Ministry of Public Health

Deputy Minister Office for Health Care Services Provision

Reproductive, Maternal, Newborn, child and Adolescent Health Directorate

RESPECTFUL MATERNITY CARE ORIENTATION PACKAGE
for Health Care Providers

Participants Guide

April 2017
FORWARD:

In its on-going quest to improve the health status of its people and in line with the quality and equity improving agenda, Ministry of Public Health (MoPH) in Afghanistan has continued to strengthen health service delivery across the entire continuum of health care and ensure a respectful and caring health workforce.

According to existing evidence in Afghanistan and worldwide, Respectful Maternity Care (RMC) is known to be the most neglected area of health care services. To address this gap, MOPH prioritized RMC and adapted the RMC orientation package beside other interventions, with technical and financial support of USAID funded HEMAYAT project and other partners.

The MOPH renews its commitment to improving RMC within the continuum of care from community to facility level. It is my considered view that, with enough level of commitment and support from the MoPH and all stakeholders, promoting and institutionalizing RMC will improve the health status and will significantly contribute in reduction of preventable maternal and newborn mortality in the country.

I would like to take this opportunity to extend appreciation to RMC technical working group, Reproductive Maternal, Newborn, Child and Adolescent Health Directorate, Community Based Health Care Department, Health Promotion Department, partners and professional associations who have actively participated in the preparation of the RMC orientation package.

Sincerely,

Dr. Feda Mohammad Paiyan
Deputy Minister for Health Care Services Provision
Ministry of Public Health
Kabul, Afghanistan
ACKNOWLEDGMENTS:

The Ministry of Public Health (MoPH) of the Islamic Republic of Afghanistan is committed to increase quality skilled birth attendance to at least 60% and to enhance access to reproductive health services by 2020.

The Ministry of Public Health considers Respectful Maternal Care (RMC) as an essential component of "Quality Maternal and Newborn Health Services" and a priority to increase facility birth and ensure effective implementation of women’s rights in health services. Despite overall advances in maternal health outcomes, ensuring women have skilled and respectful care during delivery remains a challenge. Mistreatment in childbirth is a major barrier to women accessing facility-based care. It is critical for the MoPH in Afghanistan to consider how it can prevent such mistreatment, and better meet women’s socio-cultural, emotional and psychological needs as part of broader efforts to provide better quality care.

The RMC orientation package has been adapted by the RMC working group under the leadership of Reproductive, Maternal, Newborn, child and Adolescent Health Directorate (RMNCAHD), with technical and financial support of USAID-funded HEMAYAT project in close collaboration with the Community Based Health Care and Health Promotion Departments. The work was a collaborative effort of technical stakeholders who assured that both facility and community based RMC packages are adapted and aligned with Afghanistan context.

I would like to thank RMNCAHD for taking the lead of this initiative and the RMC working group members, namely; Health promotion and Community Based Health Care directorates, AMA, AFSOG, WRA, AKDN and HEMAYAT project for their continued support and provision of technical inputs throughout the RMC package’s adaptation process.

I am sure that RMNCAHD and its development partners will ensure that efforts to ensure RMC are prioritized during facility-based maternity care services. This ultimately results in increased quality of care and contributes to reducing maternal and newborn deaths in the country.

Sincerely yours,

Dr. Zelaikha Anwari
Director of Reproductive, Maternal, Newborn, child and Adolescent Health Directorate
Ministry of Public Health
Table of Contents

FORWARD:......................................................................................................................... Error! Bookmark not defined.

ACKNOWLEDGMENTS................................................................................................................. Error! Bookmark not defined.

ABBREVIATIONS AND ACRONYMS.............................................................................................. v

INTRODUCTION .......................................................................................................................... vi

RESPECTFUL MATERNITY CARE (RMC)....................................................................................... vii

WHY FOCUS ON PREVENTING MISTREATMENT DURING CHILDBIRTH? ...................... 2

ABOUT THE RESOURCE PACKAGE .............................................................................................. 2

SESSION 1: ICEBREAKER AND INTRODUCTION TO THE WORKSHOP ............................................. 3

SESSION 2: OVERVIEW OF MATERNAL AND NEWBORN HEALTH AND MISTREATMENT DURING FACILITY-BASED MATERNITY SERVICES INCLUDING CHILDBIRTH ................ 4

SESSION 3: CHILDBEARING RIGHTS ............................................................................................. 8

SESSION 4: VALUES CLARIFICATION AND ATTITUDE TRANSFORMATION (VCAT) ............. 16

SESSION 5: PSYCHOLOGICAL DEBRIEFING OF HEALTH CARE PROVIDERS ................. 25

SESSION 6: PROFESSIONAL ETHICS ............................................................................................ 27

SESSION 7: PROMOTING MUTUAL ACCOUNTABILITY: RIGHTS AND RESPONSIBILITIES OF HEALTH CARE PROVIDERS AND CLIENTS DURING MATERNITY SERVICES .......... 30

SESSION 8: PROMOTING RMC AT MANAGEMENT LEVEL ................................................................. 34

SESSION 9: MEDIATION AS AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM .......... 36

SESSION 10: COMMUNITY’S ROLE IN PROMOTING RESPECTFUL MATERNITY CARE IN FACILITIES ...................................................................................................................... 41

SESSION 11: IMPROVING QUALITY OF CARE ............................................................................. 43

SESSION 12: MONITORING AND DATA MANAGEMENT ................................................................. 46

SESSION 13: TRANSLATING EVIDENCE INTO ACTION .................................................................. 50

Appendices:..................................................................................................................................... 51

Appendix 1: Managers RMC orientation workshop Schedule (two- days) .................................................. 51

Appendix 2: Three-day training schedule for health care providers ......................................................... 52

Appendix 3: Template for organizing the RMC workshop .................................................................. 53

Appendix 4: Thinking about my values worksheet ............................................................................. 55

Appendix 5: How to hold a Maternity Open Day .............................................................................. 58

Appendix 6: Psychological debriefing – Caring for the Carers ............................................................ 59

Appendix 7: WRA’s The Universal Rights of Childbearing Women ..................................................... 62

Appendix 8: Maternity client exit interview ...................................................................................... 63

Appendix 9: Harmonized quality improvement standards ................................................................. 64

Appendix 10: action plan template ................................................................................................ 86

Appendix 11: Terms of reference for health facility quality improvement committee ......................... 87

Appendix 12: MoPH position paper for promoting RMC .................................................................. 89

Annex 13: Member of Respectful Maternity Care Orientation Package Working Group .................. 91

References: ...................................................................................................................................... 91
## ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAAQ</td>
<td>Available, Accessible, Acceptable and of Good Quality</td>
</tr>
<tr>
<td>ADR</td>
<td>Alternative Dispute Resolution</td>
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<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
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<tr>
<td>ANDS</td>
<td>Afghanistan National Development Strategy</td>
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<td>BPHS</td>
<td>Basic Package of Essential Services</td>
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<tr>
<td>CHWs</td>
<td>Community Health Workers</td>
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<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<td>EPHS</td>
<td>Essential Package of Hospital Services</td>
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<tr>
<td>EVAW</td>
<td>Ending Violence Against Women</td>
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<td>FIGO</td>
<td>The International Federation of Gynecology and Obstetrics</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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<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>MoPH</td>
<td>Ministry of Public Health</td>
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<td>NAPWA</td>
<td>National Action Plan for Women in Afghanistan</td>
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<tr>
<td>PNC</td>
<td>Postnatal care</td>
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<td>PPT</td>
<td>PowerPoint</td>
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<td>RMC</td>
<td>Respectful Maternity Care</td>
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<tr>
<td>SBA</td>
<td>Skilled Birth Attendance</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>TOTs</td>
<td>Trainers of Trainers</td>
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<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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<td>WRA</td>
<td>White Ribbon Alliance</td>
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INTRODUCTION

Pregnancy, childbirth, and their consequences are still the leading causes of death, disease, and disability among women of reproductive age in developing countries. Nearly 275,000 maternal deaths due to treatable conditions during pregnancy and childbirth occurred globally in 2011. Almost all of these took place in developing countries. A key strategy to address high maternal and newborn morbidity and mortality is to increase the proportion of births attended by skilled birth attendants to at least 60% and ensure enhanced access to quality reproductive health services (MoPH Call to Action 2015).

The Afghan health sector, with strong support from various donors and development partners, has made progress in improving the health status of the population, particularly in access to and coverage of services. However, financial, gender related and geographical barriers to accessing skilled care, as well as poor quality of care in maternity units are ongoing challenges. A little understood component of the poor quality of care experienced by women during facility-based childbirth is mistreatment by health care providers and other facility staff. Acknowledgment of these behaviors by policymakers, program staff, and civil society and community members indicates the problem is widespread.

The issue of mistreatment in childbirth is attracting a lot of global attention and in 2010, Bowser and Hill conducted a landscape analysis, which categorized the following seven manifestations:

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

A more recent publication by Bohren et al (2015) defines seven ‘third order themes’ of mistreatment as follows:

- Physical abuse
- Sexual abuse
- Verbal abuse
- Stigma and discrimination
- Failure to meet professional standards of care
- Lack of consent and confidentiality
- Poor rapport between women and providers; ineffective communication; lack of supportive care; loss of autonomy

Respectful maternity care is a woman’s right, not a luxury. Ensuring that women are not only satisfied with their care but have a positive birth experience can be the catalyst to ensuring they survive and thrive.

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Health system conditions and constraints

Important advocacy and policy gains have been made in the last 5 years including work by White Ribbon Alliance (WRA) to advance the Universal Rights of Childbearing Women thru the respectful maternity care charter. The World Health Organization (WHO) statement on “Prevention and elimination of mistreatment during facility-based childbirth” in 2014 followed by the systematic review (Bohren 2015) contributed to raising awareness at country levels. Efforts are expanding to link RMC with quality improvement efforts e.g. the WHO Quality of Care (QoC) framework emphasizes the “Experience of Care” to ensure RMC is addressed in service provision.

RESPECTFUL MATERNITY CARE (RMC)

RMC refers to the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and the period following childbirth. It respects her rights and choices through supportive communication, actions, and attitudes. Because disrespectful and abusive behaviors and environments degrade the quality of maternity care, identifying and addressing mistreatment is an important component of cultivating RMC in health facilities.

Evidence to date around “what works” to promote respectful care and/or prevent or eliminate disrespectful care is limited and many questions relevant for effective RMC program design, implementation and evaluation remain unanswered, particularly in low-resource settings where human resource and infrastructure constraints place extreme stress on patients and health workers, a situation exacerbated in fragile and conflict settings.

This resource package is designed to support health facility managers, health care providers, and communities to confront mistreatment during facility-based maternity care services and to promote respectful maternity care.

Gender-sensitive and respectful care and treatment ultimately improves health outcomes and brings positive impact as listed:

- Quality of care and patient safety
- Clients’ preference to consult with health professionals and use health facilities
- Client satisfaction and reputation of health care providers

Note: The absence of mistreatment in childbirth does not guarantee respectful, dignified care for women in childbirth.
WHY FOCUS ON PREVENTING MISTREATMENT DURING CHILDBIRTH?

There is no specific data from surveys on mistreatment in Afghanistan. Often mistreatment is normalized within health care settings and there is a lack of awareness of the problem. In Afghanistan perceptions of being treated disrespectfully was identified as a factor in care seeking. The Afghanistan Health Survey (AHS) 2013 reveals the following reasons for not seeking care: about 11% of women do not seek care because of unfriendly staff of health facilities, around 6% mentioned that the service hours are not convenient for them and more than 3% do not seek care due to religious beliefs.

In 2014 qualitative research on human elements and contextual factors affecting the quality of care women receive in Afghan maternity hospitals was conducted, and the main findings highlighted in the study are:

- Politeness and good behavior is more important than professional skills and knowledge to women seeking maternity care services
- Prior to professional lessons, health care providers should learn about ethics
- Women are neglected and abused verbally and physically
- Delivery happened in the corridors of the hospitals without any attendant
- Many women and babies are discharged after delivery without postnatal observation
- Health care providers also reported that high patient numbers, long hours and lack of shift systems affects the quality service delivery
- As in other countries much needs to be done in Afghanistan to improve quality of respectful maternity care

ABOUT THE RESOURCE PACKAGE

This orientation 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 session, meeting or 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 mistreatment during childbirth.

OVERALL WORKSHOP OBJECTIVES

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

- Outline the current status of maternal and neonatal health in relation to respectful care
- Discuss key RMC concepts, terminology, legal and rights-based approaches related to respectful maternity care and the RMC Resource Package
- Demonstrate knowledge and use of VCAT theory and practice
- Discuss selected evidence-based strategies that reduce mistreatment
- Discuss the participants’ role in promoting RMC
- Develop action plans to support the implementation of RMC interventions at various levels

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4 Rahmani and Brekke 2013 Antenatal and obstetric care in Afghanistan – a qualitative study among health care receivers and health care providers
5 Arnold R et al 2014
SESSION 1: ICEBREAKER AND INTRODUCTION TO THE WORKSHOP

Learning Objectives:
Participants will articulate their hopes and concerns about the workshop and about the topic of mistreatment.

Participants Will Write:
- My expectation for this workshop is …
- During the workshop, I hope that I will be able to…
- By the end of this workshop, I hope that I …

Required Learning:
By the end of this session the participants will:
- Be introduced to each other
- Be able to articulate their hopes and concerns about the workshop
SESSION 2: OVERVIEW OF MATERNAL AND NEWBORN HEALTH AND MISTREATMENT DURING FACILITY-BASED MATERNITY SERVICES INCLUDING CHILDBIRTH

Learning Objectives:
Participants will:
1. Outline the national current status of maternal and newborn health
2. Discuss factors contributing to maternal mortality and morbidity.
3. Explain the meaning of “respectful,” “dignified,” mistreatment
4. Discuss factors leading to mistreatment.
5. Discuss the categories and evidence from mistreatment during facility based maternity care

Required Learning:
By the end of this session you will learn about the concept of respectful maternity care, current global and context-specific maternal health status. Determinants of skilled birth attendants and contributing factors to maternal morbidity and mortality will also be main parts of learning in this session.

Overview of Maternal Health:
‘Every woman, Every newborn, Everywhere has the right to good quality care’.

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. Maternal and newborn care need to be considered together as integrated service provision and therefore all references to maternal health also include newborn.

Although more women are accessing facility based care and skilled attendance at birth the quality of that care is mixed as outlined in the Lancet Maternal Series 2016. For women using services, some receive excellent care but too many experience one of two extremes: too little, too late, where women receive care that is not timely or sufficient, and too much, too soon, marked by over-medicalization and excessive use of unnecessary interventions. Both extremes represent maternal health care that is not grounded in evidence. And other women receive no care at all particularly poorer and/or vulnerable women.

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7 The Lancet Maternal Series 2016
Hemorrhage, Preeclampsia /Eclampsia, prolonged or obstructed labor and other direct causes and infection/sepsis are\(^8\) still the major causes of maternal morbidity and mortality in Afghanistan.

Most maternal deaths are preventable, as the 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 and newborn care. It is no longer acceptable to merely encourage women to give birth in health facilities, many of which continue to lack emergency obstetric care, reliable water supply, and even the most basic capability to manage uncomplicated deliveries and provide respectful evidence-based routine care.

**Financial and Non-Financial Barriers to Accessing or Receiving Quality Maternal Health Care:**

1. **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 (Private health facilities)
   - Poor access to facilities due to weak road network and other communication network
   - Lack of available emergency transportation
   - Corruption at various levels of the health system

2. **Nonfinancial Barriers:**
   - Perceived or real negative provider attitudes
   - Poor quality of care reported in facilities during childbirth, including mistreatment 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

3. Gender Barriers:
• Difference in women and men’s health seeking behavior is influenced by the difference in their roles, responsibilities, status and use of time; the difference in their access to and control over assets and resources; the patterns of power and decision-making; cultural norms, beliefs and practices.
• Gender-based constraints in access to health facilities/services (e.g. access to household income, education, work load, women’s mobility, decision making ability, location and timing of services).

Mistreatment in Maternity Care Services:
Based on a comprehensive review of research conducted by Bowser and Hill in 2010, seven categories of mistreatment in childbirth have been identified, and exist in medical facilities around the world. This work has progressed with the review by Bohren et al in 2015. Manifestations of mistreatment often fall into more than one category, so the categories are not intended to be mutually exclusive, rather they should be seen to overlap one another along a continuum.

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

In addition to geographic, financial, and cultural barriers to quality maternal health care, the mistreatment that women sometimes experience at health facilities is an additional barrier to their seeking care.

According to a qualitative research on factors affecting the quality and equity of maternity care services in Afghanistan, women stated that “one had to be lucky to be cared for by kind health care providers”. They explained that there was no appropriate system of monitoring and it was difficult to find a doctor or someone who would help them and explain what was happening (Arnold 2014).

**PRACTICE CHECK**

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

What happens to a woman’s placenta in your facility?
SESSION 3: CHILDBEARING RIGHTS

Learning Objectives:
Participants will:
1. Define and discuss the characteristics of human rights
2. Discuss a rights–based approach to maternity care services.
3. Discuss the universal rights of childbearing women.
4. State the legal definition of the categories of mistreatment; the corresponding Universal Rights of Childbearing Women; list examples and standards of care.

In 2014, with the establishment of the National Unity Government in Afghanistan, the MoPH shared their vision for increased expansion of the services to enhanced services’ quality, with a special focus on promoting right-based and respectful services. This is in line with Sustainable Development Goals (SDGs) and achieving universal health coverage. The MOPH and partners have been very active in ensuring the policy environment is in place to support this vision. The following is a summary:

Afghanistan laws, policies, and strategies:

Commitments to health and to gender equity are embodied in the Afghanistan’s constitution, the Afghanistan Compact, the National Development Strategy (ANDS), the National Action Plan for Women in Afghanistan (NAPWA), and the Law on Elimination of Violence Against Women (EVAW).

Constitution (2003 [1382]):
Article 54 provides that the State will adopt necessary measures to ensure physical and psychological well-being of the family, especially of the child and mother, and the elimination of traditions contrary to the principles of the sacred religion of Islam.

National action plan for women in Afghanistan (NAPWA 2007-2017):
The NAPWA includes a chapter on health and notes that the government aims to ensure women’s emotional, social, and physical wellbeing and to protect their reproductive rights.

Law on elimination of violence against women (EVAW) (2009 [1388]):
The law lists 22 acts considered to constitute violence against women, including denying access to health care. International human rights commitments ratified by Afghanistan, particularly the pertinent provision in the Convention on the Elimination of All Forms of Discrimination Against Women (UN CEDAW)

EVAW law article 3: (Guarantee of basic human rights and fundamental freedoms)
States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

EVAW law article 12: (Health)
State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
Overview 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). Characteristics of human rights include rights that are internationally guaranteed, legally protected and focuses on the dignity of human beings.

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). Article 35 of the Ending Violence Against Women (EVAW) law states, if a person prohibits a woman from the right to education, work and access to medical services or use of other rights stipulated in the law, he shall, depending on the circumstance, be convicted to short-term imprisonment not exceeding 6 months.

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

Limitations of Human Rights:

Rights are not absolute. Under certain conditions limitations can be imposed by the state and/or the culture on the exercise and realization of certain rights.

Corruption in the Health Sector:

Corruption violates human rights, as people are denied the care that their governments are obligated to provide and the MOPH are currently developing anti-corruption guidelines and measures.
Human Rights and Reproductive Health

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.\textsuperscript{12,13}

More specifically, to align the concepts of international human rights laws and the mistreatment of women seeking maternity care. In 2011 the White Ribbon Alliance (WRA) and its partners developed the Charter on the \textit{Universal Rights of Childbearing Women} (see Appendix 7). Universal human rights are unalienable and thus also apply during the reproductive and childbearing periods.

The \textit{Charter on the Universal Rights of Childbearing Women} directly ties the problem of mistreatment during childbirth to human rights, and the charter identifies seven universal childbearing rights; which states that every woman has the right to:

- Be free from harm and ill treatment.
- Information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care
- Privacy and confidentiality
- Be treated with dignity and respect
- Equality, freedom from discrimination, and equitable care
- Health care and to the highest attainable level of health
- Liberty, autonomy, self-determination, and freedom from coercion

\textbf{Table 1:} Describes categories or manifestations of mistreatment, 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 mistreatment 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.

\textsuperscript{11} Adapted from definitions of SRHR in the ICPD and Beijing Platforms of Actions 2005.
\textsuperscript{13} 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>
<thead>
<tr>
<th>Type of abuse</th>
<th>Legal definition (where it exists)</th>
<th>Observable element/childbearing 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  
- Rape or inappropriate touching during examination (genitals/thighs) | Staff conducts 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. |
|---|---|---|---|---|
| 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 Hepatitis clients, Denial of services due to lack of money, poverty | Staff provides all the required services to all clients equally. |
<table>
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<tr>
<th>Abandonment/ neglect</th>
<th>The act of refusing to render medical or surgical treatment /the act of rendering medical or surgical treatment “in a manner so hash or negligent as to endanger human life or to be likely to cause harm /injury/death.</th>
<th>“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.”</th>
<th>- 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 during or after delivery</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detention</td>
<td>The act of holding a person in custody, confinement, or compulsory delay in a medical facility for reasons of failure to settle medical bills. (especially in private health centers)</td>
<td>Every woman has the right to liberty, Autonomy, self-determination, and freedom from coercion.</td>
<td>- 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</td>
<td>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.</td>
</tr>
<tr>
<td>Non-confidential care</td>
<td>The act of sharing a patient’s health and other personal information without the patient’s consent.</td>
<td>A woman’s right to privacy and confidentiality is respected.</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
SESSION 3: ROLE PLAY 1: COMMUNICATING A WOMAN’S RIGHT TO DIGNIFIED CHILDBIRTH

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

Gul Jan: Gul Jan is a 28 year’s old woman; she has four living children and is now 4 months pregnant; one of her babies died shortly after birth. Her sister died in childbirth last year.

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

Situation:
Gul Jan has come to the health center with her mother. Gul Jan’s mother and grandmother helped her to deliver each of her babies at home. Gul Jan has been to the health center once before: she brought her 5-year-old son there when he had pneumonia last year. The women are interested in learning more about the care available at the health center because a relative delivered her baby there 6 months ago. Gul Jan 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, Gul Jan, and her’ mother as they discuss Gul Jan’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 Gul Jan’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 Gul Jan can be involved in the decisions about her care
• Discuss Gul Jan’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

Gul Jan 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 Gul Jan and her mother?
2. Did the midwife give Gul Jan 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 Gul Jan 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)

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

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

What Is Values Clarification?
Values clarification is the process of assessing the effect of personal values on decision-making. It determines the outcome of an action. This means that a person’s personality can be determined by looking at what he or she does.14 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.”15

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.16

• 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

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16 Fishbein M, Raven B: The AB scales: An operational definition of belief and attitude. Human Relat 1962, 15(1)
aware of your personal beliefs and how they affect others – both positively and negatively – will help you do just that.

- Childbirth brings up many emotional, private, and sensitive issues in most cultures around the world. However, specific issues and concerns differ from place to place.

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

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

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

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

**Motivation to Change:**

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

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

**Process of Values Clarification:**

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

1) Choosing, 2) Prizing, and 3) Acting.¹⁷

1) **Choosing:**

A value must be chosen freely from alternatives with an understanding of both positive and negative consequences of that choice. Once values have been clarified, an informed choice can be made about which values we truly and consciously want to uphold.

2) **Prizing:**

A chosen value must be associated with some level of satisfaction and affirmation, as well as confidence in the value. Some questions to consider:

- How do you feel about your choice? How satisfied are you with your decision?
- Is this something that is really important to you?
- Would you be prepared to stand up and announce your choice in public?
- Are you willing to put it in writing?

3) **Acting:**

A freely chosen, affirmed value must translate into action. Ideally, the action will lead to some positive outcome and be done repeatedly. Some questions to consider:

- What are the first steps you will take or have taken to make this choice a reality?
- Have you made definite plans to act on this value?
- Is your decision definite or tentative?
- Is this something you have done or will do regularly?
- Have you been consistent in your actions?

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

- Use rational thinking and emotional awareness to examine personal belief systems and behavior patterns
- Identify and analyze issues for which their values may conflict through thoughtful reflection and honest self-examination
- Specify how they can act in a manner consistent with their clarified value(s)
- Experience new or reframed information or knowledge designed to be accessible and relevant (personally, socially and politically)
Figure 4: values clarification for RMC attitude transformation theoretical framework\textsuperscript{18}

MATERIALS FOR SESSION 4 ACTIVITIES:

ACTIVITY 1: CROSSING THE LINE EXERCISE\(^\text{19}\)  (SESSION 4)

In this activity the purpose will be to draw participants’ views on mistreatment, and address the connection between care in childbirth and professional practice. It also helps improve participants’ understanding of how mistreatment in childbirth affects different viewpoints.

1. 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 mistreatment affect women’s emotional experience and care seeking behavior with future childbirth? How would it affect a woman’s family?
   - How might normalization of mistreatment impact the experience of health workers and providers working in promoting respectful maternity care?

2. 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.

Crossing the Line Statements:

Cross the line if:

1. At some point in your professional life, you witnessed or heard a mother in labor being shouted at by a colleague
2. If you have seen staff shouting and naming an unmarried girl who finds herself pregnant
3. If you have ever heard a colleague treat woman from another ethnic group differently
4. If you have ever written an incident report on a case of a baby’s or mother’s death in the maternity ward
5. If you were ever told to cover up a report of abuse by a colleague or someone in charge
6. If you have seen a poor woman being asked to pay for a service and you know she and her family have no money
7. If you have ever wanted to report a colleague, you witnessed treating a mother very badly but didn’t know who to go to or what to do
8. If you have seen staff neglecting a woman with HIV
9. If you believe all women deserve access to safe, high-quality maternal health care services
10. If you believe that all health care providers are entitled to be respected by each other

\(^{19}\)Activity adapted and modified from: Exhale. 2005. Teaching support: A guide for training staff in after-abortion emotional support. Oakland, CA, Exhale
ACTIVITY 2: THINKING ABOUT MY VALUES

This session will help you explore how your values and experiences contribute to what you do. You will be asked to reflect on how your professional life and practice during childbirth may have been affected by training, role models, or colleagues.

1. Think carefully about the above and answer honestly, according to their personal experiences.

2. Write brief responses on “Thinking about My Values”.

3. Share your responses if you feel comfortable discussing with others.

4. Ask participants to spend 20 minutes filling out the worksheet (Appendix 4).

5. Was it useful? How do you feel? If you are happy sharing your responses with others, you may do so.
ACTIVITY 3: THE SELF-CONCEPT MODEL AS A TOOL FOR UNDERSTANDING ONE'S OWN BEHAVIOR

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

UNDERSTANDING OUR BEHAVIOR: THE SELF-CONCEPT MODEL IN OFFERING CARE DURING CHILDBIRTH

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

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

The self-concept model is divided into four equal and interrelated parts: self-image, ideal self, body image, and self-esteem. The four parts of the self-concept have three intrinsic circles superimposed on them: the public, the private, and the hidden domains.\(^{20}\), \(^{21}\)

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

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

**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

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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.\(^{22}\)

**Body Image:** Body image is our perception of our physical self — including feelings of attractiveness or unattractiveness.\(^{23}\) How we think our body looks may not always be acceptable to us. Some people are not happy with their body weight or size or shape, perceiving their bodies to be undesirable, no matter how they may actually appear to others. They may not like the fact that they are short, tall, dark, big, or thin.

**Ideal Self:** The ideal self is the person we wish we could be (i.e., “how I would like to see myself”). This includes the way we wish we could look, behave, feel, and think. In many cases, when a person’s self-esteem is low, the way a person sees his or herself and the way they would like to be does not quite match up.\(^{24}\)

**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.\(^{25}\) 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.

**The Impact of Self-Esteem on Interactions with Other People:**

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


\(^{23}\) idshealth.org/teen/your mind/body image/body_image.html

\(^{24}\) 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.

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.

**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.
**Learning Objectives:**

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

**Required Learning:**

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

**Work-Related Stress:**

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

- **Physical symptoms:**
  - Fatigue, muscular tension, headaches etc.

- **Psychological Symptoms:**
  - Anxiety, irritability, pessimism (won’t make it and can’t happen), feelings of being overwhelmed and unable to cope and reduced ability to concentrate or make decisions.

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

**The Impact of Difficult or Traumatic Work Experiences on Providers:**

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

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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 mistreatment during facility-based maternity care services; mainly 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. The qualitative study on respectful care in Afghan maternity hospitals showed that there is a punitive environment which does not encourage transparency. Health care providers fear of being blamed for a professional mistake, moreover the hostile environment appeared to affect relationships at all levels. It is therefore important that health providers be given opportunities for psychological support to address their emotional distress following any traumatic or critical incidents.

Conducting psychological debriefing sessions for providers: “Caring for the Carers”:

“Caring for the Carers” refers to the provision of supportive services for health care providers as a way to relieve anxiety and distress arising from work situations. One such service includes psychological debriefing sessions. This is an approach that enables groups and individuals to deal with work-related stress. 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/midwife, or psychologist. The facilitator should have the professional and interpersonal skills to guide the established process that will help group members recover from their distress. The facilitator will assess the need for individuals who might benefit from further individual counseling, and will make recommendations for individual follow-up.

The debriefing sessions follows seven phases:

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

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

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SESSION 6: PROFESSIONAL ETHICS

Learning Objectives:
Participants will:
1. Define health care ethics, code of conduct, courtesy, scope of practice, professional associations.
2. Discuss the principles of ethics.
3. Explain the themes of ethics that promote RMC.
4. Describe the role and responsibilities of regulatory bodies in promoting RMC.
5. Describe the roles and responsibilities of professional associations in promoting RMC.
6. Describe concept of patient charter of rights.

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

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

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

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

- The International Council of Nurses (ICN) Code of Ethics\(^{29}\) and The International Confederation of Midwives (ICM) Code of Ethics\(^{30}\): 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 Ethics\(^{31}\): 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).

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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:

• 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.
• Courtesy during maternity care services may include:
  o To introduce self to client and companion, if any
  o To obtain client’s consent on the continued presence of her companion, if any
  o To encourage the client and companion to ask questions during an examination (giving priority to the primary client’s questions and concerns)
  o To respond to questions with promptness, politeness, and truthfulness and to the client’s/ companion’s satisfaction
  o To explain procedures, progress, diagnosis, findings/ results and options in simple and appropriate language/ words that is understood by the client/ companion, or to seek someone who can assist in this regard
  o To explain what is being done and what to expect throughout labor and birth; and to give periodic updates on status and progress of labor
  o To encourage/ allow the client to move about/ walk around during labor
  o To ask and allow the client her preferred birth position
  o To explain the reason for treating for complication (cesarean section, episiotomy, etc.)
  o To obtain the client’s informed consent or permission prior to any procedure (e.g., tubal ligation, hysterectomy, caesarian section, etc.)

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.

Some themes found in codes of ethics include the health care worker’s relations with coworkers, 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. 

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 profit making 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.

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SESSION 7: PROMOTING MUTUAL ACCOUNTABILITY: RIGHTS AND RESPONSIBILITIES OF HEALTH CARE PROVIDERS AND CLIENTS DURING MATERNITY SERVICES

**Learning Objectives:**

Participants will:

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

**Required Learning:**

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

**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 client (patients') charter?** Client 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. The charter is guided by the MoPH vision, mission, values, culture and ethical policies.

The vision of the Afghan MoPH is to assure all citizens reach their full potential in health contributing to peace, stability and sustainable development in the country as stated: “The Ministry of Public Health of the Government of the Islamic Republic of Afghanistan is to prevent ill health and achieve significant reductions in mortality in line with national targets and sustainable development goals and to reduce impoverishment due to catastrophic health expenditure. Also to be responsive to the rights of all citizens through improving access and utilization of quality, equitable, affordable health and nutrition services among

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all communities especially mothers and children in rural areas and through changing attitudes and practices, promoting healthy life-styles and effectively implementing other public health interventions. All in coordination and collaboration with other stakeholders within the framework of strong leadership, sustained political will and commitment, good governance, and effective and efficient management; in its continuous pursuit to become a ministerial 'Institution of Excellence'."

Responsibilities of health service providers include but are not limited to:

- Promotion of healthy lifestyles
- Prevention of diseases
- Protection of the public against harm (waste management)
- 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 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
- Participate in the planning and management of health care services

CLIENT RESPONSIBILITIES:

- 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 (especially in private sector)
- 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
Case Study- Caring for the Carers:

What feasible and sustainable actions can programs take to support front-line providers especially midwives?

The importance of an educated, competent, enabled and motivated nursing and midwifery workforce within effective and responsive health systems is emphasized by GHWA. Investment in the health workforce is one of the best buys in public health: e.g. investing in midwifery education, with deployment to community-based services, can yield a 16-fold return on investment in terms of lives saved and costs of caesarean sections avoided (State of the World’s Midwifery 2014).

It is imperative to understand the context of care and the complex challenges that even highly motivated healthcare providers face in their work environment and lives. Many midwives work in situations of adversity, with negative effects on wellbeing, morale and retention. Preventing and eliminating mistreatment during childbirth requires a “systems approach” to address underlying triggers for mistreatment, such as gender inequalities, shortages of staff and disempowerment of midwives. WHO have been gathering evidence around working conditions for midwives as well as their lack of ‘voice’ a significant barrier to providing care\(^{34}\). This evidence will inform their program of action on how best to address empowerment, respect and safety for midwifery personnel with the goal of \textit{improving quality of care by building a global consensus on actions to enable empowerment, respect and safety of midwifery personnel}.\(^{35}\)

Changing the Heart of the Provider

- When framing RMC – both sides of the issue need to be addressed
- Values clarification and attitude transformation training with healthcare providers helps them reflect on how they work and cope with working in under-resourced facilities. Providers process & reflect on their own experiences
- Mediation offered to process challenging situations
- Recognition – by community & social accountability
- Women’s activism

\(^{34}\) WHO, ICM and WRA (2016) joint report entitled “Midwives’ Voices, Midwives’ Realities.”

\(^{35}\) \url{http://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0153391}
ACTIVITY 1: 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.

Refer to Appendix 5 for TOR of maternity open days
SESSION 8: PROMOTING RMC AT MANAGEMENT LEVEL

Learning Objectives:

Participants will:
1. Discuss the composition of the health facility management committees/boards including hospital management board at the level of EPHS
2. Discuss the role of the committee including Shura-e-Sehee in promoting RMC at the level of BPHS
3. Discuss the powers of the health facility management committees/boards.
4. Review the criteria for selecting Hospital Management Board members by facility management

Required Learning:

By the end of this session you will learn the composition, role and responsibilities of hospital management board and Shura-e-Sehee, reviewed the current performance of the hospital management board and Shura-e-Sehee and the linkages between the community and the health facility including community involvement in the facility management. Leaners will also be able to identify the role of the hospital management board and Shura-e-Sehee in promoting respectful maternity care.

The Health Shura at Health Facility Level

Facility Shura-E-Seehe Formation:

The staff of each level health facility will facilitate the establishment of facility level “Shura-e-Sehee”. The Shura-e-Sehee involves different users groups in the management of the health facility and also promotes community-based activities which aim to improve the health status of the population living in the catchments area of the health facility. The Shura-e-Sehee members will be selected/elected from the community health Shura at health post level as well as the catchment’s area of respective facility. Members for the Shura may vary from 13-15 depending on community size (population and geographical distribution) and opinion.

Shura Composition Will Be:
- Chairperson: 1
- Member 12 – 14
- One third of the members should be women if possible.

The Shura members will be selected/elected on the basis of the above mentioned criteria for HF Shura

Roles and Responsibilities:
- Be knowledgeable on selected BPHS, CBHC policies and CHW’s job description
- Write and sign a constitution of the facility level Shura. The constitution will record the names of the elected chairperson and member secretary along with the name and gender of the members and their location of origin (to ensure equitable representation of the communities within the catchments area),
- The facility in-charge will act as member secretary of the Shura. The member secretary will be responsible for recording and maintaining meeting minutes.
- Facilitate a health need assessment with the facility level Shura members. The need assessment should focus on the major health related problems perceived to be faced by the community.
- Based on BPHS and the health problems perceived by the communities they represent, they will develop an annual action plan.
- If possible every six months an “open door event” will be organized (For visiting the health facility to know about services provided and getting an idea of ownership and trust to people) this resembles to maternity open day concept.
• Mobilize local resources for strengthening and sustaining BPHS activities
• Support facilities and community health Shura in performing their responsibilities
• Conduct monthly meetings and maintain meeting minutes
• Monitor monthly performance of the facility and record client satisfaction
• Review implementation status of annual action plan

Hospital Management Boards
To strengthen community involvement and support, hospital management boards must be established. Community support for hospitals is often poor; communities using a hospital tend to regard it as the “government’s hospital” or the “NGO’s hospital” rather than “their” hospital. A hospital board will provide general direction and guidance for the management and operation of the hospital, as well as serving as a link between the community and hospital. Hospital community boards will be made up of volunteers with diverse skills and experiences who will be responsible for the long-term viability of the hospital and ensure that it meets the real and felt needs of the community. Their responsibilities will include:

- Ensuring that high quality services are provided
- Maintaining community and government relations and generating community support for the hospital
- Serving as the policy and strategy-setting body of the hospital
- Supporting the leadership of the hospital
- Providing financial oversight
- Helping develop the hospital’s strategic plan
SESSION 9: MEDIATION AS AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM

Learning Objectives:
Participants will:
1. Define alternative dispute resolution (ADR) mechanisms.
2. Describe examples of ADR mechanisms available in the local context.
3. Discuss mediation as an ADR mechanism in dealing with mistreatment 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 mistreatment cases.

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

Alternative Dispute Resolution (ADR) Mechanism:
ADR is a process of resolving disputes by using methods other than conventional litigation (i.e., Shura-e-Sehee, hospital management board, Family Health Action Groups and so on. It is the act or process of mediating between parties, to effect an agreement or reconciliation.

Definition of Mediation, A Mediator, And the Mediator’s Role

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

Childbirth is a stressful yet joyous moment for the mother, family, and the service provider. However, sometimes the mother, spouse or relatives may feel that some of the events occurring around the labor and delivery process are not well handled. Incidents of mistreatment 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 mistreatment and to promote respectful and dignified care during childbirth. 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
• Is less confrontational or adversarial
• Encourages creativity for solutions
• Improves communication between parties
• Results in more durable solutions
• Is less costly
• Is flexible
• Is less formal
• Is party-controlled/driven
• Is 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 (If exists)

Stage Two – Presentation by the parties
• Parties provide perspective of dispute without interruption:
✓ Gives party’s 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, seven– 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 party’s 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

**MATERIALS FOR SESSION 9 ACTIVITY - Role Play 1: USING MEDIATION TO RESOLVE AN INCIDENT OF PHYSICAL ABUSE**

**Participant Roles:**

**Health Provider:** The provider is a midwife at the local health center who is accused of slapping a woman during childbirth in her facility.

**Mrs. Parwin:** Mrs. Parwin, 21 years old, is a first-time mother who delivered at a 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 Shura-e-Sehee.

**Situation:**

Mrs. Parwin 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. Parwin thinks she was mishandled during childbirth and reported the incident to the head of the maternity unit. But she was told that she should just forget about the issue. Mrs. Parwin was unsatisfied with the response and was aware that she has a right to seek redress. She sought help from the Community Health Worker, Family Health Action Group and Community Health Supervisor to resolve the incident. The Community Health Worker advised Mrs. Parwin 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. Parwin’s wishes. The provider agreed to a mediator and the date for mediation. The provider, Mrs. Parwin, 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. Parwin, her relatives, and the mediator.

The mediator should follow the mediation stages described above to perform 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 sustainable solutions
- Stage 7 - Closure
**Discussion Questions:**

1. How did the mediator approach Mrs. Parwin, 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. Parwin respond to the mediator?
4. How did the mediator demonstrate objectivity, no coercion, and control of the discussions during interactions between Mrs. Parwin and the provider? And during the interactions with Mrs. Parwin relatives?
5. Were the mediator’s explanations and communication effective in resolving the incident?
SESSION 10: COMMUNITY’S ROLE IN PROMOTING RESPECTFUL MATERNITY CARE IN FACILITIES

Learning Objectives:
Participants will:
1. Outline community members’ roles in promoting respectful maternity care.
2. State community structures available for dealing with incidents of mistreatment.
3. Demonstrate techniques for strengthening community–facility links and methods to deal with incidents of mistreatment at the community level.

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

The community’s role in promoting respectful maternity care:
Community Health Workers (CHWs), Family Health Action Groups (FHAGs), and Shura-e-Sehee at Community level structure play a role to deal with mistreatment and to promote 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
- Inadequate knowledge of their rights
- Failure to fulfill obligations or demand rights
- Cultural beliefs and practices
- Myths and misconceptions
- Financial barriers
- Unavailability of female health Shura at health facility level
- Unavailability of female health care providers
- Inadequate enabling environment, poor health facility infrastructure (rush of clients in one room that prevents privacy, work shift), Behavior of health facility staff

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 maternity care
- Encourage women who have experienced mistreatment during childbirth to speak out and seek redress through mediation, counseling, or other available avenues
- Offer emotional support to women and their birth partners/families that experienced mistreatment during childbirth
- Mobilize community resources (money, materials, and people) to support initiatives promoting respectful maternity care, such as legal and maternal health advocates, facility health Shura community members/ (community health workers), etc.
- Where possible hold community sensitization and participatory action planning workshops to develop community-owned action plans to hold health system...
accountable for RMC in line with “Citizens Charters,” and to improve male involvement by discussing the importance of birth planning and finances with men/elders.
SESSION 11: IMPROVING QUALITY OF CARE

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

Quality improvement (QI):
QI refers to the combined and ongoing efforts of everyone, health care professionals, patients and their families, researchers, planners, and educators to make changes leading to better patient health outcomes and care, better professional development, and improved access to care.\(^\text{37}\)

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

Maternal 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.\(^\text{38}\)

Introduction to QI in childbirth:
In labor and childbirth, QI 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.

\(^{37}\) World Health Organization 2005, Preparing a Health Care Workforce for the 21\textsuperscript{st} Century: The Challenge of Chronic Conditions, WHO, Geneva

3. Is ‘holistic’ in terms of addressing the needs engendered by a woman’s physiology, psychology, ethnicity, socioeconomic circumstances, culture, 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.

Managers and providers need to devise ways to ensure QI teams exist and function with a specific remit for maternity care. There is a specific terms of reference for health facility quality improvement committee that encourages health care providers to deliver quality services to clients and to assure an appropriate compliant system is functioning at the health facility (Appendix 11). The harmonized quality improvement standards for maternity care can be followed cautiously, it will help managers to assure effective monitoring of the RMC interventions (Appendix 9).

Components for forming or strengthening QI care teams

- Review the current policy of QI 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
- Set goals, objectives, (and ToR) to be achieved by the team

In improving services towards evidence-based, respectful maternity care the intrapartum period is of particular interest and special areas of RMC focus should include:

- Respectful care and communication and birth companions.
- Offer women the possibility of being cared for by a midwife; provide one-to-one continuous supportive care
- Allow and encourage women to have a birth companion of their choice
- Treat every woman with respect, provide her with all information about what she might expect, ask her about her expectations, and involve her in the decisions about her care.

These principles are included in the clinical standards in Afghanistan and are more fully addressed in the WHO Quality of MNH Care Framework\textsuperscript{39} which gives equal emphasis to the ‘experience of care’ and the ‘provision of care’ – the former is detailed in Table 2.

\textsuperscript{39} WHO 2016 STANDARDS FOR IMPROVING QUALITY OF MATERNAL AND NEWBORN CARE IN HEALTH FACILITIES
<table>
<thead>
<tr>
<th>Standard</th>
<th>Quality Statement</th>
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<tr>
<td><strong>Standard 4: Communication</strong>&lt;br&gt; with women and their families is effective and responds to their needs and preferences</td>
<td>4.1 All women and their families receive information about the care and have effective interactions with staff&lt;br&gt;4.2: All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals.</td>
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<tr>
<td><strong>Standard 5:&lt;br&gt;Women and newborns receive care with respect and preservation of their dignity.</strong></td>
<td>5.1: All women and newborns have privacy around the time of labour and childbirth, and their confidentiality is respected&lt;br&gt;5.2: No woman or newborn is subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.&lt;br&gt;5.3: All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained.</td>
</tr>
<tr>
<td><strong>Standard 6:&lt;br&gt;Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens the woman’s capability.</strong></td>
<td>6.1: Every woman is offered the option to experience labour and childbirth with the companion of her choice.&lt;br&gt;6.2: Every woman receives support to strengthen her capability during childbirth.</td>
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**Practice Check:**

*Kindness, Compassion and Respect Matter in Maternity Care*

What QI team strategies do you have in place to promote woman-centered care in your facility/ward?
- How can we strengthen the QI teams to ensure accountability through?
  - Providers?
  - Facility/ward managers?

An activity to review gaps in RMC provision related to quality of care standards in Afghanistan is included in the final Session.
SESSION 12: MONITORING AND DATA MANAGEMENT

**Learning objectives**

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

**Required Learning:**

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

**Definitions**

- **Recordkeeping:** Recordkeeping involves physically recording and retaining information with the purpose of facilitating future planning or reference needs.
- **Reports:** Report involves filling out and compiling specific information and data for use at different levels of planning.
- **Monitoring:** 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:** 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 Maternity Care:**

- **Admission registers:** Admission registers retain data on admission history, reason for visiting/medical complaints, next of kin, etc.
- **Maternity/delivery registers:** These registers keep data on child delivery, time, mode, status of the baby, sex, blood loss, etc.
- **Nursing midwifery notes:** These notes record the midwifery care given to the mother/baby.
- **Partograph:** Partograph record progress of labor and condition of mothers and babies.
- **Stock keeping records:** Stock keeping reports e.g., bin cards: record the drugs and supplies in the ward or the facility or service delivery points.
- **Reports:** This can include reports submitted to different levels of management, e.g., daily/shift reports, monthly reports/HMIS report, incident reports (maternal death, loss of...
baby); Continuous Professional Development reports (CPD), monitoring reports,

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

Home base MCH handbook: This records ANC, PNC services, and care received by mothers and babies for up to five years.

Maternal & Neonatal Death and Surveillance reviews/reports: Death report includes maternal and perinatal death review forms, verbal autopsies, and other informative sheets.

Other: Other register book, ward and OPD log sheets, etc.

**Importance of recordkeeping and reporting in promoting RMC:**

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

**Importance and Purpose of Medical Records:**

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

- In disciplinary or peer review matters, medical records can justify (or refute) the need for a particular treatment
- Medical records improve accountability
- In reimbursement and utilization disputes, medical records document what services were rendered and whether they were medically necessary. Medical records are the single most important evidence for a provider during a malpractice claim or other inquiry concerning patient care. In today’s health care environment that features multi-specialty care within ever-changing health care networks, consumers transfer to different providers, thus the need for comprehensive, accurate medical records cannot be overemphasized
- Medical records should contain sufficient, legible information that clearly demonstrates why a course of treatment was undertaken or why an indicated course of treatment was not
- Records must contain sufficient information to identify a patient, support their diagnosis, justify their treatment, and accurately document the course and result of their treatment.
- Records must include: patient histories; subjective complaints; examination results; test results, x-rays; objective assessments; treatment plans; reports of consultations and hospitalizations; record of prescription drugs dispensed or administered; actual treatment rendered; and copies of records or other documents obtained from other providers
- Certain patient information such as billing records or test results should be part of the patient’s medical records (esp. private health facilities)
**ACTIVITY 1: USE OF MONITORING TOOLS**

**Supportive Supervision for Promoting Respectful Maternity Care:**

Supportive 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.\(^{40}\) The RMC supervision guide below could be incorporated into existing maternal and neonatal health supervision structures.

<table>
<thead>
<tr>
<th>Table 3 Supervision and monitoring for RMC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions</strong></td>
</tr>
<tr>
<td>What support structures exist to strengthen dignified and respectful care?</td>
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<tr>
<td>Does the facility support the Caring for the carers?</td>
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<tr>
<td>Does the facility have Maternity Open Days?</td>
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<tr>
<td>Follow-up system on reported cases of mistreatment</td>
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<tr>
<td>Community involvement in dealing with mistreatment</td>
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<tr>
<td>Managers’ support and commitment in:</td>
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<tr>
<td>Check for availability and use of the RMC guidelines</td>
</tr>
</tbody>
</table>

\(^{40}\)USAID. 2010. Uganda Ministry of Health and USAID Deliver Project – Encourage Supportive Supervision, USAID.
<table>
<thead>
<tr>
<th>program briefs, tools, and posters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>• What health messages are shared with your clients?</strong></td>
</tr>
<tr>
<td>What health messages are shared with your providers?</td>
</tr>
<tr>
<td>RMC concept</td>
</tr>
<tr>
<td>Mistreatment Values clarification and attitude transformation in promoting RMC</td>
</tr>
<tr>
<td>Patient charter of rights</td>
</tr>
<tr>
<td>Others.............................................................................................................</td>
</tr>
</tbody>
</table>
SESSION 13: TRANSLATING EVIDENCE INTO ACTION

Learning objectives
Participants will develop action plans that include:
1. Initiating or strengthening the tested interventions discussed during the RMC workshop.
2. Orienting/updating other service providers in the participants’ respective work stations through mentorship and support supervision.

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

What will I change now?

Activity:
Translate evidence into action by reviewing the quality standards and develop action plans focused on RMC.
1. Refer to the clinical standards in Annex 10 and select one RMC related Verification Criteria’ (these are all highlighted) which you know is not in place – that is a gap exists.
2. Think about your own facility and do a simple cause analysis of why this is gap exists?
3. Complete the action plan in Annex 14 to address this gap.
### Appendices:

Appendix 1: Managers RMC orientation workshop Schedule (two- days)

<table>
<thead>
<tr>
<th>Time</th>
<th>Day one activity</th>
<th>Day two activity</th>
</tr>
</thead>
</table>
| 08:30  | Climate setting  
Participants expectations/norms  
Workshop objectives  
RMC concept and RMC toolkit  
Workshop logistics | Alternative dispute resolution  
Mechanism – mediation in RMC  
• Demonstration on conducting mediation  
• Involving communities in RMC |
| 09:00  | Brief overview of the project  
Brief overview of maternal health  
Understanding health rights and Law  
Mistreatment during facility-based childbirth |  
| 10:30  | **Tea/Coffee Break** |  
| 11:00  | Brief overview on interventions to promote facility-based Respectful Maternity Care (RMC)  
Attitude transformation and values clarification training- *It starts with me*  
• Introduction to values clarification and attitude transformation (VCAT) in RMC  
• Group work VCAT exercises – Crossing the line  
• Thinking about my values – Exercise on my worksheet  
• Understanding self – self concept  
• Introduction to the caring for the carers concept in RMC |  
• Monitoring and data management for RMC  
• Managers' roles in RMC – action plans  
• Plenary  
• Workshop evaluation  
• Way forward |
| 01:00  | **Lunch** | **Lunch and departure** |

- Improve working environment
- Health Facility Management Committees
- Continuous quality improvement teams
- Addressing providers and clients – Service charter

- Professionalism
- Codes of ethics and scope of practice
- Professional associations and RMC
## Appendix 2: Three-day training schedule for health care providers

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climate setting</td>
<td>Recap</td>
<td>Recap</td>
</tr>
<tr>
<td>Participants</td>
<td>Psychological debriefing: “Caring for the carers”</td>
<td>Monitoring and data management for RMC</td>
</tr>
<tr>
<td>Expectations/norms Pretest</td>
<td>Professional ethics and code of conduct</td>
<td>RMC indicators – discussion on data</td>
</tr>
<tr>
<td>Workshop objectives RMC concept and RMC Resource package Workshop logistics</td>
<td>Role of professional associations and regulatory bodies in RMC</td>
<td>Monitoring tools</td>
</tr>
<tr>
<td>Overview of maternal and neonatal health</td>
<td>Rights and responsibilities of clients and providers for mutual accountability</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>Human and childbearing rights Understanding mistreatment</td>
<td>Group work</td>
<td>Introduce clinical objectives</td>
</tr>
<tr>
<td>Tea/Coffee Break</td>
<td>Tea/Coffee Break</td>
<td>Tea/Coffee Break</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>Tea/Coffee Break</td>
<td>Alternative dispute resolution mechanism – mediation in RMC</td>
<td>Clinical practice</td>
</tr>
<tr>
<td>Lunch</td>
<td>Tea/Coffee Break</td>
<td>Lunch</td>
</tr>
<tr>
<td>Group work VCAT exercises</td>
<td>Role plays on mediation</td>
<td>Post test</td>
</tr>
<tr>
<td>Crossing the line</td>
<td>Community’s role in promoting RMC</td>
<td>Review of clinical experience</td>
</tr>
<tr>
<td>Thinking about my values</td>
<td>Group work</td>
<td>Workshop evaluation and closure</td>
</tr>
<tr>
<td>Thinking about my worksheet</td>
<td>Community’s role in RMC</td>
<td></td>
</tr>
<tr>
<td>Tea/Coffee Break</td>
<td>Tea/Coffee Break</td>
<td>Tea/Coffee Break</td>
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<tr>
<td>Understanding self-concept</td>
<td>Continuous quality improvement group work</td>
<td></td>
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<tr>
<td></td>
<td>QI teams and RMC</td>
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</tbody>
</table>
## Appendix 3: 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>
</thead>
<tbody>
<tr>
<td>Ensure that the workshop venue has been appropriately selected (classroom and clinical) and is adequate to create a positive learning climate, conduct the planned activities, and meet the course objectives</td>
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</tr>
<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</td>
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<tr>
<td>Ensure that client scheduling is arranged with clinic staff or management as needed</td>
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<tr>
<td>Prepare clinical staff if additional preceptors are needed</td>
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<tr>
<td>Ensure participants have been invited (include information on Travel reimbursement, per diem, lodging facilities, etc.)</td>
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<tr>
<td>Ensure any consultants needed (WHERE APPROPRIATE) are Arranged for (scope of work and contracts, etc.)</td>
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<tr>
<td>Ensure logistics are being managed: Included dietary needs, travel 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

<table>
<thead>
<tr>
<th>Ensure that the necessary workshop materials are prepared in time</th>
<th>Facilitators materials</th>
<th>Participants materials</th>
<th>Workshop supplies</th>
<th>Reference documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure the day before that all the necessary models, instruments and supplies are in good condition and will be available</td>
<td></td>
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<tr>
<td>Ensure needed supplies are in place for projection of AV materials (extension cords, power supply, surge protector)</td>
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<tr>
<td>Ensure that participant certificates of qualification or participation</td>
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<tr>
<td>SHORTLY BEFORE</td>
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<td>-------------------------------------------------------------------------------</td>
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<tr>
<td>Review any workshop needs assessment or learning needs</td>
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<tr>
<td>assessment information</td>
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<tr>
<td>Review course materials and adapt if needed</td>
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<tr>
<td>Review pre- and post- assessments for accuracy, practice skills</td>
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<tr>
<td>Reconfirm clinical workshop site arrangements</td>
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<tr>
<td>Reconfirm role of consultants</td>
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<tr>
<td>Meet with Facilitators to coordinate roles and responsibilities</td>
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<tr>
<td>Ensure workshop manuals/reference resource materials are there</td>
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<tr>
<td>Prepare certificates for statements of qualification or participation</td>
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<tr>
<td>Visit classroom and arrange it, check supplies and equipment</td>
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</tbody>
</table>
Appendix 4: Thinking about my values worksheet

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 service

Racial/Ethnic  [ ]  Family who raised you  [ ]
Professional  [ ]  Activist community  [ ]
Religious/spiritual  [ ]  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  [ ]
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*
MATERNITY OPEN DAYS: CLARIFYING MISCONCEPTIONS ABOUT CHILDBIRTH

Maternity Open Days provide an opportunity for pregnant women and their families to interact with health care providers and visit the maternity unit to demystify birthing practices and mitigate any fears regarding childbirth in a facility.

WHY MATERNITY OPEN DAYS?
Fear of mistreatment and misconceptions about the procedures required to assist women during childbirth negatively influence their decisions to seek care at a health facility. This approach brings together women, their families and providers to enable pregnant women to understand what happens in a maternity unit. Misunderstandings, myths and misconceptions of the birthing process were indicated in the baseline findings:

- Some clinical aspects of labor, delivery and postnatal care were perceived as disrespectful by men and women.
- The consequences of this result in fear of clinical procedures. Providers may also lack empathy and perceive women as being uncooperative.

OBJECTIVES
Maternity Open Days are designed to:
- Promote mutual understanding between community members and service providers.
- Improve knowledge and demystify procedures during labor, childbirth and the immediate postnatal period.

HOW TO HOLD A MATERNITY OPEN DAY
- Agree on a suitable date for the open day with health facility managers and community leaders.
- Send invitations through the existing community information systems.
- Invite pregnant women and their families to visit the maternity unit in order to share information on labor and delivery procedures.
- Arrange simple refreshments to be made available (if possible).
- Offer screening for other diseases (cervical and prostate cancer) to encourage attendance.
- Invite community leaders and health providers to speak about care and treatment in the maternity unit. Allow for discussion to try and dispel any misconceptions or rumors.
- During the maternity unit tour, ensure that privacy and confidentiality of mothers in labor are maintained.
- Following a tour of the maternity units, midwives and other health care providers engage with community members through a question and answer session about what women should expect when they come to give birth in the maternity units.
Appendix 6: Psychological debriefing – Caring for the Carers

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

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

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

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

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

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

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

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

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

Expectations/narrative/facts phase

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

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

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

Impressions and thoughts phase

The leader focuses on the participants’ thinking and decision making by asking this question: What was your first thought upon encountering or learning about the event?

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

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

Emotional reaction phase

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

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

Normalization/education phase

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

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

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

**Conclusion**
Psychological debriefing accelerates the recovery of normal people experiencing normal reactions to abnormal events.
Appendix 7: WRA's The Universal Rights of Childbearing Women

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

RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN

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 INFORMED CONSENT AND REFUSAL, AND RESPECT FOR HER CHOICES AND PREFERENCES, INCLUDING COMPANIONSHIP DURING MATERNITY CARE; NO ONE CAN FORCE YOU OR DO THINGS TO YOU WITHOUT YOUR KNOWLEDGE AND CONSENT

3. Every woman has the right to PRIVACY AND CONFIDENTIALITY; NO ONE CAN EXPOSE YOU OR YOUR PERSONAL INFORMATION

4. Every woman has the right to BE TREATED WITH DIGNITY AND RESPECT; NO ONE CAN HUMILIATE OR VERBALLY ABUSE YOU

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.

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

For more information visit: www.whiteribbonalliance.org/respectfulcare
Appendix 8: Maternity client exit interview

Questionnaire Number 

Date. 

Facility. 

Mode of delivery. 

Condition of baby. 

Condition of mother. 

Instructions

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

Introduction

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

<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>
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</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>
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</tr>
<tr>
<td>3. Did the service provider physically examine you a. immediately after delivery?</td>
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</tr>
<tr>
<td>b. within 6 hours in the ward?</td>
<td></td>
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</tr>
<tr>
<td>4. Was privacy offered during examination and childbirth?</td>
<td></td>
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</tr>
<tr>
<td>5. Did the service provider explain the results of the health examination?</td>
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</tr>
<tr>
<td>Did any service provider tell you when you should return for another visit? Specify which services.</td>
<td></td>
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<tr>
<td>6. Do you feel you were offered adequate care a. on admission?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>b. during labor and delivery?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>c. after delivery?</td>
<td></td>
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</tr>
<tr>
<td>7. Did you feel that the providers who attended to you used appropriate/friendly language?</td>
<td></td>
<td></td>
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<tr>
<td>8. Do you feel that the service providers responded in a timely way any time you called for help?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. On which day after delivery were you discharged?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) 1st day (within 24 hours)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b) 2nd day</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>c) 3rd day and beyond</td>
<td></td>
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<tr>
<td>11. If the response is 3rd day and beyond indicate why?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do you have any suggestions on areas that can be improved?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I appreciate your time, participation, and insights during this interview.
Appendix 9: Harmonized quality improvement standards

HARMONIZED QUALITY IMPROVEMENT STANDARDS

AFGHANISTAN

NORMAL LABOR, CHILD BIRTH AND IMMEDIATE NEWBORN CARE

DISTRICT HOSPITAL (DH)

2015
## Part one: Rapid assessment of pregnant women during labor

1. *The provider perform rapid initial assessment of pregnant women in labor and prioritize admissions.*

<table>
<thead>
<tr>
<th>PERFORMANCE STANDARDS</th>
<th>VERIFICATION CRITERIA</th>
<th>1-0-NA</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>The provider perform rapid initial assessment of pregnant women in labor and prioritize admissions.</strong></td>
<td>Observe in the registration/admission and/or in the examination room, or in the emergency room, during a period of time the provider perform rapid assessment of pregnant mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>1.1</em></td>
<td>Greets the women/ husband or companion in a cordial manner, Introduces her/himself and talk her with local language</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>1.2</em></td>
<td>Insure privacy( door is close, and confidentiality, the woman id covered and existing of curtain) and confidentiality (the woman document is keep secured)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions for the assessor:** For any verification criteria fill in each unblocked cell with one of the following options “1” if the verification criteria is met, “0” if the verification criteria is not met or partially achieved, “NA” if Not applicable. Any cells left unfilled will be considered as missing data.
<table>
<thead>
<tr>
<th>PERFORMANCE STANDARDS</th>
<th>VERIFICATION CRITERIA</th>
<th>1-0-NA</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>*1.3</td>
<td>Explains care before any examination or procedures and take permission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*1.4</td>
<td>Determines if birth is imminent (desire to bear down, perspiration, anxiety)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Asks the woman whether she has or has had:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>Vaginal bleeding</td>
</tr>
<tr>
<td>1.6</td>
<td>Rupture of membranes</td>
</tr>
<tr>
<td>1.7</td>
<td>Convulsions</td>
</tr>
<tr>
<td>1.8</td>
<td>Severe headache and blurred vision</td>
</tr>
<tr>
<td>1.9</td>
<td>Severe abdominal pain</td>
</tr>
<tr>
<td>1.10</td>
<td>Respiratory difficulty</td>
</tr>
<tr>
<td>1.11</td>
<td>Fever</td>
</tr>
<tr>
<td>1.12</td>
<td>Records the information on woman’s clinical history</td>
</tr>
</tbody>
</table>

**Total:**

**Cumulative % of part one:** Rapid assessment of 1st part

**Part two:** History and Examinations
<table>
<thead>
<tr>
<th>PERFORMANCE STANDARDS</th>
<th>VERIFICATION CRITERIA</th>
<th>1-0-NA</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. <strong>The provider properly reviews and fills out the clinical history of the woman in labor</strong></td>
<td>Observe one woman in labor and determine whether the provider review and record the clinical history of the woman in labor (in the labor and delivery rooms):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1 Previous births by caesarean section, forceps, or vacuum</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2 Other general medical problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3 Use of medications or herbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4 Background of the woman and her partner with regard to sexually transmitted infections (STIs)/HIV and tuberculosis (TB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.5 Gestational age, last menstrual period (LMP), and estimated date of childbirth (EDC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.6 Asks the woman about her labor:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.7 Avoids asking questions during contractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.8 When the painful regular contractions began</td>
<td></td>
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<tr>
<td></td>
<td>2.9 How frequently they are occurring</td>
<td></td>
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<tr>
<td></td>
<td>2.10 If her “bag of waters” broke: when, what color, and what smell it had</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>2.11 Whether she feels the baby’s movements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
<td>1-0-NA</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-----------------------</td>
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</tr>
<tr>
<td>2.12*</td>
<td>Provide information continuously about labour and delivery process, Whether she has any doubts or concerns about her labor, and responds using easy-to-understand language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.13</td>
<td>Records the information in to clinical history</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total:**

3. *The provider properly conducts the physical examination between contractions and if time allows.*

Observe one woman in labor and determine whether the provider (in the labor and delivery rooms) properly conduct the physical examination

<p>| 3.1* | Ensures privacy during the entire process of provision of care and Ensures that the woman remains covered with her robe or clothing | | |
| 3.2* | Explains to the woman and her husband/companion what the provider is going to do and encourages her to ask questions and answer the question with cordial manner | | |
| 3.3 | Asks the woman to urinate (send urine to lab) | | |
| 3.4 | Washes hands before and after examination | | |
| 3.5 | Check vital signs sign (Temperature, BP, Pulse, RR) | | |
| 3.6 | Checks the conjunctiva and palms of hands for anemia | | |
| 3.7 | If the woman did not receive ANC visits, send the blood sample for RH factor, HB, HIV test | | |
| 3.8 | Sends blood for hemoglobin test if suspicious of anemia | | |</p>
<table>
<thead>
<tr>
<th>PERFORMANCE STANDARDS</th>
<th>VERIFICATION CRITERIA</th>
<th>1-0-NA</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.  * The provider properly conducts the obstetric examination between contractions</td>
<td>Observe the provider perform obstetric examination properly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Observes the shape and size of the abdomen and checks for the presence of scars</td>
<td></td>
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<tr>
<td>4.2 Determines fetal lie and presentation</td>
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<tr>
<td>4.3 Identifies degree of engagement by abdominal palpation (from five to zero fingers above the pubis)</td>
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<tr>
<td>4.4 Evaluates uterine contractions (frequency and duration over a 10-minute period)</td>
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<tr>
<td>4.5 Auscultates fetal heart rate (FHR)</td>
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<tr>
<td>4.6 Records the results of the obstetric examination on the clinical history and partograph if cervical dilation is 4 cm or more</td>
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<tr>
<td>4.7* Explains her findings to the woman/husband/companion and encourage them to ask question</td>
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<tr>
<td>Total:</td>
<td></td>
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<tr>
<td>Observe one woman in labor and determine whether the provider in the labor and delivery rooms: conduct vaginal examination properly</td>
<td></td>
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<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
<td>1-0-NA</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-----------------------</td>
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</tr>
<tr>
<td>5. The provider properly conducts a vaginal examination.</td>
<td>5.1* Explains to the woman in easy-to-understand language what is going to do and encourage woman to ask question, answer the woman question with cordial manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.2 Washes hands with soup/alcoholic hand rub</td>
<td></td>
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<tr>
<td></td>
<td>5.3 Puts new clean examination gloves</td>
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<tr>
<td></td>
<td>5.4 Examines the vulva (blood, liquid, secretion)</td>
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<tr>
<td></td>
<td>5.5 Cleanses the perineum with nonalcoholic antiseptic solution using the hand that will not be used to perform the examination</td>
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<tr>
<td></td>
<td>5.6 Uses the thumb and index finger of the non-exam hand to separate the labia</td>
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<tr>
<td></td>
<td>5.7 carefully inserts two lubricated fingers of the exam hand into the vagina and does not withdraw fingers until the examination has concluded</td>
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<tr>
<td></td>
<td>5.8 Assesses cervical dilatation, molding, and station of presenting part and carefully withdraws her fingers once the examination has concluded</td>
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<tr>
<td></td>
<td>5.9* Explains to the woman her findings and what they mean</td>
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<td></td>
</tr>
</tbody>
</table>
### PERFORMANCE STANDARDS | VERIFICATION CRITERIA | 1-0-NA | COMMENTS
--- | --- | --- | ---
5.10 | If gloves are disposable, immerses both gloved hands in a 0.5% chlorine solution, removes gloves by turning inside out, and places them in a container with a plastic liner; if they are reusable, immerses them in a 0.5% chlorine solution for at least 10 minutes before transferring them for sterilization |  |  |

**Total**

**Cumulative % of part three:** History and examination

**Part Three:** Prepare for delivery

6. *The provider prepares mother for delivery according to the findings*  

<table>
<thead>
<tr>
<th></th>
<th>Observe one woman in labor and determine whether the provider in the labor and delivery rooms:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1*</td>
<td>Who she would like to have as a companion during labor and birth (one person)</td>
</tr>
<tr>
<td>6.2*</td>
<td>What position she prefers to adopt during labor and birth as appropriate</td>
</tr>
<tr>
<td>6.3*</td>
<td>What did she bring to eat and/or drink</td>
</tr>
<tr>
<td>6.4*</td>
<td>Implements the birth plan, instructing the woman about the importance of</td>
</tr>
<tr>
<td>6.5*</td>
<td>Going to the bathroom often to empty her bladder</td>
</tr>
<tr>
<td>6.6*</td>
<td>Taking liquids and light foods whenever she wants</td>
</tr>
<tr>
<td>6.7*</td>
<td>Walking and changing position according to desire and comfort</td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td>7. The provider uses the partograph to monitor labor and make adjustments to the birth plan</td>
<td>Observe / review the previous partograph whether the provider uses the partograph and record the finding every 30 minutes</td>
</tr>
<tr>
<td></td>
<td>7.1 Name</td>
</tr>
<tr>
<td></td>
<td>7.2 Gravida, para</td>
</tr>
<tr>
<td></td>
<td>7.3 Hospital number</td>
</tr>
<tr>
<td></td>
<td>7.4 Date and time of admission</td>
</tr>
<tr>
<td></td>
<td>7.5 Time of ruptured membranes, If has ruptured</td>
</tr>
<tr>
<td></td>
<td>7.6 Controls and Records every half hour</td>
</tr>
<tr>
<td></td>
<td>7.7 FHR in every one minute</td>
</tr>
<tr>
<td></td>
<td>7.8 Uterine contractions (frequency and duration over a 10-minute period)</td>
</tr>
<tr>
<td></td>
<td>7.9 Maternal pulse</td>
</tr>
<tr>
<td></td>
<td>7.10 Records temperature every two hours</td>
</tr>
<tr>
<td></td>
<td>7.11 Records BP every four hours</td>
</tr>
<tr>
<td></td>
<td>7.12 Vaginal examination (every four hours or less according to evolution of labor):</td>
</tr>
<tr>
<td></td>
<td>7.13 Records the condition of the membranes and characteristics of the amniotic fluid</td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>7.14</td>
<td>Graphs cervical dilation</td>
</tr>
<tr>
<td>7.15</td>
<td>Graphs the degree of molding of the head</td>
</tr>
<tr>
<td>7.16</td>
<td>Graphs the descent of the head or buttocks</td>
</tr>
<tr>
<td>7.17</td>
<td>Records the amount of urine output</td>
</tr>
<tr>
<td>7.18</td>
<td>Adjusts the labor plan according to the parameters encountered</td>
</tr>
<tr>
<td>7.19</td>
<td>If parameters are normal, continues to implement the plan (walk about freely, hydration, light food if desired, change positions, etc.) OR</td>
</tr>
<tr>
<td>20</td>
<td>If parameters are not normal, identifies complications, records the diagnosis and makes adjustments to the birth plan (refer to management of complications)</td>
</tr>
</tbody>
</table>

Total:

8. The provider prepares to assist the birth.

Observe one woman in labor and determine whether the provider (in the labor or delivery rooms) has prepared the following equipment:

**Newborn kit**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Table for new born resuscitation with warmer equipment</td>
</tr>
<tr>
<td>8.2</td>
<td>Ambo back</td>
</tr>
<tr>
<td>8.3</td>
<td>Mask for new born size 0 and 1</td>
</tr>
<tr>
<td>8.4</td>
<td>Tetracycline Eye Pomade</td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8.5</td>
<td>Chlorhexidine Di gluconate 7.1 %</td>
</tr>
<tr>
<td>8.6</td>
<td>Thermometer</td>
</tr>
<tr>
<td>8.7</td>
<td>Statoscope</td>
</tr>
<tr>
<td>8.8</td>
<td>Sterile gauze to clean baby’s mouth and nose</td>
</tr>
<tr>
<td>8.9</td>
<td>Suction</td>
</tr>
<tr>
<td>8.10</td>
<td>Oxygen balloon ( if available )</td>
</tr>
<tr>
<td>8.11</td>
<td>Two large and dry towel</td>
</tr>
<tr>
<td>8.12</td>
<td>One small towel</td>
</tr>
<tr>
<td>8.13</td>
<td>Newborn cap</td>
</tr>
<tr>
<td>8.14</td>
<td>Two pairs examination gloves</td>
</tr>
<tr>
<td><strong>Delivery kit</strong></td>
<td></td>
</tr>
<tr>
<td>8.15</td>
<td>Sterile tray</td>
</tr>
<tr>
<td>8.16</td>
<td>One sponge Forceps for cleaning of perineum</td>
</tr>
<tr>
<td>8.17</td>
<td>Two hemostats (clamps)</td>
</tr>
<tr>
<td>8.18</td>
<td>One scissors</td>
</tr>
<tr>
<td>8.19</td>
<td>One cord clamp or sterile tape or sterile tie</td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8.20</td>
<td>Two sterile towels</td>
</tr>
<tr>
<td>8.21</td>
<td>One syringe with 10 IU of oxytocin</td>
</tr>
<tr>
<td>8.22</td>
<td>Two pairs of sterile or HLD gloves</td>
</tr>
<tr>
<td>8.23</td>
<td>Containers in order to dispose the materials which used in delivery (refer to IP standards)</td>
</tr>
<tr>
<td>8.24*</td>
<td>Ensures the privacy (she remains covered with a sheet,Separates the area with curtains, sheets, or screens, as appropriate) Ensures that the minimum number of individuals are present during birth woman)</td>
</tr>
<tr>
<td>8.25*</td>
<td>Ensures that the minimum number of individuals are present during birth (the provider attending the birth and a family member—the individual chosen by the woman)</td>
</tr>
<tr>
<td>8.26*</td>
<td>The provider behave to the woman with cordial manner and Encourages the mother to ask questions and respond in easy-to-understand language</td>
</tr>
</tbody>
</table>

**Total**

**Cumulative % of part Three**: Prepare for delivery

**Part four**: Management of delivery

Observe one woman during a delivery and determine whether the provider (in the labor or delivery rooms):
<table>
<thead>
<tr>
<th>PERFORMANCE STANDARDS</th>
<th>VERIFICATION CRITERIA</th>
<th>1-0-NA</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. <em>The provider assists the woman to have a safe and clean birth.</em></td>
<td><strong>9.1</strong> Monitors, or has assistant monitor, FHR every five minutes during second stage. Or monitors every 15 minutes in case of normal FHR and absence of meconium</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>9.2</strong> Cleanses the perineum with water or a nonalcoholic antiseptic solution</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*<em>9.3</em> **Allows the woman to bear down when she feels the desire (does not force her to bear down) and avoid from abusive words</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>9.4</strong> Performs an episiotomy only if necessary (breech, shoulder dystocia, forceps, vacuum, poorly healed 3rd or 4th degree tear, or fetal distress)</td>
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</tr>
<tr>
<td></td>
<td><strong>9.5</strong> Allows the head to spontaneously crown while guarding the perineum</td>
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<tr>
<td></td>
<td><strong>9.6</strong> After the emergence of the head, asks the woman to briefly refrain from bearing down (open mouth breathing)</td>
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<td></td>
<td><strong>9.7</strong> Cleans the baby’s mouth and nose using a sterile gauze if meconium present</td>
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<td></td>
<td><strong>9.8</strong> Quickly palpates to determine nuchal cord:</td>
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<td></td>
<td><strong>9.9</strong> if it is loose, slides it over the baby’s head,</td>
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<td></td>
<td><strong>9.10</strong> if it is very tight, clamps it in two places and cuts it before unraveling it from around the baby’s neck</td>
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</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
<td>1-0-NA</td>
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<tr>
<td>9.11</td>
<td>Allows spontaneous external rotation without manipulation if it happens quickly</td>
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<tr>
<td>9.12</td>
<td>Carefully takes the baby’s head in both hands and applies downward traction until the anterior shoulder has emerged (no neck holding)</td>
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<tr>
<td>9.13</td>
<td>Guides the baby’s head and chest upward until the posterior shoulder has emerged</td>
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</tr>
<tr>
<td>9.14</td>
<td>Holds the baby by the trunk and places it on a sterile towel on the mother’s abdomen</td>
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<td></td>
</tr>
<tr>
<td>9.15</td>
<td>Dries baby vigorously, assesses the baby’s breathing, changes wet towel for a clean dry one and cover the head of baby with cap</td>
<td></td>
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</tr>
<tr>
<td>9.16</td>
<td>Guided the mother which how to hold the baby</td>
<td></td>
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</tr>
<tr>
<td>9.17</td>
<td>Clamps and cuts the cord after at least 1 minute or when pulsations stop</td>
<td></td>
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</tr>
<tr>
<td>9.18</td>
<td>Use pomade chlorhexidine 7.1% on umbilical cord</td>
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<td></td>
</tr>
<tr>
<td>9.19</td>
<td>Enthusiastically informs mother of the sex of her child (with same enthusiasm if male or female) and shows sex of baby to mother</td>
<td></td>
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</tr>
<tr>
<td>9.20</td>
<td>Passes the wrapped baby to mother for skin-to-skin contact on breast and to initiate breastfeeding</td>
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<tr>
<td>9.21</td>
<td>Notes the date and time of delivery</td>
<td></td>
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<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
<td>1-0-NA</td>
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</tr>
<tr>
<td>9.22</td>
<td>If baby does not begin breathing (Apneic) or gasping or having respiratory less than 20/min, asks for assistance, rapidly cuts and ties the cord, immediately inject mother with 10U oxytocin or advice 600 microgram misoprostol at 1st minute of delivery and initiates resuscitation( see the new born resuscitation standards)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.23*</td>
<td>Informs the husband/parents/relatives of the baby’s condition, If her medical condition allows, informs the mother</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**

**10. *The provider adequately performs active management of the third stage of labor***

<p>| 10.1                  | Touches the mother’s abdomen to rule out the presence of a second baby (without stimulating contractions)                                                                                                                 |        |          |
| 10.2                  | Tells the woman that she will receive an injection of oxytocin, Administers 10 IU of oxytocin IM                                                                                                                                 |        |          |
| 10.3                  | Re-clamps the cord near the perineum and Holds the cord and clamp with one hand                                                                                                                                 |        |          |
| 10.4                  | Places the other hand on the woman’s symphysis pubis (over the sterile towel) and gently pushes upward in the direction of her abdomen                                                                                   |        |          |
| 10.5                  | Maintains firm traction on the cord and waits for the uterus to contract                                                                                                                                            |        |          |</p>
<table>
<thead>
<tr>
<th>PERFORMANCE STANDARDS</th>
<th>VERIFICATION CRITERIA</th>
<th>1-0-NA</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.6</td>
<td>Upon contraction, applies firm and sustained downward traction on the cord with counter force above the pubis to guard the uterus, until the placenta is expelled</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>10.7</td>
<td>If this maneuver does not provide immediate results, ceases to apply traction, holding the cord and clamp until the next contraction</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>10.8</td>
<td>Repeats controlled cord traction while simultaneously applying counter pressure above pubis to guard uterus</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>10.9</td>
<td>With both hands, assists in the expulsion of the placenta, by turning it over in the hands, without applying traction, “teasing out” the membranes and insure from completeness</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>10.10*</td>
<td>Immediately tells the woman what she is going to do and:</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>10.11</td>
<td>Massages the uterus with one hand on a sterile cloth over the abdomen, until the uterus contracts firmly</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**Total**

**Cumulative % of part four:** Management of delivery

**Part Five:** Immediate Mother and Newborn Care

**11.  *The provider adequately performs immediate postpartum care***

<table>
<thead>
<tr>
<th>Observe one woman during a delivery and determine whether the provider (in the labor or delivery rooms):</th>
</tr>
</thead>
<tbody>
<tr>
<td>*11.1  Inform the woman what she is going to do before proceeding, then carefully examines the vagina and perineum</td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>11.2*</td>
</tr>
<tr>
<td>11.3</td>
</tr>
<tr>
<td>11.4</td>
</tr>
<tr>
<td>11.5</td>
</tr>
<tr>
<td>11.6*</td>
</tr>
<tr>
<td>11.7*</td>
</tr>
<tr>
<td>11.8</td>
</tr>
<tr>
<td><strong>total:</strong></td>
</tr>
<tr>
<td>12. The provider properly monitors the newborn in immediate postpartum period</td>
</tr>
<tr>
<td>12.1</td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>12.2</td>
</tr>
<tr>
<td>12.3</td>
</tr>
</tbody>
</table>

**Total:**

<table>
<thead>
<tr>
<th>13. The provider closely monitors the woman for at least two hours after the birth.</th>
<th>Observe the women after the delivery and determine whether the provider:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>Keeps the woman in a place within the labor and delivery ward to be monitored for at least two hours after the birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.2</td>
<td>Monitors the woman every 15 minutes after delivery at first hour and every one hours at second –four hour after delivery and then every 4 hours up to 24 hours in checking:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.3</td>
<td>Uterine tone</td>
<td></td>
<td></td>
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<tr>
<td>13.4</td>
<td>Vaginal bleeding</td>
<td></td>
<td></td>
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<tr>
<td>13.5</td>
<td>BP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.6</td>
<td>Pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
<td>1-0-NA</td>
<td>COMMENTS</td>
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<td>-----------------------</td>
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</tr>
<tr>
<td>13.7</td>
<td>Bladder distention</td>
<td></td>
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<tr>
<td>13.8</td>
<td>Performs initial management in the event of hemorrhage( refer to PPH standards)</td>
<td></td>
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<tr>
<td>13.9</td>
<td>Records the information on woman’s clinical record</td>
<td></td>
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<tr>
<td></td>
<td><strong>Total:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. The provider properly performs new born care and perform resuscitation of the newborn if required</td>
<td>By observation, or by using a clinical simulation with a model, determine whether the provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.1</td>
<td>Quickly wraps and covers the baby, except for the face and the upper portion of the chest and remove the wheat clothe, monitor newborn breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.2</td>
<td>Positions the head of the baby so that the neck is slightly extended, which may be achieved by placing a rolled up piece of cloth under the baby’s shoulders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.3</td>
<td>Quickly sucks the baby's mouth and then nose (does not sucks deep in the throat which may cause bradycardia)</td>
<td></td>
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</tr>
<tr>
<td>14.4</td>
<td>Stimulate with hand across the baby back. If the baby does not start to breathe, clump the umbilical cord and shift baby to resuscitation table for assisted ventilation. Insure during ventilation the baby is covered except chest</td>
<td></td>
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</tr>
<tr>
<td>14.5</td>
<td>If the baby does not breathe quickly initiates ventilation</td>
<td></td>
<td></td>
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<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
<td>1-0-NA</td>
<td>COMMENTS</td>
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</tr>
<tr>
<td>14.6</td>
<td>In the event of resuscitation with bag and mask or tube and mask:</td>
<td></td>
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</tr>
<tr>
<td>14.7</td>
<td>Places the mask so it covers the baby’s chin, mouth, and nose</td>
<td></td>
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<tr>
<td>14.8</td>
<td>Ventilates one or two times and sees if chest is rising</td>
<td></td>
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<tr>
<td>14.9</td>
<td>Ventilates 40 times per minute for 1 minute</td>
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<tr>
<td>14.10</td>
<td>Pauses and determines whether the baby is breathing spontaneously</td>
<td></td>
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</tr>
<tr>
<td>14.11</td>
<td>If the baby is breathing and there is no sign of respiratory difficulty (intercostal retractions or grunting), place the baby in skin-to-skin contact with mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.12</td>
<td>If the baby does not begin to breathe, Assesses the need for special care(Positions the head of the baby, Places the mask, sucks the baby's mouth and then nose, Continues to ventilate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.13</td>
<td>If the baby does not begin to breathe or if breathing is less than 30/min minute and hearth rate is less than 100, gasping or cheats in drawing, ventilate with oxy gen if needed, quickly refer to newborn equipped center</td>
<td></td>
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<tr>
<td>14.14</td>
<td>Explains to the mother what is happening, if possible</td>
<td></td>
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</tr>
<tr>
<td>PERFORMANCE STANDARDS</td>
<td>VERIFICATION CRITERIA</td>
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<td>COMMENTS</td>
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<tr>
<td>14.15</td>
<td>If there is no breathing after 10 minutes of ventilation and no hearth sound or newborn hearth rate is continuously less the 60 or the baby is not breathing spontaneously after 20 minutes ventilation, after that stop resuscitation</td>
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<tr>
<td>14.16</td>
<td>Records the time of death</td>
<td></td>
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<tr>
<td>14.17</td>
<td>Provides emotional support to mother/parents and family members</td>
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<tr>
<td>14.18</td>
<td>Record all actions taken on the woman’s clinical record</td>
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</tbody>
</table>

Total:

**Cumulative % of part Five: Immediate Mother and Newborn Care**

Total of standards: 14
Total of parts: 6

Cumulative % of part one (Rapid assessment of pregnant women during labor)

Cumulative % of part two (History and examination)

Cumulative % of part three (prepare for delivery)
<table>
<thead>
<tr>
<th>PERFORMANCE STANDARDS</th>
<th>VERIFICATION CRITERIA</th>
<th>1-0-NA</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>Cumulative % of part four (Management of Delivery)</td>
<td></td>
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<tr>
<td>Cumulative % of part five (Immediate Mother and Newborn Care)</td>
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<tr>
<td>Cumulative % of Normal labor area</td>
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</table>
Appendix 10: action plan template

**ACTION PLAN for IMPROVING QUALITY of CARE**

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Health Facility</th>
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<tbody>
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<td>____________________</td>
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</table>

Gaps in quality of care are identified if something is NOT seen or practiced. All the areas marked 'No' require to be analyzed then an intervention to close the gap identified, resources needed listed and an accountable person identified.

<table>
<thead>
<tr>
<th>GAP</th>
<th>REASON/CAUSE</th>
<th>RESOURCES NEEDED</th>
<th>RESPONSIBLE PERSONS/INSTITUTION FOR PROVISION OF RESOURCES</th>
<th>BY WHEN</th>
</tr>
</thead>
<tbody>
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</table>
Appendix 11: Terms of reference for health facility quality improvement committee

Islamic Republic of Afghanistan
Ministry of Public Health
General Directorate of Curative Medicine
Improving Quality in Health Care Unit (IQHC)

Health Facility Quality Improvement (HFQI) Committee
Terms of Reference

Background:

The Ministry of Public Health (MoPH) of the Government of Afghanistan has established a clear mission “to improve the health of the people through quality health care services provision and the promotion of healthy life styles in an equitable and sustainable manner”. In order to achieve this goal, the MoPH and donors have introduced and implemented a number of different strategies, tools and methodologies aimed at improving the quality of health care services. A national strategy for improving quality in health care was developed and formally introduced across the country in 2011. To ensure smooth implementation of the IQHC strategy, there is a need to establish quality improvement committees at provincial and health facility levels. Quality Improvement Committees (Teams) currently exist in several hospitals in Kabul and 13 other provinces. The IQHC Unit is seeking to revitalize the current committees with slightly modified roles and responsibilities.

Purpose:

The purpose of the Health Facility QI Committee is to oversee the quality of healthcare within hospitals and ensure links/liaison with other HFQI teams, the Provincial QI Committee at provincial level and the IQHC Unit at central level.

Membership and Representation:

The HFQI Committee will have representation from different departments of health facility, hospital/facility managers and community health shura members.

This committee will be chaired by the manager of the health facility (e.g. Hospital Director and his/her deputy/appointee) or the QI focal point of the health facility. It is worth mentioning that the job description of the QI focal point will be revised in close coordination
between the IQHC unit and HRD, to reflect quality-related responsibilities. This committee will meet on a weekly basis or even more frequently as needed.

Roles and Responsibilities:

The Health Facility QI Committees will be responsible for overseeing the quality of healthcare within hospitals. Sub-Committees will then be created and mandated with overseeing quality improvement activities. Examples of these sub-committees include Medical Records Sub-Committee, Maternal Death Review Sub Committee, Adverse Events and Near-Miss reporting system that includes analysis, distilling of lesson learned dissemination of findings and action to reduce further risk. Organized into periodic meetings, these sub-committees will provide quality improvement recommendations with hospital leadership and aid in the implementation of these activities. The HFQI Committee has the following role and responsibilities:

1. Oversee the quality of healthcare within hospitals.
2. Ensure the implementation of the harmonized quality approach and prioritize quality-related interventions at health facility level.
3. Ensure that a responsive complaint management system is in place at health facility.
4. Ensure a proper quality-related data recording and reporting system.
5. Implementation of patient safety mechanism such as safe surgery checklist.
6. Ensure client-centered services by promotion of patient charter of right at health facility.
7. The minutes of all meetings will be collected, recorded and maintained by the facility focal point for improvement and local decision making purposes.
8. Establish links with existing structures mentioned above such as Maternal Death Review Sub-committee.
Appendix 12: MoPH position paper for promoting RMC

Ministry of Public Health
Position Paper: promoting respectful maternity care (RMC) and reducing disrespect and abuse (D&A) of women during facility-based childbirth.

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care (WHO 2014).

Summary
Advancing respectful dignified care is a priority for Afghanistan in efforts to increase facility birth and ensure effective implementation of women’s rights in health services. Despite overall advances in maternal health outcomes, ensuring women have skilled and respectful care during delivery remains a challenge. Mistreatment in childbirth is a major barrier to women accessing facility based care. It is critical for the MOPH in Afghanistan to consider how it can prevent such mistreatment, and better meet women’s socio-cultural, emotional and psychological needs as part of broader efforts to provide better quality care.

The definition of RMC
Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination. Defining the mistreatment of women during childbirth is complex and contextual. Any definition needs to adequately capture the interactions or facility conditions that local consensus seems to be humiliating or undignified and have a health, human rights, legal and sociocultural dimension.

Key Issues
Respectful Maternity Care (RMC) is an integral element of comprehensive high-quality, safe and person-centered maternal health care yet many women experience disrespectful and abusive (D&A) treatment in facilities worldwide. In Afghanistan perceptions of being treated disrespectfully was identified as a factor in care seeking.

The WHO statement on ‘prevention and elimination of D&A during facility-based childbirth’ in 2014 followed by the systematic review of mistreatment (Bohren 2015)³

---

¹ Rahmani and Brekke 2013 Antenatal and obstetric care in Afghanistan – a qualitative study among health care receivers and health care providers.
² WHO 2014 The prevention and elimination of disrespect and abuse during facility-based childbirth
• **Strengthen provider support, regulation and professional ethics**
  - Ensure supportive policies and regulations for enabling working environment
  - Ensure rapid operationalization of regulatory bodies
  - Leveraging professional associations especially AFSOG and AMA

• **Expand efforts to link RMC with quality improvement efforts** e.g. the WHO QOC framework (2015) emphasizes the “experience of care” to ensure RMC is addressed in service provision. See Annex A.

• **Advocate for strengthening cross-sectoral approaches to rights based approaches**

• **Test and evaluate promising approaches to addressing D&A**

**Implications and Challenges**

• Behavior change
• Normalized cultures

**Next Steps**

- Train health care professionals, policy makers, advocacy groups and EPHS & BPHS implementers on promoting Respectful Maternity Care package (facility based).
- Train health care professionals, community health workers, community members, advocacy groups and BPHS implementers on promoting Respectful Maternity Care package (community based).
- Integrate RMC component in RH strategy
- Integrate RMC in RH In-service training package
## Annex 13: Member of Respectful Maternity Care Orientation Package Working Group

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dr. Zelaikha Anwari</td>
<td>Acting Director</td>
<td>Reproductive, Maternal, Newborn, Child and Adolescent Health Directorate - MoPH</td>
</tr>
<tr>
<td>2</td>
<td>Dr. Zohra Shamszai</td>
<td>Maternal and Neonatal Healthcare Manager</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>RM. Najiba Zafari</td>
<td>Midwifery Program Coordinator</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Dr. Ahmad Shaker Hadad</td>
<td>Training Coordinator</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Dr. Naila Ghazi</td>
<td>Maternal Health Senior Officer</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dr. Farzana Qayomi</td>
<td>Reproductive Health Coordinator</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>RM. Muniba</td>
<td>Midwife in training department</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Dr. Nilofar Barekzai</td>
<td>Senior officer</td>
<td>HPD-MoPH</td>
</tr>
<tr>
<td>9</td>
<td>RM. Amina Sultan</td>
<td>Midwifery Specialist</td>
<td>Midwifery and Nursing Department - MoPH</td>
</tr>
<tr>
<td>10</td>
<td>Dr. Sayed Masoud</td>
<td>National CBHC program focal point</td>
<td>Community Based Health Care Department - MoPH</td>
</tr>
<tr>
<td>11</td>
<td>Mrs. Qudsia</td>
<td>Program Supporter</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Dr. Karima Joyan</td>
<td>Consultant</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>RM. Mursal Musaw</td>
<td>Gender Based Violence Officer</td>
<td>Gender Directorate - MoPH</td>
</tr>
<tr>
<td>14</td>
<td>Dr. Laila Natiq</td>
<td>Quality Improvement Team Leader</td>
<td>HEMAYAT</td>
</tr>
<tr>
<td>15</td>
<td>RM. Feroza Mushtari</td>
<td>Midwifery and Nursing Manager</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Dr. Nilofar Sultan</td>
<td>Gender Coordinator</td>
<td></td>
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<tr>
<td>17</td>
<td>Mr. Qiamuddin Samadi</td>
<td>Behavior Change Communication Officer</td>
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<tr>
<td>18</td>
<td>Dr. Najibullah Naimi</td>
<td>Professional Association Strengthen Advisor</td>
<td></td>
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<tr>
<td>19</td>
<td>Dr. Farzana Maruf</td>
<td>Maternal and Newborn Advisor</td>
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References:


3. International Confederation of Midwives.


