share A Rights-Based Approach to Participatory Video: toolkit. Orientation to a Rights-Based Approach. www/http/insights share.org, accessed on 6 May 2014
Table 1: Categories of D&A, their legal definitions, and the corresponding Universal Rights of Childbearing Women; their examples and standard of care adapted from WRA 2011 Charter

<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>Legal definition (where it exists)</th>
<th>Observable element/child-bearing rights</th>
<th>Examples</th>
<th>Standards of care</th>
</tr>
</thead>
</table>
| 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. | - 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. | Staff takes time to explain: procedures, diagnosis, progress, results, and options.  
Information is given in an open and friendly manner.  
Clients are encouraged to ask questions. |
| 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. | - Use of non-dignified language or speaking rudely  
- Threats, e.g., “if you don’t cooperate I will take you to the theater.”  
- 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. | Staff is polite and use appropriate language, gestures in communicating with clients.  
Curtains and screens used and clients covered with linen when examined.  
Every health care provider reduces the risk of infection by washing hands before and after every procedure.  
Staff implements infection prevention measures. |
<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>Legal definition (where it exists)</th>
<th>Observable element/child-bearing rights</th>
<th>Examples</th>
<th>Standards of care</th>
</tr>
</thead>
</table>
| 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.                               | - 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 harsh 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. Every woman has access to skilled attendance during delivery.” | - 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. | On arrival at facility every pregnant woman in labor is attended by skilled person within 30 minutes of arrival.  
Every woman with obstructed labor, is observed, delivered or referred within the guidelines upon the diagnosis. |
| 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.                   | - 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.                                                              | - 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. | History taking and examination done in as much privacy as possible.  
Women are never exposed unnecessarily.  
Staff actively protects women’s privacy and confidentiality.  
Women are examined or attended to behind screens.  
Staff does not discuss or disclose client information to non-health care staff. |
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 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 four months pregnant; she had one baby who died 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 one 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 six 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

By the end of this session, participants will be able to:

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.

### Training materials

- Flipchart paper, markers, masking tape
- Sheets of sticky notes, paper, or cards
- PPT presentations
- Handout on “Crossing the line” exercise

### Session length: 2 hours 50 minutes

- Brainstorm – 15 minutes
- Discuss content using PPT presentations – 45 minutes
- Activity 1: “Crossing the line” – 40 minutes
- Activity 2: “Thinking about my values” – 30 minutes
- Activity 3: “Self-concept model” – 40 minutes

### Facilitator’s Instructions

1. Introduce the session: ask the participants to brainstorm on the meaning of “values” and “attitudes.” Request that participants write down their responses on sticky notes and attach to flipchart OR write them onto a flipchart.
2. Engage the participants with a short question-and-answer sessions on how attitudes and values affect maternity care services.
3. Use presentations to discuss the process of “values” and “values clarifications,” steps in “attitude transformation,” and the impact of difficult work environments on provider behavior.
4. Lead the group through Activity 1, Activity 2, and Activity 3.

### Content

Introduction to values clarification for D&A during childbirth:

- Our values form a fundamental part of our lives and as such have an effect on how we behave both personally and professionally. Our choices and actions are a result of informed, reasoned thoughts and feelings that are influenced by our values.\(^{17}\)
- Values are what we hold dear and think is important. They influence how we conduct ourselves and live. They serve as our internal road map.

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• Values are closely related to and are affected by our beliefs, ideals, and knowledge, and can affect our attitudes and behaviors.
• Values define what is right, good and just and they help us to determine right versus wrong and good versus bad. Our values inform our decisions and influence how we act. Values tend to persist and assume a pattern in our lives.

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.\(^{18}\) 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.”\(^{19}\)

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.\(^{20}\)

Example: Without being aware of it, John held the belief that it was cool to complain and criticize. Alienation of his friends caused him to identify, question, and change this belief about what is cool and attractive to others.

• 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

\(^{20}\) Fishbein M, Raven B: The AB scales: An operational definition of belief and attitude. Human Relat 1962, 15(1)
For individuals to attain the highest standard of sexual and reproductive health, they 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: 21

1) Choosing

2) Prizing

3) Acting

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?

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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 5**: Values clarification for RMC attitude transformation theoretical framework

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**Activity 1: Crossing the line exercise**

This activity is normally used as an icebreaker. In this activity the purpose will be to draw participants’ views on disrespect and abuse to the surface and address the connection between care in childbirth and professional practice. It also helps improve participants’ understanding of how disrespect and abuse in childbirth affects different viewpoints.

<table>
<thead>
<tr>
<th>Learning objective</th>
<th>Training materials</th>
<th>Activity length: 40 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of this session, participants will be able to:</td>
<td>• Masking tape</td>
<td></td>
</tr>
<tr>
<td>1. Articulate their feelings and views on disrespect and abuse during childbirth</td>
<td>• Large clear area</td>
<td></td>
</tr>
<tr>
<td>2. Identify views among participants on how D&amp;A might affect individuals and society at large.</td>
<td>• Selected statements</td>
<td></td>
</tr>
</tbody>
</table>

**Facilitator’s preparation**

- Clear a large area of the room to allow participants to move around, and place a line in the middle of this area using masking tape.
- Review and adapt statements, if needed. Select in advance the statements you will read that most apply to your group of participants. It is advisable to end with a statement you think all participants can identify with, such as the last one in the handout below.

**Facilitator’s instructions**

1. Ask all participants to stand on one side of the line.
2. Explain that you will read a series of statements and participants should step entirely across the line when a statement applies to their beliefs or experiences.
3. Remind participants that there is no “in between,” which means they must stand on one side of the line or the other, and that there are no “right” or “wrong” answers.
4. Ask participants not to talk during the exercise unless they need clarification or do not understand the statement that is read.
5. Stand at one end of the line and give an easy practice statement, such as: **Cross the line if you had fruit for breakfast this morning.**
6. Once some people have crossed the line, give participants an opportunity to observe who crossed the line and who did not. Invite participants to notice how it feels to be where they are.
7. Ask someone who crossed the line and then someone who did not to briefly explain their response to the statement. If someone is the only person who did or did not cross the line, ask them what that feels like.
8. Invite all participants to move back to one side of the line.
9. Repeat this for several of the statements about respectful maternity care. Select the statements that most apply to that group of participants.

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10. After the statements are read, ask participants to take their seats. Discuss the experience. Some discussion questions may include:
   - How did you feel about the activity?
   - What did you learn about your own and others’ views on respectful maternity care?
   - Were there times when you felt tempted to move with the majority of the group?
   - Did you move or not? How did that feel?
   - What did you learn from this activity?
   - What does this activity teach us about the stigma surrounding respectful maternity care?
   - How might normalization of D&A affect women’s emotional experience and care-seeking behavior with future childbirth? How would it affect a woman’s family?
   - How might normalization of D&A impact the experience of health workers and providers working in promoting respectful maternity care?

Debrief in particular the last statement. If everyone in the group crossed the line, discuss this commonality. If everyone did not cross the line, discuss how these different views affect people’s work on RMC and the broader issues of skilled birth attendance.

11. Solicit and discuss any outstanding questions, comments, or concerns. Take a few moments of discussion to point out how the beliefs we hold may be transferred to clients and that we may perceive these as normal. Also stress the double standards we may exhibit that can affect practice and attitude, and how we start to value our weaknesses and work toward improving service delivery. Keep in mind that the exercise can draw a lot of disagreement, especially if participants think they were justified in saving a mother and/or their baby and therefore did their best in the circumstances at the time.

Thank the group for their participation.

**Crossing the line statements**

**Cross the line if:**
- At some point in your professional life, you witnessed or heard a mother in labor being shouted or jeered at by a colleague
- If you have been asked to keep a secret about a colleague you witnessed pinching or slapping a mother in a labor ward
- If you have ever heard a colleague or family member talk in a derogatory manner about women's actions and/or behaviors during childbirth, e.g., crying, screaming, etc.
- At some point in your life, you felt pinching a little bit or shouting was a way of helping women in labor
- If you have ever written an incident report on a case of a baby's or mother's death in the maternity ward
- If you were ever told to cover up a report of abuse by a colleague or someone in charge
- If you have ever stifled (subdued) your feelings about a mother’s screaming while in labor
- If you ever avoided the issues of childbirth abuse at your workplace in order to keep safe or away from conflict
- If you believe all women deserve access to safe, high-quality maternal health care
Activity 2: Thinking about my values

The goal of this activity is to encourage participants to examine their values, the origin of these values and the way those values have shaped their lives and the lives of those around them.

<table>
<thead>
<tr>
<th>Learning objective</th>
<th>Training materials</th>
<th>Activity length: 40 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of this activity, participants will be able to:</td>
<td>Flipchart paper, markers</td>
<td></td>
</tr>
<tr>
<td>1. Identify and examine the role of external influences, such as family and social norms, religious beliefs, and age/life stage on the formation of values about midwifery and facility-based childbirth.</td>
<td>Sheets of paper, cards, or sticky notes</td>
<td></td>
</tr>
<tr>
<td>2. Explain the ways in which their values have changed over time, in response to new knowledge and experiences.</td>
<td>PPT presentation</td>
<td></td>
</tr>
<tr>
<td>3. Articulate any conflicts between the social norms or normalized behavior with which they were raised, trained, or oriented and their current values and how they resolve such values conflicts.</td>
<td>Values worksheet (Appendix 6)</td>
<td></td>
</tr>
</tbody>
</table>

Facilitator’s instructions

This session will help participants explore how their values and experiences contribute to what they do. Introduce the session by asking the participants to reflect on how their professional life and practice during childbirth may have been affected by their training, role models, or colleagues.

1. Ask the participants to think carefully about the above and answer honestly, according to their personal experiences.
2. Provide the participants with the worksheet on "thinking about my values" and ask them to write brief responses on their reflections.
3. Inform them that they will only be asked to share their responses if they feel comfortable discussing with others.
4. Ask participants to spend 20 minutes filling out the worksheet.
5. Once they have completed the worksheet, ask them what they thought of the exercise – was it useful? How do they feel? If participants are happy sharing their responses with others invite them to do so.
Activity 3: The self-concept model as a tool for understanding one’s own behavior

(SESSION 4)

The goal of this activity is to become more self-aware through exploration of the self-concept model and to apply this awareness to techniques that aid in transforming behavior.

<table>
<thead>
<tr>
<th>Learning objective</th>
<th>Training materials</th>
<th>Activity length: 40 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of this activity, participants will be able to:</td>
<td>• Flipchart paper, markers</td>
<td></td>
</tr>
<tr>
<td>1. Discuss the self-concept model as a tool to examine one’s behavior.</td>
<td>• Sheets of paper, cards, or sticky notes</td>
<td></td>
</tr>
<tr>
<td>2. Briefly discuss behavior transformation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Demonstrate knowledge in applying the knowledge of self-concept model.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Facilitator’s instructions**

1. Inform the participants that this exercise is not about self-blame or blaming others.
2. Introduce the self-concept model by stating that change starts with each one of us. Change in behavior is a process that is first self-directed but must also be supported by the environment. Knowing where we are helps us to decide the steps or actions we want to take in order to achieve the desired change.
3. Discuss the self-concept model as a tool of reflection and the effect of attitudes and behavior on understanding oneself.
4. Ask the participants to take a moment and reflect how the self-concept model may help them improve their self-awareness, if there are behaviors or issues they need to address.
5. Discuss behavior transformation and options that exist in supporting behavior change (where applicable), e.g., debriefing sessions or providers’ counseling are strategies that can be adapted to help improve our behaviors, other examples include self-coaching and peer modeling, among others.
6. Conduct the activity on helping the participants reflect on their behavior and what behavior(s) they would like to change.

**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.

About the self-concept model:

This map or illustration can help people understand themselves better. It 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.24,25

Figure 5: Self-Concept Model

**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. Here the person has little control over that information.

**Private domain:** Information here is confidential. The individual has control over what to tell others 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...."

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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.26

Body image: Body image is our perception of our physical self — including feelings of attractiveness or unattractiveness.27 How we think our body looks may not always be acceptable to us. Some people are not happy with their body weight, size or shape and perceive 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.28

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.29 This is our total worth or our pride, values, enjoyment, or 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.

27 idshealth.org/teen/your mind/body image/body_image.html
28 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.
The impact of self-esteem on interactions with other people

BRAINSTORMING ACTIVITY
Give examples of negative or positive behaviors that may result from low or high self-esteem. How do these specific behaviors create a pleasant or unpleasant environment?

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.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length: 40 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the session the participants will be able to:</td>
<td>• PPT presentation</td>
<td></td>
</tr>
<tr>
<td>1. Explain how work-related stress can be a driver of D&amp;A during facility-based childbirth.</td>
<td>• Flipchart paper, Markers, Masking tape</td>
<td></td>
</tr>
<tr>
<td>2. Examine the impact of difficult or traumatic work experiences on providers.</td>
<td>• Psychological debriefing or “caring for the carers” brief</td>
<td></td>
</tr>
<tr>
<td>3. Discuss psychological debriefing sessions for health care providers as strategy to reduce work-related stress.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Explain the steps in conducting psychological debriefing sessions for health care providers.</td>
<td></td>
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</tbody>
</table>

Facilitator’s instructions

1. Start the session by inviting the participants to share work-related traumatic events or stress that they may have experienced during the course of their work. Allow for 5 minutes of brainstorming.

2. Draw their thoughts on how these experiences affected their emotions and behavior perhaps resulting in disrespectful behavior.

3. Use the content described below to discuss the impact of work-related stress on the providers and how psychological debriefing sessions can be used to reduce the stress, thus minimizing D&A.

4. End the session with a brainstorming session on how debriefing sessions can be implemented in participants’ work areas. Guide participants to the debriefing tools in the Resource Package.
Work-related stress is the adverse reaction people have to excessive pressures or other types of demand placed on them at work. 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 it can’t happen), feelings of being overwhelmed and unable to cope, 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.

**The impact of difficult or traumatic work experiences on providers**

Events around labor and delivery may overwhelm a person’s coping skills; this distress or trauma can result in negative behavior on the part of the provider. Maternal health care providers often witness 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

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32 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
psychological debriefing sessions. This is an approach that enables groups and individuals to deal with work-related stress.\textsuperscript{33} 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 7.

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BRAINSTORMING ACTIVITY:

What kinds of activities would make you feel supported as a care provider?

How can we implement a “caring for the carers” strategy as part of routine support services for staff and providers in our respective work areas?
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.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the session the participants will be able to:</td>
<td>• Flipchart paper, markers, masking tape, sheets of paper or cards</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>1. Define health care ethics, code of conduct, courtesy, scope of practice, professional associations.</td>
<td>• Handout on WHO-ICM-FIGO Joint Statement 2004</td>
<td></td>
</tr>
<tr>
<td>2. Discuss the principles of ethics.</td>
<td>• Reference material on country’s regulatory and professional bodies</td>
<td></td>
</tr>
<tr>
<td>3. Explain the themes of ethics that promote RMC.</td>
<td>• Reference material on ethics, scope of practice, and code of conduct for the country specific professional cadres as appropriate</td>
<td></td>
</tr>
<tr>
<td>4. Describe the role and responsibilities of regulatory bodies in promoting RMC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Describe the roles and responsibilities of professional associations in promoting RMC.</td>
<td></td>
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</tr>
</tbody>
</table>

**Facilitator’s instructions**

1. Begin the session by asking the participant to state the meaning of the terms “ethics,” “code of conduct,” “courtesy,” and “scope of practice.” Use a pen and flipchart to write the participants’ responses. Use a guided discussion to facilitate and provide the correct meaning of the terms. Discuss how ethics terms are similar to RMC terms.

2. Ask the participants what professional organizations they belong to. Ask that they state the roles of professional associations and regulatory bodies. Allow 5 minutes for a brainstorming session and discuss each of the responses given.

3. Summarize the roles and responsibilities of professional associations and regulatory bodies in promoting respectful maternity care.

4. Conduct a group activity to stimulate the participants into differentiating between ethics and courtesy in professional practice. It is also an opportunity for participants to personally interact with one another and gain insight into the relative ethics of their behaviors (see Session 6, Activity 1: professional ethical dilemma).

5. End the session by emphasizing the medical professional ethics to help inform and advise participants on making ethical decisions in maternal health care.
**Content**

**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 Ethics34 and The International Confederation of Midwives (ICM) Code of Ethics35: These reflect professional values inherent 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 Ethics36: 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.

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- 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
- Some themes found in codes of ethics include the health care workers’ relationships 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 practice\(^{37}\) (see ICM code Appendix 8)

<table>
<thead>
<tr>
<th>1: Professional issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Practice competence and relations with co-workers</td>
<td></td>
</tr>
<tr>
<td>• Conditions of employment</td>
<td></td>
</tr>
<tr>
<td>• Purpose of nursing profession and personal conduct</td>
<td></td>
</tr>
<tr>
<td>• Incompetence of other health workers</td>
<td></td>
</tr>
<tr>
<td>• Role and accountability - self-responsibility for your own actions and acting as the women’s advocate</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2: Patient issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Respect life and dignity of the patient</td>
<td></td>
</tr>
<tr>
<td>• Uphold patient confidentiality</td>
<td></td>
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<tr>
<td>• Nondiscrimination against persons</td>
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</table>

<table>
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<tr>
<th>3: Social issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Addressing and improving the health/social needs of the community</td>
<td></td>
</tr>
<tr>
<td>• Health care providers’ relation to the state and obeying laws of the country</td>
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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.

BRAINSTORMING QUESTIONS:
What professional associations do you belong to?
How do the professional associations support you?
What is the role of the professional bodies in promoting RMC?
The goal of this activity is to have participants consider what professional ethics mean in their own work environments and how to engage in a process of ethical decision making.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Activity length:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discuss ethical dilemmas that may arise in professional work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Explain how ethical dilemmas may result into D&amp;A.</td>
<td>• Flipchart paper</td>
<td>5-10 minutes</td>
</tr>
<tr>
<td>3. Discuss possible options to mitigate D&amp;A.</td>
<td>• Markers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Masking tape</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sheets of paper or cards.</td>
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</tr>
</tbody>
</table>

**Facilitator’s instructions**

1. Provide blank sheets of paper to each participant.
2. Ask participants to list situations where they were faced with an ethical dilemma.
3. Explain that these situations could include nonverbal, verbal, or physical acts.
4. Allow participants to exchange notes and ask them to take a moment to share situations/experiences in their maternity units: was it ethical? Justify.
5. Invite 4 or 5 participants to read out the notes.
6. Invite the other participants to give their input as to whether the acts were ethical or not.

End the sessions by discussing possible options that could be adapted to mitigate D&A in reference to a situation the participants shared. Note: Refer to the ICM code of ethics as appropriate (see Appendix 8).
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.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length: 1 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the session the learners should be able to:</td>
<td>• Flipchart paper</td>
<td>1 hour</td>
</tr>
<tr>
<td>1. Define the concept of a charter as a tool for ensuring a rights-based approach to maternal health care.</td>
<td>• Markers</td>
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<tr>
<td>2. Briefly discuss the core functions and responsibilities of ministries of health.</td>
<td>• Masking tape</td>
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<tr>
<td>3. State the responsibilities of health service providers in a service charter.</td>
<td>• Sheets of paper or cards</td>
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<tr>
<td>4. Discuss the responsibilities of patients/clients in the service charter.</td>
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<tr>
<td>5. Discuss maternity open days as an approach for improving mutual understanding, accountability, and respect between community members and service providers.</td>
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</table>

Facilitator’s instructions
1. Ask the participants to brainstorm about the meaning of "mutual accountability," a "charter," a "service charter," and a "health service charter." Write all the responses and review some of the responses. Provide the correct meaning of the terms.
2. Ask the participants to state examples of clients’ obligations.
3. Discuss the responsibilities and the role of providers in the service charter.
4. Ask the participants to divide into groups to represent a facility or management team (e.g., national, regional/county), and community members. Help divide the group as appropriate.
5. Provide a felt pen and a flipchart to each group and ask them to identify a leader and note taker.
6. Ask the groups to come up with draft statements for a charter that represents each stakeholder (community, service provider, manager).
7. Allow 15 minutes for discussion and then 5 minutes for each group to report in the plenary.
8. End the session with a question-and-answer session to summarize the topic.
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.

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.

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:

- 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

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

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

Goal of this activity is to discuss the concept of Maternity Open Days as an intervention to promote mutual accountability between providers, health managers and community members.

### Learning objectives
1. To strategize on building mutual accountability.
2. Practical application of how to promote mutual accountability.

### Training materials
- Flipchart paper and pens
- Markers
- PPT presentation

### Activity length:
45 minutes

### Facilitator’s instructions
1. Provide an overview of the importance of educating the community.
2. Explain briefly what constitutes a Maternity Open Day.
3. Ask participants to get into groups and develop a plan for holding a Maternity Open Day in their facility. Use brainstorm points (see box below).
4. Allow 30 minutes discussion and then encourage each group to give 5-minute feedback with input from other groups.
5. Discuss how any challenges might be overcome.
6. Summarize that Maternity Open Days aim to both:
   a. Promote mutual understanding, accountability, and respect among community members and service providers; and
   b. Improve knowledge and demystify procedures during labor, childbirth, and the immediate postnatal period.

### Content

#### The importance of educating community members

Health care clients are often unfamiliar with their rights and responsibilities in a medical setting. Specific to childbirth, many community members do not understand the events and procedures involved with giving birth in a facility.

A lack of mutual understanding can give rise to mistrust between care providers, women seeking care, and community members. This in turn can lead to fear, myths, and misconceptions surrounding facility-based childbirth, and even give rise to D&A. These misconceptions can cause women to choose not to deliver in facilities and can frustrate service providers. It is therefore important to ensure that community members are educated as to their rights and responsibilities in seeking care at a health facility.

### BRAINSTORM: PLANNING FOR MATERNITY OPEN DAYS

How can you implement maternity open days in your own facilities?
Do you have any new or different ideas for engaging the community in a maternity open day?
What challenges might you face, and how can they be overcome?
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.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length: 40 Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By the end of the session the participants will be able to:</strong></td>
<td>• Flipchart paper</td>
<td></td>
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<tr>
<td>1. Discuss the composition of the health facility management committees/boards.</td>
<td>• Markers</td>
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<tr>
<td>2. Discuss the role of the committee in promoting RMC.</td>
<td>• Masking tape</td>
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<tr>
<td>3. Discuss the powers of the health facility management committees/boards.</td>
<td>• Sheets of paper or cards</td>
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<tr>
<td>4. Review the criteria for selecting HFMC/B members by facility management.</td>
<td>• PPT presentation</td>
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</tbody>
</table>

Facilitator’s instructions

1. This session is designed so that it can be delivered to community members, health care providers, managers, or health facility management committees/boards separately or as a multi-disciplinary group.

2. Start the session by brainstorming the roles of the HFMC/Bs. Write the roles on a flipchart and review them. Clarify the roles.

3. Divide the participants into groups of five or per facility group to:
   a. Discuss the composition, role, and responsibilities of HFMC/Bs (refer to the country’s national, regional, and facilities’ standard operating procedures or guidelines to encourage discussion).
   b. Review the current performance of the HFMC/B and their linkages/involvement in the facility management.
   c. Identify the role of the HFMC/B in promoting RMC.

4. Allow a 15-minute group discussion and then have each group report to the plenary.

5. End the session by asking the participants to take note of the roles and activities learned from the discussion that would be useful in strengthening the HFMC/B in their facilities, as they will develop work plans at the end of the workshop.
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 and articulate community interests on matters pertaining to health in local development forums.
4. To facilitate a feedback process to the community pertaining to the operations and management of the health facility.
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.\textsuperscript{40, 41}

Powers of the HFMC

1. The committee shall have the authority to raise funds from within itself, 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.

\textsuperscript{40} World Health Organization. 2006. “Quality of Care. A process for making strategic choices in health systems.”

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**
By the end of the session the participants should be able to:
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.

**Training materials**
- Flipchart paper and markers
- Masking tape
- Sheets of paper or cards

**Session length:**
1 hour 30 minutes

**Facilitator’s instructions**
1. Introduce the session by asking participants to define the terms “mediator” and “alternative dispute resolution.”
2. Allow participants to share their experiences of social or political situations where mediation may be used.
3. Use an interactive lecture to discuss the role of mediation and the stages of the process.
4. Conduct a role play to demonstrate the use of mediation in resolving disputes arising from D&A.
5. End the session by restating that alternative dispute resolution offers guidance and a mechanism to resolve incidents of D&A within the health care setting. It complements other tools used to demand accountability among health workers.

**Content**

**Definition of alternative dispute resolution mechanism:** ADR is a process of resolving disputes by using methods other than conventional litigation (i.e., by utilizing traditional or community justice systems). It is the act or process of mediating between parties, to effect an agreement or reconciliation. ADR is often used as a means to avoiding the often cumbersome, slow, and expensive nature of many conventional legal systems. 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.

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**Definition of 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.

**Definition of 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 9)

**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

**BRAINSTORMING ON MEDIATION:**
Reflecting on our facilities/work stations:
- What accountability mechanisms have you used in the work stations to deal with D&A?
- How was the incident(s) resolved?
- In your opinion, how will you incorporate mediation within the health care settings in your station?
Role Play 1: Using mediation to resolve an incident of physical abuse  
(SESSION 9)

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.

Note to the Facilitator:
Selection of experienced and tested mediators is a major determining factor the success of mediation. During training, identify the participants with good communication skills to act as mediators for the role play. Inform the participants that bad feelings or mistrust can suddenly occur in a mediation that had previously been going well. The mediator should be quick to identify any tension and should terminate the meeting in time to avoid any confrontation by the aggrieved parties. Should this occur, another date is set to reconvene. If the parties cannot agree on a date, the mediator should provide referral to other mechanisms such legal services. As the facilitator, watch for any tension during the role play and intervene as necessary.

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

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 his/her 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) (SESSION 9)

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 indentified 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 job aid) 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.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length: 1 hour 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the session the participants should be able to:</td>
<td>• Flipchart paper and markers</td>
<td>1 hour 30 minutes</td>
</tr>
<tr>
<td>1. Outline community members’ roles in promoting respectful maternity care.</td>
<td>• Masking tape</td>
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<tr>
<td>2. State community structures available for dealing with incidents of D&amp;A.</td>
<td>• Sheets of paper or cards</td>
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<tr>
<td>3. Demonstrate techniques for strengthening community–facility links and methods to deal with incidents of D&amp;A at the community level.</td>
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Facilitator’s instructions
1. Introduce the session by asking the participants to brainstorm their role in promoting RMC.
2. Use an illustrative lecture to deliver the session content.
3. End the session with a group discussion on how to strengthen existing community structures to respond effectively to reports of D&A incidents.

Content
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 who 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.

**GROUP ACTIVITY: THE COMMUNITY’S ROLE IN PROMOTING RMC**

What community structures or mechanisms exist in your locality for legal redress and accountability that could be used to improve RMC?
How can we strengthen facility, community, and manager linkages for RMC and mutual accountability?

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 (HFCMs)**: 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.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length: 1 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the session the participants should be able to:</td>
<td>• Flipchart paper</td>
<td></td>
</tr>
<tr>
<td>1. Describe the term continuous quality improvement (CQI).</td>
<td>• Markers</td>
<td></td>
</tr>
<tr>
<td>2. Discuss CQI in relation to respectful maternity care.</td>
<td>• Masking tape</td>
<td></td>
</tr>
<tr>
<td>3. Explain the membership of CQI teams.</td>
<td>• Sheets of paper or cards</td>
<td></td>
</tr>
<tr>
<td>4. Determine the roles of CQI teams in promoting respectful maternity care.</td>
<td>• Handout on data collection worksheet for labor and delivery unit</td>
<td></td>
</tr>
<tr>
<td>5. Discuss ways to strengthen CQI teams so that they involve maternity units.</td>
<td>• Handout on maternity unit exit interview (Appendix 11)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PPT presentation</td>
<td></td>
</tr>
</tbody>
</table>

Facilitator’s instructions

1. Begin the session by brainstorming the definition of quality of care and continuous quality improvement. Use a pen and flipchart to note all responses from participants.

2. Summarize the responses and clarify definitions. Ask the participants if there are any quality of care initiatives in their respectful facilities and list them. Discuss how each of them relates to respectful maternal care. Use the PPT presentation to go through the content.

3. Ask participants to review their respective facility or maternity unit CQI teams using the following questions: How are the CQI teams constituted? Do the CQI teams include respectful care as an area of focus? How do community members’ views get incorporated into the CQI teams? Allow 10 minutes for discussion and reporting back to the group.

4. End the session by summarizing possible solutions for strengthening CQI teams based on the participants’ responses and explain that they could be included in the action plans that the participants will make at the end of the workshop.

Content

**Definitions of continuous quality improvement:** CQI refers to the combined and ongoing efforts of everyone—health care professionals, patients and their families, researchers, planners, and educators—to make the changes leading to better patient health outcomes, better patient care, better professional development and better access to care.\(^{45}\)

---

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. \(^{46}\)

**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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Main points for discussion</th>
<th>Next steps</th>
<th>Person responsible</th>
<th>Due by</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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 10):* 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.


**BRAINSTORMING ACTIVITY ON CQI TEAMS AND RMC**

What CQI team strategies do you have in place to promote woman-centered care in your facility/ward?

How can we strengthen the CQI teams to ensure accountability through:

- Providers?
- Facility/ward managers?
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

By the end of the session the participants should be able to:
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.

Facilitator’s instructions

1. Introduce the session by asking participants to define the terms "data" and "monitoring."
2. Allow participants 5 minutes to discuss different monitoring tools available in the facility.
   Allow one or two participants to give a quick presentation of the tools.
3. Clarify which monitoring tools that the facilities currently use.
4. Issue each participant a copy of the monitoring tools and generate discussions in three groups, then choose a participant from each group to present their findings.
5. For another group activity, split the participants into groups based on their professional roles. Share RMC monitoring tools (Appendix 12, 13 and 14). Ask participants to familiarize themselves with the materials and follow the Group Activity information in this session.

Content

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.

Reports: 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).

Postnatal registers: record the care received by the mother and baby after delivery up to 6 months.

Mother–baby booklet: records ANC, PNC services, and care received by mothers and babies for up to five years.

Death reviews/reports: includes maternal and perinatal death review forms, verbal autopsies, and community report forms/booklets.

Other: 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 taken.

• 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 12)
- Maternity in charge (Appendix 13)
- Community health workers (CHW) tool (Appendix 14)
**Activity 1: Use of monitoring tools** (SESSION 12)

**Introduce the monitoring tools for each level of service**

Ask the participants to form groups according to the level of service, e.g., health managers, facility or wards in charge, facility staff, and community members.

Explain that each of the groups will review the monitoring tools and discuss the following:

- Sources of data, e.g., registers, minutes, exit interviews, suggestion boxes, etc.
- Ensuring data quality
- Using the data to ensure RMC
- Reporting – frequency and to whom
- Mode of reporting and feedback – hand delivery, email, phone

Table 2 shows indicators for measuring respectful maternity care. Indicators provide evidence that a certain condition exists or certain results have or have not been achieved. The inputs refer to resources mobilized to undertake a set of proven activities, in this case promoting respectful maternity care. The outcomes indicators show the direct results of effects of the interventions. The impact indicators are the long-term changes associated with carrying out a set of interventions.\(^\text{47}\)

<table>
<thead>
<tr>
<th>Table 2: Indicators for measuring respectful maternity care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>A. FACILITY-LEVEL INDICATORS</strong></td>
</tr>
<tr>
<td>1</td>
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</tbody>
</table>

\(^\text{47}\)Jan Mainz. Defining and classifying clinical indicators for quality improvement. DOI: http://dx.doi.org/10.1093/intqhc/mzg081 523-530 First published online: 6 December 2003
<table>
<thead>
<tr>
<th>Inputs</th>
<th>Indicators</th>
<th>Outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. FACILITY-LEVEL INDICATORS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mentorship approach to improve skills according to need</td>
<td>- Number of mentors identified and mentees trained</td>
<td>- Staff has the capacity and skills to provide quality maternal and neonatal (MNH) care</td>
</tr>
<tr>
<td>4</td>
<td>Management of resources at facility levels (equipment, supplies, staffing levels)</td>
<td>- Supply stock maintained. - Appropriate staffing levels on all shifts</td>
<td>- Health system drivers of D&amp;A are reduced</td>
</tr>
<tr>
<td>5</td>
<td>Caring for the Carers to reduce health provider stress and burnout</td>
<td>- Number of staff counseled - Number of staff who feel supported by management</td>
<td>- Reduced staff stress levels</td>
</tr>
<tr>
<td>6</td>
<td>Maternity Open Days</td>
<td>- Number of Maternity Open Days held per quarter - Number of women attending</td>
<td>- Increased utilization of delivery services</td>
</tr>
<tr>
<td>7</td>
<td>Establish/strengthen health facility committees (see below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. COMMUNITY-LEVEL ACTIVITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Community members training to generate awareness of rights to/maternal care. Develop disseminate fliers/posters that capture the RH/MNH rights.</td>
<td>-The number of reported D&amp;A cases. -The number of women referred to health facilities.</td>
<td>Increased number of women delivering in the health facilities -Increased number of D&amp;A cases reported -Increased number of women utilizing health facilities</td>
</tr>
<tr>
<td>2</td>
<td>Society leaders training to act as intermediaries between the community and the facility in addressing issues relating to D&amp;A Open Legal Forums.</td>
<td>The number of mediation cases. The number of cases dealt with by opinion leaders. The number of cases handled by a FIDA counselor/referred to a FIDA counselor for legal action.</td>
<td>Number of resolved disputes -Increased number of women accessing justice through the existing channels</td>
</tr>
<tr>
<td>3</td>
<td>Counseling community members who have experienced D&amp;A Counseling at community level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Establish/overhaul HFMC/B Train HFMC/B on client childbirth rights and obligations. Develop D&amp;A reporting and monitoring tools for HFMCs Ensure community membership of HFMCs</td>
<td>-Number of functional HFMC/Bs -Number of community forums held by HFMC/Bs -The number of D&amp;A cases reported to the facility level -Number of D&amp;A cases discussed by HFMC/Bs at the community level</td>
<td>-Strengthened and supportive working environment for maternity services by midwives and other health providers -Strengthened customer service philosophy -Improved accountability for D&amp;A by facility management and providers</td>
</tr>
<tr>
<td>5</td>
<td>Male involvement and birth planning to prevent detention</td>
<td>-Reduced number of women detained in facilities</td>
<td>-Increase in male support during labor and delivery</td>
</tr>
</tbody>
</table>
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. The RMC supervision guide below could be incorporated into existing maternal and neonatal health supervision structures.

Table 3 Supervision and monitoring for RMC

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Services</th>
<th>Comment</th>
</tr>
</thead>
</table>
| 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 Open 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:  
• 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:                                        | 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 |                                                                                                                                                                                                                                                                                                                                                                                                   |
| • Resolving D&A incidents  
• Improving working conditions for maternity staff  
• Improving clients’, companions’, and relatives’ comfort | Brochures on RMC  
Service charter |                                                                                                                                                                                                                                                                                                                                                                                                   |
| Check for availability and use of the RMC guidelines program briefs, tools, and posters | Brochures on RMC  
Service charter |                                                                                                                                                                                                                                                                                                                                                                                                   |
| • 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.................................................................................................................................................. |                                                                                                                                                                                                                                                                                                                                                                                                   |

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48 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.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length: 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the session the participants will be able to identify acts of inclusion or negligence that result in D&amp;A or to identify acts of inclusion that promote RMC as they observe the following:</td>
<td>• Flipchart paper and markers, masking tape</td>
<td></td>
</tr>
<tr>
<td>1. History-taking of admitted mothers.</td>
<td>• Notebooks and pens</td>
<td></td>
</tr>
<tr>
<td>2. Physical examinations at any stage of labor or postnatally.</td>
<td>• Copy of the clinical objectives</td>
<td></td>
</tr>
<tr>
<td>3. Proper infection prevention practices.</td>
<td>• PPT presentation</td>
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</tr>
<tr>
<td>4. Effective use of delivery registers and other data management tools.</td>
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</tr>
<tr>
<td>5. The level of cleanliness of the ward/unit/facility.</td>
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<td></td>
</tr>
<tr>
<td>6. An example of the public display of a service charter and general information.</td>
<td></td>
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<tr>
<td>7. An optimal state/condition of ward areas, e.g., is there privacy and confidentiality.</td>
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</tr>
<tr>
<td>8. Positive, professional provider working relationships with colleagues, patients, relatives, and/or community members.</td>
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</tbody>
</table>

Facilitator’s instructions

**NOTE:** The facilitator needs to prepare for this visit separately (see Appendix 3)

1. Check that the site/facility is ready to receive the participants and organize for transport before the visit. A three-hour visit is recommended.
2. Divide the participants into groups of 5 people. Ask them to identify a leader for each group.
3. Discuss the objectives of the clinical experience.
4. Conduct the site visit.
5. After the visit, allow groups 15 minutes to discuss the clinical experience.
6. Allow 10 minutes for groups to share their findings with the plenary.
7. Use the groups’ findings to reinforce the positive behavior observed.
8. For any acts that result in D&A observed during the visit, discuss how they can be overcome.
9. Allow participants to use their experience and reflect on their work stations to identify areas that need strengthening in order to promote respectful maternity care.
10. End the session asking the participants to share how they will strengthen the areas identified.

**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, at the ward, unit, or facility level, and at the health management level.

<table>
<thead>
<tr>
<th>Learning objectives</th>
<th>Training materials</th>
<th>Session length: 90 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop action plans that include:</td>
<td>Copies of action plan template in Appendix 15</td>
<td>90 minutes</td>
</tr>
<tr>
<td>1. Initiating or strengthening the tested interventions discussed during the RMC workshop.</td>
<td>Pen, paper</td>
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</tr>
<tr>
<td>2. Orienting/updating other service providers in the participants' respective work stations through mentorship and support supervision.</td>
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</tbody>
</table>

Facilitator’s instructions

Initiating or strengthening the tested interventions discussed during the RMC workshop

Ask participants to write down what is needed to implement each of the intervention components:

1. **The intervention component** *(Refer to course content and add another context-specific intervention that may arise during the workshop)*
   i. What needs to be done? By whom? By when?
   ii. What resources are needed?

2. **Evaluation**
   i. What evidence indicates progress?
   ii. How and when will evidence be gathered?

Allow participants to work in groups and share work plans within the plenary for discussion and input from other participants. Individual work plans will not be shared, but will be a personal commitment toward behavior change.

Orienting/updating other service providers in the participants' respective work stations through mentorship and support supervision

1. Request each participant to orient others in their work stations as follows:
   a. Provide feedback to all service providers in the health facility, especially in the maternity unit, including support staff such clerks, cleaners, guards, and those offering hospitality services, e.g., serving meals, making beds, among others.
   b. All staff in the facility should be oriented to the respectful maternity care concept and the proven interventions (see program briefs in Toolkit) to deal with disrespect and abuse.
NOTE: RMC update sessions can be broken down into a series of 1–2 hour updates, and based on the intervention component in the Resource Package. However it is important to conduct the VCAT and reflective sessions in one day.

2. Use the PowerPoint printed handout provided in the training session when offering updates to ensure that standards are met for delivering the content. Refer to the tools provided in this RMC tool kit and share them with the staff.

3. Evaluate knowledge gained by asking questions.

4. Once the staff is oriented they need to make implementation action plans as above.

5. Remember to make your presentation lively and highly interactive.
Bibliography


Global Health; Obstetrics & Gynaecology (Obstetrics, Reproductive medicine, Obstetrics & gynecology-other). 2014 World Health Organization Published by Elsevier Ltd. The Lancet Global Health, Early Online Publication, 6 May 2014 doi: 10.1016/S2214-109X(14)70227-X Cite or Link Using DOI.


International Confederation of Midwives.


Warren, C., Njuki, R., Abuya, T., Ndwiga, C., Maingi, G., Serwanga, J., Mbehero, F., Muteti, L., Njeru, A., Karanja, J., Olenja, J., Gitonga, L., Rakuom, C., and Bellows, B. Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya,  


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### Appendix 1: Managers RMC orientation workshop Schedule (1.5 days)

<table>
<thead>
<tr>
<th>Time</th>
<th>Day one activity</th>
<th>Day two activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.30</td>
<td>Climate setting</td>
<td>Alternative dispute resolution mechanism – mediation in RMC</td>
</tr>
<tr>
<td></td>
<td>Participants expectations/norms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workshop objectives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RMC concept and RMC toolkit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workshop logistics</td>
<td></td>
</tr>
<tr>
<td>09.00</td>
<td>Brief overview of the project</td>
<td>• Demonstration on conducting mediation</td>
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<tr>
<td></td>
<td>Brief overview of maternal health</td>
<td>• Involving communities in RMC</td>
</tr>
<tr>
<td></td>
<td>Understanding health rights and Law</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disrespect and abuse during facility-based childbirth</td>
<td></td>
</tr>
<tr>
<td>10.30</td>
<td><strong>Tea/Coffee Break</strong></td>
<td></td>
</tr>
<tr>
<td>11.00</td>
<td>Brief overview on interventions to promote facility-based Respectful Maternity Care (RMC)</td>
<td>• Monitoring and data management for RMC</td>
</tr>
<tr>
<td></td>
<td>Attitude transformation and values clarification training: <em>It starts with me</em></td>
<td>• Managers' roles in RMC – action plans</td>
</tr>
<tr>
<td></td>
<td>• Introduction to values clarification and attitude transformation (VCAT) in RMC</td>
<td>• Plenary</td>
</tr>
<tr>
<td></td>
<td>• Group work VCAT exercises – Crossing the line</td>
<td>• Workshop evaluation</td>
</tr>
<tr>
<td></td>
<td>• Thinking about my values – Exercise on my worksheet</td>
<td>• Way forward</td>
</tr>
<tr>
<td></td>
<td>• Understanding self – self concept</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Introduction to the caring for the carers concept in RMC</td>
<td></td>
</tr>
<tr>
<td>01.00</td>
<td><strong>Lunch</strong></td>
<td><strong>Lunch and departure</strong></td>
</tr>
<tr>
<td></td>
<td>• Improve working environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health Facility Management Committees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continuous quality improvement teams</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Addressing providers and clients – Service charter</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Professionalism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Codes of ethics and scope of practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Professional associations and RMC</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2: Three-day training schedule for providers

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climate setting&lt;br&gt;Participants&lt;br&gt;Expectations/norms&lt;br&gt;Pretest&lt;br&gt;Workshop objectives&lt;br&gt;RMC concept and RMC&lt;br&gt;Resource package&lt;br&gt;Workshop logistics</td>
<td>Recap&lt;br&gt;Psychological debriefing: “Caring for the carers”&lt;br&gt;Professional ethics and code of conduct&lt;br&gt;Role of professional association and regulatory bodies in RMC</td>
<td>Recap&lt;br&gt;Monitoring and data management for RMC&lt;br&gt;• RMC indicators – discussion on data&lt;br&gt;• monitoring tools</td>
</tr>
<tr>
<td>Overview maternal and neonatal health&lt;br&gt;Human and childbearing rights&lt;br&gt;Understanding disrespect and abuse</td>
<td>Rights and responsibilities of clients and providers for mutual accountability&lt;br&gt;Group work&lt;br&gt;• Where are we with the health service charter?</td>
<td>Clinical practice&lt;br&gt;• Introduce clinical objectives</td>
</tr>
<tr>
<td><strong>Tea/Coffee Break</strong></td>
<td><strong>Tea/Coffee Break</strong></td>
<td><strong>Tea/Coffee Break</strong></td>
</tr>
<tr>
<td>• Role play on women’s rights</td>
<td>Maternity open day</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>Introduction to values clarification and attitude transformation (VCAT) in RMC</td>
<td>Health facility management committee</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>Alternative dispute resolution mechanism – mediation in RMC&lt;br&gt;• Demonstration on conducting mediation</td>
<td></td>
<td>Clinical practice</td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td><strong>Lunch</strong></td>
<td><strong>Lunch</strong></td>
</tr>
<tr>
<td>Group work VCAT exercises&lt;br&gt;• Crossing the line&lt;br&gt;Thinking about my values&lt;br&gt;• Thinking about my worksheet</td>
<td>• Role plays on mediation&lt;br&gt;Community’s role in promoting RMC&lt;br&gt;Group work&lt;br&gt;• Community’s role in RMC</td>
<td>Post test&lt;br&gt;Review of clinical experience&lt;br&gt;Workshop evaluation and closure</td>
</tr>
<tr>
<td><strong>Tea/Coffee Break</strong></td>
<td><strong>Tea/Coffee Break</strong></td>
<td><strong>Tea/Coffee Break</strong></td>
</tr>
<tr>
<td>Understanding self-concept</td>
<td>Continuous quality improvement group work&lt;br&gt;• CQI teams and RMC</td>
<td></td>
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</tbody>
</table>
## Appendix: 3 Community members' TOT training schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator</th>
</tr>
</thead>
</table>
| 08.30 | • Participant registration  
      • Welcome and Introductions  
      • Logistics                  | Community/project staff       |
| 08.45 | • Expectations and norms    
      • Workshop objectives       |                              |
| 9.00  | • 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 | **Dealing with disrespect and abuse**  
      • 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 | • Mediation as alternative dispute resolution  
      o Role play demonstration on conducting mediation  
      • Community monitoring and data management in RMC  
      • RMC- Action Plans                      |                              |
| 04.30 | **Departure**                  |                              |
Appendix 4: Template for organizing the RMC workshop

### LOGISTICS (SHOULD BE AT LEAST 1–2 months prior to workshop)

<table>
<thead>
<tr>
<th>Task</th>
<th>Person assigned</th>
<th>Date due</th>
<th>Done</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Ensure that the training venue has been appropriately selected</td>
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<td>(classroom and clinical) and is adequate to create a positive</td>
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<td>learning climate, conduct the planned activities, and meet the</td>
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<td>course objectives</td>
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<tr>
<td>Confirm clinical training sites:</td>
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<tr>
<td>Location</td>
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<tr>
<td>Capacity for training</td>
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<tr>
<td>Meet with clinical staff and management</td>
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<tr>
<td>Ensure that client scheduling is arranged with clinic staff or</td>
<td></td>
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<tr>
<td>management as needed</td>
<td></td>
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<tr>
<td>Prepare clinical staff if additional preceptors are needed</td>
<td></td>
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<tr>
<td>Ensure participants have been invited (include information on travel</td>
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<tr>
<td>reimbursement, per diem, lodging facilities, etc.)</td>
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<tr>
<td>Ensure any consultants needed (WHERE APPROPRIATE) are arranged for</td>
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<tr>
<td>(scope of work and contracts, etc.)</td>
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<tr>
<td>Ensure logistics are being managed: included dietary needs, travel</td>
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<td></td>
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<tr>
<td>and transportation, lodging, and per diem</td>
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<tr>
<td>Ensure transportation to clinic site is arranged (if needed)</td>
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</tbody>
</table>

### MATERIALS

Ensure that the necessary training materials are prepared in time:
- Trainee 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 5: 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, 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**

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.

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

For more information visit: www.whiteribbonalliance.org/respectfulcare
Appendix 6: 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?
   ...............................................................................................................................

Adapted from Ipas, Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences 2008
Appendix 7: 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/cop ing 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 extraordinary 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 8: 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.

Appendix 9: D&A incidence reporting and consent form (Session 9)

Community unit............... Facility attached to............... Month............. Year...........

I........................................................................on this day...............of year ___________, consent to
my information being shared by the Ministry of Health for the purposes of recordkeeping and for
any other relevant action pertaining to promoting dignified and respectful care during childbirth.

The information will not affect the services that I and my family or any other community member
receives from any of the health facilities now and in future. I understand that that any information
offered will be confidential and will be kept under lock and key dedicated to this study, which only
the study team can access.

I understand that I may agree to give the information or choose to end information-giving at any
time without penalty or loss of existing benefits to which I am entitled. I am free to withdraw at
any time without affecting my relationship with the MOH and the project partners.
I have read/received an explanation of the benefits of and privacy in sharing my personal
information. I agree to provide information on my own experience with regard to inhumane
treatment during childbirth. I understand that providing the information is voluntary.

Your name........................................................................ Your signature...................................................

Telephone Number.............................. Location/community unit..........................

Details of D&A case
............................................................................................................................................................
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Reported by
............................................................................................................................................................

Community Contact Person............................................................................................ Telephone...........................................................
Signature.................................................. Date .............................................................
Appendix 10: 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? Probes 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 11: Maternity client exit interview (Session 11)

**Questionnaire Number** ..........................  
**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.

<table>
<thead>
<tr>
<th>Questions and Filters</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were you allowed to come with a birth companion who stayed with you during the birth of this baby?</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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) 1st day (within 24 hours)  
  b) 2nd day  
  c) 3rd day and beyond |     |    |     |          |
| 11. If the response is 3rd 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 12: Facility in charge monthly monitoring data form (Session 12)

Health facility management tool promoting RMC

Facility manager …………………………………………………………………. Phone number …………………

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

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

Any comments-----------------------------------------------------------------------------------------------------------------------------------

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

Signature----------------------------------------------- Date-----------------------------------------------
Appendix 13: Head of Maternity Unit monthly monitoring data form (Session 12)

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

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

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

Facility contact person----------------------------------Signature----------------------------------Date---
Telephone ------------------
## Appendix 14: Monthly monitoring data form for community health workers (CHWs) and community health extension workers (CHEWs) (Session 12)

Promoting dignified care to women during childbirth

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

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

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

Any comments---------------------------------------------------------------------------------------------------------

----------------------------------------------------------------------------------------------------------------------

CHWs contact --------------------------------------------------------------- CHEWs contact __________________________________________

Telephone ------------------------------------------------------------------ Signature------------------------------- Date---------------------

---

49 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 15 Translating evidence into action: implementation action plans (Session 14)

<table>
<thead>
<tr>
<th>County</th>
<th>Sub county/district</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>Plan's facility/sub county/district supervisor:</td>
</tr>
<tr>
<td>Facility Code/No.</td>
<td>Telephone contact:</td>
</tr>
<tr>
<td></td>
<td>Email address:</td>
</tr>
</tbody>
</table>

### Person(s) completing the plan

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Position in facility/sub county/county</th>
<th>Telephone contact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### Statement of goal and objectives

**Goal:**

**Objectives:**

### IMPLEMENTATION

<table>
<thead>
<tr>
<th>What needs to be done?</th>
<th>By whom?</th>
<th>By when</th>
<th>What resources?</th>
<th>What evidence indicates progress?</th>
<th>How and when will evidence be gathered?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### EVALUATION

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